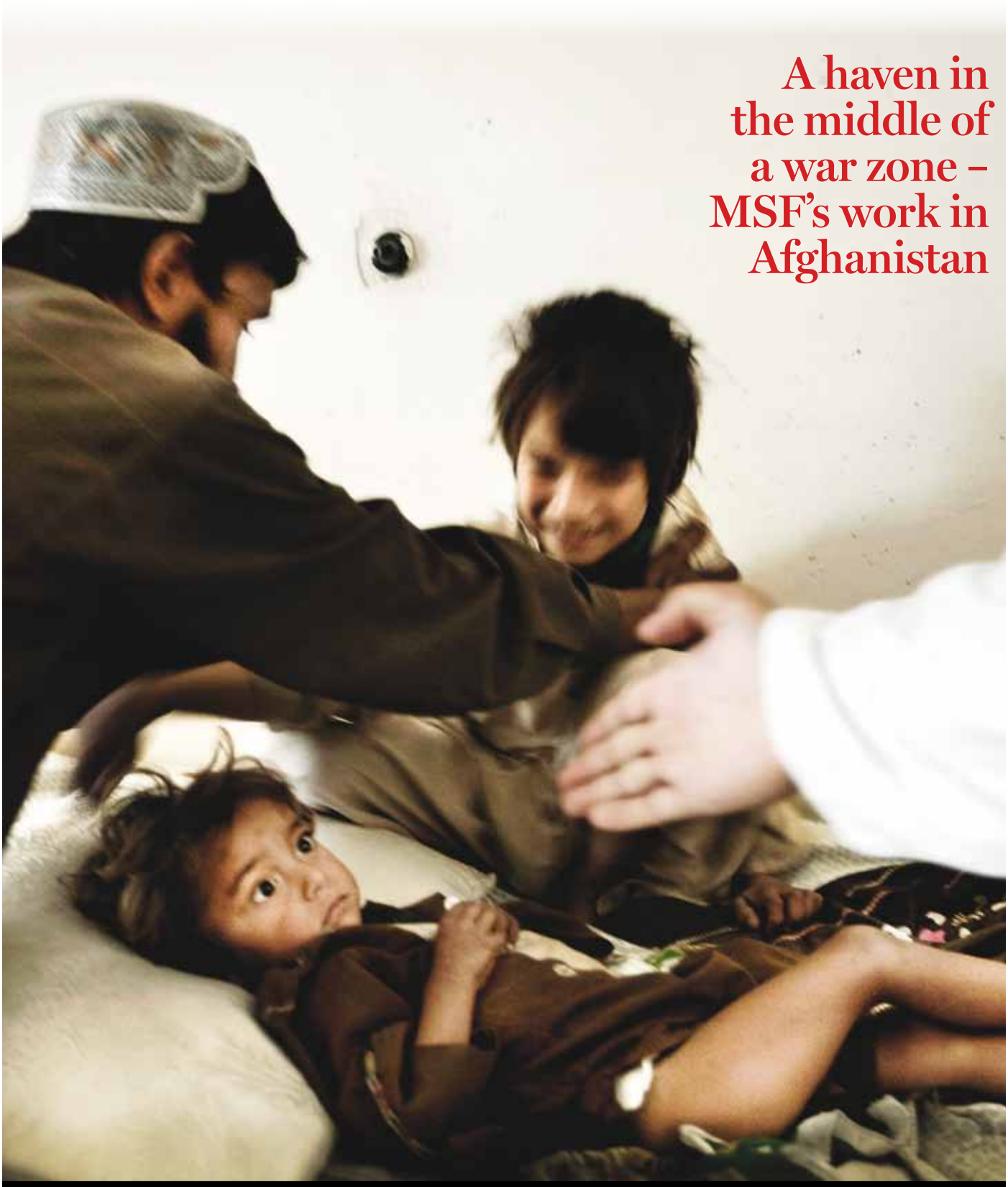
DISPATCHES

Médecins Sans Frontières is a leading independent humanitarian organisation for emergency medical aid. In more than 60 countries worldwide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

A haven in the middle of a war zone – MSF's work in Afghanistan



Patients at Boost hospital in Lashkargah. MSF is offering free treatment in this region of southern Afghanistan Photograph © Mads Nissen/Berlingske, 2009

Summer 2010
No 57

Afghanistan: where actions speak louder than words

"There were no drugs or healthcare available in my village," says Nadeem*, a patient in Boost hospital in Lashkargah, capital of Helmand province. "The entire way here I thought I was going to die – not because of my disease, but because of the shelling and the landmines."

Nadeem suffers from severe stomach problems and urgently needed treatment. He managed to leave Marjah in the middle of an armed offensive in a Red Crescent taxi. "My wife and my children are in Marjah. As soon as I get better, I need to go back there. But I am worried because it is very dangerous."

MSF worked in Afghanistan from the mid-1980s until the targeted assassination of five staff members forced a complete withdrawal in 2004. In late 2008, Afghan refugees started telling MSF medical teams in Iran about the horrific levels of violence they faced inside their country. Free and impartial medical assistance was a clear and urgent need and in 2009 MSF returned to Afghanistan, working in the Ahmed Shah Baba hospital in the outskirts of Kabul and in Boost hospital, the only public referral hospital for the one million people in Helmand province.

Dr Waliullah is an Afghan doctor who has been working with MSF in rural areas of Pakistan since 2004 and is now MSF's deputy medical coordinator in Afghanistan. He recalls the problems at Boost hospital when MSF started working there.

"The hospital was almost empty because patients had to pay for medicines and treatment and many people in rural parts of Helmand cannot afford even a pack of paracetamol," he says. "And the doctors were not around for much of the time – they had their own private practices to run and were not paying enough attention to the public hospital.

"I particularly remember seeing five wounded patients together in a room, all from the same family. A mortar, they don't know from which side, had landed in their house. The mother was badly burned and the children had broken arms and legs and two of them needed to have amputations. The nurses had found them outside the hospital one morning. They had no money and everything from the Ministry of Health had to be paid for, including treatment, medicines and food.

"The hospital director told me he had to go out himself and ask rich people in the community if they would help. I think he found someone willing to pay, but I remember thinking it was not a good solution."

MSF's goal is not to take over Boost hospital. Instead, the objective is to ensure that high quality treatment is available free of charge, 24 hours a day. We are supplying essential medicines and international MSF staff are now in the hospital assisting in the maternity, paediatrics, surgery and A&E departments.

A child with an injured hand waits for treatment at Boost hospital, Lashkargah © Mads Nissen/Berlingske, 2009 **Left, Fatima*, who was afraid to go to clinics nearer her home** © Pascale Zintzen/MSF, 2010

Online

Working in the middle of open warfare requires MSF to be totally **neutral**, **impartial** and **independently funded**. You can read an in-depth account of the challenges of working in Afghanistan at **msf.org.uk/afghanistan**

"Word is getting around that this is now a safe place to come," says head of mission Michiel Hofman. "When we started in November last year we had around 30 patients in the hospital, and now there's an average of 100.

"We have been meeting as many elders as possible from the surrounding area. We explain that that we treat everyone for free and assure them that the hospital is safe because no weapons or military police are allowed inside. They normally reply that the proof is in the eating and they'll wait and see.

"If people come back to their village happy with their treatment and saying they were approached with respect, the elders say they'll start to believe us. And of course this is quite understandable, because actions speak louder than words. It's in our actions that we can really show our impartiality, that anyone can come to the hospital and be safe and have good free treatment."

Dr Waliullah has seen the changes happening. "Things have got so much better. Before, the mortality rate was around 30 per cent, and now it is about four or five per cent. There's much more work for the staff and they are always busy – the nursing staff complain that they don't have time for tea breaks!

"Day by day things are improving. But there is a still lot to do. If you're going to provide the MSF standard of care, you need to hire more staff and in Helmand that's hard because this is a war zone."

Even though the community is starting to trust us and the treatment is free, people still face enormous challenges getting medical care. "The war makes it extremely difficult for people to travel even short distances," says Hofman. "Often they have to detour through the desert because main roads are either the scene of fighting or have been mined by one side or other. It's also a very costly affair because at some point they'll come across a Taliban checkpoint where they have to pay and then further along they'll find an Afghan army checkpoint where the soldiers will also demand money and maybe the next one will be an Afghan police checkpoint...

"As a result people wait until the last minute before going to hospital and the patients that come are mostly very sick indeed. A hundred patients doesn't seem like a lot, but a hundred patients in a really bad condition means that there's a heavy workload for the medics."

"We see a lot of wounded people," he adds, "but I find the most terrible thing is the patients who have treatable conditions but who die because they waited too long. It's desperately sad that in the middle of a war zone people are dying of easily treatable things like measles, malaria or diarrhoea."

It's in our actions that we show our impartiality, that anyone can come and be safe and have good free treatment'

"We are collecting medical data so we better understand the health situation in rural areas," says Dr Waliullah. "We know there are outbreaks of infectious diseases in villages by talking to the patients who manage to get to Boost. But at the moment it's just not safe enough for our medical teams to move around Helmand province.

"We need to continue building up trust among the community and then maybe one day soon we will be able to start providing medical care directly in some of the more rural areas. For now, I'm pushing for the staff in Boost to learn and follow MSF's standard medical practices. This alone will make a difference, providing genuinely good treatment that has been lacking here for years."

• *Names have been changed to protect the anonymity of the patients.*

THE NO GUNS POLICY

An essential aspect of MSF's work in Boost has been to ensure that the hospital is a safe environment. This has been one of the greatest barriers to people who would otherwise seek medical care. Fatima*, who brought her five-month-old baby for treatment, says she is afraid to go to clinics near her town because armed people are staying there.

"One of our top priorities here has been to work on the 'No Guns' policy inside Boost hospital," says Volker Lankow, project coordinator at Boost. "Every day, people tell me that they are suffering from the war raging in the province, and that they are afraid to enter a hospital full of people walking around with their guns. Every patient has the right to be treated and to recover in a safe place, and we are working hard to ensure that the no weapons policy is respected."

At the entry gate of the hospital, a sign reading 'no guns allowed' stands next to guards who make sure that all patients and visitors leave their weapons behind.

The Tall Yellow Lady and the boy from Manipur

Dr Fiona Fisher, known to her patients as The Tall Yellow Lady, left her work as a GP in Surrey for the north-east Indian state of Manipur, where MSF teams are combating TB and HIV

I'm working in Manipur, a stunning part of north-east India that people sometimes forget exists. A low-intensity conflict between the authorities and several 'underground groups' means it's hard to get the required 'protected area permit' to enter the region, so there are few foreigners.

I don't know what people make of me: I am very tall – unusual for a woman here – and I'm also blond, so I'm known as 'The Tall Yellow Lady'. In the villages the children are really shy - they won't greet us, they'll just stop and stare, then they pluck up courage as we walk away and spurt out everything they know in English all at once: "good morning good night hello I love you", before running off giggling.

My work is so different from what I was doing back home as a GP in Surrey. Though our main base in Churachandpur is quite far from the Myanmar border, we see lots of Burmese people who have travelled for days to get to our clinic because they've heard of our free care and our antiretroviral drugs.

We have four remote clinics out in the hills, reached by driving a 4x4 on mud-path roads on the edge of steep hills. There's little room for error. The clinics are basic bamboo and mud buildings so we have to bring the bare essentials with us, like a microscope for the lab.

We employ a local nurse and registrar in each of the clinics so by the time we arrive they have begun registering the patients and queuing them up so that the most seriously ill are at the front of the line. Then the clinic just runs beautifully - the people wait patiently in turn and everyone is grateful because the treatment is all completely free, which is unusual here.

One of the biggest health problems here is the number of people with both HIV and tuberculosis. There's one little boy who's got both, and his story is so amazing that I took two photos to try and show his recovery.

Vanlalsiam's parents and two siblings have died (we assume due to AIDS) so he is cared for by his grandmother. When we first saw him he was being treated for HIV/AIDS and TB by the Ministry of Health, but was not getting any better.

When we looked at his chest x-ray we could see a lot of fluid in the lungs and also big cavities where lung tissue had been eaten away by the TB. Listening with a stethoscope you could hear his breathing sounded harsh and rasping, which is a sign there's fluid in the lungs. He was really struggling to breathe; his shoulders would go up and down with each breath and you could see his rib cage working hard with the effort of sucking the air in and out.

It was hard for us to decide whether the problem was multidrug resistant TB or whether he had a drug-resistant

form of HIV. He was so weak that it was difficult to get a sputum sample to test for multidrug resistant TB, but when his HIV viral load came back from the lab as extremely high we hedged our bets and went with HIV resistance. This meant changing his regime to unusual and expensive second line drugs.

I took the first picture on the day his special tablets arrived – the MSF coordination team in Delhi had gone to great lengths to get them for us. That's why I took the photo – I wanted to show them that they'd done this for a real human being and also as a way to say thank you to them for all that effort. But I didn't think that he would survive, because he was so ill.

He was taking three tablets for his HIV treatment and one combined tablet for his TB drugs (at first he had four months of daily injections for his TB); but on top of that he also needed iron supplements, and folic acid supplements, and he had thrush on his tongue so he had a tablet for that as well, and he was taking another tablet to prevent lung infection. That's a lot of drugs for a little boy to swallow.

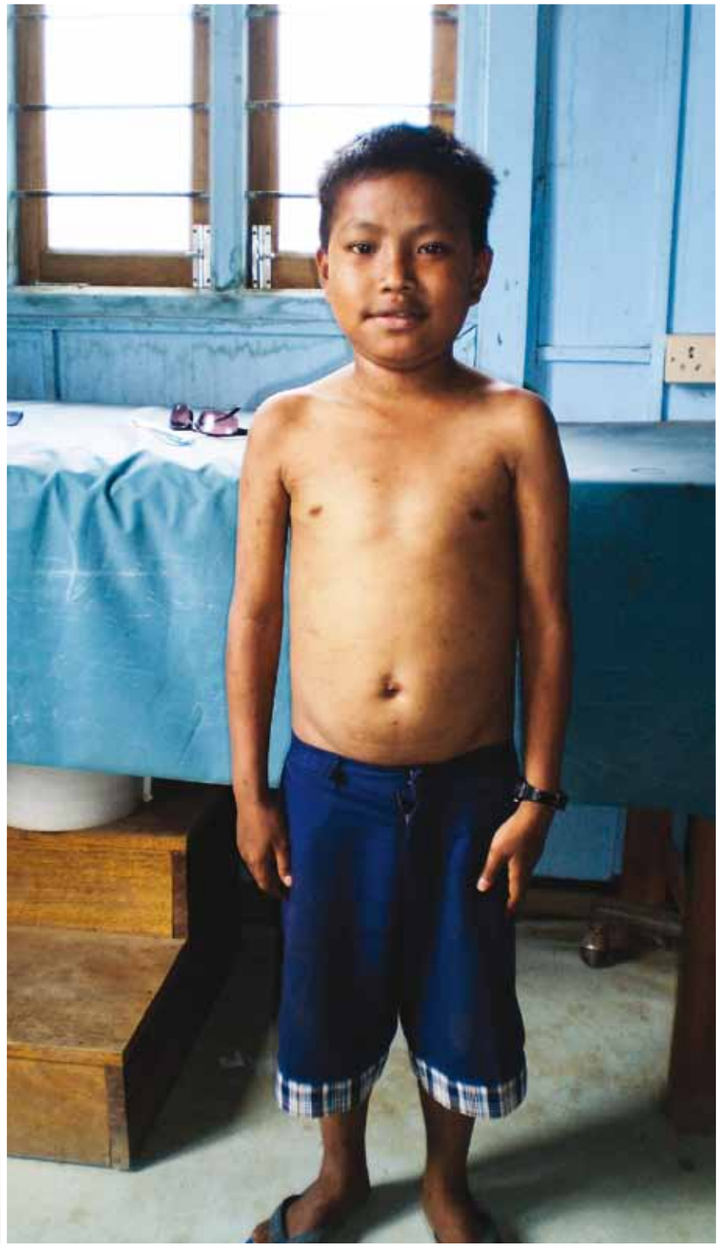
I was working out in the remote clinics and so didn't see him for a long time. But our local doctors saw him regularly and they told me he was getting better. So in April I made sure I was available on the day he was coming for his next follow-up appointment. I really wanted to see for myself that he'd improved. That's when I took the second photo. I just couldn't believe he was the same child!

What's particularly special about him is that he's a really bright, switched-on boy. Although it's a lot of drugs, together he and his grandma make certain he adheres to his treatment. We're sure he's swallowing all his tablets properly at home, and he comes to all of his appointments on time. His grandma is so grateful, and spoils him rotten (he was eating a big bag of crisps!). She now walks him several kilometres to school each day and waits there until after class to walk him home again. When I last saw him, he was happily playing with his classmates like any healthy 11-year-old boy.

November 2009

Vanlalsiam, 10, with his grandmother, who is also his caregiver

'His shoulders would go up and down with each breath and you could see his rib cage working hard with the effort of sucking the air in and out'



April 2010

Vanlalsiam, now 11, after treatment for HIV and TB

'When I took the second photo, I just couldn't believe he was the same child!'

PHOTOGRAPHS: © FIONA FISHER/MSF; © SAMI SIVA, INDIA, 2009

i DRUG RESISTANCE

Viruses and bacteria constantly change as they replicate. When a virus or bacteria, such as HIV or TB, has changed in such a way that the medication used to treat it is less effective or does not work at all, this is known as drug resistance.

If a patient takes their regimen of drugs regularly, enough of the viruses or bacteria will be killed or rendered harmless to make it unlikely that drug-resistant mutations of the disease will develop. But if a patient cannot or does not take his or her drugs regularly, there is a greater chance of resistance to that drug developing.

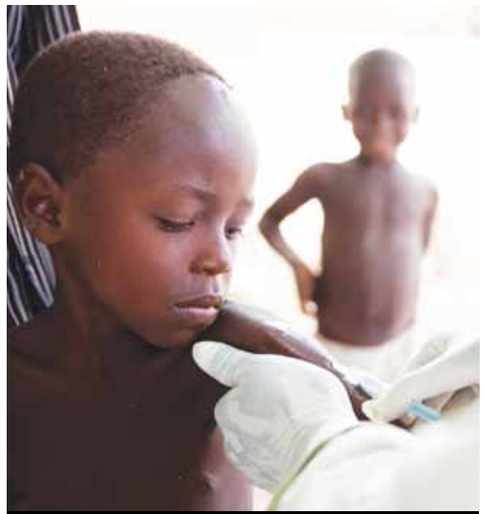
When a virus or bacteria is resistant to several of the common drugs, it is said to be multidrug resistant, and the patient must start taking drugs that are highly potent and usually very expensive. Worryingly, more people, like Vanlalsiam, are contracting forms of TB that are already drug-resistant.

Minimum cost to MSF of one year's regimen of second line HIV/AIDS drugs **£415**

31,000 Number of basic healthcare consultations in Manipur in 2009

What if MSF had never come to my home town?

Hamza Atim is a Ugandan doctor who has worked with MSF since 2003. Here he explains what made him want to join MSF



Dr Atim Hamza makes sure everything is prepared at one of the measles vaccination points. Above, vaccinating children in Kebbi state, north-western Nigeria. In April MSF vaccinated 38,000 children there. Below, the morning rush before the vaccination teams depart Photographs: © Olga Overbeek/MSF, 2010

There was a war in northern Uganda that lasted twenty years and I joined MSF in 2003 towards the end. I had finished my training in clinical medicine and public health and had started working with a missionary hospital near my hometown of Lira. At this point the war advanced so fast that thousands and thousands of people fled into Lira. People's livelihoods were destroyed and the only place where you could get cheap healthcare for the malnourished children was this missionary hospital.

We made a therapeutic food for the malnourished children using milk we bought from the dairy corporation mixed with groundnut paste, small fish, margarine and stuff like that. We were recording good results – children were improving, deaths went down – but we ran out of money in the hospital. We were all out of options and we had 70 children on admission and we didn't know what to do.

It was at this point that MSF came and did an assessment in the displaced people's camps. They saw the needs and, among other things, they started a big therapeutic feeding programme in a local hospital. I moved all our children to that hospital and then I moved with them – and I ended up working with MSF.

For me the conviction was: OK, we need this help now and these people can do it, so let's go for it.

Over the next two years with MSF we treated more than 7,000 children with malnutrition; children I'm sure would otherwise have died. We did lots besides treating malnutrition, but my main recollection is: what would have happened to these 7,000 children if MSF hadn't come?

I wanted to do for someone else exactly what MSF did for my people. And this is why I started working with MSF full time.

After a short training course in Germany, I did missions in Somalia and south Sudan before coming here to Nigeria as vaccination coordinator for the big meningitis vaccination campaign in 2009 and I'm now back here again as the emergency response project coordinator.

'If it's a challenge worth taking on, we'll go through brick walls to make it work'

It's a busy job because there are lots of potential medical emergencies that we're prepared for: meningitis, measles and cholera outbreaks; nutritional crises; yellow fever; and clashes, which frequently end up with casualties here. We have pre-positioned supplies to be ready in the event of any of these scenarios and in general we can expect at least two emergencies a year in Nigeria.

This year measles started earlier than usual so we have both measles and meningitis to contend with – two outbreaks at the same time. We're sending medical teams out to do surveillance and treat anyone who has one of these diseases. And we're currently running a measles vaccination campaign in an area where there are 38,000 children who need to be vaccinated. It takes a lot of organisation, and it's crazy in the morning when 39 vehicles turn up at the MSF base and 160 people all come to collect their supplies. It's like a taxi park or a busy market. We have to make sure the right team is in the right vehicle and that they know exactly where they need to go. Everybody is carrying something and it looks a bit chaotic, but there is actually organisation behind it all.

Vaccination campaigns can be very stressful, but the best part of my job is when I'm overcoming challenges. If it's a challenge worth taking on, we'll go through brick walls to make it work.

The weekends are the hardest time. I come from a very large family in the north of Uganda and my wife and four-year-old daughter are living back there. I think about them quite a lot.

In the week you are busy and your head is full of stuff and you have to get things done and it stops you from being homesick. But weekends, especially Sundays, it gets to you sometimes. My daughter misses me – she says it sometimes on the phone: 'Daddy, when are you coming home?'

It's a big sacrifice to be away, but if I don't do this, probably no one would do it. There are many doctors and nurses in the world who could do an MSF job, but not everyone's ready to leave their country to work somewhere else.

As an MSFer, you come to a foreign country, and you probably have to work harder than you do at home, and the bits and pieces of your life that you cherish are left behind. So it is rare to find people who can make these sacrifices.

'I wanted to do for someone else exactly what MSF did for my people'

But somebody had to make this sacrifice to come and save the many children that MSF treated for malnutrition in my country, in my home town. So I feel I should be able to do this for somebody else.

Each time I see a child suffering I want to help, because this child could be my daughter. So whatever I expect someone to do for my daughter if she is in trouble, now I am doing for somebody else's child if they need the care. I still keep that candle burning.

MSF UK volunteers

Afghanistan Michiel Hofman *Head of mission*
Bangladesh Jose Hulsenbek *Head of mission;* Patrick Shaw-Brown *Project coordinator;* Kathryn Richardson *Doctor;* Jennifer Luscombe *Nurse*
Bolivia Thomas Ellman *Head of mission*
Central African Republic Flaminia Ahmed *Financial coordinator;* Carme Abello *Supply logistician;* Nell Gray *HR coordinator;* Orla Condren *Nurse;* Kevin Davies *Psychologist*
Chad Conor Prenderville *Supply logistician;* Kathryn Johnstone *HR coordinator;* Megan Craven *Nurse*
Colombia Dolores Allariz-Santiago *Nurse;* Pilar Moreno Arco *Nurse*
Democratic Republic of Congo Aisa Fraser *Nurse;* Boris Stringer *Logistician;* Estrella Lasry *Doctor;* Laura Rinchey *Doctor;* Thomas Skrinar *Financial coordinator;* Kiran Jobanputra *Field coordinator;* Colin Beckworth *Nurse*
Ethiopia Sarah O'Shea *Midwife;* Mary O'Brien *Doctor;* Niamh Ryan *Nurse*
Guatemala Olivia Blanchard *Humanitarian affairs officer*
Guinea Hans-Jorg Lang *Doctor*
Haiti Tim Tranter *Logistician;* Declan Overton *Logistician;* Josie Gilday *Nurse;* Anthony Kilbride *Water & sanitation specialist;* Benjamin Caulfield *Water & sanitation specialist*
India Liza Cragg *Head of mission;* Fiona Fisher *Doctor;* Bruce Russell *Trust administrator;* Yasotharai Ariaratnam *Financial coordinator;* Gareth Barrett *Medical coordinator;* Miriam Bord *Nurse*
Iraq Colin McIlreavy *Head of mission*
Kenya Duncan Bell *Project coordinator;* Susan Sandars *Regional information officer;* Jane Bell *Doctor;* Sophie Dunkley *Epidemiologist;* Amber Arnold *Doctor*
Lebanon Alison Jones *Medical coordinator*
Liberia Anna Kilonback *Doctor;* Alice Clack *Doctor*
Malawi Neil Stone *Doctor;* Ines Carretero *Pharmacist*
Malta Penelope Blackburn *Psychologist*
Mozambique Christopher Peskett *Project coordinator*
Myanmar Sarah Quinnell *Medical team leader;* Wai Ching Loke *Doctor;* Maria Verdecchia *Epidemiologist;* Thomas How *Project coordinator*
Niger Fergus Glynn *Doctor*
Nigeria Alison Criado-Perez *Nurse;* Danielle Wellington *Nurse*
Pakistan Siama Latif *Doctor;* Leanne Sellers *Nurse;* Hilary Bower *Medical coordinator;* Edward Crowther *Logistician;* Matthew Lowing *Logistician*
Palestine Sophia Paracha *HR coordinator*
Papua New Guinea Keith Longbone *Logistician;* Jenna Broome *Doctor;* Adam Thomas *Project coordinator;* Sarah Maynard *Logistical coordinator*
Russia Jonathan Heffer *Project coordinator*
Somaliland Joan Hargan *Nurse*
South Africa Danielle Ferris *Financial administrator*
Sri Lanka Jane-Ann McKenna *Financial coordinator;* Joan Wilson *Medical coordinator;* Barbora Klimkova *Nurse*
Sudan Richard De Butts *Doctor;* Ross Duffy *Head of mission;* Simon Tyler *Logistician;* Elin Jones *Medical coordinator;* Stephen Flanagan *Nurse*
Thailand Paul Cawthorne *Communications coordinator*
Uganda Alvaro Mellado Dominguez *Project coordinator;* Michael Patmore *Biomedical analyst*
Uzbekistan Juma Khudonazarov *Doctor*
Zimbabwe Iago Pérez-Lafuente *Pharmacist;* Daniela Stein *Nurse;* Philippa Millard *Project coordinator;* Jessica Cosby *Nurse;* Sarah Taaffe *Doctor*

Cost of a VHF handset for the vaccination teams to remain in contact with base **£362**

£1.95 Cost of a ten-dose vial of measles vaccine

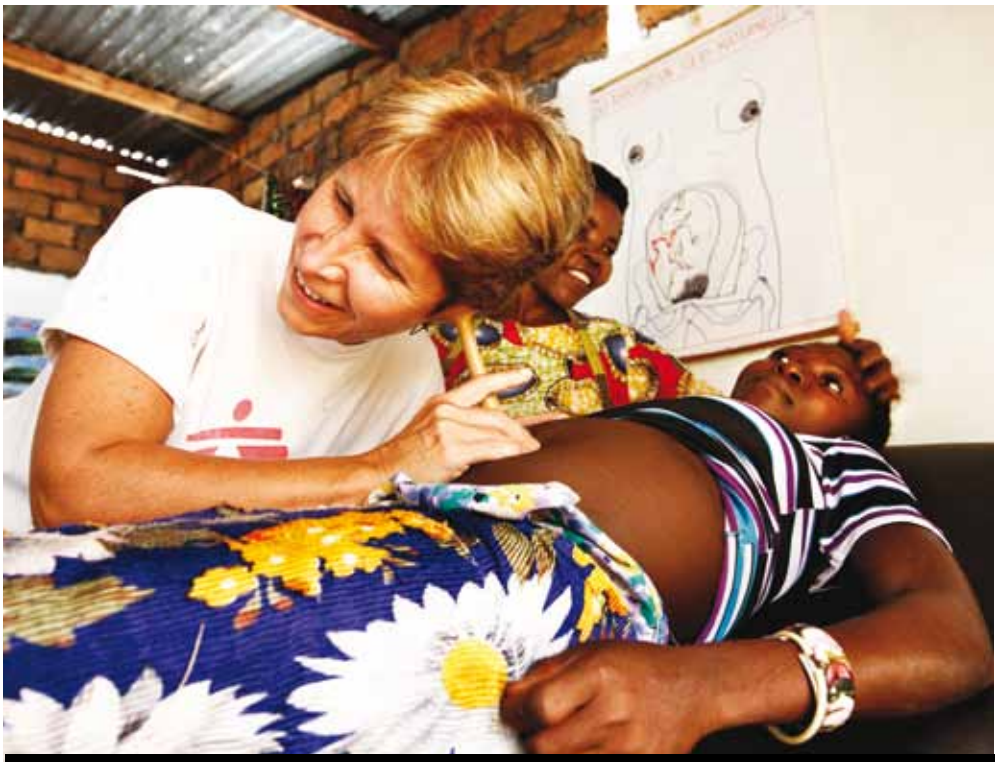
CONGO

Fistula surgery ends post-childbirth ordeal

In the Democratic Republic of Congo, with few hospitals and maternal health services, prolonged obstructed labour can cause obstetric fistula. A hole (fistula) develops in the vagina when the blood supply is cut off, through which urine and/or bowel waste passes uncontrollably. Those women who survive the ordeal will be left with a permanent injury to their birth canal, and the smell caused by the continual leaking means they are often rejected by their husbands and the community.

MSF is currently running a fistula camp in Shamwana, Katanga province, where skilled fistula surgeon Dr Völker Herzog is operating on 80 women to repair their internal injuries and provide a cure for their incontinence.

The surgical procedure usually lasts about one hour for a simple case but can take up to three hours for complicated cases. "The outcome is very successful with a cure rate of 90%" said Dr Herzog. "These women have had their dignity returned to them - they are no longer outcasts from society and can look forward to their new lives." With over 200 women on the waiting list, MSF is already planning a second camp later this year in Manono.



An antenatal consultation at MSF s clinic in Shamwana, southern Congo Photograph: © Pim Ras, 2008

ZIMBABWE

Women footballers make winning respect their goal

"They thought we were just playing games," says Meria Kabudura in MSF's short film about a group of HIV positive patients in Zimbabwe. "They would laugh at us and say: How can you women play football? How can you sick people play soccer?"

Women in Zimbabwe don't usually play football and HIV positive women are stigmatised so much that they are afraid to disclose their status even to close family members. But this group of women, from one of the poorest townships in Zimbabwe, decided to form a football team to show the world that they can be proud of themselves. The film follows the daily lives of four players during the build-up to the team's first tournament.

"I have to score, I have to score," thinks team captain Annafields Phiri as the final hangs in the balance. "Our team has to win. We will show the whole world. They will never look down on us again!"

We think this story about strength in the face of adversity is important and we would encourage you, our supporters, to order a free DVD of the film and lend it to any friends or colleagues you think might be interested. You can watch a trailer and order a DVD by entering your details and supporter number at **msf.org.uk/positive**

HAITI UPDATE

Since the earthquake MSF has provided medical care to more than **92,000** people and performed nearly **5,000** surgeries, in 16 operating theatres at 19 health facilities.

Latest news at msf.org.uk/haiti

Photograph © Brigitte Guerber-Cahuzac/MSF, 2010

EUROPEAN UNION

Last chance for affordable life-saving medicines

India produces cheap generic versions of many essential medicines, including the AIDS medicines that MSF uses in 80 percent of its programmes.

A draft free trade agreement between the EU and India contains several alarming provisions on intellectual property that would alter India's patent law and threaten the supply of such medicines.

"The impact of this proposed agreement is truly global, as treatment will become considerably more expensive, and countries and funders may have to ration the number of people they can put on treatment," says Ariane Bauernfeind, MSF HIV/AIDS programme manager.

The EU has indicated that it wants to conclude the negotiations ahead of the EU-India summit in October. MSF warns this is the last chance to remove provisions that will block access to life-saving medicines for people living in the developing world.

To find out more and watch patients and healthcare workers in Kenya explain how essential generic drugs are for AIDS treatment, go to **msf.org.uk/fta**

Your support

ABOUT DISPATCHES

Dispatches is written by people working for MSF, sent out every three months to our supporters and volunteers in the field, and edited in London by Robin Meldrum.

It costs 8p per copy to produce and 22.5p to send, using Mailsort Three, the cheapest form of post. We send it to keep you informed about our latest activities and how your money is spent. *Dispatches* also gives our patients, staff and volunteers a voice to speak out about the conflicts, emergencies, and epidemics in which MSF works and about the plight of those we strive to help.

0207 404 6600

www.msf.org.uk/support

M decins Sans Fronti res,
67-74 Saffron Hill,
London
EC1N 8QX

MAKING A DONATION

You can donate by phone, online or by post. If possible please quote your supporter number (located on the top right-hand side of the letter) and name and address.

CAN WE HELP?

If you have any questions about your support of MSF's work we would be delighted to hear from you. We also welcome your feedback on *Dispatches*. Please contact us by the methods listed or email **uk.fundraising@london.msf.org**

CHANGING YOUR ADDRESS?

Please call **0207 404 6600** or email **uk.fundraising@london.msf.org**

CHANGING A REGULAR GIFT

To increase or decrease your regular gift, please call us on **0207 404 6600** or email **uk.fundraising@london.msf.org** with your request. Please also get in touch if your bank details have changed.

Eng Charity Reg No. 1026588

MEDECINS SANS FRONTIERES