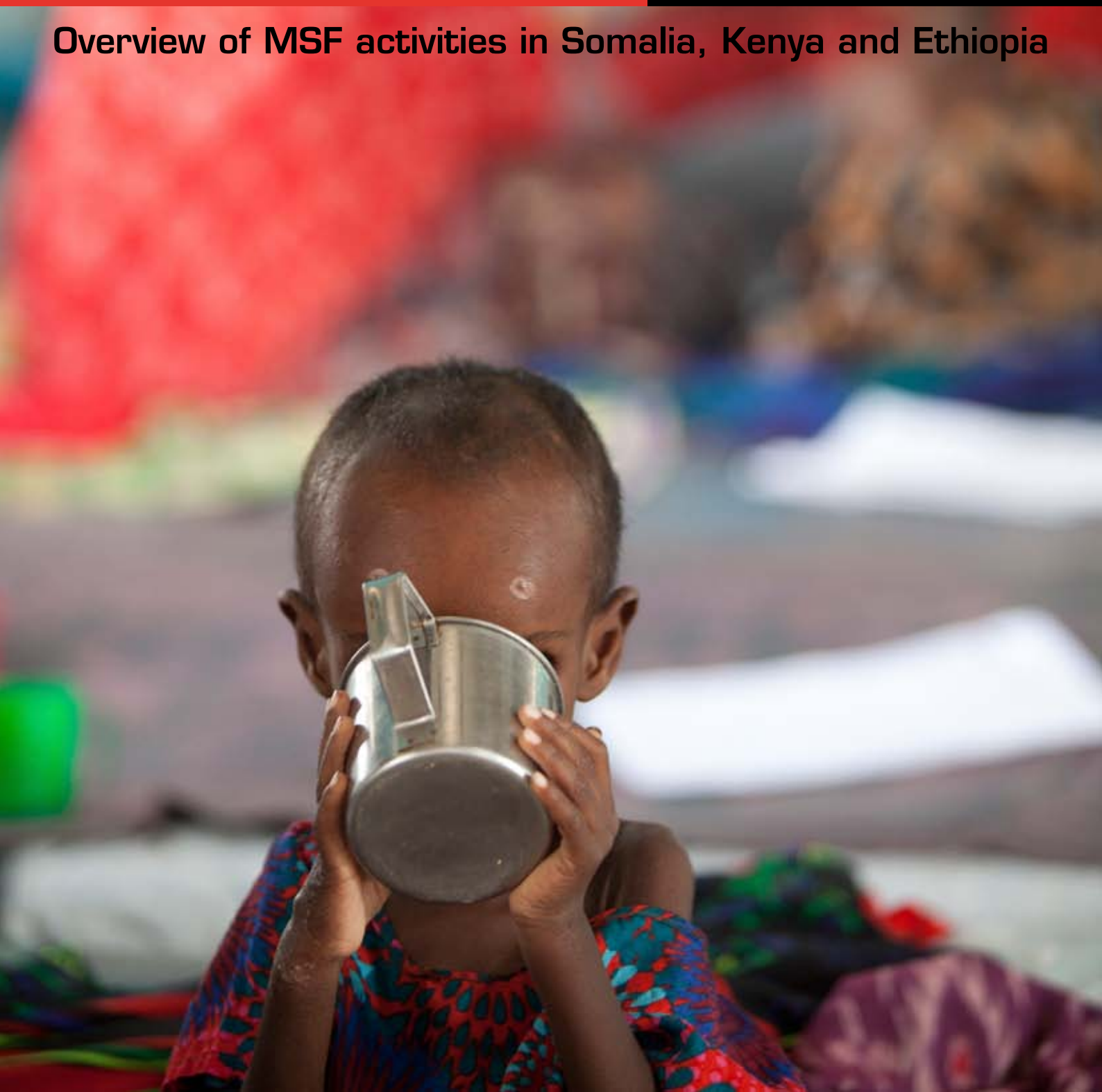
Assisting the Somali population

affected by the humanitarian crisis of 2011

MEDECINS SANS FRONTIERES

Overview of MSF activities in Somalia, Kenya and Ethiopia



This document gives an overview of MSF activities related to the humanitarian crisis in Somalia and neighbouring Kenya and Ethiopia, which have received large numbers of Somali refugees throughout 2011. The data presented, though being provisional, account for MSF's medical activities and financial income and expenditures in this region, whereas the narrative sketches how MSF as a medical aid organisation responded to this evolving crisis.

March, 2012.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TRYING TO REACH THE MOST VULNERABLE OF THE SOMALIA CRISIS

Somalia's humanitarian crisis continues to be one of the worst in the world. This year, Somalis have faced the devastating effects of drought, compounding a long-lasting conflict and the absence of a functioning healthcare system.

Throughout 2011 Médecins Sans Frontières (MSF) has run medical projects in up to 22 different locations in south-central Somalia, the epicentre of the crisis, as well as large-scale programmes in the camps for Somali refugees in Ethiopia and Kenya.

In the period from May to December 2011, MSF treated over 95,000 patients for malnutrition; treated over 6,000 patients for measles and vaccinated almost 235,000 children against the disease. Within its various healthcare structures MSF assisted in over 5,500 deliveries and provided over 450,000 consultations.

However, despite intense negotiations with armed groups, access to the most affected regions inside south-central Somalia has remained difficult.

May – June 2011

In May-June 2011, MSF medical teams started to deal with a worsening nutritional situation in south-central Somalia. The numbers of malnourished children admitted to the MSF therapeutic feeding programmes and MSF-supported healthcare facilities were steadily increasing.

The same period saw a sudden massive influx of refugees crossing the border from Somalia into Kenya and Ethiopia. In the refugee camps of Dadaab (Kenya) and Dolo Ado (Ethiopia), the number of monthly new arrivals quickly rose from 10,000 to 30,000. Living conditions for the refugees arriving at the overcrowded camps at Dadaab were deteriorating, as services were insufficient to respond to such massive influx. The health of refugees was worsening as they waited to be officially registered by the UNHCR and to receive timely assistance including food rations.[1]

July – August 2011

While continuing to negotiate a scale-up of its activities inside Somalia, MSF expanded its emergency response programmes aimed at refugees arriving at the ever-expanding camps in Kenya and Ethiopia. In July only, 48,000 new arrivals were registered at Dolo Ado camp, Ethiopia.[2]

As the frontline moved away from inner-city Mogadishu, MSF could significantly expand its existing activities in the Somali capital, despite a still very volatile and insecure situation. MSF teams opened therapeutic feeding programmes to care for malnourished children, and provided treatment for measles and cholera. Through outreach activities in the Somali capital, MSF carried out medical consultations, vaccinated children against measles and distributed basic relief items to both the displaced and the local populations.

Outside Mogadishu, MSF extended its activities to provide medical care, food, water, shelter and cooking items to 22,000 displaced Somalis in Guri El and, out of its longstanding project in Marere, to a camp for displaced Somalis in nearby Jilib.

From the outset, the ongoing crisis had been depicted simplistically as a famine related to natural causes. MSF has emphasised that its humanitarian activities in the region were not only in response to a drought, but also to a chronic, complex and highly politicised conflict.[3]

September – October 2011

Throughout September and October 2011, an epidemic of measles quickly became the most daunting challenge that MSF teams in the region faced, mainly in Mogadishu and in Guri El. Combined with malnutrition, measles became the main killer of children in Somalia. Mass vaccinations against the

1 "No Way In: The Biggest Refugee Camp in the World is Full" (briefing paper, 9 June 2011)
2 "Somalia: People on the Move in Unseen Proportions" (22 July 2011 – web update)
3 "A Reality Check on Somalia" (3 September 2011 - Opinion Editorial / The Guardian + follow-up coverage)

disease were urgently needed but teams were facing a continued ban in large parts of south-central Somalia.[4]

In October 2011, two MSF workers were abducted from the refugee camps of Dadaab, Kenya, while they were providing humanitarian assistance to Somali refugees. MSF condemned the abduction of Blanca Thiebaut and Montserrat Serra and called for the unconditional release of its two colleagues. As a result of this attack, MSF temporarily suspended some of its medical activities in Dadaab except for ensuring the continuation of life-saving medical activities in its 243-bed hospital. The abduction also limited MSF's capacity to respond to the growing needs of the population inside Somalia.

The subsequent military intervention by the Kenyan army, partly justified by the recent spate of kidnappings of foreigners, led to further confusion between humanitarian organisations providing aid and regional governments seeking to advance their strategic objectives.

The increasingly international nature of the conflict added to the general insecurity for civilians. The military push – by Kenyan forces in south-central Somalia and by the Transitional Federal Government (TFG) forces north of Mogadishu – once forced the suspension of some field activities.[5]

Another unforeseen consequence of the military intervention occurred in the vicinity of a camp for displaced people in Jilib, where an alleged aerial bombardment left dozens of people dead or injured. MSF treated the vast majority of the injured and called on the warring parties to respect the safety of civilians caught up in conflict.[6]

November – December 2011

By November 2011, the continued displacement of civilians fleeing the spiralling violence in south-central Somalia was putting increased pressure on aid providers, including MSF, to respond adequately to the needs of refugees in both Ethiopia and Kenya.

In Somalia itself, despite the rains ending the drought in most areas, the population remains dependent on food and medical aid before being able to benefit from the first harvests in 2012.

In November, the start of the rainy season combined with the crowded and very unhygienic living conditions in the camps for internally displaced Somalis, led to a steady increase of cholera patients.

As of mid-December, MSF teams had cared for 1,875 cholera patients throughout Somalia. In the Hodan district of Mogadishu, over 100 patients per week had been admitted to the MSF cholera treatment centre since the beginning of November.

MSF closed two projects in Mogadishu following the killing of two staff members, Philippe Havet and Dr. Karel Keiluhu, on the 29th of December 2011. These projects included a 120 bed cholera treatment centre in Hodan district and a 120 bed hospital for patients affected by measles and malnutrition in Wadajir.

This closure halved the assistance MSF was providing in Mogadishu. Other MSF projects continued to provide medical care in the other districts of the capital, as well as in 10 locations in the rest of Somalia. However, the continuation of MSF work to assist Somalis in need of medical care is dependent upon the respect for personnel, patients and medical facilities. Where these conditions prevail, MSF remains committed to continue its activities in Somalia.

Conclusion

The needs of the Somali population are likely to remain acute. While Somalis continue to seek refuge in safer parts within and outside Somalia, humanitarian access remains blocked in many parts of the country, limiting MSF's efforts to scale up its activities such as mass vaccination campaigns in several regions to combat the spread of communicable diseases such as measles and cholera.

MSF will remain actively engaged in providing an independent and impartial response to the huge medical and humanitarian needs of the Somali people, wherever the security conditions allow. MSF will also continue to direct all its efforts towards the safe release of its two abducted colleagues.

4 "Fighting Measles in Somalia – Rising t a Difficult Challenge" (3 October 2011 – web update)
5 "Somalia – Vaccination Campaign Suspended due to Fighting in Dayniile" (24 October 2011 – web update)
6 "MSF Treats Wounded after Camp for Displaced is Hit by Bombardment in Southern Somalia" (30 October 2011 – press release + Update on 01 November 2011)

OVERVIEW OF MSF MEDICAL AND NUTRITION ACTIVITIES

Horn of Africa – Somalia, Kenya, Ethiopia
Week 20 to week 52, 2011 (mid-May to end-December)

Summary table

	Total
Admissions in the therapeutic feeding center	79067
Admissions in the supplementary feeding program	30941
Measles patients	7232
Cholera patients	2572
Admissions at the outpatient department	539454
Hospitalizations (inpatient department)	26639
Deliveries in health facilities	6452
Persons vaccinated against measles	255733
Beneficiaries of non-food items distributions	61340

Source of the data

The following data were collected for 23 programs operating in the Horn of Africa for the Somali, Kenyan and Ethiopian populations affected by the medical-nutrition emergency. These programs were located in Liben zone refugee camps (Ethiopia), in Turkana, Liboï and Dadaab refugee camps (Kenya), in South and Central Somalia, including Mogadishu. Data from other programs operating in Ethiopia, Kenya or North Somalia were not included.

The data presented in this report cover week 20 to week 52, 2011.

Standardized indicators were compiled on a weekly basis for all the programs. Indicators were chosen to follow the nutrition situation, the main diseases prone to epidemics, and the MSF activities. Standard definitions were suggested but, in practice, were allowed to vary for each program.

The data compiled were routine data collected through the usual routine health information system of each program and, therefore, rely on the quality of the data collection system of each program. It should be kept in mind that some projects are conducted in remote control and that the accuracy/validity of their data has not been crosschecked through field visits since months or years.

RESULTS

Nutrition

In total over the period, 79067 children were treated for severe acute malnutrition7 in the therapeutic feeding centers (TFC), one fifth of them as inpatient (Table 1). The vast majority were less than 5 year-old. Trends in weekly admissions to the TFC is shown in the Figure 1.

In addition, 30941 persons were admitted for the treatment of moderate acute malnutrition8 in the supplementary feeding program (SFP) (mainly children but also pregnant and lactating women).

Table 1: Admissions in the nutrition programs, MSF Projects, Horn of Africa, week 20 to week 52, 2011

Number of direct admissions	Kenya	Ethiopia	Somalia	Total
Therapeutic Feeding Center				
Inpatient	3766	2239	9960	15965
Ambulatory	10933	23786	28383	63102
Total	14699	26025	38343	79067
Supplementary Feeding Program	20135	5637	5169	30941

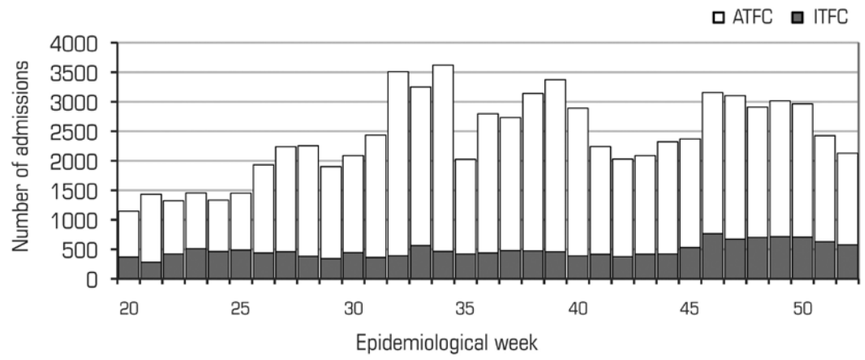

Figure 1. Weekly admissions in the inpatient and ambulatory therapeutic feeding center (ITFC and ATFC), MSF programs, Horn of Africa, week 20 to week 52, 2011

Communicable diseases

In total over the period, 2572 patients have been treated for cholera and 7232 for measles (Table 2). The trends of measles and cholera patients treated from week 20 to 52, per country, are shown in the Figures 2 and 3.

Table 2: Communicable diseases, MSF programs, Horn of Africa, week 20 to week 52, 2011

Number of new patients	Kenya	Ethiopia	Somalia	Total
Measles	1467	152	5613	7232
Cholera	476	0	2096	2572

7 **Standard admission criteria for severe acute malnutrition:** children with a weight-for-height index lower than -3 z-scores compared to the reference population (WHO standard), or children with a mid-upper arm circumference less than 115 mm, or children with bilateral edema.
8 **Standard admission criteria for moderate acute malnutrition:** children with a weight-for-height index between -2 and -3 z-scores compared to the reference population (WHO standard), or children with a mid-upper arm circumference between 115 and less than 125 mm.

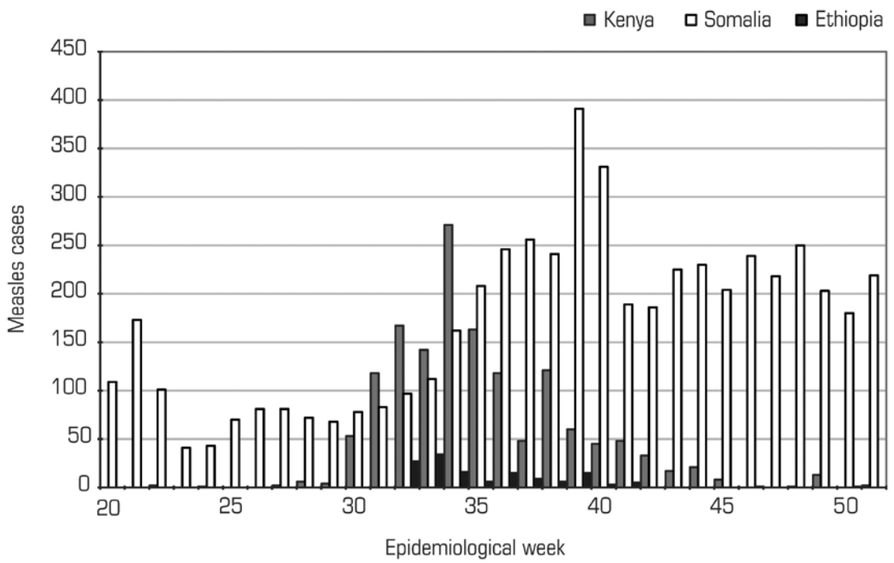

Figure 2. Number of new measles patients, per week and per country, MSF programs, Horn of Africa, week 20 to week 52, 2011

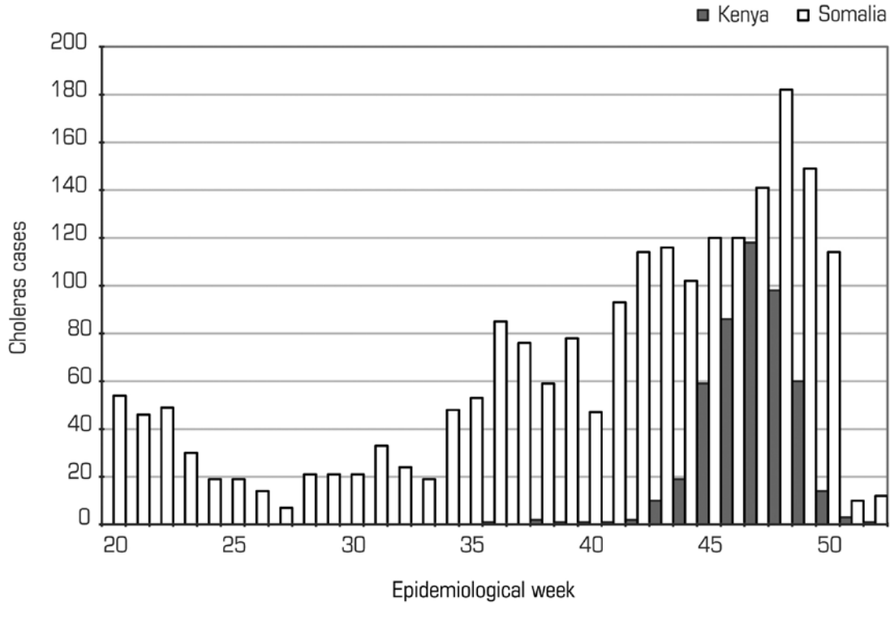

Figure 3. Number of new cholera patients, per week and per country, MSF programs, Horn of Africa, week 20 to week 52, 2011


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Medical activities

The consultations at the outpatient departments totaled 539454 patients. About 2 fifths of them were aged less than 5 year-old. In total, 26639 patients were hospitalized, half of them being aged less than 5 year-old. In addition, 6452 women delivered in medical facilities.

Table 3: Admissions to the outpatient and inpatient departments and deliveries, MSF programs, Horn of Africa, week 20 to week 52, 2011

	Kenya	Ethiopia	Somalia	Total
Outpatient department	150634	61406	327414	539454
Inpatients department	11744	991	13904	26639
Deliveries in health facilities	1942	124	4386	6452

Interventions

MSF teams have vaccinated 255733 people aged 6 months to 30 years against measles (Table 4). Total beneficiaries of food and non-food items distributions are shown in Table 4.

Table 4: Measles vaccinations, food and non-food items distributions, MSF programs, Horn of Africa, week 20 to week 52, 2011

	Kenya	Ethiopia	Somalia	Total
Children vaccinated against measles in health structures	25587	36349	36412	98348
Persons vaccinated against measles through vaccination campaigns	31820	16875	108690	157385
Beneficiaries of non-food items distributions	0	0	61340	61340
Households beneficiaries of general food distribution	0	0	6624	6624
Children beneficiaries of selective food distribution	7012	0	18850	25862

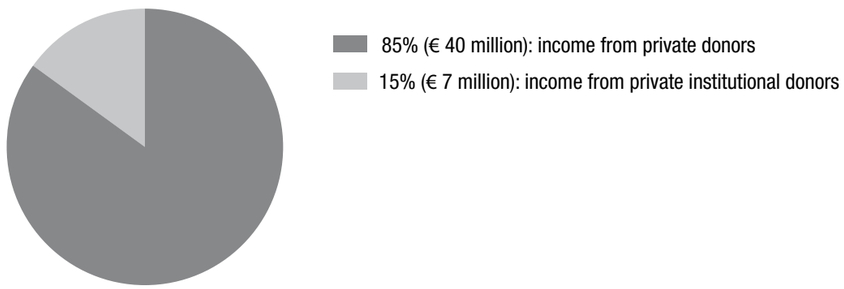
SOMALIA ACCOUNTABILITY REPORT

MSF has received impressive financial support through 2011 to respond to the humanitarian needs of the people of Somalia. By the end of December, we had received almost € 47 million specifically for the medical-nutritional crisis in Somalia and support to Somali refugees in Ethiopia and Kenya.

Approximately 85 per cent of this support, or just over € 40 million, came from thousands of private donors around the world. Somalia is a country in conflict and thus, in order to avoid any political interference to the way we are delivering aid, MSF is not accepting funds from any government for its work inside the country.

Our support to refugees from Somalia in the camps in Kenya and Ethiopia received € 7 million in public institutional funds.

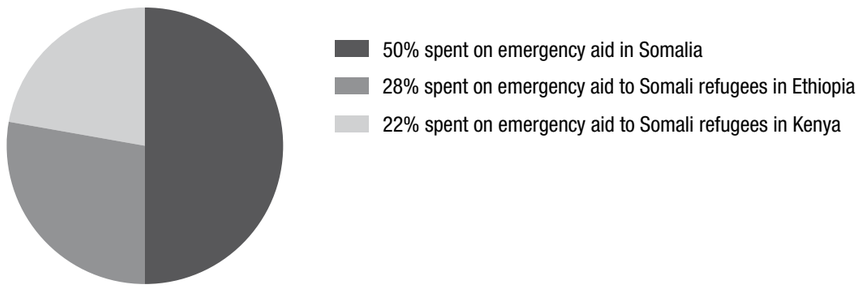
Sources financial support Somalia crisis



In the period from April until and including December, MSF spent € 45 million of the funds received to assist the people of Somalia. We estimate that the remaining € 2 million will be spent before the end of the first quarter of 2012.

Approximately 50 per cent of the spending has been for projects inside Somalia. Our work for Somali refugees in Kenya accounts for 22 per cent of the spending and 28 per cent for those who fled to Ethiopia.

Division expenditures per country April-December 2012

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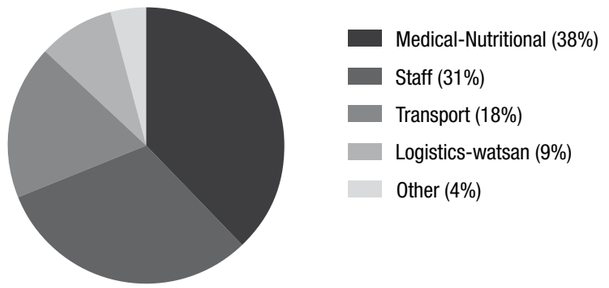
Around 38 per cent of the money has been spent on medical and nutritional materials, including therapeutic food, medicines and vaccines. Logistics and water and sanitation support account for 9 per cent, while almost 18 per cent of the expenses accounts for transport.

With more than 4,200 staff working to support the Somali people, employment-related costs take up around 31 per cent of all spending.

Expenditures Somalia crisis April-December 2012



Over 96 percent of our staff are from Somalia, Kenya and Ethiopia.

Footnotes:
- The reporting period for funds received covers January through December and includes some restricted funding received before MSF started asking the public for donations for this medical-nutritional crisis. The reporting period for funds spent covers April through December.
- The financial figures contained in this report are provisional and will be confirmed once we close our accounting books.

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