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DISPATCHES

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Médecins Sans Frontières is a leading independent organisation for emergency medical aid. In over 60 countries world-wide, 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.

10 untold stories

SPECIAL EDITION

Every year MSF publishes a list of the 'Top Ten Underreported Humanitarian Stories', to spotlight 10 humanitarian crises that have received little or no attention from the world's media. This special edition of Dispatches brings you first hand accounts from MSF staff working in the crises we highlighted in the 2007 'top ten' list. All are providing desperately needed medical care to people in corners of the world forgotten by the TV cameras.

2 Sri Lanka

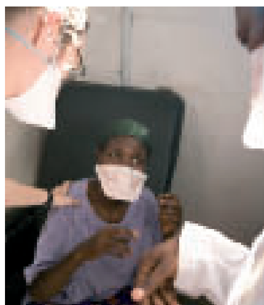
3 Zimbabwe

4-5 Somalia

6-7 Central African Republic

7 Malnutrition

8-9 Chechnya



8-9 Tuberculosis

9 Democratic Republic of Congo

10-11 Myanmar

12 Colombia

Paediatric care in Kilinochchi hospital
© Henk Braam [2007] Sri Lanka

Conflict is once again dominating the lives of people in the north and east of Sri Lanka. The ceasefire of 2002 between the Government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE) brought some hope. But, while people are still recovering from the devastating tsunami in 2004, the war has returned. Daily fighting on the front lines, aerial bombing, roadside mines, suicide attacks, restrictions on movement and arbitrary arrests make day-to-day life in Sri Lanka increasingly perilous. The ceasefire was officially abandoned in January 2008, starting "Eelam War IV".

Either side of the frontline: conflict in Sri Lanka

In 2007 MSF set up two new projects in Sri Lanka; one in Kilinochchi, the administrative centre of the LTTE-controlled north, the other in Vavuniya, a major town just 13km south of the frontline. The project coordinator of each describes the situation from their side of the frontline:

Jonathan Henry in Vavuniya: "As well as serving its own district, Vavuniya hospital is also the main referral hospital for the 250,000 people in LTTE-controlled areas. MSF is responsible for all the general surgery here and our team comprises of two surgeons, an anaesthetist and a project coordinator. It's a tense environment and a volatile situation. Every morning the road we take to the hospital is swept for mines by soldiers, helicopter gunships fly over constantly and three or four times a week fighter jets pass overhead.

The violence in and around Vavuniya is increasing; in the last three weeks alone we've treated 41 general and domestic violence patients on the surgical wards, including victims of Claymore bomb attacks and air raids. Much of the time we're dealing with general, but nevertheless essential, day-to-day surgical work – a calm but busy surgical ward. But then you get the war wounded and it becomes an emergency.

About a month ago, for example, we received a mother and her son. They had been caught up in the 2004 Tsunami and were living in a 'resettlement camp'. There was an air raid and when they heard the plane coming, they both put their arms around a tree to protect their bodies from the shrapnel and ball bearings that come from the bombs. But in the act of doing so, their hands were severely wounded. They were transferred to our surgical wards. We operated on them and the child was later referred to a hospital in the capital for plastic surgery, while the mother remained here to be treated. The boy has made a full recovery, but has lost two fingers. We discharged the mother yesterday, having saved half of her hand. Physically and psychologically scarred, they returned together yesterday to their resettlement camp."

Bruce Russell in Kilinochchi: "The fact that a war is on is quite apparent. We're getting more and more aerial attacks in Kilinochchi. It started increasing again in January and February and we hear a lot of aircraft going over. There has been some bombing in the town itself, once just 800 metres from the MSF house.

We're a team of eight working in a big Ministry of Health referral hospital. It's a lovely hospital with lots of equipment, most of which works fine. But it's severely understaffed. Medics do not want to work here because they're frightened of working this close to the conflict zone; they do not want to get trapped in the north where the working conditions are comparatively sparse.

Our biggest challenge has been building up acceptance and relationships with some of the hospital staff. It's been hard – people here have been through the Tsunami and years of conflict. Crossing the frontline is another challenge. It's a heavily militarised zone and there are extremely thorough checks of all vehicles, supplies and personnel going in and coming out of the north. Going south it's only a lucky few vehicles that can get through and cars are totally stripped down. Coming north it's not as bad, but it's still hard. The medical supplies for the whole of Kilinochchi district have been held up. They're apparently on their way, but right now we're running out of supplies.

Despite the challenges, I feel we are making a difference; hundreds of patients are being treated by our team. And we have started to support the hospital laboratory, so now the hospital can do many more of its own examinations and diagnoses and thereby reduce the number of unnecessary referrals."

"I don't look sick – I am strong!"

Overcoming the stigma of HIV/AIDS in Zimbabwe

Epworth is a huge settlement on the outskirts of Harare, Zimbabwe's capital. Most of its inhabitants moved to the area in 2005 after the demolition of illegal slums and live in cramped, hastily constructed houses with no clean drinking water or sanitation facilities. MSF works with a local organisation called 'New Start' that provides HIV testing. Nearly half the people who come to be tested are found to be HIV positive.

Epworth is a huge settlement, with a population of around 400,000
© Heather Culbert/MSF [2008] Zimbabwe

Providing care in the face of this scale of HIV/AIDS pandemic is very challenging. Key to MSF's Epworth team are the 17 'peer educators'. These are HIV positive patients who are trained to encourage other people to go for HIV testing, show patients how to take their medicine and help people cope with living with HIV/AIDS. This team has done much to encourage women, particularly those who are pregnant, to seek voluntary testing and counselling. But encouraging men to come to the clinic is proving difficult, as Chipo Takawira, head of MSF's Community Liaison Team, explains:

"Only 30 percent of our patients are men, and when men do come to our clinic it's usually when they are already critically ill. Many of the HIV education programmes here target women and children, so men don't have enough information about what happens if they test positive or what treatment is available. Many are too afraid to make that first move and get tested, scared of being abandoned and stigmatised.

Sometimes men accompany the women to the clinic, and when we see them waiting outside we talk to them and encourage them to get tested. But the trouble is a lot of men don't come to the centre; most of the women come alone.

Chipo outside MSF's clinic at Epworth
© MSF [2008] Zimbabwe

Not long ago a pregnant woman came to our clinic to be tested for HIV while her husband waited outside. One of the male peer educators approached him and asked him why he was sitting outside. He replied, *"The testing is only for women, she is the one who is pregnant"*. The peer educator suggested that he should get tested as well. The man said, *"Ah well, I don't think I am HIV positive... I don't look sick!... I am strong!"* – the usual things people say when they think they are not positive.

The wife got the results. She was positive. She told her husband, who was still waiting outside, and he freaked out. *"Oh well"* he shouted at her, *"What have you been doing?" You have been fooling around!"* The peer educator explained to him more about HIV and AIDS and that he also needed to get tested to find out his status – there would be decisions they'd have to make as a couple and he would need to know where he stood. But he just said *"Look at me, do I look infected? Those are her results!"* The peer educator tried to calm him down but he wasn't in the mood to listen and the wife looked very lost and in need of support. So they made an appointment for a home visit.

The peer educator had to visit their house twice a week for a whole month before the man was convinced to come to the clinic to get tested. When he did come, he tested positive. After he got his results, his attitude towards his wife changed, he apologised and became more supportive. The wife is now receiving antiretroviral therapy, the husband is still quite healthy and is therefore receiving medicine to help him fight off common infections. The baby is being monitored in our Prevention of Mother To Child Transmission programme. We see this often. It is only after the man gets tested and sees he is also positive that his attitude changes."

One of MSF's objectives in Epworth for 2008 is to organise better HIV education and services for men. The team is training more male peer educators and will be working closely with a local men's community organisation that educates men about issues such as HIV/AIDS.

MSF has worked in Zimbabwe since 2000 supporting the Zimbabwean Ministry of Health. MSF is providing free medical care to more than 35,000 people living with HIV in Zimbabwe. 11,000 patients are receiving antiretroviral therapy, which accounts for over a fifth of all antiretroviral provision in the country. The teams also focus on malnutrition, tuberculosis and epidemic outbreaks.

Looking forward to a new beginning: fistula surgery

"We were overjoyed – we could never have imagined that this could be achieved," says nurse Mohamed Derri of MSF's fistula surgery project. With no functioning government or public health services since 1991, Somalia is facing a critical emergency of escalating violence and acute medical needs. This is a hard place to provide any sort of medical aid. But last year Brighton-based midwife Sarah Quinell set up a unique project: MSF flew in a specialist surgeon and, for the first time in Somalia, ran two "fistula camps", short projects providing surgery for women suffering from obstetric fistula. The second "camp" took place over 12 days in a town south of Mogadishu called Kismayo. Sarah kept a daily record of MSF's work:

What is fistula?

Vesicovaginal Fistula (VVF) is a condition that affects women who have experienced prolonged obstructed labour. This usually occurs if a pregnant woman cannot get maternity or emergency obstetric care and her labour does not progress normally. Damage is caused by the pressure of the baby's head against the soft tissues of the pelvic organs, resulting in the formation of a hole between the bladder and the vagina. The consequence is that urine continually passes from the bladder into the vagina and leaks without control. "Women with VVF become outcasts," explains Sarah. "They feel shame and hide from society."

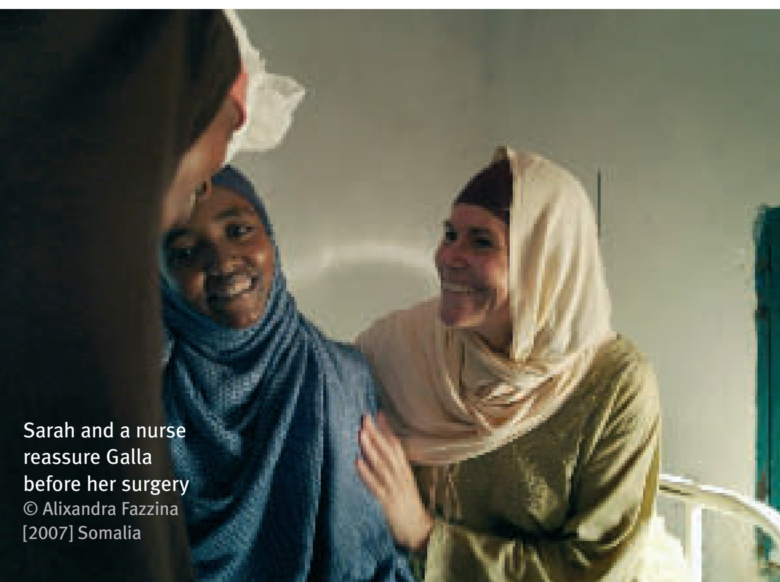
VVF was eradicated in many countries when caesarean section became widely available; however in poor and conflict-affected areas, caesarean sections are simply not an option.

The operation to repair a fistula is delicate and specially trained surgeons are required. MSF plans to continue running "fistula camps" in countries where obstetric services are absent or inadequate.

DAY 1

Expectant faces awaited us when we arrived on the ward this morning. Word has quickly spread and many women have started to arrive complaining of incontinence, eager to be cured.

After greeting both the local team and our prospective patients, my first job was supplies. The operating theatre was empty bar the operating table, abandoned in the middle of the floor. So we had to stock up with all the equipment and medical supplies that we will need. Meanwhile, the team gathered together medical information for each woman in order to create individual case files. It was a hectic day and, in the middle of it all, I lost the surgeon Peter to a couple of emergencies, one of which was a caesarean section for an obstructed labour – the very thing that is the primary cause of fistulas in this community. Thankfully both mother and baby – a healthy girl – are doing well. At the end of the day we are ready to start the assessments. We now have eleven days and counting – the pressure is on.



Sarah and a nurse reassure Galla before her surgery
© Alixandra Fazzina [2007] Somalia

DAY 3

We have completed the first set of assessments and 19 women have been accepted for surgery. We have nine days left – it will be tight. We aim to operate on two women a day, one in the morning and one in the afternoon. On one of the days we will have to operate on three women. I hope that we don't come across too many obstacles.

Today the first two women selected for surgery, Kuso and Galla, passed their pre-operative screening with flying colours and now eagerly await the morning. Kuso is 22 years old and developed a fistula following the delivery of her first child two years ago. Galla is 18 and developed a fistula one year ago following a prolonged labour of five days. She eventually delivered in hospital, a stillborn baby boy.

> "Often women with VVF are so socially and physically harmed that they willingly ask their husbands to divorce them" Mohamed Derri

DAY 4

Our first day of operating. Despite fluctuating electricity and an air-conditioning unit that died spectacularly in a puff of smoke, we finally managed to perform Kuso's and Galla's operations as planned. They are encouraged to eat and drink straight afterwards and the only evidence of the operation is a urinary catheter (a flexible plastic tube) draining into a bottle at the side of the bed. They are immediately visited by the other women in the ward who are eager to see for themselves that all is well. The following morning, we get Kuso and Galla to walk as soon as the effects of the anaesthetic have worn off, and they return to their own beds, making way for the day's new arrivals. For the first few days the two most important things are that they drink six litres per day and that the catheter does not become blocked.

Galla recovering after surgery
© Alixandra Fazzina [2007] Somalia

"The surgeon really did his level best to help these innocent women"

Mohamed Derri

DAY 8

We have now established a routine and consequently the surgical camp is running well. The hospital is contained within a sprawling compound of near-derelict buildings. Palms sway in the breeze, black-faced monkeys eagerly grab at the little orange fruit ripening in the trees and the antelope, adopted by the guards, wander the grounds at whim. All this would provide for a relaxed and laidback atmosphere, were it not for the sound of distant gunfire and the constant stream of casualties.

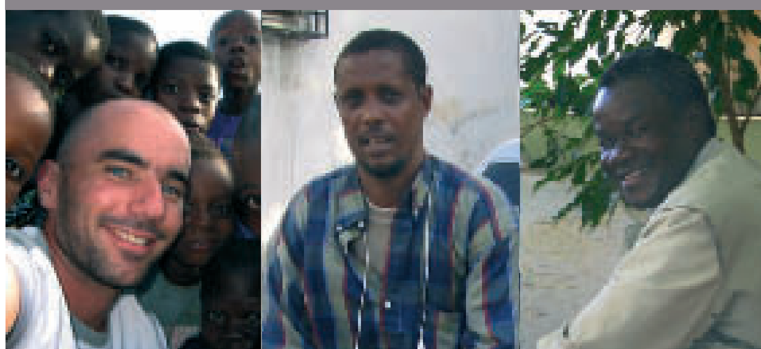
Immediately following surgery, the patients are returned to the ward on a stretcher and nursed in a small recovery area that has been created at one end to allow close observation. It's a bit like a production line, but the routine helps. Each morning two women are chosen to have their operation the following day. They receive a medical examination to make sure that they are physically fit for the surgery and then final arrangements are made to gain consent for the operation.

DAY 12

My last day in Kismayo, and all of the women have now been operated on. They are smiling, laughing and joking - beautiful women, looking forward to a new beginning. It's the day of the first catheter removals – Kuso's and Galla's. They have both recovered well and have continued to drink plenty during the post-operative period. They have helped to encourage the other women along the way and have remained positive throughout. I pray that both these women will be 'dry'. We are all nervous and excited and everybody is watching and waiting. The catheters are removed and all is fine, they are dry. They are beaming – they couldn't be happier!

Kuso on day 12, her operation confirmed as successful
© Sarah Quinell/MSF [2007] Somalia

Tragedy in Somalia


Damien Lehalle Mohamed Abdi Ali Victor Okumu

On 28 January, all of us at MSF were shocked and horrified when three of our colleagues were killed in Kismayo, southeast Somalia.

After a morning of carrying out emergency surgery in Kismayo Hospital, the MSF team was on its way home when a roadside bomb hit the second vehicle in our convoy. The explosion caused the tragic deaths of **Victor Okumu**, a surgeon from Kenya; **Damien Lehalle**, a logistics specialist from France; and **Mohamed Abdi Ali** (known as Bidhaan), a driver from Somalia. We extend our heartfelt sympathies to the friends and families of Victor, Damien and Bidhaan.

MSF has evacuated all its international staff from Somalia as a precautionary measure following this attack. Christopher Hippchen, MSF Head of Mission for Somalia, explains what this means for MSF projects in Somalia:

"The attack on our team in Kismayo was an attack on the very idea of humanitarianism and our ability to alleviate the suffering in Somalia. We have worked in Somalia for over 17 years and, particularly over the past year, the country has been facing a critical emergency. We are deeply concerned for the people that we are now unable to help.

The absence of international staff on the ground has affected our programmes. We have not, however, suspended our activities altogether. I would like to emphasise that all our activities rely heavily on our 800 Somali staff who provide medical care to our patients in all our projects. We are sending supplies to our projects in Somalia where they continue to run the medical programmes at the best of their capacity.

Despite the fact that most activities continue in the absence of international staff, this attack has been a set back. We should do more during this time when the people in Somalia are in such desperate need and yet we cannot just carry on and ignore the murder of our colleagues. We know that our presence in Somalia is relevant and we have received much support from our Somali staff and the local population in the aftermath of the brutal attack on our team. In Kismayo people have taken to the streets and condemned the attack in solidarity with MSF. We are determined to provide assistance in Somalia, but we need to understand more about why the Kismayo tragedy happened before we can take decisions about returning with international staff."

Central African Republic

Since 2005 the Central African Repub
groups and government forces. Tens
in the bush to avoid being killed in th
photographer with Getty Images, spe
extreme distress of people living in a

Tens of thousands of people have sought refuge from the fighting by living in the bush. "We have no real shelter and only eat one meal a day. The last time I ate, it was just some millet flour mixed with water," said one 26-year-old villager in Ouham province.

"In the bush people live in appalling conditions. These aren't proper refugee camps with tents... they are living under straw," says Dr James Pallett. The pervasive fear means that people only return to their village to check on their homes or collect water from the well.

Some people have gathered together in makeshift camps. With no water or facilities, these are scarcely better than being in the bush.

Two children play in the evening light in a camp for displaced people near Kabo Town.

Through the lens

How can a photographer express in images what it is like to be in the midst of a humanitarian crisis? Spencer Platt has produced an audio slideshow using the photographs he took in CAR, with a voiceover describing why he photographed certain scenes and how he felt about the situations he encountered. You can see this slideshow at www.uk.msf.org

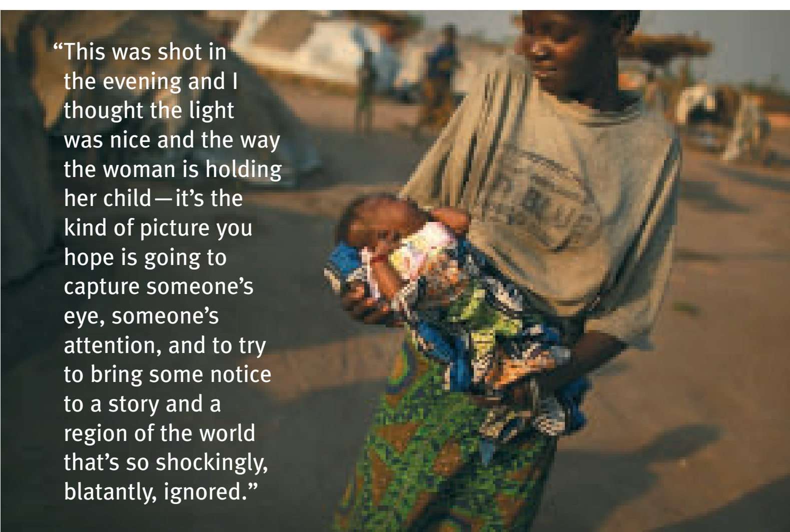
"As a photojournalist, the challenge for me was to come up with images that would draw the viewer into this story [of deserted villages] and show the kind of dire nature of it—because very often there just wasn't anyone."

"So this little girl—what I'm trying to capture in her expression is the apprehension that she feels, probably having in her young life fled her home on numerous occasions, and certainly being taught not to trust people that you don't know."

lic (CAR) has witnessed intense violence between armed of thousands of civilians are living desperately hard lives heir villages. In December 2007 Spencer Platt, a staff nt two weeks with MSF trying to depict in images the conflict that is largely ignored.

His mother travelled for hours over rough dirt roads to save this malnourished 10-day-old baby's life. MSF teams try to visit as many villages as possible. For most people, the only way to get medical care is to get to the village when MSF visits.

The workload for MSF teams is high. Between mid-2006 and June 2007 MSF provided medical care to 140,000 people.



"This was shot in the evening and I thought the light was nice and the way the woman is holding her child—it's the kind of picture you hope is going to capture someone's eye, someone's attention, and to try to bring some notice to a story and a region of the world that's so shockingly, blatantly, ignored."

All images © Spencer Platt/Getty Images, December 2007

Malnutrition: it's what's in the food that counts

Malnutrition can be fatal: every year, it contributes to the death of five million children under the age of five. MSF believes that the current food aid system is not doing enough to address the needs of young children most at risk and is calling for a massive scale up of 'ready-to-use food' products which save lives fast.

"It's not just about how much food children get, it's what's in the food that counts," says Dr. Christophe Fournier, MSF's International President. "As any parent knows, children grow and develop at breakneck speed until age three, and sound nutrition is vital to a healthy life. Without the right amounts of vitamins and essential nutrients in their diet, young kids become vulnerable to diseases they would normally be able to fight off easily."

Over the past five years, MSF and other relief organisations have been increasingly using ready-to-use food to treat malnourished children. This paste of powdered milk, ground peanuts, oil, sugar, vitamins and minerals doesn't need to be prepared with water, making it suitable for use in places where water sources are contaminated.

It can be produced locally, has a long shelf life even without refrigeration, and children can eat it directly from individual foil packets. Crucially, most children can be treated at home, rather than being hospitalised, which vastly increases the number of children who can be reached. It allows mothers – not doctors and nurses – to be the main caregivers.

MSF has used ready-to-use food extremely successfully on a huge scale in the Maradi region of Niger, treating 65,000 malnourished children in 2006, with a 90 percent cure rate.

As one of the mothers whose child was treated in Niger explained, "I prefer to use ready-to-use food rather than staying in a treatment centre, because I have to take care of the fields and my other children – I have three other children at home. Without this project I wouldn't have sought help, even if my child was very sick, because I can't leave my other children alone for weeks."

Yet despite the successes achieved using ready-to-use food, these products are only available to a tiny fraction of the severely malnourished children who need them. The World Health Organization estimates that there are 20 million young children suffering from severe acute malnutrition at any given moment. MSF estimates that only three percent of them received ready-to-use food in 2007.

Therefore, MSF is calling for a massive scale-up and expansion of ready-to-use products. We are urging international donor bodies and UN agencies to support systematic purchasing and use of ready-to-use food in countries where it is needed. It will cost about £500 million a year to reach the most vulnerable. But if ready-to-use food is distributed more widely and replaces the blended flours that are currently used, fewer children will die of malnutrition.

Where a cough can kill: tuberculosis in Chechnya

Patients taking their medication in an MSF clinic
© Misha Gulastov [2006] Chechnya

Chechnya, a region that rarely makes headlines anymore, still simmers with unresolved tension and insecurity. Following its claim for independence from Russia 12 years ago, two successive wars brought vast physical destruction to the North Caucasus republic. Although it has been nearly four years since the most intense fighting subsided between Russian government and rebel forces, and the current government has instigated a reconstruction boom in the capital city Grozny, there are still sporadic outbreaks of violence and most health services are woefully lacking.

Solveig Hamilton worked as MSF's Medical Coordinator for Chechnya in 2007. She describes the uneasy Chechen peace: "It's exciting to see the current regeneration of Grozny, the capital, as new buildings spring up. But you don't have to move far from the main streets of the city centre to find the rubble, the broken water mains, the shattered houses without electricity. Some ruins have painted signs on them that say 'People Live Here'. What kind of lives must they be forced to live in the ruins of those once fine buildings? I watched young, very young, soldiers sweeping their metal detectors along the sides of the road in the early morning and recall my sense of gratitude that they were doing this and my sense of concern for their lives. And my sadness that this needed to be done at all."

The once-envied Soviet system of rural health posts, which fed larger hospitals, was destroyed in the wars and is now hopelessly understaffed. This is particularly and worryingly true of Chechnya's tuberculosis (TB) programmes, since TB is a serious public health problem in the region. There are only five functioning TB clinics in the entire republic for a population of a million people.

MSF is working in four of these clinics, training doctors and diagnostic teams and supplying the necessary drugs. Much of the success of these programmes can be attributed to MSF's TB Educators; Chechen staff who support patients from the time of their initial diagnosis to the end of their treatment and run public information campaigns about TB.

Madina Yusupova, an experienced MSF Health Educator, recounts the story of Magomed* and his family, all of whom were sick with TB. "During the second Chechen war Magomed, his two brothers and their mother lived in a dark and damp basement which they hardly ever left for fear of their lives. Many Chechens lived like that. They lost their father in the war, the mother was sick, and the teenage brothers were looking after her, little knowing that they would contract TB from her. Magomed treated his coughing and weakness with commonly available anti-flu drugs and herbal tea. In the spring of 2005, MSF ran a wide public campaign about TB, including messages in the local press and on TV. Only then did Magomed consider that his ailment could be TB, and that's how he entered our programme.

"After one month of treatment, when Magomed started

*name changed

What is tuberculosis?

Tuberculosis (TB) is caused by TB bacteria, which most commonly affect the lungs. Only one in ten people infected by the bacteria will actually go on to develop the disease, because a healthy immune system keeps the infection dormant. However, TB can reactivate decades later if the immune system becomes weak. The bacteria are spread through the air when contagious people cough or sneeze and a third of the world's population have TB bacteria in them. Each year more than nine million people develop active TB and two million die from it.

TB treatment is lengthy and extremely unpleasant; patients must take a noxious cocktail of drugs for around six months – or up to 24 months if one is unlucky enough to develop resistance to anti-TB drugs. The side effects of taking these drugs can be severe, including nausea, vomiting, abdominal pain, diarrhoea, fever, flu-like symptoms and kidney problems. The drugs used were developed over 30 years ago and the most recent diagnostic tests are nearly 100 years old. MSF is therefore urging governments, foundations and companies to increase funding into research for new and more effective drugs and diagnostic tools.

Around the world, MSF treats TB patients in areas of chronic conflict or political instability such as the Democratic Republic of Congo and Chechnya; in refugee camps such as in Chad and Thailand; in prisons in Kyrghzstan; and in primary health clinics in numerous countries.

feeling better and had gained some weight, he was arrested by local security forces under suspicion of past involvement with a criminal group, which was never proved. There was nobody in the detention centre who would supervise his treatment. It is very dangerous to interrupt the course of anti-TB drugs, so MSF took the unprecedented decision to continue with his treatment by 'remote control'. Drugs were delivered for Magomed, and we wrote him letters and gave him consultations by correspondence. All this to ensure that he carried on taking his treatment. He was released after more than five months, and he was cured of TB while in detention."

This man has lived in an abandoned building in Grozny since his apartment was destroyed in a missile strike
© Misha Gulastov [2007] Chechnya

Violence, disease and flight: daily life in DRC

Left for dead when he was shot whilst fleeing his village, this man was found in time by a neighbour and brought to an MSF hospital, where he is now recovering
© Susan Sandars/MSF [2007] DRC

The sun beats down on a corrugated iron shelter that serves as Bukama health centre's waiting room. It is December 2007, a Friday, and a market day. The health centre where MSF conducts regular clinics is crowded.

"Just a few days ago, this health centre was pillaged by armed men; there was almost nobody left here," says MSF nurse Angelina Palmer. "Thanks to the bravery of Congolese health staff who agreed to come back to work here, we have been able to treat a huge number of patients."

Bukama is a small community in North Kivu province, in the Democratic Republic of Congo (DRC). In a day's visit, the MSF medical team will carry out around a hundred consultations there, only a few kilometres from the blurred frontline where various armed groups are manoeuvring.

"Our visits to these clinics are the only way for many people to receive medical care," continues Angelina. "We know that further north people are dying of diseases that are easily treatable, but we have not been able to reach them."

Wracked by tensions and violence for over a decade, North Kivu saw some of its most intense fighting between August 2007 and January this year. Following a peace agreement signed on January 23, there is a glimmer of hope for the region. But Philippe Havet, one of MSF's project coordinators, focuses on how desperate people are: "Their crops are lost. All their property is lost. People are tired of the situation. Violence, disease and running have been their daily life for years."

The sheer scale of the humanitarian crisis in the region is massive. Hundreds of thousands of people have fled their homes, looking for somewhere they can feel safe. "The long-term impact of violence in Congo is that people cannot get access to basic healthcare and that's what we're fighting for every day," explains Head of Mission, Jane Coyne. "With the current displacement we have, people are living in terrible conditions, children are getting respiratory infections, the infections aren't treated, they come into hospital with pneumonia and it's too late. People are not dying from complicated things; they're dying from completely preventable problems."

“Luckily she is a very strong person” HIV/AIDS treatment in Myanmar

Isolated from the outside world, the people of Myanmar (formerly Burma) are suffering from repression and neglect. The crackdown on monks marching for democracy in September brought international attention to this long-suffering population, but it did not expose what ordinary Burmese go through every day. Faced with high malaria and HIV rates, the impoverished population is provided with little healthcare from the government – only 1.4 percent of the regime's budget supports healthcare services.

A nurse gives an injection to a patient with HIV/AIDS and TB in one of MSF's Yangon clinics
© Chris de Bode [2006] Myanmar

HIV/AIDS in Myanmar

The slow response to Myanmar's HIV/AIDS pandemic has fuelled the spread of the disease. While there is little independent information on the number of Burmese in clinical need of life-prolonging antiretroviral (ARV) treatment, of the UN-estimated 360,000 people who are living with HIV/AIDS, only 10,000 are believed to be receiving ARVs. MSF provides ARV therapy to 8,000 of them, in several regions of the country.

The thousands of HIV/AIDS patients who come for treatment to the five MSF clinics in Yangon (former capital of Myanmar) receive an extremely high level of care. The MSF staff are split into teams consisting of a doctor, a nurse and a counsellor. Patients therefore get to know their carers – which is very important for building trust and helping people to stick to a lifetime's course of treatment.

Here three of MSF's Burmese staff from one of the Yangon clinics explain their involvement in one patient's treatment:

Medical Doctor Sandi Aye*

“Khin May Tway* is 24. Her husband died of HIV/AIDS. After his death she was confirmed as HIV positive in July 2007. She also tested positive for tuberculosis. Khin used to live in a village 40 miles outside Yangon, but to be eligible for antiretroviral (ARV) treatment patients have to stay in Yangon for proper monitoring. She had no other choice if she wanted to survive so together with her mother she decided to move to Yangon. Renting a house was a huge burden on the family. Her father was not well and therefore not working, so Khin's sister paid to support her.

Because of her weak state and low immune resistance she was very vulnerable to ‘opportunistic infections’. In October she developed severe symptoms of a rare blood disorder, and was sent to the government hospital where she received blood transfusions.

Two weeks later, however, the symptoms reappeared and she also developed a severe bowel obstruction with a very swollen belly. She only weighed 32kg, and was not able to walk on her own any more. We suspected that her TB drugs were failing, and decided to change her TB treatment. In the meantime the father at home in the village had become very ill and the mother could not cope with two dying family members at the same time.

They were very scared of another long stay in the hospital and did not have money to pay for it. We decided to treat Khin as an outpatient at the MSF clinic, where she needed to come every day for two months to receive her injections, infusions, etc. After changing the TB drugs, she started to improve. But in the meantime her father had died. Her mother did not dare to tell her until much later because she was so sick.

She has now been on ARV treatment for five months and on the new TB drugs for four months. Her situation has improved dramatically. She weighs 53kg and is able to walk again and function normally. She expects eventually to move back to her village and start to work again.”

> “I think this particular girl made a big impression on all of us who treated and cared for her because of her positive outlook, her eagerness to get better and the support and kindness she gave and received from her surroundings. It is very rewarding to treat a patient like this and it makes me happy that she now has a future in front of her.” Dr. Sandi Aye

Nurse Soe Soe Chan*

"I treated this patient from the first day she arrived. We had to send her to the hospital twice for treatment but she did not get better. When she had the abdominal obstruction and a very swollen belly she became very wasted and was in a lot of pain. I was very upset at that time because I thought the girl would die. We treated her in the MSF clinic and I remember that she had to be carried into the treatment room every day, where I gave her the injections.

Her mother was very supportive. She wanted it to work. We don't see patients with that much support very often. Unfortunately many of our patients are alone or rejected by their families and society and this can be very depressing. Therefore it was very nice to see how much love and support this girl was getting from her mother through all the difficult times, and how this helped her to stay positive."

The waiting room in one of MSF's Yangon clinics
© Chris de Bode [2006] Myanmar

Counsellor Whin Maye*

"I started counselling sessions with Khin after she moved to Yangon. Before being started on ARVs, patients receive five counselling sessions to make sure that they know what they are getting into. Patients need to understand how the drugs work, that they really have to take all of them and not just half and sell or share the other half. They need to understand that they will always have to continue taking the drugs even when they start to feel much better. Initially adherence and social counselling sessions are once a week. When the patient is stable and is taking the drugs properly, counselling is reduced to one session a month and then to once every three months.

I remember the period when Khin became so sick, we all feared for her life. She could not walk by herself and had to be carried into the clinic, she was very weak and could not remember things well. But even under these circumstances she was very motivated and eager to get information and to receive treatment.

During this period she received daily treatment at our clinic and I had counselling sessions with her on a daily basis. We became close, like friends during this period. She was very open with me. I was afraid that she would not survive and did not want her to give up hope. We are the same age as well, and she has already been through so much. Luckily she is a very strong person. Even after all the difficult hospital treatments and the pain and later when she heard that her father had died, she still wanted to survive and get better. I was very happy and relieved when the treatment worked and she improved so much. She is now so stable that we decided to reduce the counselling visits from every week to once every month."

*names changed

MSF UK volunteers currently in the field

Bangladesh Kolja Stille *DOCTOR* **Bolivia** Thomas Ellman *HEAD OF MISSION* **Burundi** Anna Halford *FIELD COORDINATOR* **Central African Republic** Anat Aharoni *PROJECT COORDINATOR* Anthony Kilbride *LOGISTICIAN* Dominic Deville *LOGISTICIAN* James Pallett *DOCTOR* Kathleen MacEwan *NURSE* Nicole Hendriksen *NURSE* **Chad** Alexis Gallagher *HR ADMINISTRATOR* Emily Bell *LOGISTICIAN* Ian Atkinson *LOGISTICIAN* Paula Brennan *PROJECT COORDINATOR* Sophie Sabatier *MANAGEMENT TRAINER* **Colombia** April Baller *DOCTOR* Haresh Mulchandani *ANAESTHESIST* Lucia Gonzo *MENTAL HEALTH SPECIALIST* Sally Tillett *NURSE* Simon Midgley *MENTAL HEALTH SPECIALIST* **DRC** Anna Halford *PROJECT COORDINATOR* Christophe Hodder *PROJECT COORDINATOR* Cokie Van Der Velde *LOGISTICIAN* Gina Bark *ASSISTANT HEAD OF MISSION* Katie Johnstone *HR OFFICER* Katy Peters *NURSE* Nitisha Nababsing *DOCTOR* Simon Wright *FINANCIAL CONTROLLER* Sophie Tilt *LOGISTICIAN* **Ethiopia** Christine McVeigh *NURSE* David Cook *LOGISTICIAN* Joanna Knight *LOGISTICIAN* Rosemary Davis *CAMPAIGNER* Tom White *HEAD OF MISSION* **Guinea** Clara Van Gulik-Mackenzie *DOCTOR* **India** Adam Thomas *PROJECT COORDINATOR* Alice Thomas *MEDICAL OFFICER* Anthony Solomon *DOCTOR* David Sweeney *LOGISTICIAN* Hilary Evans *DOCTOR* Jacob Stringer *HEAD OF MISSION* Joanna Cox *MEDICAL COORDINATOR* Maria Dominguez *DOCTOR* Orla Condren *NURSE* Pawan Donaldson *PROJECT COORDINATOR* Simon Woods *LOGISTICIAN* **Ivory Coast** Christopher Pritchard *LOGISTICIAN* **Jordan** Colin McIlreavy *HEAD OF MISSION* Maria Siemer *FINANCIAL CONTROLLER* Peter Sleap *ANAESTHESIST* Pirkko Fischer *SURGEON* **Kenya** Lucy Pamment *NURSE* Susan Sandars *REGIONAL INFORMATION OFFICER* **Liberia** Annas Alamudi *ADMINISTRATOR* Foday Kargbo *FINANCIAL CONTROLLER* Fran Miller *MENTAL HEALTH SPECIALIST* Pauline Scheelbeek *WATER & SANITATION EXPERT* **Malawi** Margaret Othigo *BIOMEDICAL SCIENTIST* Bryn Button *LOGISTICAL COORDINATOR* **Myanmar** Helen Bygrave *DOCTOR* Sabina Ilyas *DOCTOR* **Nepal** Alyson Froud *PROJECT COORDINATOR* Simon Heuberger *FINANCIAL CONTROLLER* Zelda Goad *NURSE* **Nigeria** Sean Nadaraja *ANAESTHETIST* **Pakistan** Chris Lockyear *HEAD OF MISSION* Hannah Denton *MENTAL HEALTH SPECIALIST* Philippa Farrugia *DOCTOR* **Russia** Valerie Powell *MEDICAL COORDINATOR* **Sierra Leone** Sophie Dunkley *EPIDEMIOLOGIST* **Somalia** Anthony Munster *LOGISTICIAN* Duncan Bell *DEPUTY HEAD OF MISSION* Joan Wilson *MEDICAL COORDINATOR* Kenneth Lavelle *HEAD OF MISSION* Kiran Jobanputra *DOCTOR* Leanne Sellers *NURSE* Luke Arend Deputy *HEAD OF MISSION* Paul Critchley *PROJECT COORDINATOR* Tom Quinn *HEAD OF MISSION* **South Africa** Louise Knight *EPIDEMIOLOGIST* **Sri Lanka** Bruce Russell *PROJECT COORDINATOR* Jonathan Henry *PROJECT COORDINATOR* Mesfin Senbeto *MEDICAL COORDINATOR* Natalie Thurtle *DOCTOR* Sarah Quinell *MIDWIFE* **Sudan** Aisa Fraser *NURSE* Angela Cave *NURSE* Anna Greenham *DOCTOR* Boris Stringer *DEPUTY HEAD OF MISSION* Catherine McGarva *MENTAL HEALTH SPECIALIST* Colin Beckworth *NURSE* Elizabeth Harding *NURSE* Emily Russell *LOGISTICIAN* Felix Over *NURSE* Freda Graf *NURSE* Gill Ross *DOCTOR* Helen Austin *PROJECT COORDINATOR* Laura Rinchey *MEDICAL COORDINATOR* Malcolm Townsend *LOGISTICAL COORDINATOR* Maria Doyle *NURSE* Patricia Drain *NURSE* Peter Camp *LOGISTICIAN* Philippa Millard *NURSE* Simon Burling Assistant *MEDICAL COORDINATOR* **Thailand** David Wilson *DOCTOR* Paul Cawthorne *PROJECT COORDINATOR* **Turkmenistan** Gemma Davies *LOGISTICIAN* Zoe Shimanska *LOGISTICAL ADMINISTRATOR* **Uganda** Alexandra Von Lieven-Knapp *PROJECT COORDINATOR* Alison Criado-Perez *NURSE* Harriet Cochrane *PROJECT COORDINATOR* Sandi Chit Lwin *DOCTOR* **Uzbekistan** Jonathan Polonsky *EPIDEMIOLOGIST* **Yemen** Cristian Ghilardi *PROJECT COORDINATOR* **Zimbabwe** Andrew Mews *LOGISTICAL COORDINATOR* Cielo Rios *DOCTOR* Daniel Williamson *PROJECT COORDINATOR* Lily Cummins *NURSE* Stephen Hide *HEAD OF MISSION*

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Photography is still difficult in in the sensitive Bajo Atrato region. Here, an MSF team is visiting communities on the nearby Rio San Juan river
© Francesco Zizola [2007] Colombia

Returning to a hidden corner of Colombia

The Bajo Atrato region in northwest Colombia is largely impenetrable jungle and has a complex network of small rivers, making it a haven for trafficking illegal hardwood and narcotics. Because of this, the region is also a crucible of violence, with civilians caught in the midst of a conflict between guerrilla groups, government forces, paramilitaries and narcotics criminal groups. Suffering frequent epidemics, the communities in Bajo Atrato have the worst health statistics in Colombia and most people have not received a visit from a doctor for several years. After long negotiations with various armed groups, in November 2007 MSF managed to return to the region for the first time in years. Caroline Brant, MSF's Project Coordinator in Bajo Atrato, describes the team's first exploratory expedition.

"After months of work – gathering information, planning, and negotiating our access to the area with the armed groups – we are ready. At 5:30am the team begins loading three dug-out canoes with our seemingly endless boxes of medicines, medical supplies, vaccines, microscope and lab supplies, food, water, hammocks, etc... Our main aim is to carry out a full vaccination campaign, but this is the first visit so we have to make sure we have enough medicines and supplies to deal with almost any eventuality. We know what illnesses we are likely to encounter, but you never know exactly what you'll find or how much, so we have to be prepared for everything. We also take all our own food, not wanting to take anything from communities who have so little, and needing to ensure that our team keep up their energy for the tough week ahead. We turn off the main river and up a smaller one for seven hours – distance is measured in time here. After only relatively small delays with engine problems we arrive at the first of the four indigenous communities we will visit on this trip.

More than a hundred people are crowding the muddy riverbank to welcome us and help us unload our boxes into the school building. Like the other village buildings, it is wooden and raised above the ground on poles and it is where we will set up our clinic for the next day. This village once had a 'health post' building but it was washed away in a flash flood – more frequent now due to the enormous scale of illegal deforestation happening further upstream. While the children put on our lifejackets and run around shrieking and laughing, we introduce ourselves and explain that we have come to offer vaccinations and medical and nursing consultations. We are also doing something that I find very difficult, given the huge needs in all of these communities – we're trying to prioritise where we should be concentrating our efforts in the future since we simply cannot respond everywhere.

Several days later, at the last community on the expedition, I take five minutes out to sit down with April, the doctor. We are tired, we have vaccinated children in all the villages and we have found that there are worrying cases of tuberculosis that need our immediate attention. We're on a small hill overlooking the village, with low hills of dense jungle stretching out in every direction. A group of children stand around and unashamedly stare in fascination, until two girls pluck up the courage to sit down next to us. "Which river are you from?" one asks. "From the river Trent," I reply."

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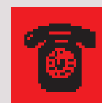

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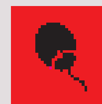

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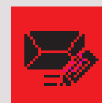

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Why *Dispatches*?

Dispatches is written by people in MSF and sent every three months to our supporters. It costs 8 pence per copy to produce and 22.5p to send, using Mailsort Three, the cheapest form of post. We send it to keep you, our supporters, informed on how your money is spent and what our latest activities are.

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.

The *Dispatches* cover letter

The letter sent with this issue of Dispatches is written by Katy Peters (pictured). Whilst at school, reading her parents' copies of Dispatches inspired Katy to choose nursing as a career – specifically so she could work with MSF. She wrote this letter between 'outreach' visits to remote Congolese villages on her first MSF placement. If you would like to respond to Katy, please feel free to do so. The satellite phones do not allow direct emails, but we will forward to Katy any emails sent to james.kliffen@london.msf.org or letters sent to Katy at the postal address above.

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