MSF
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Somebody help

The forgotten population of Jebel Si in North Darfur is left without healthcare as MSF struggles to continue its medical activities in the region

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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Introduction

In the remote Jebel Si area of North Darfur, Médecins Sans Frontières (MSF) runs a hospital, five health posts and a mobile clinic. These are the only health facilities in the area, and serve a permanent population of 100,000, as well as about 10,000 seasonal nomads. The majority of MSF's patients in Jebel Si are women and children.

As the only medical organisation with a permanent presence in Jebel Si, the population is entirely dependent on MSF for healthcare and emergency assistance. MSF's relationship with the local community is one of mutual trust and cooperation.

Now this is under threat, as a series of obstacles are seriously hampering MSF's ability to deliver medical assistance. Vital medical and logistical supplies have been prevented from reaching the area, work permits have not been granted, and physical access of staff to the region has become increasingly difficult.

As a result of these obstacles, MSF has been forced to scale down its activities dramatically. Unless urgent steps are taken to rectify the situation, the people of Jebel Si will be faced with the reality of a future without essential healthcare.

MSF presence in Sudan

MSF in Jebel Si

MSF first started working in Darfur in 1985, and has been working in the region continuously since 2004. Currently, MSF works in various locations in North Darfur, including Kaguro, Shangil Tobaya, Tawila, Dar Zaghawa, as well as Shaeria locality in South Darfur, providing a range of services including primary and secondary healthcare, as well as responding to emergencies.

MSF began providing primary healthcare in Kaguro, in the Jebel Si area of North Darfur state, in 2005 through a health post. In 2008 MSF built a rural hospital in Kaguro, where the primary focus is on providing healthcare to mothers and children.[1] The hospital provides outpatient and inpatient care, an immunisation programme, an outpatient therapeutic feeding centre, an inpatient therapeutic feeding centre/stabilisation unit for children, a women's health clinic, and surgical treatment.

MSF also runs five health posts in the isolated mountain villages of Burgo, Bourey, Lugo, Useige and Bouley, where teams provide primary healthcare along with nutritional support and immunisations. Patients with complicated medical conditions are referred to Kaguro hospital

In numbers

In 2010

63,900 medical consultations conducted

827 children under five treated for malnutrition

809 patients admitted to inpatient department of Kaguro hospital

845 patients treated for malaria

2,862 women provided with antenatal care

In 2011

47,178 medical consultations conducted

978 children under five treated for malnutrition

370 patients admitted to inpatient department of Kaguro hospital

97 patients treated for malaria

3,422 women provided with antenatal and delivery care

Situation in Jebel Si

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In Darfur as a whole, conflict and insecurity have taken a heavy toll on the population. In the remote Jebel Si area, people suffer from their physical isolation from the region's commercial and political hubs and from an almost total absence of humanitarian aid. Major concerns for the population are food insecurity, too little water and a lack of healthcare provision.

There are no medical or humanitarian programmes in the Jebel Si area run either by national non-governmental organisations (NGOs) or governmental institutions. For international NGOs, gaining access to the conflict-affected areas of Darfur is a major challenge. An increase in security incidents, including a spate of kidnappings in 2009-10, has made the situation worse.

1
The management of the Kaguro project changed from MSF Belgium to MSF Spain in 2011.

A phantom health system

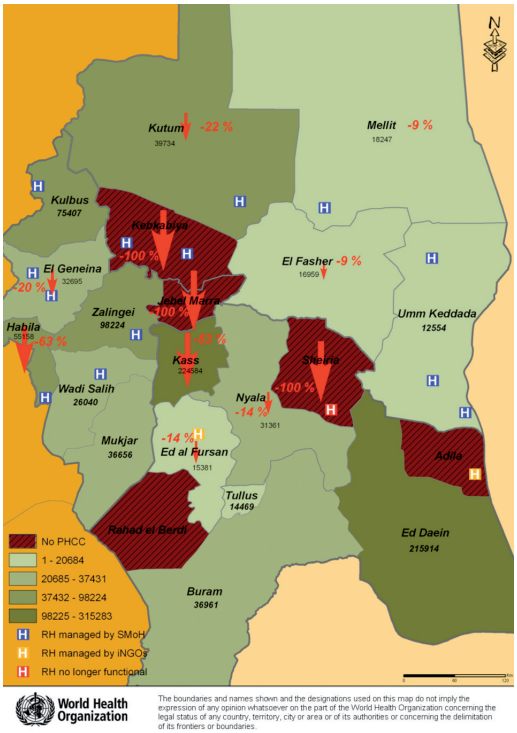
The population of the Jebel Si area has extremely poor access to medical care. MSF is the sole provider of healthcare in the region: there are no local health services, and there are no other international organisations providing medical assistance. Apart from MSF, the only healthcare available is from unqualified individuals who sell drugs at the weekly markets or provide injections – practices which are dangerous, unhygienic and carry the risk of serious infection.

The nearest Ministry of Health (MoH) facilities are several hours drive away in Kabkabiya, Tawila and El Fasher, but the mountainous terrain and the poor state of the roads can make access difficult. Referring and transporting the most complicated cases to El Fasher hospital present problems, with the capacity for referrals often limited to market days using commercial trucks. This system is extremely unreliable, as was seen in 2010 and 2011, when security issues and the rainy season stopped truck movements to and from El Fasher.

In the Jebel Si area, minimum health standards are very far from being met.[2] The number, level and location of health facilities in the Jebel Si region are clearly not appropriate to people's needs. As the World Health Organization (WHO) map below shows, no Primary Health Care Centres (PHCCs) have existed in the Jebel Marra and Kabkabiya area since March 2009, when 13 international NGOs were forced to leave the country.

With MSF forced to scale down its activities, the 100,000 people of Jebel Si are in danger of being left entirely without healthcare. In such a situation, disease outbreaks become more likely, and maternal and perinatal mortality rates are likely to build up gradually until they reach emergency levels.

Decrease in functioning primary health care centers (%) and resulting availability (*persons per health facility*) on 16th of March 2009 in Darfur



Source: WHO http://www.who.int/hac/crises/sdn/maps/en/

2
Sphere minimum standards in health services:
one community health worker per 500-1,000 population at community level.
one skilled/traditional birth attendant per 2,000 population.
one peripheral health facility per 10,000 population.
one central health facility (with inpatient care and 24-hour services) per 50,000 population.
one doctor with surgical skills per referral hospital.
one nurse for 20-30 beds per shift.
Source: *Sphere Standards, Minimum Standards in health services*. P. 267
http://www.emro.who.int/sudan/media/pdf/hdbk_c5.pdf

Basic health indicators

Before MSF started working in the Jebel Si region in 2005, there were no health facilities and medical data was not collected in a systematic way. As a result, there is no available area-specific historical data on child or maternal mortality rates, nor does a detailed analysis exist of the medical needs of the population.[3]

Figures exist for Sudan as a whole. However, due to the medical and humanitarian situation in the Jebel Si area, these data are unlikely to be representative for Kaguro and its surroundings.[4]

Critical levels of maternal mortality

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In the Jebel Si area, there are an estimated 4,000 children below the age of one[5] and 24,000[6] women of childbearing age (crude birth rate: 3.1 births per 1,000 people per year).[7] Out of 4,200 pregnant women, approximately 15% (630) are likely to develop complications that require essential obstetric care and up to 5% of pregnant women (210) will require some type of surgery, including caesarean sections.[8]

At present, with MSF's activities scaled down, caesarean sections are no longer available in MSF's hospital in Kaguro. For a woman with a complicated delivery, an eight-hour journey to El Fasher could put at risk both her life and that of her baby.

MSF has worked to reduce maternal mortality rates through health education and training. Traditional health practices can be the cause of health problems for women and children. Women in the Jebel Si area traditionally deliver at home, attended by traditional birth attendants who often have a low level of education. In response, MSF has sensitised 100 traditional birth attendants in Kaguro and Useige in caring for women during pregnancy and childbirth. Health staff hired locally by MSF have also been provided with continuous training and close supervision.

3
The international NGO Action Contre La Faim (ACF) was initially charged to carry out a mortality survey, but was expelled from the country in 2009.
4
Sudan as a whole has 98% vaccination (EPI) coverage (WHO, 2008); 95% global health access; 95% of births attended by skilled health staff (2006, WHO); and an under-five mortality rate (U5MR) of 112/1000 live births (WHO, 2009). Source: http://www.who.int/countries/sdn/en/
5
Children under one year usually represent 4% of the total population.
6
Women of childbearing age usually represent 24% of the population.
7
http://www.unicef.org/infobycountry/sudan_statistics.html
8
http://www.emro.who.int/sudan/media/pdf/hdbk_c5.pdf

Massive prevalence of preventable and treatable diseases

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The Jebel Si region lies in Africa's so-called meningitis belt, and there is an outbreak of the disease every eight to ten years. The North Darfur region was last hit in 2005. However, there are no vaccines or drugs to treat meningitis available locally, and the population's only protection from the disease is afforded by its isolation. Once a single case is reported, it can quickly spread to the whole community.

Vaccination coverage in the region is very low due to frequent stock ruptures. The WHO launched a recent alert regarding a possible polio epidemic in the country,[9] while in 2011 multiple alerts were launched in North Darfur for outbreaks of diphtheria (December 2011), measles (April 2011)[10] and whooping cough (September 2011).[11]

MSF has been providing vaccinations for children (pentavalent, measles, polio) and pregnant women (tetanus toxoid 2) in collaboration with the MoH. In 2011, 4,000 children aged nine months to five years were vaccinated against polio and 6,000 children under five were vaccinated against measles. UNICEF has also been running sporadic polio vaccination campaigns through local people.

The nomadic tribes who pass through the region on their seasonal migration are not recognised by the MoH and their vaccination coverage is unknown. Between September and December 2011, there was a whooping cough outbreak among nomads in the Wadi Asum area.[12] The same nomads usually pass through the area around Kaguro.

Malaria is a disease which peaks seasonally. In the Jebel Si region, its incidence is generally low and concentrated in specific locations. During the rainy season, however, there have been wider outbreaks of the disease. In September 2011, 23.4% of all admissions to the inpatient department in Kaguro hospital were due to malaria. In the same month, an outbreak was reported in Tabit, also in North Darfur. In 2010, MSF treated 845 malaria patients in the Jebel Si region.

Since being obliged to scale down its activities, MSF is no longer able to treat complicated cases of malaria.

9
http://www.who.int/csr/don/2009_03_02a/en/index.html
10
From the minutes of the health cluster meeting in El Fasher
11
From the minutes of the health cluster meeting in El Fasher
12
From the minutes of the health cluster meeting in El Fasher

The incidence of other diseases in the region is hard to quantify. A stock rupture of the syphilis testing kit means that MSF is now unable to investigate patients' symptoms and test them for the disease. A high prevalence of bilharzia was detected and treated by MSF in Tabaldia in January 2010, following the investigation of several cases of haematuria.

Kala azar (visceral leishmaniasis) and tuberculosis (TB) are also present in the region, but there are neither laboratories for diagnosis nor drugs to treat these diseases.

For health providers, it can be very challenging to detect a disease outbreak early, respond promptly and deploy resources to contain the epidemic. Heavy outbreaks can go underreported, while responses rely on the scarce resources available in North Darfur.

The combination of low vaccination coverage, an absence of health facilities, no early warning system and living in a risk area could be fatal for the 100,000 inhabitants of the region.[13] An epidemic in the region could potentially spread beyond North Darfur towards neighbouring regions.

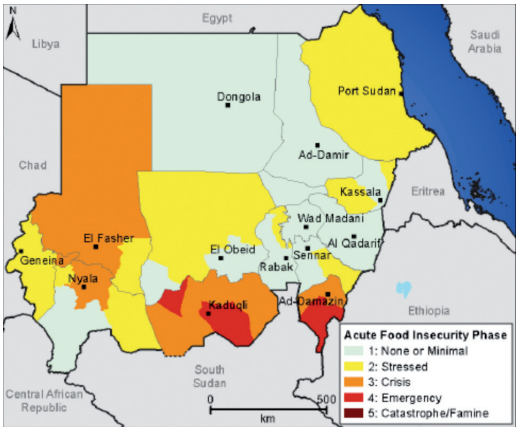
13
In the past, MSF reported suspected measles and meningitis cases to the authorities in less than 24 hours.

Food insecurity and malnutrition

By the end of 2011, the overall food security situation in North Darfur had deteriorated considerably compared to November 2010. The most recent harvest season has been poor in terms of crop production, limiting access to and availability of food commodities.[14] Due to the late start of the rains, followed by below-normal rainfall and long dry spells, crops experienced moderate to severe water stress.[15] In North Darfur, a pest infestation has damaged the existing crop, which was already scarce.

Currently, local markets in the state are facing a low to scarce supply of sorghum, an inexpensive cereal consumed by many poor households.

Acute Food Insecurity Phase



Source: *FMoA/FEWS NET*

Recovery from the lean season is very unlikely, as the prices of food commodities have remained high, while there are reduced income opportunities, particularly in rural areas. The price of cereals and cooking oil increased significantly during the period May-November 2011, and are likely to remain at current levels or rise even higher in the coming months. Sorghum prices have almost doubled compared to the five-year average.[16]

The families in the Jebel Si area are, for the most part, self-sufficient, growing their own food. Given the poor harvest production prospects, it is very likely they will face a serious food crisis in the near future, leading to high levels of malnutrition. Food assistance is not readily available. Resident communities only received seasonal support until October 2011. In November 2011, only six percent of the total households within resident communities had reportedly received food assistance.[17]

© MSF

When combined with poor hygiene conditions, malnutrition provides the ideal conditions for the fast spread of transmissible diseases.

In the past two years, MSF has treated 1,805 children under five for malnutrition in Kaguro. The number of admissions has stayed constant over this time. Currently, screening of under-fives for malnutrition shows a severe acute malnutrition rate of 1.3%, but this could easily change for the worse.

MSF's nutrition programme is currently facing major difficulties because of the interrupted supply of therapeutic food. With its current stock of food supplements, MSF will not be able to treat patients beyond February 2012.[18]

14
WFP Food Security Monitoring System (FSMS), North Darfur State, November 2011.
15
http://www.fews.net/docs/Publications/Sudan_FSOU_2011_11_final.pdf
16
http://www.fews.net/docs/Publications/Sudan_Alert_2011_12_final.pdf
17
WFP Food Security Monitoring System (FSMS), North Darfur State, November 2011.
18
Therapeutic milk F100 and F75 have been blocked by customs a number of times.

Requirements for MSF's work

Despite a dire situation and significant medical needs, MSF is encountering extreme difficulties working in the Jebel Si area. Over the past two years, it has become increasingly hard to obtain the necessary authorisation to operate in the area, making it almost impossible for MSF to continue providing quality medical care to the people of Jebel Si. The main obstructions involve permits for international staff, transport of staff, and medical and logistical supplies.

Permits for international staff

MSF needs to have sufficient and qualified medical staff, with a good balance of international staff to complement those hired locally. This helps to ensure quality care, as well as impartial and independent action. In addition, sharing experience and expertise between national and international staff , including training, is essential for quality healthcare, and is greatly to the benefit of patients and communities.

However, over the past two years, obtaining permits for international staff has become increasingly difficult.

On 27 October 2011, the work permit of an expatriate doctor – the only one in Kaguro at that time – was rejected by the authorities at the final stage of the renewal procedure. No explanation was given.

In order to run activities in Darfur, technical agreements need to be signed on an annual basis. Work permits and travel permits for international staff depend on such agreements. In the meantime, there is the risk that MSF's projects will be left unsupervised and international staff will be unable to travel to project locations to carry out their work.

In the 2012 technical agreement, MSF requested authorisation for 19 international staff, all considered essential for running activities in four project locations in Darfur. However, so far the authorities have agreed to a total of just five members of international staff. Negotiations are still ongoing, and MSF is hopeful that the required number of international staff will be allowed in the near future.

Transport for staff to Jebel Si

Due to security constraints, the only way that MSF staff can reach Kaguro is by air, flying from El Fasher to Sortony with the United Nations Humanitarian Air Service (UNHAS). However, in recent months, all helicopter flights have been cancelled due to negative security travel advisories given by the Government of Sudan to the United Nations Department of Safety and Security (UNDSS).

At the time of writing (January 2012), there has been no UNHAS flight to Sortony since mid-September 2011, despite the fact that, on several occasions, sources in the area indicated that it would be possible to travel there safely.

On 18 October 2011, MSF wrote to the Humanitarian Aid Commission (HAC) requesting it to facilitate a UNHAS helicopter trip from El Fasher to Sortony to drop off two international staff and bring another back. Since mid-September 2011, none of MSF's staff have managed to travel to or from the project.

Due to the lack of flights, the team in Kaguro is incomplete. For the past four months, MSF has had international staff, in possession of valid travel authorisations, waiting in El Fasher to travel to the project location. Not only does this represent a loss of money and human resources for MSF, but the absence of a full quota of staff also has a major impact on healthcare provision for the people of the Jebel Si region.

Similar constraints were encountered in 2010. Between March 2010 and May 2011, MSF presented 105 travel requests for the transport of MSF staff by UNHAS helicopters between El Fasher and Sortony, 67 of which received no authorisation, while an additional five were cancelled due to poor weather conditions.

Reliable supply of medicines

Getting sufficient medical supplies to MSF's hospital and health posts is absolutely critical. To transport drugs and other supplies to Kaguro hospital from the MSF base in El Fasher, MSF must obtain authorisation from the regional authorities. In the past two years, this authorisation has frequently been denied, resulting in stock ruptures of vital drugs, with serious consequences for patients.

The problems in obtaining the necessary authorisation come in spite of the fact that MSF has a technical agreement signed with the Humanitarian Aid Commission, with a detailed agreed drugs list and procedures to ship drugs to Kaguro.

In 2010, MSF's medical team in Kaguro received incomplete stocks of drugs every three to four months. The stocks were often missing essential medicines which had been ordered but had been refused the necessary authorisation. Since June 2010, the supply of drugs has been extremely irregular, resulting in serious shortages of vital drugs.

The last authorisation for a medical supply cargo was given at El Fasher level on 14 February 2011. Since then, the hospital and health posts have been slowly running out of all essential medical materials and lifesaving medicines.

In June 2011, the situation was so critical that MSF felt it could no longer guarantee the standards of medical care that it considers essential, and wrote a letter of concern to the MoH. The letter explained that MSF's pharmacy no longer had any drugs, and that there were no other health facilities in the area to which MSF could refer patients in urgent need of medical assistance. MSF asked for the urgent release of all necessary authorisations to send the medical supplies from its warehouse in El Fasher to the Kaguro project.

Despite the urgency of the situation, and MSF's repeated communications with the authorities, MSF went through an exhausting three-month procedure to have the list of medicines for shipment approved by all relevant authorities (HAC, MoH, Military Intelligence, National Security). On the day finally arranged for the cargo shipment (16 September 2011), approximately 50 percent of the boxes of medicines were confiscated at El Fasher airport prior to the flight leaving for Sortony. These boxes contained essential lifesaving medicines.

Despite a number of meetings and official requests for the return of the medicines, with all authorities and at all levels, at the time of writing (January 2012), MSF is still waiting for their return.

MSF's stock of both medicines and medical supplies is now at a dangerously low level. Essentially there are no drugs left to treat patients. This critical situation has forced MSF to take the difficult decision to reduce activities to a bare minimum.

Working vehicles

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In the Jebel Si region, vehicles are essential for the efficient provision of healthcare over a wide and remote area. MSF staff need transport to run activities in the five outlying health posts, while patients in a critical condition need to be brought from health posts to the hospital by vehicle.

However, MSF no longer has any functioning vehicles due to the difficulties of obtaining spare parts for maintenance; vehicle tyres, for example, have not been replaced for more than 18 months. A number of requests to the relevant authorities for the authorisation of spare parts have been rejected.

As a result of having no functioning vehicles, all health post support activities are now conducted by donkey. It is no longer possible to run ambulance activities or referrals from the health posts to Kaguro hospital. Patients are obliged to travel on their own to the hospital by donkey or camel, or to be carried for long distances on homemade stretchers, usually resulting in their medical condition deteriorating further. Patients in urgent need of treatment are delayed for crucial hours, and even days, and inevitably some people do not arrive at the hospital until it is too late.

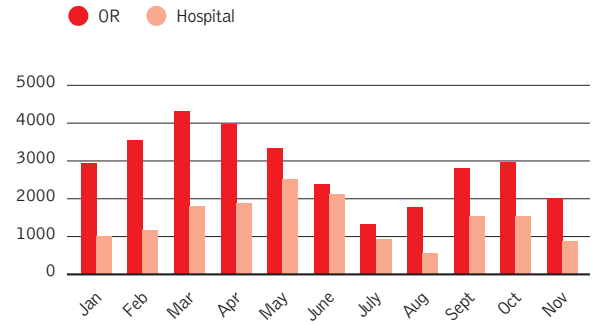
In addition, MSF has been advised by the authorities to look for different makes of vehicle than the ones currently deployed in the Jebel Si region to reduce the risk of vehicles being stolen by bandits. Most NGOs passing through the area have lost cars due to thefts. MSF car movements in the region have been quite limited for fear of attacks and carjacking. However, changing the make of vehicle and transporting new vehicles to Kaguro is a challenging logistical procedure. Besides, it is unlikely to result in a decrease in insecurity.

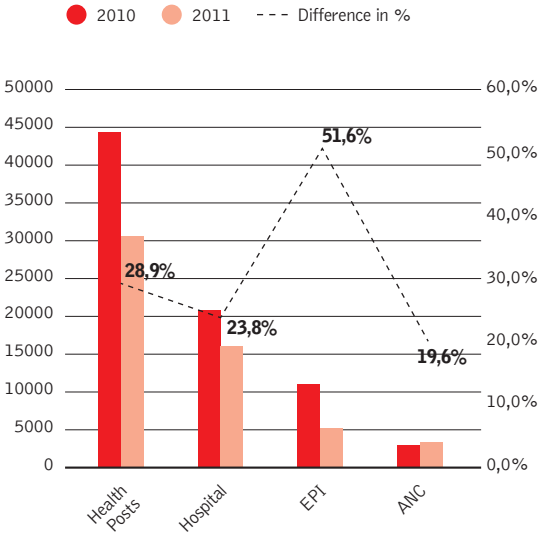
Consequences

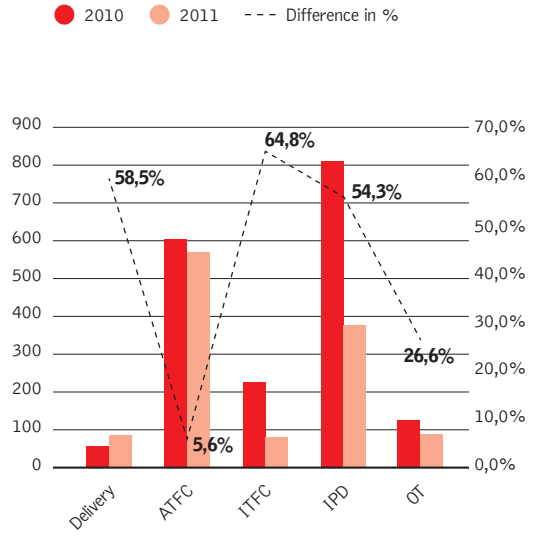
The direct result of these obstacles is that MSF has been forced to radically scale down its activities in the Jebel Si region.

The three graphs below clearly show the decreasing trend in patients´ admissions and treatment during 2011.

Admissions in 2011







Between January and November 2011, MSF provided 3,426 antenatal consultations (covering 81.5% of pregnant women). It provided 840 measles vaccinations and 1,007 pentavalent vaccinations to children under the age of one, achieving 30% EPI coverage. In the second half of 2011 MSF discharged 350 children from the nutrition programme, 279 (79.7%) of whom were cured. Despite the fact that, due to cultural reasons, women still prefer to give birth in the community, MSF attended 75 deliveries and performed 24 caesarean sections.

Now, in early 2012, as a result of the serious shortages of medical staff, lifesaving drugs and logistical supplies, the only activities that MSF is able to provide are a reduced antenatal care service,[19] therapeutic feeding for malnourished children, health promotion, and medical surveillance. If a new shipment of medicine and therapeutic milk fails to arrive on time, even these activities may have to stop.

MSF's vaccination programme has closed down, increasing the risk of disease outbreaks.

The hospital's outpatient department has been forced to close, leaving the people of Jebel Si without basic medical care.

The inpatient department has had to shut. In recent months, patients were no longer able to receive vital fluids intravenously as stocks of IV lines had run out.

The maternity ward can now manage only simple deliveries. Supplies of lidocaine and sutures for performing episiotomies have run out, and there is no oxytocin available to prevent postnatal haemorrhaging, increasing the risk of women bleeding to death after complicated deliveries.

The operating theatre, a particularly precious service in such a neglected region, closed in April 2011 due to a lack of drugs and equipment. Without anaesthesia, doctors were forced to stop performing lifesaving caesarean sections for women with complicated deliveries.

The desperate situation at Kaguro hospital means that MSF staff are no longer able to stabilise critically ill patients, and have no choice but to refer them to the hospital in El Fasher. Even when transport is available to El Fasher by truck, this involves a long and dangerous journey. Children, pregnant women and elderly people are particularly vulnerable.[20] In particular, women with emergency obstetric complications have little chance of survival.

The end result of MSF's forced reduction in services is that the people of Jebel Si are no longer able to access the healthcare they need, and lives are being lost unnecessarily.

19
The antenatal clinic is no longer able to boost tetanus coverage due to the breakdown of the supply chain, which is likely to have dramatic consequences regarding the control of neonatal tetanus.
20
Project proposal, MSF OCBA, June 2010.

A call for support

As a party to the International Covenant on Economic, Social and Cultural Rights, Article 12, the Sudanese government is responsible for ensuring that its people enjoy the highest attainable standard of physical and mental health. This involves steps such as reducing infant mortality rates, ensuring the healthy development of children, and preventing, treating and controlling epidemics. It also involves creating conditions in which everyone is assured proper medical attention in the event of sickness. The Vision for Health of the Federal Ministry of Health of the Republic of Sudan is to build a healthy nation, with emphasis on the health needs of the poor, underserved, disadvantaged and vulnerable populations.[21]

MSF has been one of many actors working towards meeting medical needs, reducing mortality rates and improving the health condition of the Sudanese population. This has been done by respecting the Sudanese government's laws, procedures and technical agreements.

However, in the Jebel Si region, MSF is being gradually deprived of medical staff, medicines, supplies and transport, to the extent that it has become impossible to carry on working. If MSF has to abandon its medical activities in the region, more than 100,000 people will face a future without essential healthcare.

MSF is hopeful that the situation can be resolved. The organisation is ready to resume activities once the restrictions to its work are lifted. When international staff, medical supplies and logistical equipment are once again able to reach Kaguro, MSF is ready to continue delivering lifesaving medical care to all those who need it.

MSF calls on the Government of Sudan to support the organisation in its efforts to provide critical medical aid to the people of North Darfur.

21
http://www.fmoh.gov.sd/English/index.php?id=1