Health and Security Overview: Select Readings

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Disease is among the oldest and most elemental threats to human society. Diseases like plague and smallpox shaped the course of human history, shattered societies, and transformed populations. The flu pandemic of 1918 killed as many as 50 million people worldwide, dwarfing the 17 million death toll of the “Great War” that just preceded it. Disease can strike rich and poor, east and west with impunity—but it preys most cruelly on the weak, the vulnerable, and the poor. Given the power of disease over society, it is no surprise that health care, along with food, water, and shelter, is among the most basic and vital service people require and a fundamental test of the value of governments and institutions entrusted with providing it. Mother Nature can wreak havoc enough, but she is by no means the only threat. The deliberate, malicious use of disease is among the gravest and most horrifying of national security threats—against which our defenses are limited at best. The 2001 anthrax attacks only resulted in five deaths but gripped the nation in fear, brought the postal system to a near standstill, and cost the nation more than $1 billion in response and recovery. Fourteen years hence, it is still prudent and chilling to weigh the implications of a larger more effective attack or one involving a contagious pathogen.

The last century has marked stunning progress in man’s conquest over disease—antibiotics, vaccines, and a host of health improvements have transformed the disease landscape, aided by scientific and technological advances and the maturation of public health institutions. Smallpox has been eradicated and polio nearly eliminated. A decade and a half ago, HIV/AIDS was seen as a grave threat and source of hopelessness: today 15 million persons living with HIV are on life-sustaining treatment. The march of progress against disease, however, is under threat in varied and unprecedented ways. New, naturally occurring disease threats such as H1N1, MERS, and Ebola are emerging, their spread accelerated by today’s urbanized, globalized, and highly mobile world. Accordingly, the time and space between outbreak and epidemic is shrinking. The use or manipulation of disease for nefarious purposes is easier and more accessible than ever, while treatment grows more challenging as antimicrobial resistance has worsened. The natural incubators of both disease and terrorism—weak, poor, fragile, and conflict-ridden states—are spreading rapidly across Africa and the Middle East, along with unprecedented flows of refugees and displaced populations. In a world where biological threats may be one plane ride away, even wealthy, prosperous nations need reminding of how fragile and interdependent health security is today.

The recent West Africa Ebola outbreak serves as a vivid demonstration of what’s at stake. In December 2013, a two-year-old child died in a remote corner of Guinea, the index case for the first recorded Ebola outbreak in West Africa. By late summer 2014, the disease was razing in its wake the marginal public health systems of Guinea, Sierra Leone, and Guinea, gravely disrupting agriculture, mining, tourism, and the normal flow of people, goods, and services. As the fall unfolded, the region witnessed an enormous, often chaotic and ad hoc international response, including, fortunately, the essential deployments of 750 UK troops and 2,800 U.S. defense and military personnel. Ultimately, more than 62 countries

1 http://csis.org/publication/health-security-takes-new-vivid-forms
participated in the international response, at an estimated cost that today exceeds $5 billion. 11,000 have died, 27,000 have been infected, and 13,000 survivors struggle with the grave physical and mental health consequences. No senior World Health Organization (WHO) official has been fired or resigned, while the fight to get “to zero” continues. The specter looms that Ebola may indeed prove endemic to the region. How that might be managed, and what the long-term implication might be, remain unclear.

Inside the United States, the fear that Ebola triggered had profound, complex impacts. The two American missionaries medevacked in late July 2014 to Atlanta brought the nation to the edge of its seat. Thomas Eric Duncan’s tragic death at Texas Presbyterian Hospital in Dallas, followed by the secondary infection and survival of two valiant nurses (one of whom ventured to Cleveland to plan her wedding) created chaos. The subsequent case of a young doctor who returned to (and circulated around) New York City after having become infected while providing care for Ebola victims in West Africa frayed the patience of Governor Andrew Cuomo of New York. That was just before Traci Hickox, a headstrong media-savvy nurse, returned from West Africa, stared down an angry and exasperated Governor Chris Christie of New Jersey and prevailed in court in Maine, all the while antagonizing much of the American public. These events disrupted the U.S. public health and health care communities, damaged the standing of the Centers for Disease Control and Prevention (CDC), generated acute panic, and required multiple interventions by the president and senior officials to restore calm. They fed directly into congressional approval in mid-December of a $5.4 billion Ebola emergency appropriation, which for the first time, dedicated $800 million to creating health security capacities in Ebola countries, their neighbors, and more distant fragile states.

Ebola rocked West Africa, shook us at home, forced us to think and act in new ways about the intersection of health and security, and ignited a process of serious introspection over what it will take to better protect ourselves against dangerous, unforeseen outbreaks. The international response to Ebola has raised important questions about the capacity of future responses, trust and confidence in WHO, and if international leadership will seize on the moment to reform practices to ensure future responses are competent, orderly, accountable, and transparent. No fewer than four international panels have been convened to analyze the root causes of the Ebola catastrophe and advise on concrete steps to create a more reliable system of international preparedness and response.

But as awful as the Ebola outbreak was, it could have indeed been far worse. Weak and impoverished, Liberia, Sierra Leone, and Guinea could not manage the outbreak for their own citizens, let alone the world. But they welcomed the assistance of the international community, which operated freely and at modest security risk. Health care workers bore significant risk of infection—over 500 died, of the more than 800 who contracted Ebola—but violent episodes and refugee flows were limited.

Elsewhere in the Middle East, Africa, and South Asia, a widening arc of violent instability is generating broken, chaotic, fragmented states, often with a heavy radical Islamic dimension. We see the disturbing evidence of the deteriorating security environment in several dramatic ways. There are today 60 million refugees and displaced persons worldwide, the highest level seen since the end of World War II. That has given rise to the illicit trafficking of the desperate from the Middle East and the Horn of Africa, crossing from Libya and Turkey into Europe, that exceeds 350,000 thus far in 2015. In Syria alone, more than 250,000 people are estimated to have died since the internal war ignited in March 2011. Presently, more than half of the Syrian population—almost 8 million internally displaced and 4 million now
refugees—comprise a vast human catastrophe that imposes enormous financial, health, and political burdens—within Syria, on already vulnerable neighboring countries, and now extending into Europe.

At its core, the problem driving the new global political disorder is not an alien pathogen, but rather the dissolution of mal-governed states—Syria, Iraq, Yemen, Libya, northeast Nigeria, Mali, Afghanistan, South Sudan, Somalia, Central African Republic, eastern Ukraine—and the rise of new quasi-sovereign dangerous forms of extremism, most notably the Islamic State (ISIS). In the past five years, 12 new wars have broken out—the most virulent being the post-9/11 wars and the Arab Spring failures—adding to the several unresolved, long-term conflicts.

ISIS, now in the control of over one-third of Syria and Iraq, with external recruits exceeding 25,000, has displaced 3 million people and aspires to create franchise affiliates elsewhere, in North and West Africa and the Middle East. Syria as a sovereign entity has shrunk to a fraction of its previous dimensions. Increasingly, in these regions where governments and institutions can no longer meet the basic health needs of their citizens, terrorist, militant, or insurgent entities are stepping in to fill the void and curry favor. Moreover, as these substate and nonstate actors increasingly “govern” territory they hold and control, their ability to manipulate and control science and health related facilities and expertise for nefarious purposes is growing as well. A case in point is Mosul University in Iraq, taken over by ISIS during the summer of 2014, which provides ISIS unprecedented access to bench science and research facilities and a trained research faculty. With money, facilities, and skilled personnel in hand, ISIS has the potential to pose a serious biosecurity challenge. News reports now point to multiple alleged chemical weapons attacks in the last month by ISIS using sulfur mustard, possibly independently developed and weaponized by the organization. If true, the international community should be legitimately concerned that the biological weapons domain could come next.

Preventing and responding to disease threats—both naturally occurring and manmade—is exceedingly problematic in these broken and hostile regions. In the wake of these rapidly evolving developments is massive human suffering, breakdown of basic health services, and rising vulnerability to dangerous highly mobile infectious outbreaks. Diseases previously slated for eradication (polio) or easily treated through modern medicine (measles) may be poised for a comeback in these broken settings. It is not clear how far and how fast the trajectory of this Middle Eastern–centered decay will advance. Nor how the United States, other countries, and international organizations will respond both to address the security threats and ameliorate the human crisis and public health threats.

Today the international humanitarian machinery is increasingly overwhelmed and increasingly constrained by worsening insecurity and the worsening shortfalls in funding, staffing, and operational capacities. The United Nation’s estimated annual humanitarian requirements total $19.2 billion; as of mid-September 2015, pledges amount to only one-third of that need, with the United States covering 50 percent of the load. Other wealthy, developed countries are flagging in their commitments.

Instability directly affects health care providers and relief workers who are operating on the front lines of crisis and conflict around the globe, struggling to save lives and protect public health while coming under fire themselves. The Islamic State’s deliberate, predatory attacks on international humanitarian workers and other personnel of nongovernmental organizations (NGOs), combined with similar attacks by Boko Haram, the Taliban, and Islamic militias in Libya and Yemen, have fundamentally changed the global environment for response. Neutrality and impartiality for health and other humanitarian services have dissolved. International organizations and NGOs have had to shift increasingly to a minimal on-the-
ground presence, organizing operations from remote, safe locations, and working through local intermediaries. Inside the International Committee of the Red Cross (ICRC), Doctor without Borders (MSF), UN agencies, and many operational NGOs, there is active soul-searching under way, internal deliberations over how the change in the operational context alters their mission, their assessment of risk, and their programmatic approaches.

Given all these factors, global health security will be an enduring challenge, requiring engagement and thought leadership from both health and security sectors.

The Global Health Security Agenda (GHSA), launched by President Obama in February 2014, has taken several critical steps in the right direction. The GHSA is a multilateral initiative that now brings together more than 44 partner countries and organizations in an effort to better prevent, detect, and respond to infectious disease threats through targeted global capacity building. The agenda focusses on key priorities such as preventing antimicrobial drug resistance, promoting biosafety and biosecurity systems, enhancing biosurveillance and diagnostics and improving emergency response. The Ebola outbreak brought new energy and resources to the agenda—a stunning $800 million dollars in just a few months. But with that new enthusiasm comes concern about sustainability, efficiency, and practicality of a leadership-driven global effort lasting beyond the Obama administration. On September 9, 2015, ministers from around the world gathered in the Republic of Korea to take stock of the initiative and issue the “Seoul Declaration,” an impressive international pledge to advance health security, affirming the initiative’s momentum and deepening commitments. Most notably, President Park Geun-hye of Korea pledged $100 million in capacity-building assistance to 13 countries over the next five years, while nine countries, including the United States, pledged to permit external assessments, in addition to the five now completed pilot assessments.

The Global Health Security Agenda is a promising, creative effort to focus on the diplomatic, security, and public health requisites to build a safer world, better equipped to cope with both natural and manmade threats. More, however, will be needed to meet the burgeoning demands of a worsening global disorder over the next 5 to 10 years. Looking into the future, the United States will need to think and operate innovatively in its emergency response and preparedness for biological threats, whether at home, abroad, or both, including respective roles for military and health sectors. The United States will need to work with international partners to better support international aid and health providers in broken and fragile societies, where national capacity building is impossible or impractical, where access is challenged, and where multitudes of threats coexist, to prevent the next global health catastrophe. Across all of these efforts that blend health and security considerations will be the need to build solid, enduring bipartisan support for expanded U.S. engagement in health security and to continue using U.S. diplomatic finesse to motivate our partners to do more themselves.
On Friday, December 18, the UN Security Council passed resolution 2254 by a 15-0 vote, calling for a cease-fire in Syria and political talks to create a transitional government, followed by national elections. This hopeful step reflects a greater international unity on Syria, even while major divisions persist over Bashar al-Assad’s future and the definition of who is a moderate Sunni opposition. By itself, however, passage of the resolution is not likely to spur near-term action and inspire compassion and engagement from the world community to address the immediate mass suffering of Syrians. Other actions are needed to achieve that end.

Syria’s massive human crisis has up to now inspired a paralysis among the world’s major powers and in bodies such as the UN Security Council. Recently, however, shifting geopolitical realities in Syria and beyond may provide an opening for U.S. leadership to create an international alliance, with U.S.-Russian cooperation at its core, committed to expanding access and coverage of humanitarian operations to reach the acutely vulnerable inside Syria as well as in the borderland areas. Actions of this kind are not dependent on a prior comprehensive political framework nor a comprehensive cease-fire. Any such humanitarian initiative can benefit from the lessons learned from the successful U.S.-Russian collaboration in removing and destroying Syrian’s chemical weapons.

Paralysis in the Face of Colossal Tragedy

Since Syria’s internal war began in March 2011, an estimated 300,000 people have been killed, Syria’s population has dropped from 22 million to under 17 million, and half of the citizens who remain are now internally displaced. At least 4 million, and more likely over 5 million Syrians, have been forced into exile in neighboring Turkey, Lebanon, and Jordan. Many more will certainly come that direction as Syria steadily empties. In turn, more than half of the 1.2 million refugees who have flooded in desperation this year into Europe are Syrians. This desperate spiral shows no sign of abatement. Up to now, the Assad government has been wholly willing to destroy its society to survive, backed by Iran’s Quds Revolutionary Guard, Hizballah fighters imported from Lebanon, and Russia’s political, materiel, and (since September) air campaign, directed overwhelmingly against opposition forces.

Rather than galvanize action, Syria’s startling human crisis has engendered a conspicuous international numbness, rooted in several factors. The Iraq and Afghan wars created deep fatigue. Competing geostrategic priorities stole a lot of attention, most notably the Iran nuclear negotiations and the Ukraine crisis. It has been difficult to argue against the common refrain that there are simply no meaningful, realistic options to reach the imperiled populations inside Syria and reverse Syria’s burgeoning human crisis, so long as the Assad government has been willing to use industrial military violence against its own civilians, its health community, and the providers of emergency relief. Further, Syria’s multiple internal conflicts, involving a shifting array of dangerous armed Islamist movements battling Assad and other opposition forces, have stymied access, as has the absence of any agreed political framework to resolve Syria’s war.

The UN Security Council passed resolution 2177 in 2012, demanding humanitarian cooperation from the Assad government and others, but that measure has proved meaningless in the absence of any shared high-level political will to enforce it. Action to rid Syria of chemical weapons in 2014, following the killing of 1,400 Syrians through the government’s use of sarin, was largely successful but had no “humanitarian bounce” as many observers initially had hoped. In the meantime, the internal security environment has grown ever more dangerous, fragmented, chaotic, and violent. International organizations and nongovernmental organizations (NGOs) no longer enjoy any measure of protection, as the respect for their neutrality and impartiality has decayed. Health care in Syria is in complete disarray—40 percent of ambulances have been destroyed, more than half of hospitals have been destroyed or seriously damaged, more than half of Syria’s 30,000 doctors have exited, and child vaccination rates have plunged. Health care, along with food and clean water, have become tools of coercion and targets for violence. Just in the last few weeks, air strikes have hit grain silos, water treatment facilities, hospitals, and bakeries—affecting hundreds of thousands of people.

The United States, to its credit, has been generous in investing over $4.5 billion in humanitarian emergency assistance by international organizations and nongovernmental organizations to answer Syria’s human crisis—fully half of the international response—but funding alone cannot solve the access and security challenges at the heart of the crisis.

ISIS’s arrival in mid-2014 in Raqqa, Syria, and Mosul and Falluja in Iraq, changed the security landscape profoundly while at the same time suddenly enlarging the human crisis. As it fed off the chaos of Syria’s internal war and deep Sunni discontent in Iraq, and as it instituted its rein of pathological terror, ISIS rapidly displaced an estimated 3 million people, brought under the caliphate’s roof 8–10 million people, and effectively erased the Syrian-Iraqi border. In control of nearly a third of Iraqi and Syrian territory, ISIS controls delivery of essential services in these territories and has broadened access to scientists, funds, and materials to support its own weapons ambitions.

A Shifting Geopolitical Environment

The geostrategic environment has shifted in important ways, possibly creating the opportunity for renewed U.S. leadership on the humanitarian front, even as countering the ISIS security threat and pushing for a negotiated political resolution to Syria’s internal war have come to dominate the headlines. Humanitarian crises sometimes reach a tipping point at which the international community can look away no longer and the status quo is more dangerous than the options to change it. Such a moment may be at hand in Syria, in terms of expanding access to and coverage of humanitarian operations. In Washington, the mounting pressure from many political directions to “do something” is reflected in the unresolved debate “over whether to deploy American military forces to establish no-fly zones and safe havens in Syria to protect civilians caught in its grinding civil war.” In reality, that debate may be a red herring that distracts us from the far more practical discussion of feasible humanitarian initiatives that would not entail additional U.S. military involvement on the ground.

Geopolitically, we see four big changes that taken together favor taking another look at what is possible on the humanitarian front.

First, the explosion in refugees, and the resulting political, financial, and ethical havoc, have brought the Syrian crisis directly to Europe’s door. With the winter months bearing down, the conflict is escalating, conditions are worsening, and the political and economic pressures of refugee outflows continue to
grow for receiving nations. While resettlement is an essential component of the international response, the motor force behind this surge of desperate migrants into Europe lies inside Syria and Iraq. Now that the crisis has arrived directly in Europe’s backyard, the pressure to stem the crisis at its source has risen steeply.

Second, the dramatic expansion of ISIS-inspired terrorist attacks outside of Syria/Iraq—the killings in Paris, Beirut, Sousse (Tunisia), Ankara, over the Sinai, and now San Bernardino—convey a similar message: the security threat ISIS poses has considerable reach and cannot be simply contained. As outlined in the UN Security Council Resolution 2249 passed unanimously on November 20, 2015, this threat must now be confronted through heightened, concerted international action—including in the humanitarian sphere—by the United States, Russia, and others. ISIS is both creating and encouraging this flight of humanity and also seeking to leverage it to export terror and intimidation. Arresting and mitigating humanitarian conditions on the ground are essential elements of any campaign to defeat ISIS.

Third, since September, Russia has expanded its presence on the ground and in the air over Syria, deepening Russian involvement in the crisis and its expansive armed intervention, including attacks in opposition territories and targeting of hospitals and clinics. This shift has only worsened, not lessened, the human crisis. But also, the stakes for Russia have climbed. Russia now bears increasing responsibility for conditions inside Syria that drive this international crisis. Three months of aerial bombing have not materially changed the military situation on the ground in Syria but has resulted in loss of Russian lives and a dangerous clash with Turkey. Increasingly, Russia now faces the specter of a quagmire. That begs the question: might it be possible to persuade President Vladimir Putin to compel the Assad government to take certain actions that dampen the crisis and create the conditions necessary for a negotiated resolution? Could Russia use both its presence and its influence on the ground to expand access to essential humanitarian services?

Fourth, here at home, the Paris and San Bernardino killings have generated fear, political opposition, and in some cases active bigotry, an ugly American face to the outside world. Political opposition and even hostility toward Syrian refugees have escalated: governors of more than 23 U.S. states have stated their opposition to the resettlement of any Syrian refugees in their states. These developments raise the issue of whether there are active measures the White House might take to reinforce America’s image as a compassionate and generous nation and achieve concrete humanitarian results, short of committing U.S. ground forces and airpower to enforce safe havens and no-fly zones inside Syria. If a moment for action may be approaching, how might U.S. leadership be best channeled?

**A Possible Way Forward?**

We see two broad, and not mutually exclusive, options.

The United States has the immediate opportunity to significantly enlarge U.S. humanitarian investments in Syria’s borderlands with Turkey, Lebanon, and Jordan, by expanding existing operations that are under way by UN agencies, other international organizations, and nongovernmental groups. In addition, support and assistance must be directed to both the refugee and the host communities to reduce resentments, build more sustainable and enduring capacities, and encourage better host-nation cooperation with cross-border assistance—to include facilitating inspection and accelerating bureaucratic processes and paperwork. Too little has been done to support those countries sharing the front lines of this conflict, and existing assistance efforts suffer from a lack of coordination and
deconfliction. Expanding assistance and improving the coordination process to better synchronize assistance through multiple international and nongovernmental organizations are steps that can and should be taken right away. These efforts should be matched by intensified diplomacy to leverage higher commitments from other wealthy donors.

Potentially as part of this effort, the United States and European partners can leverage the Global Health Security Agenda (GHSA) to direct resources and attention to the refugee crisis and promote investment in the borderland states to better protect refugee populations and create stronger capacities there to prevent, detect, and respond to infectious outbreaks. That mobilization under a GHSA flag can feature in discussions at the G7 Summit in Japan in May 2016 and at the GHSA summit in the Netherlands in the fall of 2016.

The United States also has the option to press the Russians and others to join with the United States to expand access and coverage in specific zones inside Syria: particularly those under government control; under the Syrian Free Army; and under Syrian Kurds. It might be possible to move ahead incrementally without the precondition that Vienna talks first achieve a political framework—and without committing U.S. military assets. A humanitarian initiative would likely require the ad hoc creation of an international relief commission of some sort, blessed by the UN Security Council. It would call for actively exploiting any openings created by local cease-fires, as seen in Homs. It would require compelling the Assad government to accept cross-border relief operations and to cease attacks on humanitarian operations. It might feature an expeditionary team of monitors and inspectors, comprising Russians, Americans, and others, that reports to the commission and focuses on cross-border and other delivery channels. Similarly, it would require the Russians cease attacks on moderate Sunni opposition, as well as commitments to humanitarian principles by the Syrian Free Army and the Syrian Kurds. And it would require very close interaction with the likes of the International Committee of the Red Cross, Doctors Without Borders, UN agencies, international NGOs, and the Syrian Red Crescent to address their security concerns and win their agreement to expand on-the-ground relief operations.

If successful, an international humanitarian initiative might provide an important parallel track that brings relief to populations in these three zones, opens roadways and air access for the flow of commodities and relief personnel, improves civilian security, and staunches the human outflow. It might strengthen incentives for a negotiated settlement, while demonstrating U.S.-Russian common resolve.

Learning from Success

There can be no cookie cutter solutions to a crisis this expansive and complex, but neither can “it’s impossible” be the excuse to do nothing. Any international humanitarian initiative in Syria, with U.S.-Russian cooperation at its core, could also draw lessons from the one relatively successful instance of international cooperation in this bloody conflict: the elimination of Syria’s chemical weapons program following the tragic Sarin attacks in East Ghouta in August of 2014.

Under threat of U.S. missile strikes against the Assad government, the United States and Russia negotiated a bilateral framework agreement for the elimination of the vast majority of one of the largest known, active chemical weapons programs in the world—a program including more than 23 sites spread across an active war zone during a catastrophic humanitarian disaster. This included the removal and safe destruction of more than 1,200 metric tons of dangerous chemicals and precursors in bulk form. With the full support of the UN Security Council and the Organization for the Prohibition of Chemical
Weapons, partner states banded together in a sizeable coalition committed to implementation of the plan.

The successful removal and destruction of chemical weapons proves that with sufficient coercive pressure and robust international cooperation, resources, and expertise, coordinated international action to achieve a specific, near-term objective in Syria is indeed feasible. Yes, the situation has only grown more complex over the last year. Yes, in the chemical weapons instance Assad was the single culprit and the threat of violent retaliation against continued violations was credible; whereas, in the humanitarian sphere there are numerous bad actors, and it is far from clear how to enforce compliance and punish violators. Nonetheless, a few key lessons from that experience can inform any humanitarian initiative to mitigate suffering on the ground and reassure suffering populations and overburdened neighboring countries that the United States and the world have not forgotten them.

(1) Elevate stabilizing the humanitarian situation to a top-line priority. If everything is a priority, then nothing is a priority. The United States can most profitably lead by winning Russia and others’ consent to a declaration that improved protection of Syria’s displaced, besieged, and refugee populations is an urgent priority, essential both to any plan to defeat ISIS and any transition process to restore peace and governance in Syria.

(2) Any humanitarian compact with Russia has to be clearly grounded in mutual interests. Military interventions are not realistic or effective options, for either the United States or Russia. Both countries have a powerful stake in quelling rather than exacerbating the burgeoning refugee crisis. As with the chemical weapons removal and destruction effort, a core argument has to be that it is in the mutual self-interest of Russia and the United States to devise a bilateral (or even trilateral with Iran) framework agreement for the rapid expansion of humanitarian aid and protection of civilians and humanitarian workers. A bilateral framework outlining the concepts, goals, and targets between the United States and Russia could provide the essential foundation for a humanitarian initiative. With an agreement in place, Russia could then wield its political influence in Syria and compel cooperation, at the same time that the United States could galvanize the international community and assemble the coalition to execute critical tasks. All parties would need to agree to modify airstrikes and refuse to target humanitarian facilities providing food, health care, and sanitation.

Such an agreement need not undercut the longer-term agreement currently under negotiation. In fact it should be separate and independent, focusing on saving lives and improving conditions in the immediate term. In the medium to longer term, it could be a confidence-building measure that contributes in support of a negotiated political settlement.

(3) Most critical is to define the mission in concrete, realistic terms, with specific targets and timelines and practical approaches. Targets might encompass full approval and support for humanitarian convoy requests; acceptance of joint monitoring and inspection teams; increased access to essential health care and nutrition for besieged populations by a concrete percentage; and expansion of health and education services in bordering refugee facilities by a quantifiable measure. These would not be contingent on no-fly zones or safe havens, although perhaps small joint U.S.-Russia inspection teams could provide assurances that the convoys are strictly humanitarian. Regardless, the operational experts on the ground should be charged with defining and shaping creative implementation strategies, and both the United Nations and contributing nations should support and encourage “out of the box” thinking.
(4) Avoid unrealistic preconditions. Rigid preconditions will only invite delays and “kick the can down the road.” It is most critical to focus on what is truly essential to accomplish the task, not what is desirable or preferable. The focus should not be on requiring a viable comprehensive cease-fire to initiate such an effort, rather it should involve acting swiftly to take full advantage of localized shifts in security conditions to enlarge humanitarian access and coverage.

(5) No business as usual. We cannot expect to meet unprecedented challenges with business-as-usual approaches and a traditional tool kit. Addressing a catastrophe this complex, spread over multiple countries and regions, and in an environment of extreme violence and instability requires technical, operational, political, and bureaucratic innovation, as well as the expertise and participation of multiple UN entities and NGOs. The trick will be to devise a unified, flexible mechanism and coordinating body that can convene multidisciplinary expertise from across the international system and navigate the highly complex operational and political terrain.

(6) Remove excuses with a clear mandate. A large, complex mission will ultimately need the blessing of the Security Council to ensure that Syria has an obligation to comply and that donor nations have an obligation to support. An initiative of this magnitude needs a robust international mandate to provide authority, resources, and we hope, ultimately accountability. The Security Council must call this crisis what it is—a threat to peace and security in the region and beyond—and call for the support of all nations in carrying out measures to address it. This is essential to building a viable coalition, generating in kind and financial contributions, and establishing an expectation that noncompliance could result in additional consequences.

A Way Forward?

It may be possible to graduate out of numbness and take action to expand humanitarian access and coverage to the millions of vulnerable, underserved Syrians. It will rest on U.S. leadership to clearly define and ruthlessly prioritize a humanitarian mission that has specific measures and limited objectives. It will rest on a political framework with Russia to guide the effort and bind both of our nations to the outcome. And it will rely on the establishment, in conjunction with a clear international mandate, of an “on the ground” multilaterally empowered entity to bridge the political and operational minefields and synchronize operational efforts. In combination, these steps might make the “impossible” seem just a little more doable.

It’s worth a try.
As 2015 unfolded, the worst of the Ebola catastrophe had ended, leaving in its wake a terrible trail. Ebola has, as of November 2015, killed more than 11,000 (including over 500 health workers) and infected more than 30,000. Thousands of survivors today struggle with heavily impaired personal health, amidst heavily damaged national health systems. The global response, tragically late by several months and organized in extreme haste in late 2014, was, in effect, a $5 billion scramble. It unfolded amid widespread panic, fear, and chaos. Today, the outbreak is under control, though it persists at very low levels and the region may not be effectively cleared of the virus. In the course of this suffering and its aftermath, accountability has been elusive. It is difficult to name a single official—international, national or otherwise—who was fired.

There were many moments of exceptional courage, sacrifice, and impromptu brilliance. Doctors Without Borders (MSF) were true heroes, as were countless less well-known Liberian, Sierra Leonean, and Guinean individuals, civil organizations, and government health officers. Cooperation accelerated across governments, regulatory bodies, industry, and the World Health Organization to advance the testing of vaccines and antivirals. U.S. leadership, though late, was pivotal to bringing the outbreak under control: the U.S. Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) each distinguished themselves, fielded hundreds of American staff on the ground, and accounted for no less than half of the international response. The 2,800 U.S. troops deployed to Liberia were strategically important in breaking panic and opening logistical operations. Congress in December 2014 approved $5.4 billion in emergency Ebola funding, of which $3.7 billion was to complete the job of control in West Africa, continue to advance the development of new scientific and medical tools, and build basic health security capacities.

Soul Searching Begins

Ebola also triggered considerable introspection in 2015 by no fewer than four international panels. Many feel, it seems, that this historical—and preventable—failure warrants in-depth introspection and a concrete plan of action for the future.

I served on the Independent Panel on the Global Response to Ebola, organized by the Harvard Global Health Institute and the London School of Hygiene and Tropical Medicine, released its full report in November. The panel struggled with answering two fundamental questions. How are we to make sense of—and account for—the wide-ranging, egregious failures to prepare, detect, and respond? And most important and arguably most urgent, what are the next steps to restore confidence and trust that when the next outbreak occurs, the world is reliably better prepared? That means ensuring that there will be robust high-level political leadership. It means taking steps to build core capacities in vulnerable countries. It rests on external assistance being mobilized quickly and effectively, and ensuring that medical tools, protections of workers, and knowledge of best practices are available. And it rests on strengthening the international organizations and other institutions charged with leading a coherent

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response so that they are competent, speedy, and accountable, and that they operate according to an agreed set of priorities and responsibilities.

**So What Is to Be Done?**

There are many answers detailed in the panel’s 10 primary recommendations. Two considerations are of penultimate importance.

First, now is the time to act—at a high level—if the opportunity to effect real change in how the world prepares for infectious outbreaks is not to slip away. The risk is we return to business as usual, with modest reforms on the margins, and continued high vulnerability.

The perceived threat of Ebola has declined precipitously, as other crises muscle their way onto center stage. The most prominent, of course, is the worsening global disorder, centered in the Middle East and North Africa, that is contributing to a colossal human crisis (millions of Syrian refugees in neighboring states, 500,000 refugees entering Europe in 2015) that now dominates airwaves and high-level political debate, alongside consideration of Russia’s expanded military role in the widening Syrian war. The much weakened WHO Director General Margaret Chan are simply in no position to carry forward an agenda of deep structural change in how the world prepares for infectious outbreaks: that can only come from a committed and determined nucleus of North and South heads of state and other high-level leaders.

How might that nucleus form? That is far from certain but still possible. It may emerge from German president Merkel, who in her role as chair of the 2015 G-7 rallied other G-7 members around a shared commitment to follow through with major reforms in the global approach to disasters like Ebola, as the picture settles and the work of investigative panels is completed. It is hoped that Merkel will receive aid from Japanese Prime Minister Abe, who will chair the G-7 in 2016 and has indicated his desire to carry forward the commitments made by G-7 members in Berlin. And UN secretary general Ban Ki-moon and members of the UN Security Council will play potentially pivotal roles, along with leaders of Liberia, Sierra Leone, and Guinea, as well as the Africa Union. All four investigative panels will have completed their work by year’s end, will overlap to a considerable degree, and can help spur high-level debate in 2016. Any further dangerous outbreaks, such as MERS (Middle East Respiratory Syndrome) or pandemic flu, will concentrate attention but can hardly be predicted.

Second, fixing WHO needs to be the top priority. That is the single most conspicuous requisite for restoring the trust and confidence of the world’s leaders that there will not be a repeat of the Ebola catastrophe when the next outbreak occurs. Half measures will not suffice. If WHO is not fixed, the world’s powers will revert tacitly to plan B: assume the worst on the part of WHO, and assume the United States, other major powers, the UN Security Council, and UN agencies will again scramble, in an ad hoc and chaotic fashion, to piece together a response.

The WHO Executive Board commissioned a panel, chaired by Dame Barbara Stocking, which completed its work in July and made several recommendations: the establishment of a Center for Emergency Preparedness and Response; modest budget increases; and a $100 million pandemic response fund. A committee will consider incentives for early notification of emergency outbreaks and steps to deter unwarranted disruptions of trade and travel.

These changes, while worthwhile, simply do not go far enough. The newly formed WHO Emergency Center needs to be much more than a simple merger of outbreak response and humanitarian
emergency capacities. It needs to be muscular and autonomous: to have an independent director and board, be able to fulfill a full range of critical functions. The latter include support to governments in building core capacities; rapid early response to outbreaks; technical norms and guidance; and convening parties to agree upon a strategy that sets clear goals and effectively mobilizes money and political will.

The decision power within WHO for declaring an emergency needs to be moved from the WHO director general to a Standing Emergency Committee that is far more technically competent, transparent, and politically protected. WHO needs to step into the lead in developing a framework of rules for the sharing of data, specimens, and benefits during outbreak emergencies. Deep internal reforms of WHO, long overdue, are essential if member countries are to be persuaded to invest in it seriously over the long term. Those include narrowing WHO’s focal priorities and finally resolving that WHO will interact in a more open, balanced and productive way with private industry, foundations, and nongovernmental groups. An inspector general and an overhaul of human-resource policies will bring WHO up to global standards.

How to carry forward this ambitious agenda? An interim WHO senior manager should be appointed in early 2016 to work through mid-2017. The selection of the next WHO director general (who will take office in June 2017 for a five-year term) will be pivotal. She or he needs to be a statesperson—someone with gravitas, dynamism, and skill in crisis management, mediation, organizational reform, strategic communications, and coalition building.

2016, Year of Decision

Several other very significant innovations are detailed in the Harvard Global Health Institute/London School of Hygiene and Tropical Medicine report. Reliable new financing mechanisms will build capacity, ensure quick response, and support long-term research and development. A UN Security Council Health Security Committee will strengthen high-level engagement. An Accountability Commission can provide independent expert oversight.

The year 2016 will be the test of whether it is at all feasible to execute reforms of the world’s preparedness for dangerous infectious outbreaks. The deciding factor will not be knowing what needs to be done; the concrete reform agenda is known. It will be whether there is sustained, high-level political commitment.
BEIRUT—Aid workers on Tuesday described a harrowing scene in Madaya, the day after the first humanitarian-aid convoy reached the Syrian town after a seven-month siege by the Assad regime.

Clinics and field hospitals were out of medicine, children were too hungry to play and many new mothers were unable to produce milk as a result of malnutrition, workers traveling with the United Nations and other international organizations said.

On Monday, the U.N. and other agencies sent 44 trucks to the Damascus suburb.

The next day, a local committee began distributing food, medicine and blankets to the town’s 40,000 residents, who say they have been surviving by eating leaves and stray cats and dogs, with some families consuming only boiled water with spices. Aid agencies called for regular access to the country’s besieged areas, saying the latest deliveries wouldn’t improve the situation over the longer term.

In the past seven months, aid agencies have been allowed into the town just once to deliver food and medicine, in October. Besides that delivery, neither humanitarian assistance nor commercial deliveries have been allowed in and numerous people trying to flee the town have been killed by pro-regime forces or by walking through minefields, residents said. At least 23 people have died from starvation alone, including six children.

“From what we saw in Madaya, we are requesting unhindered access to all of the besieged areas,” said Elizabeth Hoff, the World Health Organization representative in Damascus.

She was part of Monday’s aid convoy and said she was alarmed by the malnutrition she saw in Madaya and the stories residents told her.

Doctors said between 300 and 400 patients are suffering from severe malnutrition, adding that there are deaths from starvation each day.

Sieges have become a common tactic in Syria’s nearly five-year conflict, used not only by the regime but also by rebels and Islamic State.

Bashar al-Jaafari, Syria’s ambassador to the U.N., on Tuesday denied that his government has besieged any areas, blaming terrorist organizations for using civilians as human shields and blocking aid delivery. The Syrian regime describes all opposition as terrorists.

“The health situation here is tragic, I cannot explain how bad it is,” said Pawel Krzysiek, a Red Cross spokesman who accompanied the convoy and echoed the call for aid groups to be given regular access to Madaya. “It’s heartbreaking.”

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As bags of rice were being unloaded Monday night, some of the children licked their fingers and tried to gather grains that had fallen onto the back of the trucks, Ms. Hoff said.

“The people were distressed, they didn’t talk about politics at all. They only talked about the lack of food. They said they hadn’t eaten for several days,” she said. “You could see the children, there were no smiles on any of their faces. I asked them, ‘Don’t you play?’ They said, ‘We have no strength to play.’”

She said that while visiting a field hospital, which was in a dark basement down a steep flight of stairs, she met a mother who wasn’t producing milk to feed her infant child. The mother, who was weak from malnutrition, said she fed her other children water boiled with salt and pepper, Ms. Hoff said.

She said she also met a 45-year-old man who said he hadn’t eaten in many days. “I was worried he would not survive the night.”

Aid agencies including the United Nations, the International Committee of the Red Cross and Syrian Arab Red Crescent are scheduled to return to Madaya on Thursday.

On Monday, 21 aid trucks were also sent to the regime-controlled Shiite towns of Fua and Kafraya in northwest Syria, which rebels have besieged by for months.

Eight aid agencies, including Save the Children and Oxfam, called for lifting the siege on Madaya and other blockaded areas and to be allowed sustained access.

“Today’s delivery will provide food for up to a month...but agencies warn that this one off permission to deliver will be insufficient given the current shocking reported levels of malnutrition,” the agencies said.
MADAYA, Syria, Jan 12 (UNHCR) – Starving civilians trapped in this besieged Syrian town foraged for grass and herbs in a horrifying humanitarian crisis only broken when an aid convoy arrived this week, the UN Refugee Agency said on Tuesday.

UNHCR took part in a convoy of more than 40 trucks that delivered life-saving aid of food and blankets overnight to thousands of people trapped inside rebel-held Madaya, where more than 40,000 civilians have been cut off in dire conditions without aid for nearly three months.

At the same time humanitarian assistance in a 21-truck convoy was delivered in the same manner to Foa'a and Kefraya in the Governorate of Idlib to about 20,000 people.

The first four trucks rolled into the town shortly after dark on Monday (January 11) in bitter cold. They were immediately surrounded by shivering children and adults, some showing clear signs of malnourishment and desperately asking for food, according to the UNHCR’s representative in Syria, who was on the convoy.

"We were pretty horrified," Sajjad Malik said. "Most of them have not had bread, rice or vegetables for quite some time. They were desperately looking for something while we were offloading cars... kids and everybody around the cars were asking for anything (to eat) ... we could see how desperate the situation is."

The aid of UN/ICRC/SARC convoy that got through following a negotiated ceasefire was the first to reach Madaya since October. A local doctor reported that hunger had killed a number of residents, and that 300-400 others were suffering from malnutrition in the town, where food stocks had been all but exhausted, Malik said.

WHO and SARC are planning to do an assessment to determine the number of people suffering from malnutrition in the coming days.

"There is nothing available in Madaya ... in the market obviously there is nothing," he told reporters in a conference call from Damascus, shortly after returning from Madaya.

Aid workers unloaded a cargo of food aid, blankets and medicines throughout the night in the isolated community, where starving residents, including children, have been forced to forage for grass – their last source of nutrition – in surrounding areas in the isolated town.

"They have been going around looking for grass or herbs ... and they use a bit of spices and make soup. (There is) no real food," Malik said

Malik said that the few meagre supplies of food that remained in the town were being sold at exorbitant prices – with US $300 sought for a kilo of rice. "Reportedly someone sold a motorbike to get five kilos of rice because there is no food," he said.
Two further convoys are planned to reach Madaya in coming days. Malik stressed that it was vital that further aid was allowed to reach the town throughout the winter, as well as all other hard-to-reach and besieged areas that remain cut off under siege.

"If we are not able to sustain this support to these communities, even this effort ... with all these trucks now is going to be another band-aid, because within a month they will run out of food and medicines," he said. "What we saw in Madaya should not happen anywhere in this century, it should not have happened now."

As the crisis in Syria nears its sixth year, up to 4.5 million people in the country live in hard-to-reach areas, including nearly 400,000 people in 15 besieged locations who do not have access to the aid that they desperately need.

NYT – Suicide Bomb Near Polio Center in Pakistan Kills at Least 16

JANUARY 13, 2016

ISLAMABAD, Pakistan — At least 16 people were killed on Wednesday in a suicide bombing outside a polio vaccination center in the southwestern Pakistani city of Quetta, officials and witnesses said.

Thirteen of the victims were police officers, said Syed Imtiaz Shah, a senior official with the Quetta police. He said the officers were there to guard polio workers, who are often targeted by Islamist militants in Pakistan.

The attack came on the third day of a vaccination campaign in the province of Baluchistan, of which Quetta is the capital. The bomber, who was also killed, walked up to police officers and detonated what Mr. Shah said amounted to more than 20 pounds of explosives.

A spokesman for the Pakistani Taliban, Muhammad Khurrasani, claimed responsibility for the attack on the militants’ behalf. Two civilians and a paramilitary police officer were also killed, and 10 police officers and nine civilians were wounded.

Hard-line Islamists in Pakistan have long opposed polio vaccination campaigns, saying that polio workers are Western spies and that such campaigns are part of a conspiracy to leave Muslims infertile. Resistance to such campaigns increased after 2011, when it emerged that the C.I.A. had used a vaccination drive as cover in the hunt for Osama bin Laden.

Baluchistan, a restless province that borders Afghanistan and Iran, has been racked by separatist and sectarian violence for years. “Such a cowardly act could not deter our resolve of eliminating terrorism from the region,” the province’s home minister, Sarfraz Bugti, said by telephone, referring to the attack.

World Health Organization – Syrian Arab Republic: Crossing Borders with Life-Saving Support

JANUARY, 2016

Walking over to a map of Syrian Arab Republic affixed on her wall, she traces the Jordanian-Syrian Arab Republic border with her finger. As WHO’s health and nutrition sector coordinator based in Amman, Jordan, Jennyfer manages the logistics behind WHO’s effort to get emergency health assistance across the border to people in the southern part of Syrian Arab Republic.

Since a United Nations Security Resolution was passed in mid-2014, WHO has been coordinating the movement of life-saving supplies into Syrian Arab Republic from its hub in Jordan.

“My work involves getting surgical equipment to the hospitals that need them the most,” Jennyfer says. WHO also works with partners such as UNICEF and UNFPA, on procuring medicines and equipment for the treatment of noncommunicable diseases and to assist with births. “Health support from WHO and its partners in Damascus, which is quite substantial, cannot reach all the facilities that need it, and so we complement it with efforts from Jordan,” she explains.

Cross-border support

This cross-border support focuses on Syrian Arab Republic health facilities in areas including Al-Jeezah, Busra ash-Sham, Daraa City, and Tal Shihab.

To deliver services and supplies to areas with compromised health services, WHO cross-analyses locations reporting increases in shelling, trauma and displacement with local health actors and uses a Health Resource Availability and Mapping System (HeRAMS). The Mapping System is a database of information that shows the functionality of health facilities and availability of services, medicines and equipment. WHO then coordinates shipments of supplies earmarked for dispatch from hub warehouses via United Nations convoy.

“Our kits are designed to cater to trauma injuries,” says Jennyfer. “Injuries requiring surgery are incessant due to the ongoing conflict.”

Surrounding country support

WHO also provides support from Turkey, where it is working to improve the medical skills of Syrian Arab Republic health partners, particularly in disease surveillance.

The Organization is also working towards increasing coverage of routine immunization services in Syrian Arab Republic – a massive challenge since much of the north is under opposition control.

“We push on despite the insecurity and access challenges and will continue to provide as much support as we can from WHO hubs to strengthen our response,” says Jennyfer.

Expanding deliveries of surgical supplies

WHO’s cross-border support for 2016 will focus on improving the quality of the current health information system, expanding deliveries of surgical supplies, increasing the range and quality of primary health care services to include mental health and nutrition, and improving the referral system for trauma cases.

Almost 6.5 million Syrians remain displaced within Syrian Arab Republic and more than 4 million registered Syrian refugees are living in Egypt, Iraq, Jordan, Lebanon and Turkey.

ICRC – Syria: Key Operation Begins to Bring Aid to People in Besieged Areas

JANUARY 11, 2016

Damascus / Geneva – The International Committee of the Red Cross (ICRC), working alongside the Syrian Arab Red Crescent (SARC) and the United Nations (UN), has begun delivering vital aid to thousands of people living in three besieged areas in Syria.

Food, medical items, blankets and other materials are being delivered by convoy to the towns of Madaya in Rural Damascus, and Foua and Kefraya near the city of Idleb. There has been growing international concern about the suffering of thousands of people in these areas. The ICRC will concentrate on delivering medical assistance.

"The operation has started. It is likely to last a few days. This is a very positive development. But it must not be just a one-off distribution. To relieve the suffering of these tens of thousands of people, there has to be regular access to these areas," said the head of the ICRC delegation in Syria, Marianne Gasser.

There are believed to be around 40,000 people in Madaya and around 20,000 people in Foua and Kefraya. The operation has been brokered by the UN with the agreement of the different parties on the ground.

"We have to remember that there are more than 400,000 people living in besieged areas across Syria. The suffering is intense. Aid agencies must be given safe and unimpeded access to all these people to provide them with the aid they need, especially now in the midst of winter," said Ms Gasser.

An upsurge in fighting and bombing over the past week in northern Syria's Azaz District, near the Turkish border, is jeopardizing medical activities in the few hospitals and health posts that are still functioning, the international medical humanitarian organization Doctors Without Borders/Médecins Sans Frontières (MSF) said today, warning that it may be forced to close its own hospital in Aleppo province.

The increased violence has also paralyzed the delivery of humanitarian aid—which was already limited—to more than half a million people in the area.

"In recent days, with fighting in the east and west of Azaz district, and with the bombing getting closer and closer to our hospital, the risk to our patients and health staff is reaching unsustainable levels," said Carlos Francisco, coordinator of MSF projects in northern Syria. "The flow of patients continues to grow as other health posts have closed in the last months due to clashes. Last weekend we had to reduce activities in our hospital. The next step will be to close a hospital assisting some 50,000 people."

MSF's hospital in Azaz district is one of the main medical facilities still functioning in the rural area between Aleppo and the Turkish border, providing emergency surgery, inpatient care, and safe deliveries.

In October, MSF documented 12 hospitals bombed in the north of Syria, including six supported by MSF. Most recently, two hospitals supported by MSF—in Zafarana, Homs Province, and in Erbin, rural Damascus—were hit in aerial bombing raids over the past three weeks.

"With such a frequent rate of hospitals being bombed, we are extremely concerned about the safety of our patients and medical staff," Francisco said.

The main road from Kilis in Turkey to Aleppo—a key supply route into eastern Aleppo—is close to being completely cut off from humanitarian aid. Several convoys have been bombed in the past few days, and on December 3 a truck on the way to deliver winter kits to families in Aleppo was fired on. Over the weekend, MSF had to halt the distribution of relief items to about 40,000 people in eastern Aleppo.

"This route brings all the food, fuel, and humanitarian aid for some 600,000 people living in Azaz District and the east of Aleppo city," said Francisco.

MSF once again calls on all parties to the Syrian conflict to make every effort to protect civilians and civilian infrastructure, including hospitals and ambulances. It calls for an end to attacks on medical facilities, which have increased in recent months, causing hundreds of deaths among civilians, including women, children, and medical staff. MSF calls for all possible measures to be taken to guarantee the delivery of basic supplies to people in the area, including food and water, and to provide protection and medical care.

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Between June and October 2015, staff at MSF’s hospital in northern Syria’s Azaz region provided 23,000 consultations, received more than 11,000 people for emergency treatment, and performed some 1,000 surgical operations. MSF also supports 35 hospitals and health posts in Azaz district and in the east of Aleppo city.

MSF runs six medical facilities across northern Syria and directly supports more than 150 health posts and hospitals across the country, many of them in besieged areas. Most are temporary structures run by Syrian doctors, without MSF staff, but provided with practical support and distance learning by MSF to help them deal with the extremely high level of medical needs.
Seven people were killed and a hospital supported by the international medical humanitarian organization Doctors Without Borders/Médecins Sans Frontières (MSF) was partially destroyed in a series of barrel bomb attacks in Syria’s Homs region on November 28, the organization said today.

The series of bombings occurred in Al Zafarana town, a besieged zone in northern Homs governorate where local medical workers at the Al Zafarana hospital received an influx of 47 wounded patients. Half of the wounded — 23 out of 47 people — were women and children under 15 years old. As the bombings continued and caused damage to the hospital, many of these patients had to be moved to other hospitals and five people died in transit.

The attacks began at approximately 9:40 a.m. local time on Saturday, November 28, when a barrel bomb was dropped from a helicopter on a populated area of Al Zafarana town, killing a man and a young girl, and wounding 16 people. These patients were admitted to the Al Zafarana hospital in the mass casualty influx.

Soon afterward, another barrel bomb landed next to the hospital, causing damage to the kidney dialysis unit. Then 40 minutes later, at around 10:30 a.m. local time, when the wounded from the first bomb were being treated in the hospital, two more barrel bombs were dropped very close to the front entrance, killing one bystander and wounding 31 of the patients under treatment and medical staff, including two paramedics working for the Syrian Civil Defense ambulance service, one of whom sustained critically serious head injuries. This blast also caused partial destruction of the hospital.

"This bombing shows all the signs of a double-tap, where one area is bombed and then a second bombing hits the paramedic response teams or the nearest hospital providing care," said Brice de le Vingne, director of operations for MSF. "This double-tap tactic shows a level of calculated destruction that can scarcely be imagined."

The most critically wounded patients were transferred to three nearby hospitals. The 16 from the initial influx were immediately sent to one hospital. A second facility received 21 injured and four patients who died on the journey, and the third facility received 10 injured, with one person dead-on-arrival.

It is unclear at this stage whether the hospital will be able to resume activities after the bombing. Sections of the outside wall have been blown in by the blast and the dialysis unit and part of the medical stock have been destroyed. MSF is offering support to repair or relocate the facility, and is preparing to send the hospital team essential medical supplies should it be possible for them to continue operating.

"This makeshift hospital was providing a lifeline of care to around 40,000 people in Al Zafarana town and the surroundings," said de le Vingne. "It is already a tragedy that seven people — including a small girl..."
— have been killed, but if the hospital has to close down or reduce activities, that is a double tragedy for the people living under the permanent threat of war, with nowhere else to turn for medical assistance."

MSF once again reiterates its call that all efforts should be taken by all parties to the Syrian war to avoid striking civilians and civilian infrastructure, including hospitals and ambulances. The multiplication of these atrocious attacks, with overwhelmingly high numbers of civilians wounded or killed, including women, children and medical staff, must cease.

*MSF operates six medical facilities in the north of Syria and directly supports more than 150 health posts and field hospitals throughout the country, with a particular focus on the besieged areas. As in Al Zafarana, these are mostly makeshift facilities with no MSF staff present, where MSF provides both material support and distance training support to help the Syrian medics cope with the extreme medical needs. This support network has been built up over the past four years.*
The medical team did all they possibly could, but the condition of the patient was extremely critical upon arrival at the hospital six days ago.

The blast at the MSF-supported hospital initially resulted in the death of five people, and eight were injured, two of them critically. While those critically wounded were transferred to the Intensive Care Unit in Saada, the rest were treated at the hospital in Razeh.

"We extend our condolences to the victim's family, whilst we condemn again the fact that a hospital was targeted in this conflict that has been ravaging the country for the past 10 months. We need to repeat over and over that the civilian population, the medical staff and the medical facilities should be protected during this conflict. One week after the explosion, patients and health workers are still scared to go back to the hospital. Attacking hospitals inflicts a terrible toll on the local population", says Juan Prieto, General Coordinator of MSF projects in Yemen.

Sana’a – An MSF-supported hospital has been hit by a projectile in northern Yemen resulting in at least four deaths, 10 injured and the collapse of several buildings of the medical facility. Three of the injured are MSF staff, two in critical condition.

According to our staff on the ground, at 09.20am one projectile impacted the Shiara hospital in Razeh District, where MSF has been working since November 2015. MSF cannot confirm the origin of the attack, but planes were seen flying over the facility at the time. At least one more projectile fell near the hospital. The numbers of casualties could rise as there could still be people trapped in the rubble. All staff and patients have evacuated and patients are being transferred to Al Goumoury hospital in Saada, also supported by MSF.

“All warring parties, including the Saudi-led coalition (SLC), are regularly informed of the GPS coordinates of the medical sites where MSF works and we are in constant dialogue with them to ensure that they understand the severity of the humanitarian consequences of the conflict and the need to respect the provision of medical services”, says Raquel Ayora, Director of Operations. “There is no way that anyone with the capacity to carry out an airstrike or launch a rocket would not have known that the Shiara hospital was a functioning health facility providing critical services and supported by MSF”.

“We reiterate to all parties to the conflict that patients and medical facilities must be respected and that bombing hospitals is a violation of International Humanitarian Law”, says Ayora.

The conflict is particularly acute in Razeh District. The population in the area has been severely affected by constant bombings and the cumulative weight of 10 months of war. Shiara hospital had already been bombed before MSF started supporting it and services were reduced to stabilisation, emergency, maternity and life-saving activities.

11 http://www.msf.org/article/msf-supported-hospital-bombed-yemen-death-toll-rises-six
This is the third severe incident affecting an MSF health facility in Yemen in the last three months. On 27 October Haydan hospital was destroyed by an airstrike by the SLC and on 3 December a health centre in Taiz was also hit by the SLC and nine people were wounded. MSF teams struggle on a daily basis to ensure the respect of health facilities by all armed groups.

“We strongly condemn this incident that confirms a worrying pattern of attacks on essential medical services and we express our strongest outrage as this will leave a very fragile population without healthcare for weeks”, says Ayora. “Once more it is civilians that bear the brunt of this war.”

MSF asks for an immediate end to attacks on medical structures and requests that all parties unequivocally commit to creating the conditions for the safe delivery of humanitarian assistance. MSF also requests that those responsible for this attack investigate the circumstances of the incident.

In Yemen, MSF is working in Aden, Al-Dhale’, Taiz, Saada, Amran, Hajjah, Ibb and Sana’a governorates. Since the start of the current crisis in March 2015, MSF teams have treated more than 20,000 war-wounded patients. More than 790 tonnes of medical supplies have been sent by MSF so far. MSF is managing 11 hospitals and health centres and regularly supports 18 health centres. With the healthcare system barely functioning, MSF is also providing non-emergency health services.
Nearly 60 million people are displaced around the world because of conflict and persecution, the largest number ever recorded by the United Nations. About 14 million of those fled in 2014, according to a report released this week.

[Interactive Map]

SYRIAN DISPLACEMENT

About 11.6 million Syrians have been displaced, nearly half of Syria’s entire population. Most of them are scattered within Syria, but 3.9 million were living abroad by the end of 2014 – nearly all of them in Turkey, Lebanon, Jordan and Iraq.

Beyond the millions who have fled to Syria’s immediate neighbors, Egypt has received the largest number of Syrian refugees, roughly 138,000 by last December. All other countries combined have received a relatively small number, some 140,000, as shown above.
OVERLOOKED CONTINENT

Despite the drama of migrants trying to cross the Mediterranean to reach Europe, most Africans displaced by conflict stay in Africa.

About 15 million people are displaced in sub-Saharan Africa — 4.5 million of them fled last year. Long-lasting conflicts in Somalia, Sudan, and the Democratic Republic of Congo, as well as the civil war in South Sudan, are some of the top contributors.
MAIN DESTINATIONS

When refugees flee their own countries, most wind up with their immediate neighbors, often some of the world’s poorer nations.
IN THE DEVELOPED WORLD

The United States and France, some of the top hosts of refugees in the developed world, have the greatest variety of refugees and asylum-seekers by country of origin.

In terms of hosting displaced people, developed countries pale in comparison with nations bordering conflict zones. Combined, the United States and France had 760,000 refugees last year. Ethiopia, for example, is host to some 665,000, most from Somalia and South Sudan. Rich nations offer most of the funding to aid refugees in the developing world. The United States contributed about a third of the United Nations refugee agency budget in 2014.