



FACING UP TO REALITY

Health crisis deepens as violence escalates in **Southern Sudan**



Médecins Sans Frontières (MSF) is an international medical relief organisation. MSF is an independent and neutral aid agency that serves all people regardless of race, political and religious affiliation. MSF has been working in Sudan since 1979, and currently has projects in Southern Sudan, Kordofan, Red Sea State and Darfur.

December 2009

Cover photo ©Brendan Bannon - *Refugees fleeing LRA attacks arrive at Nyori camp, Central Equatorial State. June 2009*

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INTRODUCTION

This year Médecins Sans Frontières (MSF) has witnessed a worrying deterioration in the situation in Southern Sudan, with severe medical humanitarian implications for the population.

Though the challenges facing the semi-autonomous region of Southern Sudan occur within the context of Sudan as a whole, this paper will focus solely on the worsening situation in the South. However, there are also clear medical humanitarian needs in other parts of Sudan, most notably Darfur, to which MSF is also responding.

Since December 2008, there has been a disturbing escalation in violent clashes across Southern Sudan, from attacks by rebel group, the Lord's Resistance Army (LRA) in the Equatorial States to the so-called 'tribal clashes' in Upper Nile, Jonglei, Lakes and Central Equatoria States. The intensity and targeted nature of the violence to which MSF responded in Jonglei and Upper Nile States represents something more than 'inter-tribal cattle rustling' and suggests a targeting of villages. This trend in violence has resulted in death, injury and the displacement of thousands from their homes. Displaced people are then forced to live in precarious conditions where diseases thrive, leading to outbreaks such as cholera, and heightening the risk of malnutrition.

This increased violence and its consequences compound the already grim medical humanitarian situation in Southern Sudan, where medical needs are critical. Mortality rates remain high, malnutrition is chronic, and regular outbreaks of preventable diseases, such as meningitis, measles and cholera, continue to pose a persistent threat to the lives of the population.

In January 2010, Sudan will mark the fifth anniversary of the signing of the Comprehensive Peace Agreement (CPA), which ended 21 years of violent war in which an estimated two million people died from conflict or disease, and four million people were displaced.¹ Before the war, Southern Sudan had a severe lack of general infrastructure and health systems, and the decades of conflict destroyed what little existed. At present, it is commonly estimated that up to 75 percent of the population have no access to even the most basic healthcare.² Non Governmental Organisations (NGOs) are providing 86 percent of the available health services in Southern Sudan and are paying the salaries of three quarters of the health staff.³ Another serious barrier to survival is the near-total lack of secondary and tertiary level medical provision, even in many of Southern Sudan's major cities.

Today, the disturbing reality is that the population of Southern Sudan remains mired in a worsening medical and humanitarian crisis following the most violent year since the signing of the CPA. Yet, despite this reality, many governments' approach to addressing the needs in the South is from a 'post-conflict' development perspective. Consequently, international donors have focused their response on establishing pooled funding mechanisms to address the chronic underdevelopment of the south and to support the establishment of the Southern government. Although development is important and necessary in Southern Sudan, it is essential that emergency needs are also addressed. MSF considers that the most effective way of achieving this is through independent humanitarian aid that is wholly separate from the political or military considerations of the CPA. However, it is clear that despite the increasing numbers of emergencies this year, inadequate consideration has been given to ensuring that the immediate humanitarian needs of the population are met.

1 United Nations, 2005, <http://www.alertnet.org/thefacts/reliefresources/11097690704.htm>

2 <http://www.alertnet.org/thefacts/reliefresources/11097690704.htm>

3 Fenton, W and Phillips, M. 2009. Funding Mechanisms in Southern Sudan: NGO perspectives. HPN, Humanitarian Exchange Magazine. March 2009.

MSF IN SOUTHERN SUDAN

In response to the deteriorating situation in Southern Sudan, MSF runs projects across seven states and responds to medical humanitarian emergencies as they arise. In 2009, MSF's level of activities increased significantly (See Table 1).

TABLE 1 PATIENT NUMBERS IN MSF PROJECTS

MSF PATIENTS	2008	2009 (Jan-Oct)
OUTPATIENTS	310,199	360,914
INPATIENTS	8,539	8,533
MALNUTRITION ADMISSIONS	6,139	11,129
SURGICAL PROCEDURES	1,271	2,221

This rise in consultations from 310,000 in 2008 to 360,000 in the first ten months of 2009 can be partly explained by the fact that MSF increased its level of response in Southern Sudan to address the needs – including in areas such as Aweil in Bhar el Ghazal, which have not been affected by this year's increase in violence.

However, the figures also indicate a sharp deterioration in the security situation. The number of surgical interventions for 2009 in Upper Nile and Jonglei (1,426) alone are more than the number of surgical interventions for all MSF projects across Southern Sudan in 2008 (1,271). This is as a result of the increased clashes in 2009, compared to 2008.

MSF PROJECT LOCATIONS







MISSING THE POINT?

Understanding the emergency

The reality of the crisis

In 2008, an MSF report '*Southern Sudan: Immediate Health Needs Remain amid a Precarious Peace*', raised serious concerns about the response from international donor governments and institutions, highlighting their diminishing interest in emergency relief programming, in addition to the slow release of longer-term development funds needed to maintain and develop the few existing health facilities in the region.

MSF called for a serious commitment to the necessary financial and human resources for emergency aid operations, while also raising the alarm that existing emergency medical organisations in Southern Sudan were shouldering an impossible burden in trying to meet the basic health needs of the people.

Although some donors, such as the European Commission for Humanitarian Aid (ECHO), sought to address emergency needs, just a handful of NGOs had the capacity to respond to the acute needs resulting from the deterioration in the humanitarian context. In 2009, even though there are greater emergency needs as a result of increased violence and displacement, development aid is still being prioritised at the expense of humanitarian emergency aid.

The quality and quantity of aid, as well as its ability to effectively address people's needs, are important features of a development and humanitarian response. However, in Southern Sudan, neither aspect is met by the aid architecture currently in place. On the one hand, mechanisms for development aid have serious flaws, and on the other hand, little consideration is given to the pressing humanitarian needs of the population for medicine, food, shelter and sanitation.

Flaws in development aid

Efforts to support the CPA mean that donor governments choose to provide funds through pooled mechanisms. Money which was previously available for emergency funding mechanisms has been redirected to such funds, which have a more long-term developmental approach. These funds are wholly inadequate for responding quickly to emergencies.

There are a number of pooled funds available, such as the UN CHF (United Nations Common Humanitarian Fund), the BSF (Basic Services Fund) the SRF (Sudan Recovery Fund) and the CBTF (Capacity Building Trust Fund).⁴ The biggest of these pooled funding mechanisms is the bureaucratically heavy, and CPA-mandated, Multi Donor Trust Fund (MDTF). Administered by the World Bank, the MDTF comprises 14 donors. It is astonishingly slow at distributing funds and its bureaucratic nature has led to serious problems, including a potential national drug stock-out in 2010.

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⁴ MSF is an independent medical humanitarian organisation that maintains independent and emergency donor funding to ensure the ability to respond to both basic health care needs and emergencies. In Southern Sudan, MSF does not take money from the pooled funding mechanisms or the UN CHF. However, the aid system in Southern Sudan is mostly dependent on these mechanisms.

Due to the delay in allocation of funds from the MDTF, and based on the 18 month World Bank procurement procedure for these drugs, the Ministry of Health (MoH) and donors predicted that there would be a national stock depletion of essential medicines in MoH facilities, starting in February 2010 and lasting for ten months. Although some donors stepped in to try to fill this particular gap, thus reducing the potential period of drug shortage down to one month, there have been other oversights from development funding mechanisms that have cost lives.

For instance, many NGOs operating with donor funding in Southern Sudan are prohibited by the donor from purchasing drugs, as donors see this aspect of health programming as already covered by the MDTF. However, many NGO-supported clinics lack essential medical supplies, because the MoH drug kits are inadequate or missing items, from artemisinin-based combination therapy (ACT) (for the treatment of malaria) to basic, yet essential, items like examination gloves. It is impossible to know the full impact this has had on areas where MSF is not working, but from what our medical teams have seen when responding to emergencies, there is cause for concern. During an emergency response, MSF medical teams arrived in several clinics to discover gaps in essential supplies and see the consequences of these gaps on patients seeking healthcare. For example, patients who tested positive for malaria were prescribed with paracetamol instead of ACT, which is wholly ineffective in the treatment of the disease.

Compared to the amount of attention given to development, there is little consideration given to the rising emergency humanitarian needs of the population. The UN CHF and ECHO are the primary channels for emergency programme funding, yet the UN CHF is often used to fill the gaps left by the failures in the pooled funds. For example, the UN CHF is currently funding vaccine supply which makes sense for outbreaks, but regular vaccination is an ongoing and long term activity that could and should be provided for under the development mechanisms.

“The people came at night when we were sleeping. I was shot. The bullet pushed me to the ground and I was convulsing. My brothers and sisters heard the gunshots. Many of them died. I ran and fell, ran and fell, until I ran into the river to hide. This should not happen. People should live in peace.”

10 year old boy, MSF patient, Torkej, Upper Nile State

Lack of emergency response

In Southern Sudan, the primary objectives of donors and the UN have been based on efforts to support the CPA. As a result, Southern Sudan is addressed as a 'post-conflict' context and the focus on longer term development is disproportionate to that on immediate humanitarian aid.

Most NGOs in Southern Sudan have a strict development agenda and funding sources that are unable to allow for a rapid response to the emergency needs of the population. Thus, the burden of emergency response is placed on the shoulders of a handful of organisations. The symptoms of this can be seen in the lack of emergency capacity in Southern Sudan in response to the needs of the population.

There are clear examples of the implications of this focus on development: the lack of surgical capacity in Southern Sudan means that when clashes erupt, those who are wounded are sometimes unable to access treatment. Some of the gunshot wounded patients that MSF has received have walked for days to access care.

A quick and effective response at the start of an emergency, whether resulting from violence or malnutrition, is critical in order to limit mortality. Yet, the lack of availability of immediate funding results in instances where emergencies have not been responded to quickly. For instance, after the attacks in Akobo in April 2009, MSF teams were already responding to a number of other emergencies elsewhere. Though there were other NGOs in the vicinity, they were unable to respond on time. Though stretched, MSF responded to assist the wounded on site in Akobo and evacuate others for surgery, returning to set an emergency nutrition project, until other NGOs were able to respond.

This inability of the current funding mechanisms to meet the most urgent needs of the population comes at a time when the situation across Southern Sudan is deteriorating.

A GRIM REALITY

Increasing violence worsens
already desperate health situation



©Reuters/Finbarr O'Reilly - A blind woman recovers from a gunshot wound to the arm following violent clashes in Nasir, Upper Nile State, June 2009

"I have seen cattle raids before – and we always treat men after the fighting. This time, our clinic was full of women and children. That's new..."

MSF nurse in Pibor, Jonglei State, July 2009

“This is the time for peace but our children are abducted or wounded”

A disturbing trend

Seasonal cattle raiding is common in many areas of Southern Sudan. However, this year, the intensity and targeted nature of the violence represents something more than ‘inter-tribal cattle rustling’; villages are targeted and significant numbers are killed. In addition to deaths, the violence has caused serious injury and displaced thousands from their homes, which has led to outbreaks of disease, such as cholera.

Upper Nile and Jonglei have been at the epicentre of this worrying upsurge in violent clashes. With medical teams in Pieri, Lankien and Pibor in Jonglei State; Nasir in Upper Nile State; and Leer in Unity State, MSF responded to the majority of the violent clashes with emergency humanitarian assistance, including primary and secondary level health care. MSF responded in Akobo, Torkej, Lekwongole, Panyagor, Duk Padiet and Terekeka.

Based on MSF’s experience in these emergencies, the trend of the violence shifted in 2009. The attacks were more frequent, with villages, rather than cattle camps, targeted, and women and children making up the majority of victims. In the attacks to which where MSF responded (see table 2), the number of reported deaths was more than three times higher than the number wounded.

MSF EMERGENCY RESPONSE TO VIOLENT CLASHES IN 2009

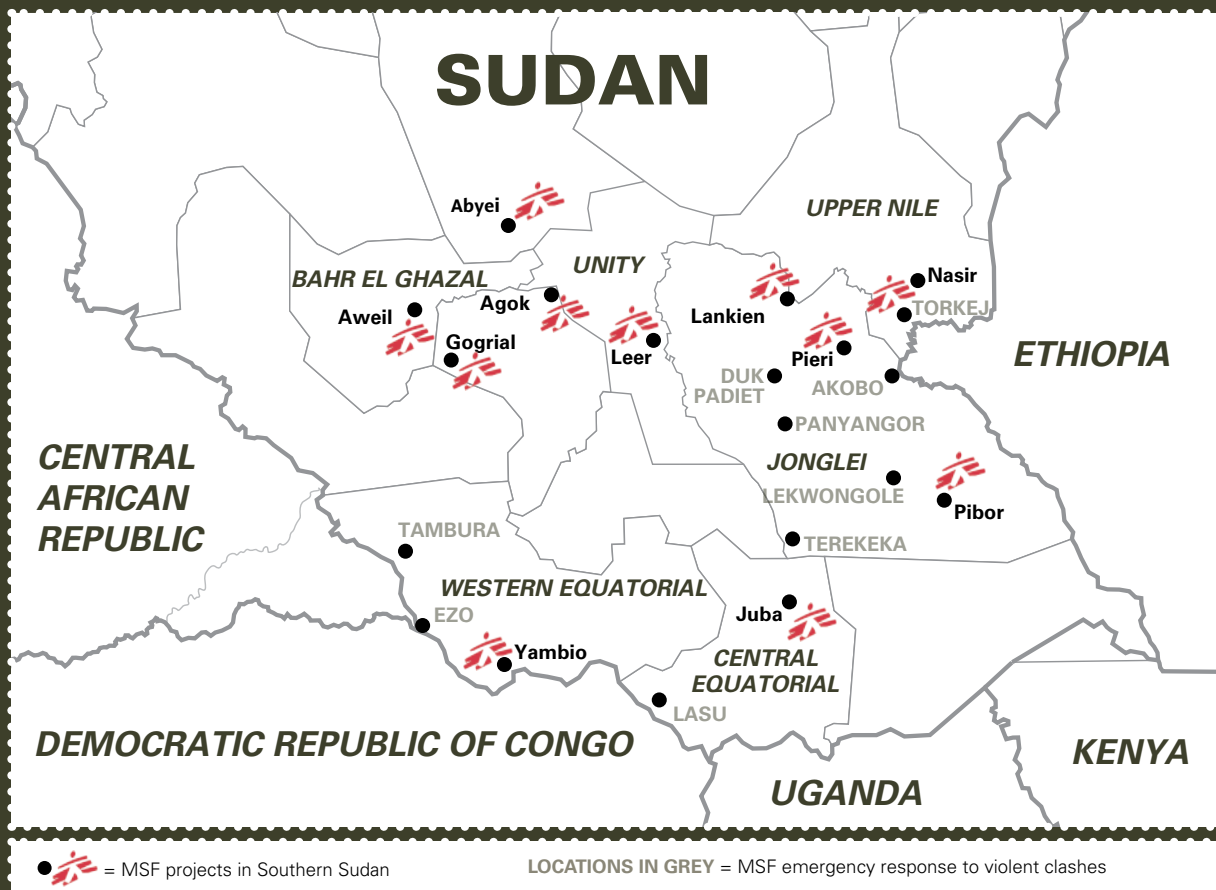


TABLE 2 VIOLENT CLASHES TARGETING WOMEN AND CHILDREN TO WHICH MSF RESPONDED IN 2009 ⁵

DATE – 2009	LOCATION	WOUNDED	KILLED	DISPLACED
MARCH	LEKWONGOLE	45	450	5,000
APRIL	AKOBO	70	250	15,000
MAY	TORKEJ	57	71	10,000
JUNE	NYARAM	38	60	10,000
AUGUST	MARENG	18	185	UNKNOWN
AUGUST	PANYANGOR	64	42	24,000
SEPTEMBER	DUK PADIET	100	160	UNKNOWN
OCTOBER	TEREKEKA	UNKNOWN	30	22,000
TOTAL		392	1,248	86,000

TIMELINE OF VIOLENCE TO WHICH MSF RESPONDED IN 2009

5 th MARCH	Attack on Lekwongole, Jonglei State, resulted in 450 deaths and 5,000 displaced.
18 th APRIL	Reprisal attack in Akobo County, Jonglei State resulted in 250 deaths, 70 wounded and 15,000 displaced.
8 th MAY	Attack on Torkej, Upper Nile State, resulted in 71 deaths, 57 wounded and up to 10,000 displaced.
5 th JUNE	Attack on barges carrying 730 metric tonnes of food in Nasir, Upper Nile State. In retaliation against the population that attacked the barges, the Sudanese People's Liberation Army (SPLA) burnt down the nearby village of Padanyang.
3 rd AUGUST	Attack on Mareng, Jonglei State, resulted in 185 deaths and 18 wounded.
29 th AUGUST	Attack on Twic East County, (near Panyangor), Jonglei State resulted in 42 deaths, 64 wounded and up to 24,000 people displaced from 17 villages.
20 th SEPTEMBER	Attack on Duk Padiet, Jonglei State resulted in 160 deaths and 100 wounded.
1 st OCTOBER	In areas east of Terekeka, 20 villages were destroyed, with more than 30 deaths, and approximately 20,000 people displaced.

The above figures are based on the most commonly quoted statistics from the authorities

In just seven months, between March and September 2009, MSF treated a total of 286 victims of violence in Jonglei and Upper Nile States. Injuries ranged in severity from bone fractures to gunshot wounds to the chest and abdomen, with the vast majority, 87 percent, treated for gunshot wounds. MSF provided emergency medical aid to these patients in its existing health centres in Pibor, Pieri, Lankien and Nasir, but also sent emergency teams out to directly collect the wounded - in vehicles whenever possible, but also by boat or plane to airlift and refer the wounded to surgical theatres. However, as a result of the low coverage of health centres across Southern Sudan, and the difficulty in accessing these centres due to the lack of roads and adverse weather conditions, some of the wounded travelled for days by foot, or were carried on makeshift stretchers for days, before they reached MSF health facilities.

For many of these clashes, warning signals of the attacks had been sent prior to the attack. However, neither the Government of Southern Sudan (GoSS) nor the United Nations Mission in Sudan (UNMIS) ensured the safety of the civilian population. Although

the protection of the population during these clashes is the primary responsibility of the GoSS, the recent upsurge in violence has been brushed aside and downplayed by UNMIS as outside of the remit of the CPA, and therefore outside of their mandate. According to the UNMIS Regional Coordinator, "these conflicts can often best be understood in very local terms – tribal terms, clan tribes, sections within clans– and not necessarily in the larger dynamic context of the CPA itself."

Based on MSF experience of responding to the medical needs resulting from the increased violence, it should be noted that the provision of independent humanitarian assistance was respected and facilitated by the authorities in Southern Sudan. It is crucial that this is maintained, so that any initiatives from UNMIS to better fulfil its mandate, or from the GoSS, do not compromise the ability of independent NGOs to provide life saving emergency assistance. The military and political responsibilities of UNMIS must be kept separate from, and not compromise, the necessity for independent organisations, such as MSF, to provide assistance.

"The people who came to attack were so many – all with guns. They burned the area and took the young girls. Not the boys, they killed them. Normally, they deal only with the men but this time they killed the women and children. I am crying, we are not protected. This is the time for peace but our children are abducted or wounded. This is not the first time we are attacked but the first time it is like that."

Woman from Burmath, Jonglei State, May 2009

“Even up to ten days after the attacks on Lekwongole, wounded people were still arriving in our clinic. They had been hiding in the bush, too afraid to move. Fearing more attacks they didn’t dare seek the medical treatment they urgently needed, so they reached us when their wounds were even more infected. The people are so fearful here. For days after the attacks the women in Pibor were too afraid to ever leave their children alone, in case there was another sudden clash and the children were killed or taken. They brought them absolutely everywhere with them, even to work, carrying them on their backs, afraid they might have to suddenly flee.”

MSF medical doctor in Pibor, Jonglei State



Displaced populations face cholera and malnutrition

The violence that has occurred throughout Southern Sudan this year has led to the displacement of 250,000 people⁶, who live in fear of further attacks and counter-attacks. Five thousand people fled to Pibor after a March 2009 attack on the village of Lekwongole, which resulted in the death of over 400 people. Nine of the 40 wounded people that MSF treated were children, with two thirds younger than five years old. Many of the displaced had little access to clean water, and as a result there was an outbreak of cholera. MSF then treated 300 cholera cases in its health facility in Pibor town.

In addition to the risk of cholera and other communicable diseases, there is an underlying nutritional problem in many states of Southern Sudan, which the violence is exacerbating. The late rains in Jonglei have led to a precarious food security situation across the state. Immediately after the March attacks in Pibor there was a worrying increase in admissions for malnutrition to MSF's therapeutic feeding programme in Pibor. While this was the traditional "hunger period" in Pibor County, the levels of malnutrition MSF saw were the worst in three years, for that time of the year. Immediately after the March attack, the patients that fled their villages made up 57 percent of the 247 new admissions to the MSF feeding programme in Pibor. The total number of children treated in that acute therapeutic feeding centre (ATFC) for the whole of 2008 was 436, yet by June 2009, MSF had already reached the same number of children.

"Nearly all the patients tell us they lost family members in the violence. We heard horrific stories – women and children were attacked and killed in their homes and children were also kidnapped. Many patients had multiple gunshot wounds – a 10 year old boy had three bullet wounds to his legs. One mother we treated had lost five children and her husband. She managed to escape with only her smallest baby who had been shot in the arm. The wounded and their families are suffering from the trauma of the attacks. Their homes have been burned, along with their food stock. The people who managed to flee have nothing with them – they ran for their lives so they couldn't bring any clothes or cooking pots. They sleep outside."

MSF medical doctor in Akobo, Jonglei State, June 2009

6 UN, 2009. 'Humanitarian perfect storm' brewing in southern Sudan, warns UN official <http://www.un.org/apps/news/story.asp?NewsID=31752&Cr=southern+Sudan&Cr1>

Attacks and counter attacks increase risks of malnutrition

Retaliation for the Pibor attacks in March was carried out in Akobo County, Jonglei State, in April, resulting in 250 deaths, the majority of whom were women and children. 70 people were wounded in the attack, and 15,000 people were displaced.⁷ These 15,000 people gathered in Akobo town, urgently in need of access to basic water and sanitation.⁸ However, their situation dramatically worsened in June when barges on the Sobat River, carrying 730 metric tonnes of food for the displaced in Akobo town, were attacked. As a result of insecurity along the river, the food supply along the Sobat was stopped, and the nutrition situation of the displaced deteriorated. Following this, the World Food Programme (WFP) began airlifting food to Akobo. However, the quantity of food dropped was not enough for the displaced or the host population that was trying to help them.

In just one week in June, MSF screened more than 1,000 children for malnutrition, admitting close to 200 with severe malnutrition to its emergency nutrition project. MSF also distributed mosquito nets, and blankets for the wounded and donated additional drugs to the local hospital. However, at the end of June MSF handed over its functioning feeding programme. This was to ensure its team could respond to the next emergency elsewhere as quickly as possible, as the context is one where many organisations on the ground are currently constrained in mounting the rapid response necessary to deal with emergencies.

By August, the lack of food pushed some of the displaced people to leave Akobo town in search of food in nearby rivers. People who gathered by the river were attacked – and 185 people were killed, with women and children as the majority of victims once again.

On 29 August 2009, another clash started in Jonglei State when violence erupted in Twic East County. The attack resulted in the deaths of 42 people, 64 wounded and the displacement of up to 24,000 people from 17 villages. MSF immediately responded with a team that donated medical supplies to the local clinic and organised an emergency food distribution for 4,500 children under the age of five in order to cover the critical time gap before assistance from other agencies arrived. While distributing the food, MSF discovered a worrying level of existing malnutrition and within the first two days of establishing an ambulatory therapeutic feeding programme the team had admitted 50 severely malnourished children.

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^{7 & 8} Official figures from meetings with Akobo County officials

We are now all sick; the people who were walking with me are here now with me, they also got the disease. I have been sick for months, because I waited two months before coming to the clinic. I get shivering and sweating, fever and weakness of the body. Before I found out it was kala-azar, I was just feeling like somebody who was crazy. I didn't know people, and I was just staying alone. But now I am feeling better. I know my family, I know everybody. I am also able to walk."

Kala-azar patient, MSF clinic in Pibor, Jonglei State



© Glenn Warren - Wera Riyo watches after her 24-year old son, Baba Dong Dong, infected with kala-azar, MSF clinic, Pibor, Jonglei State, October 2009

Disease outbreaks: the case of kala-azar

In addition to the increased violence and displacement, large-scale outbreaks of diseases such as malaria or visceral leishmaniasis (kala-azar)⁹ remain common in Southern Sudan. For instance, in 2008, MSF treated 26,346 malaria patients in Unity State. In the first eight months of 2009, MSF had already treated 24,332 malaria patients.

Kala-azar is also on the rise once again. In November 2009, MSF began treating patients suffering from this neglected tropical disease, in several locations across both Jonglei and Upper Nile States. The disease spreads quickly and easily, demanding swift diagnosis and treatment and if left untreated it is fatal in almost 100 percent of cases within one to four months of infection. However, if patients can access treatment on time there is a success rate of up to 95 percent.

Kala-azar thrives in poor, remote, and unstable areas, where there is extremely limited access to healthcare, so while outbreaks are seasonal in Sudan and are not directly linked to the violence, the current outbreak highlights the already precarious medical humanitarian situation facing the population of Southern Sudan.

For the whole of 2008, MSF treated 127 kala-azar patients. However, in 2009, within six weeks MSF had treated 175 patients, with an additional 85 patients treated by the MoH and another 462 by an NGO in Old Fangak, Jonglei State.

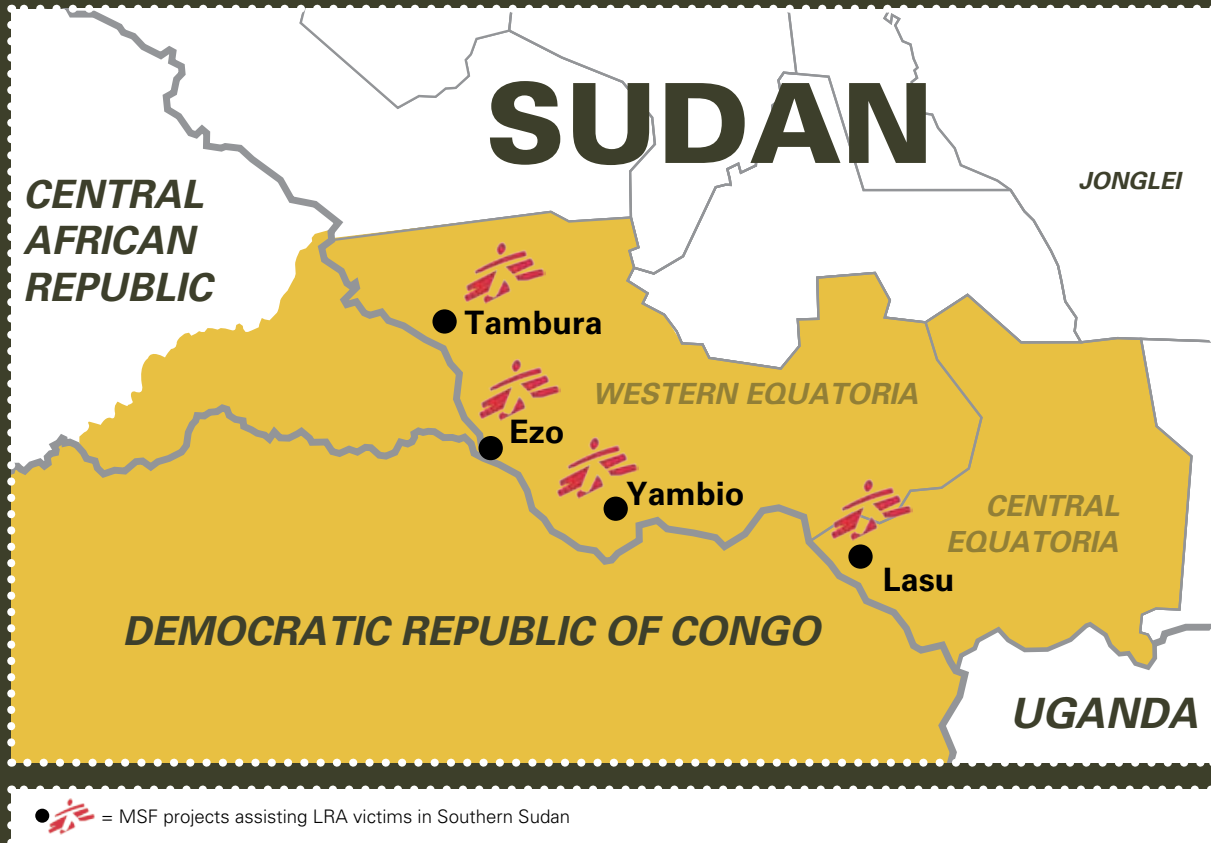
Jonglei is the most affected State. In its remote Pibor health centre, MSF admitted 24 kala-azar patients in November, two of whom died having accessed healthcare too late. MSF also admitted an additional 81 kala-azar patients to its clinic in Lankien. Further north, in neighbouring Upper Nile State, MSF deployed an outbreak response team to screen people across Rom, where 70 patients underwent treatment.

⁹ Kala-azar, or visceral leishmaniasis, is a neglected tropical disease, contracted by the bite of a sand fly carrying the kala-azar parasite, which multiplies inside the body, attacking the immune system. Symptoms include an enlarged spleen, fever, weakness and wasting.





LRA-AFFECTED AREAS IN 2009



"I will never forget one lady – she used to sit under a tree in the camp, weeping. Her daughter had been raped in front of her and then abducted. She didn't know whether she was dead or alive. The violence has destroyed lives. People don't sleep because attacks on their villages took place as darkness fell and they are afraid to close their eyes at night."

MSF project coordinator, Nyori Camp, Central Equatoria State

Under LRA attack

Violent attacks compounding existing medical emergencies have also caused a drastic increase in needs in another area of Southern Sudan in 2009. Activity by the Lord's Resistance Army (LRA) in Western Equatorial State, bordering the Democratic Republic of Congo (DRC), represents another troubling destabilising factor in the South, with significant implications for the population.

Towards the end of 2008, attacks by the LRA on numerous villages in the northeast of the DRC caused thousands of people to flee their homes. According to the UN Office for the Coordination of Humanitarian Affairs (OCHA), there are 268,000 people displaced within the northeastern Congolese regions of Bas- and Haut-Uélé.

The deaths and displacement in the Uélé regions were caused by violence perpetrated by the LRA since September 2008. These attacks were then further exacerbated by a joint military operation that was launched against the LRA by the Ugandan, Congolese and Southern Sudanese armies, with the logistical support of the UN mission in DRC.

More than one year after violence erupted in the Haut-Uélé district, attacks have forced hundreds of thousands of people to flee both within DRC and across the border into Southern Sudan. Many of these Congolese refugees have been unable to find a safe haven in the Western Equatorial region of Southern Sudan as the LRA is also active there, and has caused the internal displacement of tens of thousands of Sudanese. OCHA estimates that a total of 83,819 people have been displaced by LRA violence in Southern Sudan: 66,948 of whom are internally displaced Sudanese, while 16,871 are Congolese refugees who fled across the border. In July 2009, the LRA also reportedly moved towards Central African Republic (CAR), where attacks occurred in villages close to Obo. In Southern Sudan, MSF has seen approximately 3,000 refugees spill over the borders as a result of these attacks.

In response to the Congolese refugee flow and internal displacement in Southern Sudan, MSF intervened in Western Equatoria State at the end of 2008, supporting two primary healthcare clinics in Gangura and Sakure, close to the border with DRC, and responding to the outbreaks of violence affecting the population. As the internally displaced people and refugees moved to other areas, MSF adapted its intervention and opened new projects in Ezo, Naandi, and Makpandu, assisting a total of around 45,000 people living in camps or integrated within host communities.

Short interventions were also carried out in Ibba Mundri, Maridi, Yambio town, South Yubo, Tambura, Namutina and Andari. From February to September 2009, MSF medical teams carried out 6,182 consultations and provided psychological support to more than 700 people in Western Equatoria. Materials for shelter and blankets were also distributed to people fleeing from violence, and latrines and water points were installed in the refugee camps in the area.

Very little humanitarian assistance is provided to the population affected by the violence in Western Equatoria as a result of the insecurity. However, though security concerns along the border areas of Western Equatoria severely impede MSF's ability to access populations at risk, it has still been possible for MSF medical teams to provide a crucial level of emergency assistance.

In February 2009, in neighbouring Central Equatorial State, MSF teams began assisting Congolese refugees in Lasu, approximately 50 kilometres from the Congolese border. MSF was one of the only organisations able to intervene to assist these refugees, as other organisations were unable to respond due to their dependence on development funds and an inability to switch over to emergency funding. Initially, MSF assisted in two temporary camp locations in Libogo and Nyori where more than 6,000 people had sought refuge. In March UNHCR created one camp in Nyori to host the Congolese refugees together.

“They made us carry what they stole. They beat us, saying, ‘Go quickly. Go quietly’. I had to carry spare bicycle parts, in a sack. They killed people we passed, right in front of me – beat them, stabbed them, and threw their bodies into the river. I was afraid they would kill me too, so I marched and marched under that heavy sack. Now I am a refugee in Sudan, but they are also here. There is nothing to think about the future. What future?”

16 year old Congolese refugee who escaped the LRA, Central Equatoria State



©Brendan Bannon - Child in Nyorti refugee camp in Congo. The LRA has been kidnapping children as young as 5 years old. Boys serve as porters or soldiers in training and girls as 'wives'. June 2009





INSTABILITY IN CONTESTED BORDER AREAS

The southern border of Sudan, where the LRA is active, is not the only border area of instability. The three contested border areas between the northern and southern parts of Sudan are another source of instability. For instance, in 2009, tensions were extremely high when the Abyei area was defined by an international court. Prior to this, in mid May 2008, intense fighting in Abyei had resulted in 60,000 people fleeing.

MSF is still responding to the consequences of the 2008 fighting in Abyei, when almost 60,000 of the 130,000 inhabitants fled the area to Turalei and Agok. MSF teams were sent to Turalei and Agok to support the displaced people, bringing surgical and first aid materials to meet the needs of 1,705 families. In these two towns, MSF treated 140 wounded people.

In the Turalei hospital, which only has 40 beds, MSF teams assembled emergency medical structures and tents providing also primary health care services to the displaced population. In 2008, 8,950 outpatient consultations were provided and over 1,200 severely malnourished children were treated from both Dinka Ngok and Misseriya communities. In 2009, MSF continued running outpatient clinics, set up a reproductive health programme and provided nutritional care in both fixed and mobile clinics in Agok and Abyei.

CONCLUSION

The medical humanitarian needs of the population of Southern Sudan are increasing. Violence is escalating across Southern Sudan, from the LRA affected areas in the Equatorias, to those states beset by the so-called 'tribal clashes'. The intensity and targeted nature of the recent violence represents something more than 'inter-tribal cattle rustling'. The number of people killed in the violence is three times higher than the number wounded. In 2009, MSF treated a total of 286 victims of violence; 87 percent of these cases were gunshot wounds. Indeed, 2009 has been the most violent year since the signing of the CPA and this violence is exacerbating an already dire humanitarian situation, with regular outbreaks of disease.

As the humanitarian crisis in Southern Sudan worsens there is a need for increased preparedness and humanitarian action. Although development is important and necessary in Southern Sudan, inadequate consideration has been given to the immediate humanitarian needs of the population, especially at a time of increasing emergencies. Development aid in Southern Sudan has serious flaws and it is not wired to meet the growing emergency nature of the Southern Sudan context.

MSF considers the most effective way of addressing medical humanitarian needs is to be completely independent of all political and military interests and objectives. The focus on the CPA and its development aid components should not come at the expense of independent emergency humanitarian relief that can save lives today.







©Brendan Bannion - Southern Sudan, May 2009