

ALERT



STRONG WOMEN

HELPING WOMEN AND GIRLS SURVIVE IN EMERGENCIES



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ABOVE: Um Kalsoum survived the loss of two children killed in a military attack on the family's village in Rakhine state, Myanmar, in August 2017. Now living in a Rohingya refugee settlement in Bangladesh, she has been a frequent visitor to MSF's clinic to get care for her 18-month-old son. © Mohammad Ghannam/MSF

RIGHT: An illustration created to celebrate International Women's Day on March 8. © Núria Espinoza

DEAR FRIENDS,



I WILL NEVER FORGET THE EXPERIENCE OF WORKING AS A SURGEON NEARLY A DECADE AGO IN THE EASTERN PART OF DEMOCRATIC REPUBLIC OF CONGO, WHERE I WITNESSED THE TERRIBLE IMPACT OF VIOLENCE AGAINST WOMEN.

As part of my first assignment with Doctors Without Borders/Médecins Sans Frontières (MSF), I helped provide care for women who had been held captive and assaulted by rebel groups in the region. Many of these women had gunshot wounds, burns, or fractured limbs as physical evidence of the trauma they endured.

Adjacent to our main hospital building, MSF oversaw a small complex that provided care to pregnant women nearing term. These women had been sexually assaulted, often by combatants to the conflict. In addition to providing high-quality maternal care, the center also offered mental health counseling and support to assuage the emotional pain these women carried. These internal wounds were not necessarily as apparent as the injuries I was treating as a surgeon, but they could be just as damaging.

Women and girls are often more vulnerable in unstable settings, including in times of war, conflict, or natural disaster. They may be targeted as a way of intimidating entire communities. And of course, women have particular health risks that men do not. Some 830 women die every day from preventable causes related to pregnancy and childbirth; 99 percent of all maternal deaths occur in low- and middle-income countries.

Most of our patients are women and children. But as MSF nurse and general director Meinie Nicolai pointed out in our pioneering book on women's health, *Because*

Tomorrow Needs Her, these remarkably strong women are anything but victims.

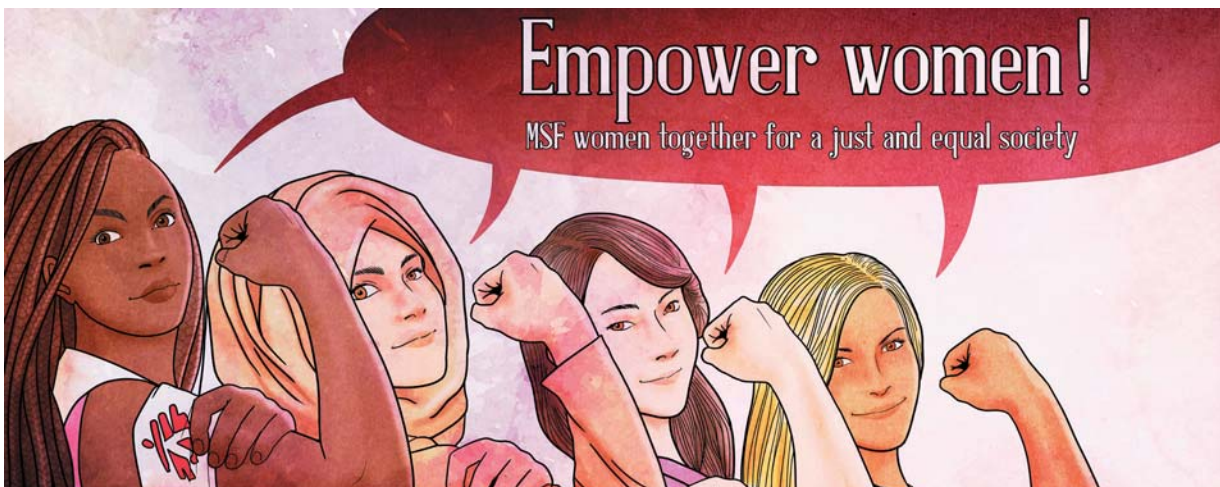
In this issue, you will read about our work with Rohingya women who have survived rape and targeted violence in Myanmar, and who continue to face threats while living in refugee settlements in Bangladesh. You will see the impressive scope of our projects: providing psychosocial support for survivors of violence in Colombia, maternity care for Syrian refugees in Iraq, and vaccination against cervical cancer in the Philippines. We are also featuring a timely interview with Catrin Schulte-Hillen, midwife and the head of MSF's sexual and reproductive health care working group, on the wider dangers of the Global Gag Rule—a US policy intended to restrict abortion-related activities but which affects public health programs more broadly around the world.

On behalf of women and girls everywhere who are safer and stronger due to your support, thank you for making this vital work possible.

Sincerely Yours,

John P. Lawrence, MD

President, MSF-USA Board of Directors



A photograph of a group of Rohingya refugees. In the foreground, a woman wears a bright pink headscarf and a matching face covering, looking off to the side with a somber expression. Next to her, another woman is completely covered in a black niqab. To the right, another woman in a black niqab is partially visible, holding a small white object. The background shows a white lattice structure. The overall mood is one of hardship and displacement.

ROHINGYA REFUGEES

STILL SEARCHING FOR SAFETY



Women and children living in the Rohingya refugee camps in Bangladesh are particularly vulnerable to abuse and exploitation. © Pablo Tosco/Angular



Under the scorching Bangladeshi sun, a group of Rohingya women trekked the steep slopes of Cox’s Bazar district singing a plaintive song:

*Rape can happen to anyone.
I am not happy for this rape.
Nobody is here to listen to me.
Rape is not my fault.*

These young volunteers are part of an MSF outreach team for sexual and gender-based violence (SGBV). They spend their days going door to door across the massive Rohingya refugee settlements in southern Bangladesh, gathering small groups of women to talk about sexual violence and the care available for survivors.

“After rape, come within three days for medicine,” sing the volunteers. “MSF offers free treatment

and is also confidential.” They tell women that when they come to the clinic, they can point to a printed symbol or use code words for rape to avoid stigma or unwanted attention.

The Rohingya are a predominantly Muslim ethnic minority who have lived in Myanmar for hundreds of years and have endured persistent discrimination and abuse. Following a massive campaign of targeted violence against the community that began on August 25, 2017, more than 693,000 Rohingya refugees fled across the border to Bangladesh. They joined thousands of other Rohingya refugees already living in Bangladesh in squalid makeshift settlements after earlier cycles of violence and mass displacement.

Health surveys conducted by MSF teams in Balukhali and Kutupalong makeshift settlements—the two largest settlements in Cox’s Bazar—indicate that at least 6,700 people, 730 of whom were under the age of five, were killed within the first month of “clearance operations” launched by Myanmar security forces. Our patients have described widespread violence, including sexual violence.



“THE CHALLENGE WITH TREATING THESE PARTICULAR WOMEN AND GIRLS WAS HOW BRUTAL THEIR EXPERIENCES HAD BEEN.”

“The challenge with treating these particular women and girls was how brutal their experiences had been,” said Aerlyn Pfeil, a midwife and MSF-USA board member who helped expand the program in Cox’s Bazar to treat survivors of sexual violence last October. “A lot of gang rape, a lot of public rape, some girls who were taken for days and assaulted, often [repeatedly].”

Rashida, a 25-year old Rohingya woman, cried as she recalled the day her village was attacked by soldiers. “They made us stand all night, until dawn,” she said. Rashida tried to escape along with a group of women, but they were recaptured by the soldiers. “They killed my beloved son right in front of me. Then they

closed the door and dishonored me.... [They] started slashing our bodies with knives.” Rashida survived by laying still among the bodies.

Even before the latest crisis, Rohingya women and girls were frequent targets of sexual violence in Myanmar. During the 2016 military campaign that forced tens of thousands to flee, many women sought care for sexual violence in MSF’s Kutupalong clinic in Bangladesh.

A number of them had been raped several months prior to seeking care. “[Even] before this, the military would often come and take women. Many women disappeared,” said a woman from Buthidaung township. “They raped them in the mountains or in the jungle, or took the women to their camp . . . We were always afraid.”

LEFT: MSF has trained Rohingya women to help raise awareness in the camps about sexual violence. © Sara Creta/MSF

ABOVE: An all-female team of volunteers lets survivors know about available care and support. © Sara Creta/MSF

Once they reached the refugee settlements in Bangladesh, many Rohingya women delayed seeking care for a variety of reasons, including lack of knowledge about the medical consequences of sexual violence, cultural stigma, and all the pressures of daily survival.

“Violence is a historical reality for a lot of Rohingya women,” said Siobhan O’Malley, MSF midwife.

“People don’t necessarily think that sexual violence is something you would seek care for unless there is a physical injury—or months afterward, when they discover they are pregnant.”



MSF medical care for survivors of sexual violence covers testing for and preventive treatment against sexually transmitted infections, menstrual regulation, and psychosocial care, as well as vaccinations for tetanus and hepatitis B. However, some medicines, such as emergency contraception and post-exposure prophylaxis for the prevention of HIV, must be given in the first 72 hours to be effective.

FINDING A PLACE OF PEACE

Prior to the latest emergency, MSF psychologist Cynthia Scott was working in Kutupalong camp counseling the Rohingya and in the capital, Dhaka, working with Bangladeshi survivors of sexual and intimate partner violence. Following the August influx, she stayed in Kutupalong full-time to help respond to the growing emergency.

“At the beginning, Rohingya women were not coming for sexual violence,” she said. “People were just focused on finding food, water, and shelter.”

During the early days of the emergency, Scott and her team at the Kutupalong hospital would only see the most vulnerable Rohingya women brought in—those with disabilities; those found in ditches or on the side of the road.

“One woman didn’t know who she was,” said Scott. “We could tell she had been beaten, so we just sat with her for a few days until she could speak.”

Later, patients would come in ostensibly seeking care for physical ailments such as body pains and headaches.

“That’s one of the benefits of integrating mental health programs in medical settings,” she said. “We can do psychosocial education in the waiting room.” MSF counselors, all of whom are Bangladeshi, hand out water and biscuits in the waiting room and explain common trauma symptoms. One day, two women at the clinic suddenly started crying. A counselor sat next to them and asked if they wanted to talk; both women were survivors of sexual violence.

“We call the center ‘shanti khana,’ which translates to a place of peace,” said Scott. If they notice anyone in distress, the MSF triage nurses will ask the patient if they would like to go to the place of peace, a name that helps reassure women and avoid stigma.



A TREMENDOUS VIOLENCE

The SGBV outreach team often starts the group sessions with a story about sexual abuse or assault that then leads into a conversation about the health care provided by MSF, including the safe termination of pregnancy.

“For Rohingya women pregnancy outside of marriage is not just frowned upon, it is impossible,” said Liza Ramlow, midwife supervisor at MSF’s hospital in Balukhali settlement. “It is a tremendous violence that happens to women and can have serious consequences.”

In Myanmar, the Rohingya were often denied access to public health care, so women and girls typically fend for themselves. They seek advice from traditional healers or buy medicines from the camp themselves to end an unwanted pregnancy. “We see a lot of incomplete, septic abortions,” said O’Malley, the midwife supervisor. Patients come into the

clinic hemorrhaging, extremely sick, and for MSF’s midwives it’s a race against time to save their lives. “Girls take matters into their own hands because they feel that is their only option.”

MSF is responding to the additional needs of pregnant survivors of sexual violence and children born from rape. Teams are working with other organizations in Cox’s Bazar to ensure the safety of both mother and child. An MSF hotline is also available for survivors of sexual violence to receive information about how to reach our services as soon as possible.

LEFT TOP: “Most of the women I speak with in the community don’t understand that violence requires medical attention,” said Zulia, a volunteer working with MSF. © Sara Creta/MSF

LEFT BOTTOM: MSF midwife Siobhan O’Malley (rear, center) gathers with members of the outreach team. © MSF

ABOVE: “I’ve helped many different women speak about their feelings and fears,” said Noor, a volunteer working with MSF in Balukhali makeshift settlement. © Sara Creta/MSF

CONFRONTING ABUSE ON ALL LEVELS

The horrific living conditions in the camp have contributed to cases of violence between intimate partners and among families and neighbors.

“Many people are on edge, not just because of the recent trauma but because of the long-time trauma of witnessing horrific things,” said Scott, the mental health supervisor.

In January, there was an increase in suicide attempts admitted to MSF’s hospital in Kutupalong. “Women came in having tried to poison themselves, and we would then discover that they are victims of domestic violence,” said Scott.

The Rohingya are denied citizenship in Myanmar and have not been officially recognized as refugees in Bangladesh, adding to the pressures. Women and children in the camps are also particularly vulnerable to exploitation, and have been targeted by human traffickers.

“One of the cruelest facts is the Rohingya have been deprived of so much,” said Ramlow, the midwife. “It’s like the water you swim in, it’s the air you breathe, it’s abuse on all levels.”

The crowded makeshift settlements are especially dangerous at nighttime. Around two-thirds of the camps’ residents are women and children, according to the United Nations. They are constantly exposed to risk—with no locks on doors, no lights after dusk, and no protection when they have to go into the forest alone to collect firewood. Many patients say they

have difficulty sleeping, paralyzed by the fear that someone might come into their homes, haunted by memories of the attacks by Myanmar security forces.

MSF’s Balukhali hospital runs a 24-hour volunteer ambulance service made up primarily of Rohingya men living in the camps and trained to identify refugees who need urgent care. At all hours of the night, they can be seen crossing the hilly landscape carrying women in blanket slings tied to bamboo poles. “No one would come at nighttime if we didn’t have these volunteers to accompany them,” said Ramlow.

The road to recovery is long and hard for survivors of sexual violence. But Roksana, a Bangladeshi midwife who has been working in Kutupalong for six years, marvels at the extraordinary resilience of her patients. She shared the story of a woman who was gang-raped during the recent violence in Myanmar, beaten, and left unconscious. This woman then managed to walk for more than 15 days to cross the border and make her way to the settlements.

“Even after this, she had the perseverance to come to Bangladesh and survive,” said Roksana, fighting back tears. “Mentally she is still strong. She deserves our respect.” □

MSF IN COX’S BAZAR DISTRICT, BANGLADESH



AUGUST 2017 – MARCH 2018

2,045

PATIENTS TREATED FOR VIOLENCE-RELATED INJURIES

AUGUST 2017 – APRIL 2018

377*

SURVIVORS OF SEXUAL VIOLENCE TREATED

AND IN APRIL 2018 ALONE:

2,203

INDIVIDUAL MENTAL HEALTH CONSULTATIONS

1,722

GROUP MENTAL HEALTH CONSULTATIONS

*MSF likely treats only a fraction of all sexual violence-related cases. Sexual violence is often underreported due to shame and stigma.



MSF works alongside traditional birth attendants from the Rohingya community in Bangladesh to identify pregnant women, inform them about antenatal and postnatal care available, and promote safe deliveries at our facilities. These attendants are trained by MSF to identify and recognize complications during delivery and help a woman in labor to reach a hospital when necessary.

Solima Hatu

Solima Hatu fled Myanmar in August when the military attacked her village, abducting and raping many women. The journey to Bangladesh was terribly frightening for her, her two sons, two daughters-in-law (one of whom was pregnant), and five grandchildren. The family went without food for four days.

As a traditional birth attendant in Myanmar, Solima says she has delivered at least 1,500 babies. “Even after my own delivery, I got up and immediately went to help another woman.” The only possessions she brought with her to Bangladesh are two certificates she received from MSF in Myanmar—one for attending a course for traditional birth attendants and the other for demonstrating her knowledge of antenatal, intrapartum, and postnatal care.

When she arrived in Balukhali settlement, Solima delivered three babies, but she didn’t have gloves. When three of her grandchildren got sick, she took them to MSF’s hospital. “I asked the doctor for gloves ... and later someone heard that I wanted gloves to deliver babies.” MSF asked Solima if she wanted to help identify pregnant and laboring women in camps who needed to come to an MSF facility, especially at night. Solima responded: “I can do everything.”

Samsun Nahar

Samsun Nahar arrived in Balukhali settlement in August. Before she fled Myanmar, Samsun was working as a traditional birth attendant at a government hospital. “One day the military came in and shot a patient. That’s when I ran away,” she said. The military also shot her mother, father, and two brothers in front of her.

On the journey to Bangladesh she delivered many babies, including while crossing the water. She lives with her two sons and her daughter in Balukhali settlement.

“It is very hot these days in Balukhali camp. There is no shade, there are no trees. There were beautiful trees in Myanmar.”

Samsun claims she has delivered 500 babies since arriving in Balukhali. “No babies have died in our blocks, in our hands.” For Samsun, life in Balukhali camp is better than it might be if she was not able to work as a traditional birth attendant helping to deliver babies. “This way, we are more able to help, Rohingya to Rohingya.”

ABOVE: Solima Hatu (left) and Samsun Nahar are proud to use their skills as traditional birth attendants to help pregnant women in the camps.



FORCED FROM HOME

Caring for women and girls on the move

At projects around the world, MSF teams are working to meet the health needs of women and girls forced from home. Margaret Bell, a registered nurse, midwife, and women's health advisor for MSF, describes some of the challenges they face.

One of the first babies born at an MSF clinic this year was a little boy at a Rohingya refugee camp in Bangladesh. Our medical staff found that his mother, Raheema, was suffering from preeclampsia, a life-threatening complication that can develop during pregnancy. Fortunately, they were able to provide her with emergency care and helped her to safely deliver a new life on New Year's Day.

Raheema (whose name has been changed to protect her privacy) is one out of 65.6 million people forcibly displaced due to violence and persecution. More people are displaced today than at any time in modern history—and around half of all those displaced are women and girls.

Displaced women have many of the same health concerns as women anywhere, such as the need for access to family planning services and a safe

place to deliver babies. But women's specific health needs are often more acute while they are on the move, and their access to medical care may be reduced or non-existent along the journey.

Many displaced women are fleeing from conflict. War and upheaval can have a devastating effect on health infrastructure, meaning that women may lose access to health care even before they are displaced. Once on the move, health care can be out of reach due to lack of services, distance, transport barriers, lack of finances, or uncertainty about available services. Prevailing insecurity can also hinder access.

Any displaced population will include pregnant women like Raheema, but many women lack access to the medical care that she was able to receive. Pregnancy carries risks for all women, and even more so when they are displaced. These women are more vulnerable to miscarriage and pre-term delivery, but are less

able to access antenatal care, a safe birthing environment, and emergency obstetric care. A lack of access to emergency obstetric care makes giving birth extremely dangerous for displaced women. For women anywhere, we know that 42 percent of all pregnancies will have a complication. For 15 percent, those complications are life-threatening.

Women on the move may also wish to delay pregnancy until their lives are more stable and secure, but they often do not have access to family planning services. They may have begun their journey with contraceptives, but have either lost or run out of them while on the move. This can lead to unwanted pregnancies, which increases the risk of unsafe abortions, which account for up to 13 percent of all maternal deaths worldwide, according to the World Health Organization.

Women and adolescent girls living in conflict situations and on the run are particularly vulnerable to sexual violence, especially if they are traveling alone. Sexual violence may be used by warring parties as a deliberate strategy to punish or control communities; by border guards abusing their power; or by human smugglers in coerced exchange for food and other basic needs. Sexual violence is a medical emergency that can lead to sexually transmitted infections, such as HIV, unwanted pregnancies, and long-term mental health consequences.

During field assignments with MSF, I have met so many displaced women exposed to sexual violence. I recall one woman who was pregnant from rape. She had only been displaced a short distance due to a natural disaster, but her husband was missing, leaving her alone and vulnerable to violence in a crowded displaced persons' camp. She came to our clinic for an HIV test, but also because she was determined to keep her baby, having lost two previous children in infancy. Like many women, she had a variety of interdependent health needs. We provided her with regular antenatal care,

42% OF ALL PREGNANCIES WILL HAVE A COMPLICATION.

15% OF THOSE COMPLICATIONS ARE LIFE-THREATENING.

13% OF MATERNAL DEATHS ARE CAUSED BY UNSAFE ABORTIONS.



but ultimately it was our psychological support that she needed most.

Mental health care is another of MSF's key activities for displaced women and girls, who have often been exposed to trauma, such as witnessing extreme violence. The uncertainty of life in a refugee settlement is another source of stress. Families are often separated, leaving women alone with the pressures of supporting children in an unfamiliar environment with little resources or services. Women may deprioritize their own health care, particularly their mental well-being, because they are so busy meeting their children's basic needs.

As global displacement has increased in recent years, so too has MSF's support for migrants, asylum seekers, and refugees. Our activities respond to the specific needs of women at various points on their journey—whether displaced in their own home countries, like Iraq or South Sudan; in transit countries, like Greece or Mexico; or in countries where they have settled, like Jordan or Tanzania.

While there are no easy solutions to the protracted conflicts that have sparked this huge wave of global displacement, migrants and refugees are also subject to restrictive policies that place their health and lives at risk. It is in this context that MSF works, providing critical medical care to women like Raheema to reduce their suffering, and ultimately to prevent them from dying while they seek safety. □

LEFT: MSF mental health supervisor Sifa Banzira Clementine joins a women's dance performance as part of the psychosocial programming at a camp for displaced people in Mweso, North Kivu, Democratic Republic of Congo.

ABOVE: Iman Derbass is a midwife at MSF's Women Health Center in Shatila camp, Lebanon. © Elisa Fourt/MSF



LIFELINE IN COLOMBIA

Helping women in a city where
“violence is contagious”

In Buenaventura, Colombia, MSF psychologists receive around 1,000 calls a month through a mental health hotline—one of the few sources of psychosocial support for people in a city scarred by violence and conflict.

Buenaventura is the country’s most important port, as well as a hub for drug and human trafficking. For decades, the Revolutionary Armed Forces of Colombia (FARC), right-wing paramilitary groups, and criminal gangs battled for control of the strategic region.

Today, despite a historic peace deal signed with the FARC in 2016, the specter of violence still looms large. Criminal groups composed mostly of former fighters control swathes of the city and surrounding areas. They terrorize the community, often committing gruesome acts of violence with impunity.

MSF hotline staff counsel people who are suicidal, depressed, or anxious after the murder or disappearance of a relative. They provide support to survivors of violence, including sexual violence, and refer callers for

“PEOPLE TELL US THEY’RE HAVING NIGHTMARES, NOT EATING, NOT TAKING CARE OF THEIR CHILDREN.... [IT’S] NOT SO DIFFERENT FROM WHAT YOU’D SEE AMONG PEOPLE LIVING IN A WAR ZONE.”

follow-up medical and mental health care. Mobile clinic teams are also deployed to areas controlled by the different armed groups that rule much of the city.

The city, with a population of around 300,000, has one of the highest crime rates in the country. At the same time, close to 65 percent of its residents live in extreme poverty and have difficulty accessing the care they need.

“Most patients present with depression and post-traumatic stress disorder, sadness, anger, trouble



relating to other people,” said Claudia Andrade, MSF psychologist. “People tell us they’re having nightmares, not eating, or not taking care of their children. These types of behaviors, they’re not so different from what you’d see among people living in a war zone.”

Gisela Díaz, a young mother who was raped by a local militia member and fled to Buenaventura for safety, said she still feels at risk. “They hardly show any of the violence against women and children in the news,” she said. “But the armed groups are still here.”

After being assaulted again after moving to the city, Díaz felt deeply depressed and tried to harm herself. Fortunately, she saw a phone number for MSF and called for help. “You feel good when you release all this repressed pain,” she said. “Because when you don’t talk to anyone, you start having crazy thoughts, like taking your own life.” Díaz is now a local leader supporting other survivors of sexual violence.

In a report published last August, MSF provided evidence that exposure to violent events or the risk of violence has led to intense mental suffering among people living in certain urban areas of Colombia affected by both the conflict and the drug war.

The report, based on data drawn from mental health consultations with 6,000 patients in the port cities of Buenaventura and Tumaco in 2015 and 2016, showed that patients suffered from a range of conditions, including depression (25 percent), anxiety (13 percent), and post-traumatic stress disorder (8 percent).

Despite the immense needs, comprehensive mental health services are generally not available at local

LEFT: Gisela Díaz survived repeated attacks and now helps other women who have endured violence and abuse. © Marta Soszynska/MSF

ABOVE: MSF psychologist Maria Renteria leads a sexual violence workshop in Buenaventura. © Marta Soszynska/MSF

“VIOLENCE ISN’T ONLY SOMETHING OUT THERE, IT ALSO EXISTS WITHIN THE HOME, WITHIN THE FAMILY... VIOLENCE IS CONTAGIOUS.”

health centers, except in the major cities. There is not a single psychiatrist in Buenaventura.

MSF began its program for victims of violence in Buenaventura in 2015. The team, comprising 11 clinical psychologists and one social psychologist, conducts outreach activities in the community and has three health centers across town. Often the first point of care is through MSF’s telephone hotline and counseling service, established last year. Counselors listen, triage calls, give basic psychological first aid if needed, and help callers make follow-up appointments for counseling or medical care at one of our health centers.

BELOW: During an outreach visit, MSF psychologist Brillith Martínez encourages a survivor of forced displacement and domestic violence to get support using the MSF helpline. © Marta Soszynska/MSF

In the last year, the team in Buenaventura has counseled more than 500 women and men who have been victims of sexual violence, including rape. (In Colombia, 89 percent of sexual violence survivors treated by MSF are women.) If a woman comes to a health center soon after a rape, MSF counselors try to ensure that she receives treatment to help prevent pregnancy and sexually transmitted diseases, including HIV. Emergency contraception and post-exposure prophylaxis treatment must be provided within 72 hours of an assault, but often survivors of sexual violence seek care months or even years after an attack.

Increasingly, women in Buenaventura are asking how to access safe abortion services. Abortion is legal in almost all cases in Colombia, but access to services can be limited, causing delays and health complications. In 2018, the MSF team has already seen five women who came in with complications after failed or incomplete





abortions. “We provide a safe place to talk to someone in the event of an unplanned pregnancy,” said Andrade. Many women were resigned to the pervasive violence and did not realize they could get help. “Violence isn’t only something out there, it also exists within the home, within the family,” said Brillith Martínez, a psychologist who began working with MSF in Buenaventura in 2016. “Violence is contagious.”

The program is literally a lifeline for people who might otherwise never have access to psychological care. “We also save lives over the phone.... When you get someone ... to climb out of that pit [of despair], it’s highly likely that person will help someone else, and then that person will help another, and so on,” said Martínez. “When MSF helps a single individual, we are also indirectly helping an entire family, a neighborhood, a whole community.” □



THIS PAGE, FROM TOP: MSF psychologist Brillith Martínez counsels an eight-year-old girl who is a suspected victim of sexual abuse. Fifteen percent of our sexual violence patients in Buenaventura are children. © Marta Soszynska/MSF

A woman at the MSF call center explains the services provided. A simple mood chart is a useful tool. © Jason Cone/MSF



NEW LIFE

Creating a safe place for mothers at a Syrian refugee camp in Iraq

Midwife Abla Ali despaired as she crouched on the floor of a tent in Domiz refugee camp in northern Iraq. Abla had no equipment or extra help as she attended a mother struggling to deliver a baby whose shoulder was stuck. She summoned all her strength and eventually pulled the small baby safely into the world.

“There were no basic services in the camp—no toilets, no water,” Abla said, recalling her experiences after arriving at Domiz camp in 2013. “It was cold, and it was raining, and it was so hard to look inside a tent and know we had to stay there.” She had fled Syria with her family when fighting started in their city. A neighbor’s house was bombed, killing everyone inside. Abla felt lucky to be alive, yet life was still hard in the camp.

Abla had trained as a midwife in Syria and set to work in Domiz almost immediately. She helped women give birth in their tents because it was too far to travel to the nearest hospital. Abla said it was manageable unless there was a complicated birth. “I just had to try my best with what I had and hope the baby survived,” she said.

In response to the needs, MSF built a maternity clinic in Domiz where women from the camp can safely deliver their babies and access care before and after giving birth. Over the past four years, MSF medical teams have delivered more than 3,400 babies and provided more than 27,400 gynecological consultations. Women here no longer give birth on the floor of a tent.

Domiz has now grown to shelter more than 40,000 Syrian refugees, and many of them have settled in for the long haul as the war next door continues. The tents have been replaced with basic concrete houses clad with iron sheets, makeshift cafes serve steaming plates of Syrian food, and carpet shops display their wares along dusty roads.

MSF launched the sexual and reproductive health and maternity project in Domiz camp in 2013. Teams initially provided prenatal care, antenatal care, and family planning services. In 2014, the project was expanded to a full maternity unit with a 24-hour delivery room, triage, and gynecological consultations.

Twenty-nine-year-old Shorash was the first mother to deliver at the clinic. She gave the midwives who delivered her baby the honor of choosing a name: Isla. Since then, Shorash has also given birth to baby Shifa at the facility.

“I heard about the maternity unit from my neighbors, and someone from MSF visited us and informed us that there would be a new unit,” Shorash said. “The services here are really good, and they take care of us.” She was grateful to have access to free and comprehensive support. “They visited me and did tests and monitoring before, during,

and after delivery. It was important for me because I wanted to know the baby was okay,” she said.

MSF has now handed over the maternity unit to the Dohuk Directorate of Health to carry on this important work.

Abla—who started working at the maternity clinic first as a midwife and later as a sexual and reproductive health care supervisor—recently gave birth to her own baby at the clinic. “We provide a good service for women—the full package of care from the beginning of the pregnancy until after the birth,” she said. “Women feel more comfortable here because the staff are from the camp, and the staff are Syrian.”

She is proud of her legacy having worked closely with families at the camp over several years. “The best part of being a midwife is the appreciation from the mothers,” Abla says. “They stop me in the camp when I pass, and they say to their children: ‘This is Abla, she’s a good midwife and she delivered you.’” □



LEFT: MSF teams have delivered more than 3,400 babies at Domiz camp over the past four years. © Trupal Pandya

ABOVE: Abla Ali, who worked with MSF as a midwife and supervisor, recently gave birth to her own baby at the clinic. © Sacha Myers/MSF

Isla, the first child born at the clinic built by MSF, was named by midwives there at the request of her mother, Shorash. © Sacha Myers/MSF

GLOBAL GAG RULE

Why the new Global Gag Rule is more dangerous than ever





When President Donald Trump reinstated the Mexico City Policy last January as one of his first acts in office, advocates for women’s health were alarmed. The policy, better known as the Global Gag Rule, cuts off US funds for programs overseas that are involved in abortion-related activities, including counseling and informing women about their reproductive choices. This restriction is literally a “gag” on health care providers worldwide, including in countries where abortion has been decriminalized.

Historically, the Global Gag Rule has been enacted in the US via executive order by every Republican president and rescinded by every Democratic president since it was first introduced in 1984. But this time is different.

The Trump administration has expanded the policy to apply restrictions on all US-funded global health assistance, not only aid to organizations involved in family planning. In practice, this means that if an organization provides information, referrals, or services related to safe abortion care, they will no longer be eligible to receive US aid for HIV or tuberculosis treatment, contraception services, mother and child health care, nutrition programs, malaria treatment, or any other care. This massive expansion of the policy sent shock waves across the global public health community, including MSF.

The rule has nothing to do with US funding for abortions—the government made it illegal to provide funds for abortion internationally with the passage of the Helms Amendment in 1973. The policy’s intent is to censor discussion of abortion in any context—even if non-US funds are used for those discussions. The new version of the policy effectively influences what care providers do with funds from other donors.

Many organizations face a difficult dilemma: either to continue with their abortion-related activities and risk losing vital US funding, or to drop these critical services to comply with the policy’s restrictions. Some organizations cannot afford either option and may have to shut down.

The expanded Global Gag Rule threatens progress on many fronts, from efforts to reduce mother-to-child transmission of HIV to global immunization campaigns. The impact is also greater now because the US has become the largest funder of global health programs worldwide. Between 2006 and 2017, US spending on global health more than doubled from \$4.1 billion to \$9.7 billion, according to public records.

At MSF, we believe that women should have information and access to services that protect their health and wellbeing. We know that unsafe abortion is one of the leading causes of maternal mortality worldwide—responsible for up to 13 percent of all maternal deaths in recent years, according to the

LEFT: This 17-year-old girl from a rural town in Haiti was repeatedly raped by a relative’s husband and ended an earlier pregnancy on her own using misoprostol, purchased without a prescription. © Patrick Farrell

THE POLICY'S INTENT IS TO CENSOR DISCUSSION OF ABORTION IN ANY CONTEXT—EVEN IF NON-US FUNDS ARE USED FOR THOSE DISCUSSIONS.

World Health Organization. The vast majority of unsafe abortions—a staggering 97 percent—occurred in developing countries in Africa, Asia, and Latin America.

MSF teams treat patients for complications from unsafe abortions every day across our projects, including in war zones and refugee settlements. And we provide termination of pregnancy to women and girls who request it; both services are part of our strategy to reduce maternal mortality and suffering where we work.

Since MSF is funded independently and receives no money from the US government, the Global Gag Rule does not affect our ability to continue providing care where the needs are greatest. But in the international aid world, MSF is an exception.

Catrin Schulte-Hillen is a midwife and the head of MSF's sexual and reproductive health care working group. In this interview, she explains how women and girls, as well as entire communities, could be harmed by the latest imposition of the Global Gag Rule.

What are some of the immediate consequences of the new Global Gag Rule?

Unsafe abortion has always been notoriously under-addressed, but since the 1995 UN Conference on Women, the international community has begun to recognize it as a public health issue—as it is one of the top causes of maternal mortality. And that it needs to be addressed, through the prevention of unwanted pregnancies—with contraceptive care—and through the prevention of unsafe abortions—through access to safe abortion services. If health providers agree under pressure from the US not to speak to patients about safe abortion care as one of their options when faced with an unwanted pregnancy, this just strengthens the status quo of restrictive laws and far too many maternal deaths.

For some organizations this is extremely painful. They've been working for years to help women access sexual and reproductive health services and to reduce maternal mortality. For others—organizations, or individuals in their leadership—the policy could provide a perfect excuse not to push for the provision of safe abortion care.

The bottom line is that the very limited access to safe abortion care that exists is going to be further compromised. And to me it's even worse that women will not have access to complete information about their health options. They will be stuck again with this silence and stigma surrounding abortion. Even when going to the health provider, a woman will face the taboo: "I can't talk about this." Not because of social norms but because of financial restrictions linked to US policy. A woman will be unable to talk about her pain, her struggle, and she will no longer feel like she has someone on her side who doesn't judge her.

As a midwife, what worries you most about these restrictions?

As a midwife, the most disturbing thing about this to me is that the policy basically asks medical personnel or medical organizations to work in a way that is not in line with medical ethics. Medical ethics require that patients have full insight into their treatment options and that you give patient-centered care, which includes providing all the objective information that allows them to make an informed decision.

For the largest health funder in the world to say, "You can't talk about abortion. You can't give information about it. And if you do, then we will punish you by not supporting any of your activities...." That's pretty radical.

It's worrying because it's impossible to separate the act of counseling or referring patients from all the other aspects of women's health care: providing contraception, treating sexually transmitted infections, giving guidance on birth spacing. You can't just take one piece out and say, "You can't talk about it." This is what we in women's health care mean when we talk about the continuum of care—all of the pieces of women's health are interconnected. Women should be able to get complete reproductive health care from their medical provider.

And what kind of example is the US setting? The US is saying, "We don't care about medical evidence. This is what we want, so do it." How can the US then say to another country that they should make decisions based on needs and public health concerns?



CLOCKWISE FROM TOP: MSF health educators in North Delhi, India, raise awareness about domestic and sexual violence in the community and encourage victims to get care at the Umeed Ki Kiran clinic. © Showkat Nanda

This 16-year-old girl from Ntipasonje village in Malawi is an MSF patient living with HIV and TB. Other health providers in Malawi have been hit hard by the Global Gag Rule. © Luca Sola

MSF supports a mother and child clinic in Choloma, Honduras, a country with a total ban on abortion. © Christina Simons



MSF does not receive US government funding, so how are we affected?

Directly, we are not affected. And in many places where MSF works, we are the only ones providing medical care, so we might not see a major difference. However, in other places where there have been projects funded by US programs I think we will find providers shutting down leaving us even more alone than before. This could be most significant where other organizations have been providing family planning services, including contraception, and a lack of access to contraception could lead to more unwanted pregnancies. Groups that have been referring women to safe abortion services or providing this care themselves are likely to stop all of their work rather than accept the policy, which could lead to an increase in unsafe abortions and the medical complications and the deaths that come with that.

So, indirectly, we could be affected because our colleagues are affected. Their ability to respond to a variety of health challenges will be compromised. And we will all lose out on a chance to push for women's health and reduce maternal mortality.

What are the sexual and reproductive care services that MSF provides at its projects?

MSF has developed all of its activities under the umbrella of reducing mortality and suffering, particularly for vulnerable people affected by crisis and conflict. Our reproductive health care activities fall into two groups: reproductive health care and sexual violence care. For the first group of activities, we focus on having a direct impact on mortality. The periods immediately before, during, and after birth are when most women and babies die—thus the importance of skilled birth attendance to prevent and manage the main complications: namely bleeding, infection, hypertensive disorder, and obstructed labor. We provide postnatal care during the potentially risky weeks after birth.

The treatment of abortion-related complications also has a direct impact on mortality. Women and girls come to our facilities with uncontrolled bleeding, trauma, and infections from non-medical attempts to abort. And, finally, we offer safe medical care for termination of pregnancy to prevent unsafe abortion.

We have additional preventative activities that contribute to reducing mortality and suffering: contraception, the prevention of mother-to-child transmission of HIV,



FROM FAR LEFT: A health educator talks about family planning in Mpanamo village in eastern Democratic Republic of Congo. © Sara Creta/MSF

MSF staff provide medical and psychological care to survivors of sexual violence in Acapulco, Mexico. © Christopher Rogel Blanquet/MSF

and screening for cervical cancer. To lessen women's suffering we also provide repair for obstetric fistula.

Treatment for sexual violence, which affects men and boys as well as women and girls, is designed to reduce short- and long-term consequences, primarily of rape. We provide medical care for physical injuries, preventive treatments for infectious diseases, prevention and management of unwanted pregnancy, and mental health support. We also provide survivors with a medical legal certificate that could one day help them seek justice and compensation.

What are some of the biggest challenges associated with providing sexual and reproductive health care in the places where we work?

The most challenging part of providing this care is ensuring that women have access to it. And that depends on how much value the community, the husband, the society, gives to a woman's health status. That can be the biggest barrier. Will a man pay for transportation so his wife can have antenatal consultations? Will he allow his wife out of the house to go to the hospital to deliver? Do women have decision-making power over the use of contraception or receiving a Caesarian section?

The other challenge, particularly with sexual violence care, is getting the information out there so people will come. To overcome the stigma and taboo and the risk of being discovered and exposed, survivors need to see the added value that medical care has for them. They will only take the risk if they understand that medical care can help prevent further suffering, whether it's HIV/AIDS, syphilis, or unwanted pregnancy.

The challenge is in knowing how to get the messages out in the right way. It's a much more refined message because it has to do with sex and power relations and crime. You always want to reach out to the victim, but you don't want to expose them, because there might be very negative repercussions if they are exposed.

Stigma, taboo, and the lack of value given to women's lives all help keep them from getting the care they need, across the board. The new version of the Global Gag Rule will only make these forces even stronger, and that is extremely worrying. □



FIGHTING CERVICAL CANCER IN THE PHILIPPINES

It is easy to get lost in Tondo, the largest slum in Manila and one of the most crowded places on earth. People here often have unstable lives, and are struggling just to survive in the maze of shacks, abandoned warehouses, and makeshift shelters.

In this chaotic corner of the city, MSF launched a massive effort to vaccinate more than 25,000 young girls against the human papillomavirus (HPV), one of the main causes of cervical cancer. Cervical cancer is preventable, detectable, and treatable at early stages, yet it remains the leading cause of cancer-related deaths in low- and middle-income countries. In the Philippines, cervical cancer kills 12 women every day.

Women and girls in the Tondo slums are trapped in Manila's shadow. They generally cannot afford to pay for health services in the capital and yet are not covered by the government's cervical cancer prevention initiatives offered in some of the country's poorest regions.

To address this gap, MSF worked with Likhaan, a local women's health organization, and Manila City health services to conduct a major HPV vaccination campaign last year aimed at reaching girls between the ages of 9 and 13 years old. Teams administered the first dose of the vaccine to thousands of girls in February, and then



had to find them again to follow up with the necessary second dose six months later.

In partnership with Likhaan, MSF carried out a large-scale information campaign and community outreach effort to encourage young girls to come back for their second vaccine dose. They went door to door, and sent text messages to remind families about the second dose. The results were remarkable: 90 percent of the girls received the second dose, far exceeding expectations.

The World Health Organization recommends vaccinating all girls aged 9–14 against HPV to reduce the risk of cervical cancer. Yet significant challenges remain, including a hesitancy to vaccinate young girls against a sexually transmitted disease like HPV, a perceived lack of urgency since symptoms of infection may take decades to present, and the high cost of the vaccine.

Indeed, price is a barrier for scaling up HPV vaccine in a number of countries around the world. For the Philippines project, Merck charged MSF around \$14 per dose—so \$28 for the two doses needed to

vaccinate each young girl. That's the same price it charges the government of the Philippines, which is doing a phased introduction of the vaccine in some of the poorest provinces rather than a nationwide rollout, in part due to the high cost. There is also currently an HPV vaccine shortage, which poses an additional concern.

Women in low- and middle-income countries account for 87 percent of all deaths from cervical cancer—yet only 5 percent of women in these regions have

CLOCKWISE FROM LEFT: A scene from the Tondo slums on the outskirts of Manila. © Hannah Reyes Morales

A group of girls come to the Likhaan clinic to receive free HPV vaccinations. © Hannah Reyes Morales

A young girl from Tondo gets vaccinated at the Likhaan clinic. © Hannah Reyes Morales

A community mobilizer tracks down patients to remind them to get their second dose of the HPV vaccine. © Hannah Reyes Morales



ever been screened for the disease. MSF also works with Likhaan through a facility and a mobile clinic to provide free, comprehensive family planning and reproductive health services, including screenings for cervical cancer.

In and around Tondo, teams screened more than 1,200 women between January and September 2017 using a method by which the cervix is swabbed with diluted vinegar (acetic acid) to test for signs of abnormal tissue. This simple, low-tech, three-minute procedure is much cheaper than a pap smear and about as effective. Women who test positive for precancerous cells during the screening are treated during the same visit with cryotherapy. Patients suspected of having a more advanced stage of cancer are referred to a local hospital for further testing and treatment.

This multi-pronged battle against cervical cancer in Tondo is working to protect thousands of women and girls, and it proves that countless more lives can be saved. □

WOMEN IN LOW- AND MIDDLE-INCOME COUNTRIES ACCOUNT FOR 87 PERCENT OF ALL DEATHS FROM CERVICAL CANCER.

CLOCKWISE FROM TOP LEFT: A community mobilizer reminds a young girl that she is due for her second dose of the vaccine. © Hannah Reyes Morales

This young girl lives in Tondo's Smokey Mountain, a landfill where families have settled. © Hannah Reyes Morales

A mother holds her newborn child near their makeshift home in Tondo's Smokey Mountain. © Hannah Reyes Morales

Two young girls displaced by a fire have made a temporary home in a basketball court in the Tondo slums. © Hannah Reyes Morales



DONOR PROFILE:

Why they give: After a loss, a couple finds comfort in helping others

YVES-ALEXANDRE AND JI-HEE LEPAGNOL SUPPORT MSF IN HONOR OF THEIR SON



Before she met Yves-Alexandre Lepagnol (or “Yal”), Ji-Hee wasn’t sure she wanted children. “Things change,” she says, smiling. The two met in their late 30s and felt an immediate connection. Within a year, they were expecting a child and planning their future.

When Ji-Hee’s pregnancy ended in miscarriage, the couple sought comfort in each other and the music they love—attending a Leonard Cohen concert and letting the melancholic songs help them heal. More miscarriages followed, but a few years later there was hope: Ji-Hee was pregnant with a baby boy.

Early last June, Ji-Hee and Yal checked into the hospital where she was scheduled to deliver. Ji-Hee had developed preeclampsia, and her doctors were monitoring her closely. That first evening, the couple received devastating news:

there was no sign of a heartbeat. And after undergoing a Caesarean section to deliver their stillborn son, Ji-Hee developed a life-threatening infection from which it took months to recover.

Even amidst their grief, Ji-Hee and Yal found themselves thinking of how much worse it could have been. They were in a world-class hospital in New York City, receiving high-quality care. “We had a support system,” says Ji-Hee. “I can’t even imagine what it would be like to go through this in Syria, Myanmar, or a refugee camp and not have access to that kind of health care.”

When loved ones and colleagues asked how they could help, Yal and Ji-Hee requested they donate to MSF. Friends from Yal’s university days worked for MSF, and the stories he heard over the years hit home. He had even raised funds for MSF before—asking for donations instead of gifts to celebrate his birthday.

This time he posted a simple message on social media: “Today we are grateful to live in the Western world with decent health care. Because elsewhere not all women are safe, donate.” And regardless of whether they knew the intimate details of Ji-Hee and Yal’s circumstances, friends took

action, contributing hundreds of dollars to MSF. Ji-Hee and Yal followed with their own generous gift. Yal says that the organization’s proven reputation for transparency and using donor dollars effectively has always made his decision to support MSF simple.

Since their loss, Ji-Hee and Yal have felt a deeper connection to MSF’s work, especially on maternal health. When Yal learned that speaking out and bearing witness are part of MSF’s charter, it resonated profoundly. As a couple they have found comfort in talking openly about their experience. “Stillbirths are a taboo subject,” says Ji-Hee. “People should know how common it is and be more open to discussing it. We need to recognize that it happens, and not stigmatize the people who go through it.”

It’s now been a year since they lost their son, who they named Léonard Soo-Hyun: Léonard because it reminds them of the music that helped them get through heartache, and Soo-Hyun because it means “bright.” It’s a name they will continue to speak and to honor.

“We’re happy,” says Ji-Hee, “that out of this terrible experience, we were able to help other women who might be in similar circumstances.”

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COVER: Lila, a Rohingya refugee, is forced to move yet again as her family's shelter in Kutupalong camp, Bangladesh, was threatened by monsoon rains.

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