Quarterly news from Médecins Sans Frontières UK Issue no 53 Summer 2009

DISPATCHES

Charity no 1026588

Médecins Sans Frontières is a leading independent humanitarian 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.

Alex Nash drilling a borehole for a lakeside hand pump

A life saved
for the cost of a London pint

"Surveying the building site in front of him, Abwe smiled and said to me, 'It will be the best CTC (Cholera Treatment Centre) in all the Kivus, a truly modern CTC'."

"I failed to suppress a smile, which was partly due to the pleasure of having met with the CTC manager Abwe's approval, but mainly at the oxymoronic idea of a 'modern' CTC. Titles like *Love in the time of Cholera* suggest that this disease is part of history. But for many the time of cholera is not over."

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Nor any drop to drink...

A 'WatSan' in eastern Congo

Alex Nash was based for four months in the small town of Baraka on the shores of Lake Tanganyika in South Kivu in the Democratic Republic of Congo (DRC). As a Water and Sanitation Engineer, Nash's job was to prevent or minimise outbreaks of waterborne diseases such as cholera. He wrote from Baraka explaining the role of an MSF 'WatSan':

"Baraka is a busy lakeside town. Too busy – in the fragile peace that seems to be holding, people from the refugee camps in Tanzania are coming home while thousands more people have arrived from the north, fleeing the violence in North Kivu province. One of the results of the population explosion here is a shortage of drinking water. Although Lake Tanganyika contains around one sixth of the world's liquid fresh water, it also contains the bacteria *vibrio cholerae* and cholera outbreaks occasionally flare up in the towns and villages here, killing quietly and quickly.

Last year 1,500 people came down with cholera in Baraka, which is not unusual. MSF runs a hospital here, as well as the new 'modern CTC', and while the doctors and nurses try to stop people from dying, we WatSan engineers try to stop them seeing the doctor in the first place. I joke with the medics that I am trying to make them redundant, but more accurately I am trying to stop them from being overloaded.

On my first Sunday morning I learned firsthand how a cholera epidemic starts. There were a large number of new cholera cases and one teenage girl who had gone to spend the night with friends died during the night, before they could get to us. Even though it was a Sunday, our outreach work supervisors immediately organised chlorination at the lakeside water collection points. By the end of the day we had 24 people chlorinating water at 12 sites. On Monday we took on more chlorinators, and six guys with megaphones who broadcast the message that cholera was stalking the town again. So for the next week I was woken up at 5am every morning by a guy with a megaphone standing outside our compound informing us in Swahili of the risks of cholera!

In my third week, on Boxing Day, we received a call from the town doctor in Lulimba, 120km away, where a cholera epidemic had started and the local health centre was overwhelmed. Six people had died. With MSF there is no bureaucracy or paperwork when it comes to a call for help like this. There are also no holidays at Christmas for an emergency medical organisation! If it's safe (by Congo standards), we just go.

It's a seven hour drive to cover the 120km to Lulimba. We went straight to the existing CTC, a dark mud hut with three beds and lots of people on mats on the floor. A man in a gloomy corner looked up at me out of the darkness with wide, grasping eyes and asked for something to drink.

> **"There are no holidays at Christmas for an emergency medical organisation! If it's safe (by Congo standards), we just go."**

While the medics treated the patients, it was clear the centre needed improving as anyone without cholera would contract it pretty quickly if they came near this place. The local men volunteered to help us for free and we more than doubled the size of the centre in the quickest way possible – a sturdy wooden frame covered in tough plastic sheeting. We made 20 beds, arranged for people to chlorinate the river water for three weeks and trained the nurses in the management of the disease. Two days of hard work, and then back to Baraka. Later the people of Lulimba wrote us a long and moving letter thanking us for not 'leaving them to their lot'. The epidemic had stopped in under three weeks, with no new cases reported.

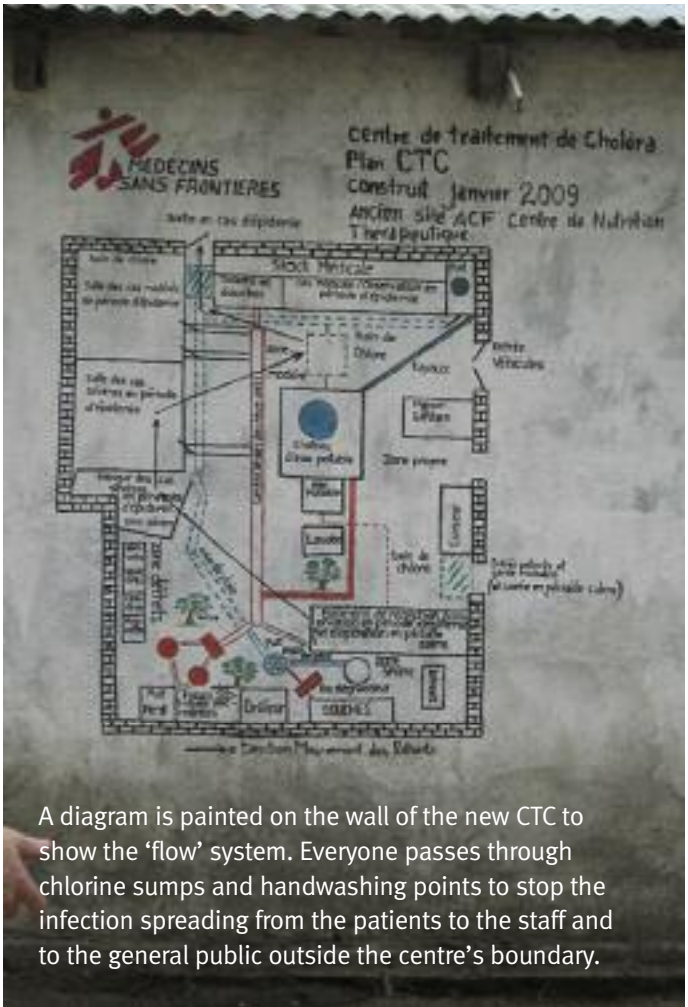
Back in Baraka, I discussed our town's water supply with another aid worker who said it was good and working well. I don't consider a town that's had two cholera epidemics this

PHOTOS LEFT TO RIGHT
One of the lakeside water collection points at Baraka; Nash testing the quality of the water in the first of the 20 hand pumps; Surveying the potential springs in the hills above Baraka.

All photos ©Alex Nash [2008] DRC

year as one that qualifies as having a 'working water supply system'. Hardly any water comes out of it.

Imagine only having three one-litre bottles per day, which is what this system provides for each person, when it's working. Unsurprisingly, many people are forced to drink the lake water for want of anything better. I often ask the women and children I meet collecting water if they drink it straight. Everyone knows that it is dirty and requires boiling, and people know to wash their hands with soap. But some people are too poor to buy soap, let alone fuel for boiling water.



A diagram is painted on the wall of the new CTC to show the 'flow' system. Everyone passes through chlorine sumps and handwashing points to stop the infection spreading from the patients to the staff and to the general public outside the centre's boundary.

"While the doctors and nurses try to stop people dying, we WatSan engineers try to stop them having to see the doctor in the first place."

As MSF we can't end poverty, but we can try to keep people alive while they end it themselves. So our WatSan team built the new CTC for those who get sick. At the same time, we started work on 20 cheap and very effective lakeside hand pumps to try to keep the new treatment centre empty. Made by local people, using local parts, and drilled by hand, we can make these pumps for £160 each (all in). They give 20 litres of drinkable water per minute.

The bigger project that I can only work on when I'm not dealing with urgent matters is to tap some springs that the local water board showed us in the hills above Baraka. To reach them is a major bushwhacking job, getting bitten by ants and stung by wasps. But it's worth the effort as it rains so much here that these streams are a pretty reliable source.

It gets hard doing so many things in parallel. I'd like to drill more wells, renovate the town supply, do more cholera education; but if we can get those springs connected and help the local water authorities double the town's water supply, then we will have made a huge difference.

Can you imagine 30% of beds in one of our NHS hospitals being occupied by people who got sick from dirty water? If we can prevent this, the medics in Baraka will then be able to concentrate on their already huge workload, without worrying so much about cholera.

I worked out it costs us under £2 worth of medication to treat a cholera patient. Plus a bit more in labour and building the CTC. All in all a life saved for about the cost of a London pint. Cholera is a bargain of a disease to treat, but a tragedy to die from."

"We have 320 patients in a ward with 45 beds," explained MSF surgeon Paul McMaster, speaking from Vavuniya hospital towards the end of Sri Lanka's recent violent conflict. "It's so crowded that the nurses cannot physically walk around the ward. We manage to get most patients into surgery – the problem is we desperately need more nurses to provide the level of aftercare they need if they're going to survive. The nurses we've got are doing an excellent job – they are working 18–20 hours a day. But there are simply too many people to treat them all."

Throughout the conflict that ended Sri Lanka's 26-year civil war, McMaster and his MSF surgeon colleagues provided emergency surgery for people who were evacuated from or managed to leave the conflict zone. Now, in the aftermath, the situation is still appalling for more than 260,000 people who fled the warzone and are now living around the town of Vavuniya, spread out among many different camps in an area called Menik Farm. Any health system would have difficulties responding to such needs. The Ministry of Health staff in the camps are doing what they can, with doctors seeing up to 300 patients a day, but facilities are simply overstretched.

Some patients needing urgent care are referred by Ministry of Health staff to the MSF teams in Vavuniya and Pompaimadhu hospitals or MSF's own tented field hospital near the Menik Farm camps. The biggest problem is at night, according to Karline Kleijer, MSF emergency coordinator: "In many camps if someone gets sick at night they have to rely on the soldier at the camp gate to decide whether they get referred to a hospital or not. This works for those who are obviously ill, but when it is a dehydrated child with a fever, the average soldier will not see that they are in urgent need of medical attention."

"The motivational coaches help them find ways to cope emotionally. People feel better when you work with them, even if they will never regain their movement."

The teams are also worried about the provision of food and clean water. In most camps people rely on community kitchens and daily distributions of rations, which sometimes do not arrive until ten o'clock at night. To try to prevent malnutrition, in eleven of the camps MSF is distributing 23,000 meals of high energy porridge daily to children, pregnant and lactating mothers and the elderly.

"It's amazing what you can be thankful

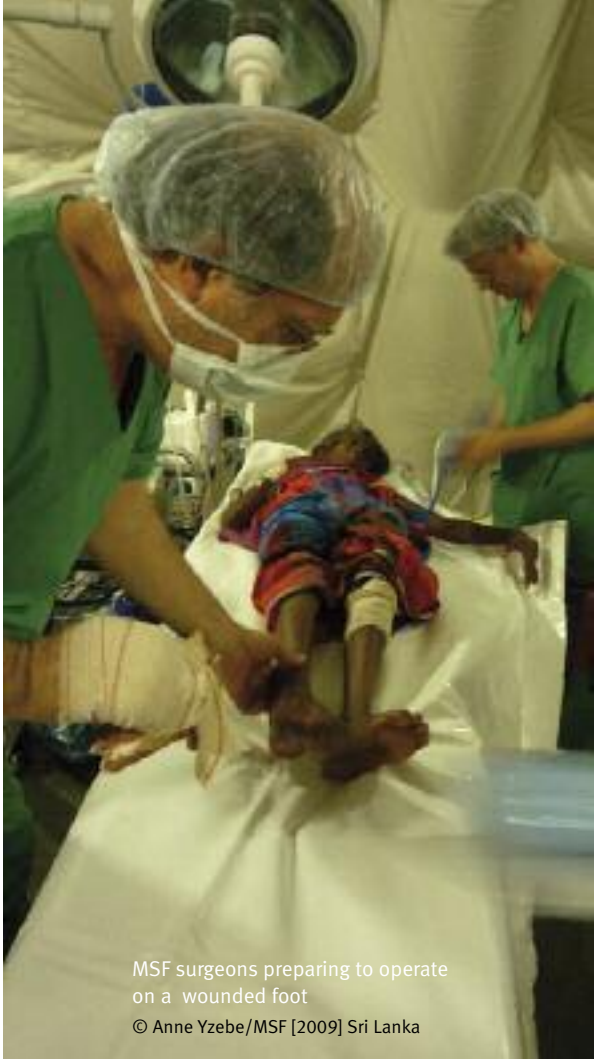
A ward in MSF's field hospital at Menik Farm

Treating a patient's wounded hand in the field hospital at Menik Farm
© Anne Yzebe/MSF [2009] Sri Lanka

Traumatised by what they experienced during the conflict, many people are finding it hard to rebuild any semblance of a normal life. There are very few job opportunities inside the camps and people are not allowed to leave, so it is difficult to search for relatives, make plans or take control of the future. The uncertainty of how long they have to remain in this situation is difficult to live with and psychological support is badly needed in the camps; but currently none is provided.

Despite already working flat out in three hospitals (see map), if permitted to the MSF teams would be able to provide much more medical support to the Ministry of Health staff inside the camps. "We have two whiteboards in our office," explains Kleijer. "One with a list of planned activities for the coming weeks: supplementary feeding, surgery, etc. And the other a list of activities awaiting approval, including mental health, basic health care and physiotherapy in the camps." MSF is currently pursuing discussions with the authorities, seeking approval to do more work in the camps. As Kleijer says, "We are ready to start!".

*name has been changed



MSF surgeons preparing to operate on a wounded foot
© Anne Yzebe/MSF [2009] Sri Lanka

for": surgery in northern Sri Lanka

Tim Pruchnic is an MSF surgeon at Pompaimadhu Ayurvedic Hospital, where MSF is running an operating theatre and a post-operative care programme. "We now have 180 patients in Pompaimadhu and the hospital is full," he explained. "I do an average of 16 to 20 surgeries a week. Some of them are major operations such as revisions of amputations that haven't healed, and then there are smaller things like taking off external fixtures and cleaning up wounds.

"One of the major procedures we're doing is a reconstructive plastic surgery operation called a muscle flap surgery. This two to three-hour operation allows us to save infected legs that have been injured in shell blasts, legs that would otherwise have to be amputated. We have done this procedure 20 times now and so far it's been really successful. The first patient we did this operation on had been injured by a big bomb blast which tore out a chunk just below his knee – he had almost no bone left. Now he is walking again and today we decided that he's improved enough to leave the hospital.

"We have also set up a spinal cord unit here and we are now the main provider of care for spinal injuries in the district. Other hospitals transfer their cases here and we now have fifty patients, most of them injured by shell blasts in the conflict. Two patients are paralysed from the neck down and the others are paraplegic, paralysed from the waist down. There are two or three lucky ones who only have temporary damage and the physiotherapy sessions are helping them regain their mobility. It's great that they're all here because it means they can all be treated together. With good nursing, their wounds will heal. We have taught their relatives how to turn them in their bed and care for them, although we sometimes have to treat their sores in the operating theatre. The motivational coaches talk to them and help them find ways to cope emotionally. People feel better when you work with them even if they will never regain their movement. It's amazing what a big difference this can make: some nursing, some physiotherapy to keep their joints moving and some moral support.

"One patient I see every day in the hospital has really stuck in my mind. He is about 20 years old and he was in the conflict zone when a shell landed on his legs. It didn't explode but it did crush both legs. He'd had two amputations that hadn't gone well and so he now had the bone sticking out and needed further surgery. We redid both amputations so everything is now nice and clean and maybe one day he'll walk again. When we asked him what had happened he told us about the shell and the funny thing is that he smiled about it, as if it was a good thing. And we were like, 'why?', and he explained: 'The shell landed on my legs – it did not explode. If it had exploded it would have killed my whole family.' It's one of those stories where you go wow, how amazing... He has no legs but he is thankful because it didn't explode. He is quite a cheerful person. You might think how depressed you or I might be in his situation, but he gets in his wheelchair and he goes off and he is thankful for everything. Despite all the bad stuff that happens, it's amazing what you can be thankful for."

The worst meningitis epidemic for ten years swept through several West African countries in March, including Niger, Nigeria and Chad. Hundreds of teams from MSF and the countries' ministries of health worked together to vaccinate some 7.5 million people against this deadly disease. In a race against time, MSF teams tracked the spread of the outbreak, ordered millions of vaccines, delivered them to remote areas, set up thousands of vaccination points and treated those who were already sick.

"Today we vaccinated 20,000 p

MSF's largest ever

With MSF's largest ever vaccination campaign almost at an end, project coordinator Elisabetta Maria Faga described the work her teams had been doing in the Maradi region of southern Niger:

"We have 17 teams and in one 12-day period, for example, we vaccinated 220,000 people, so we were extremely busy and very happy! It's really nice to work on a vaccination campaign because it is prevention work and you know that you are doing something very good for the people.

"Our typical day starts at 4am, with the teams placing the vaccines in cold-boxes with ice packs before loading the cars and rushing to their vaccination sites. We vaccinate all day long – we never seem to stop and our day often finishes around midnight. And our nights are long; every day we analyse the data to see whether we might have missed people and if necessary schedule a return visit to those villages to do more vaccinations. A lot of the people have had to walk to reach us, so we try not to have more than 5 or 10km between vaccination sites. But then, just as we think we have finished for the day, someone says that another group of walkers are on the way.

"One evening we were back at our compound and it was almost dark when a group, around 40 people, arrived wanting to be vaccinated. They had been walking three or four hours with their small babies, so the first thing we did was to give them water. They drank about 60 litres before we vaccinated them.

People heading to an MSF vaccination site in ox carts
© Olivier Asselin [2009] Niger

In southern Niger people are familiar with *chankarow* – the Hausa word for meningitis – which means someone who cannot move his head. "Sometimes at the more remote sites a small cart drawn by a donkey will arrive carrying 15 to 20 small babies, sent by the elders from nearby villages," continued Faga. "It is really good to see such collaboration in the villages. We train local people who go to remote places to pass the message that MSF is here to do vaccinations. It's crucial to pass the right message; sometimes one word can be misunderstood, so it's very delicate – but it's been working well. People understand that a vaccination could be the difference between life and death. So when we pass through the villages, people who have already been vaccinated clap their hands and are so happy to see us.

Vaccinating in a village in Maradi region
© Olivier Asselin [2009] Niger

In the region of Zinder, next to Maradi where Faga was working, Watford-based paediatrician Miroslav Stavel was overwhelmed by the scale of the response: "At one point we had 67 vaccination teams out at one time, each with eight or so people. We'd hired 150 cars in our region to do the vaccinations, and they drove a total of 400,000km (about nine times round the equator). We vaccinated around 1,345,000 people and we worked out that during daylight hours our teams in Zinder were vaccinating about one person per second. I don't know whether it was the logisticians' dream or nightmare."

Almost fully recovered, this 12-year-old boy is one of more than 5,000 meningitis patients that MSF treated in Niger

eople”

vaccination campaign

“Each of our teams has one person doing the vaccinations, two assistants and a ‘counter’ who records the number of people vaccinated per site. We also have attendants and a supervisor to ensure that the day runs smoothly. Sometimes when more people than expected arrive everybody gets involved, including our drivers. It is really good teamwork.

“We have briefed local health staff to carry out the vaccinations and they are happy to learn and proud to help their community. When they start off on their own it always takes them some time to prepare the syringes and then suddenly they are doing it quickly – pop-pop-pop-pop!”

This mass vaccination campaign in Niger, Nigeria and Chad is the biggest ever undertaken by MSF, involving more than 7,500 nationally recruited staff and 200 international staff. “It’s really huge,” continued Faga. “It has been incredible for the people who have never participated in a vaccination campaign before. People are dying of meningitis, but the injection takes just two seconds and as you do it you can be pretty sure that for the next three years that person is safe. We work very hard but at the end of the day, when we are completely tired, we say, ‘OK folks, today we vaccinated 20,000 people,’ and that is really emotional.”

WHAT IS MENINGITIS?

Meningococcal meningitis is an infection of the ‘meninges’ – the lining of the central nervous system (brain and spinal cord). The vast majority of cases and deaths occur in sub-Saharan Africa. Highly contagious, it is transmitted through the air by sneezing or coughing. The most common symptoms are headaches, vomiting, high fever, a stiff neck, sensitivity to light and a rash. On average, meningitis kills half of all infected people if not treated; but on average nine out of ten people survive if treatment is provided.

Meningococcal meningitis is found in several forms worldwide; it is the ‘A’ strain that is most commonly responsible for large epidemics in sub-Saharan Africa. The best vaccine currently available confers reasonable protection for three years. But a new longer-lasting (conjugate) vaccine to protect against this strain has been developed; from next year campaigns to start vaccinating all people between the ages of 1 and 30 in vulnerable countries such as Niger will start. MSF will be working with national health authorities and other agencies to ensure the campaigns are successful. With luck, this year’s huge meningitis epidemic will be a thing of the past.

MSF UK volunteers currently in the field

Afghanistan Michiel Hofman *HEAD OF MISSION* Bangladesh Gemma Davies *PROJECT COORDINATOR* Bolivia Thomas Ellman *HEAD OF MISSION* Central African Republic Simon Brown *LOGISTICAL ADMINISTRATOR* Chad Sarah Maynard *LOGISTICAL COORDINATOR* Tim Tranter *LOGISTICAL ADMINISTRATOR* Claire Grisaffi *WATER & SANITATION EXPERT* Colombia David Cook *LOGISTICIAN* Ruth Spelman *NURSE* Alison Criado-Perez *NURSE* Dolores Allariz-Santiago *NURSE* Democratic Republic of Congo Pavithra Natarajan *DOCTOR* Laura Rinchey *DOCTOR* Stephen Wooltorton *DOCTOR* Alexis Gallagher *LOGISTICAL ADMINISTRATOR* Geraldine Kelly *MIDWIFE* Megan Craven *NURSE* Aisa Fraser *NURSE* Renate Reisinger *NURSE* Colin Beckworth *NURSE* Maire Tobin *SURGEON* Eve Mackinnon *WATER & SANITATION EXPERT* Ethiopia Brian Watt *LOGISTICIAN* Maria de los Llanos Ortiz Montero *MEDICAL COORDINATOR* Anna Halford *PROJECT COORDINATOR* Guatamala Alison Jones *MEDICAL COORDINATOR* Guinea Miroslav Stavel *DOCTOR* India Jonathan Williams *DOCTOR* Fiona Fisher *DOCTOR* Joseph Jacob *DOCTOR* Yasotharai Ariaratnam *FINANCIAL CONTROLLER* Liza Cragg *HEAD OF MISSION* Erik Gorter *LOGISTICAL ADMINISTRATOR* Emily Russell *LOGISTICAL ADMINISTRATOR* Hannah Denton *MENTAL HEALTH SPECIALIST* Sophie Sabatier *PROJECT COORDINATOR* Pawan Donaldson *PROJECT COORDINATOR* Bruce Russell Trust *ADMINISTRATOR* Kenya Ibtehal Mohammed *DOCTOR* Sophie Dunkley *EPIDEMIOLOGIST* Jose Hulsenbek *HR OFFICER* Susan Sandars *REGIONAL INFORMATION OFFICER* Lesotho Helen Bygrave *DOCTOR* Liberia Owen Groves *LOGISTICIAN* Emily Bell *PROJECT COORDINATOR* Malawi Mwenya Mubanga *DOCTOR* Malta John Hart *DOCTOR* Mozambique Christopher Peskett *PROJECT COORDINATOR* Myanmar Luke Arend *HEAD OF MISSION* Michael Patmore *LAB TECHNICIAN* Nepal Gillian Onions *NURSE* Niger Danielle Ferris *PROJECT COORDINATOR* Nigeria Danielle Wellington *NURSE* Emily Goodwin *NURSE* Pakistan Hilary Bower *MEDICAL COORDINATOR* Georgina Brown *MIDWIFE* Palestinian Territories Kevin Davies *MENTAL HEALTH SPECIALIST* Papua New Guinea Edward Crowther *FINANCIAL CONTROLLER* Christopher Pritchard *LOGISTICAL COORDINATOR* Chris Houston *LOGISTICIAN* Philippines Elizabeth Harding *PROJECT COORDINATOR* Somalia Mario Stephan *PROJECT COORDINATOR* South Africa Louise Knight *EPIDEMIOLOGIST* Sri Lanka Joan Wilson *MEDICAL COORDINATOR* Catriona Carmichael *NURSE* Sudan Mark Shephard *LOGISTICAL ADMINISTRATOR* Simon Tyler *LOGISTICAL ADMINISTRATOR* Sonia de Alcock *MIDWIFE* Lorena Mateos *NURSE* Orla Condren *NURSE* Lily Cummins *NURSE* Christine Heward-Mills *PROJECT COORDINATOR* Mesfin Senbeto *SURGEON* Karl Lellouche *WATER & SANITATION EXPERT* Uganda Anjum Khan *DOCTOR* Janet Raymond *MEDICAL COORDINATOR* Alvaro Dominguez *MEDICAL COORDINATOR* Zimbabwe Daniel Mburu *DOCTOR* Melanie Rosenvinge *DOCTOR* Andrew Mews *LOGISTICAL COORDINATOR* Susannah Woodall *NURSE* Terri Morris *PROJECT COORDINATOR* Nick Rowe *WATER & SANITATION EXPERT*

DISPATCHES is a quarterly publication designed to keep our supporters updated on the work of Médecins Sans Frontières.

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Kutupalong makeshift refugee camp
© Espen Rasmussen [2009] Bangladesh

Outrage at conditions for Burmese refugees

Gemma Davies, who wrote the letter about MSF's expulsion from Darfur that was sent with the last issue of Dispatches, has left Hemel Hempstead again, this time to work as MSF's project coordinator in Bangladesh. With a team of three international staff and more than 150 Bangladeshi staff, she is working in the makeshift Kutupalong camp, where thousands of unregistered refugees from Myanmar (Burma) are living in appalling conditions.

"The camp itself is really bad," explains Davies. "There's an official refugee camp holding around 14,000 people. But we're working in the 'makeshift camp' for people who are not recognised and registered as refugees. About 25,000 people are living in shelters made of bits of plastic and wood on the muddy, swampy slopes below the official camp. The sludge, the human waste from the latrines in the official camp, runs directly into and around the homes of the people in the makeshift camp. All I can say is it's dire – the conditions are horrible.

"We are the only organisation working here and when we started in April, we were overwhelmed with all the medical needs – lots of malnutrition and really nasty skin infections. One day during the first week a crowd was outside literally storming the doors and people were getting hurt. So we had to close down for people's safety and to get better crowd control in place.

"But in the past two weeks the situation for these people has got even worse. First they were threatened and told to move out of the boundary region of the official camp. So they moved onto some nearby forestry land that is owned by the government, which they're also not allowed to live on. In the last two weeks they've been forced to move quite a number of times and are being cornered into a very small space. People are scared – they have been thrown around a bit and have been threatened with knifes. One day we had 27 people come to our clinic, most of them women. There was one four-year-old girl who had knife injuries and a five-day-old baby that had been thrown onto the ground.

"People are threatening suicide now. Some are saying that they will no longer move, that if people want to move them again, they will have to kill them. It's horrible. To forcibly displace this group when they are already so vulnerable is outrageous. We can't resolve this situation for them, so it's frustrating, we feel helpless. But we'll do what we can and continue to run our clinic and we'll encourage anyone who has suffered any violence to come and get treatment".

The worst incident was on July 14, when 259 shelters were destroyed. Since then local police and officials have continued to issue threats and instances of violence against the refugees are still occurring. As well as continuing to treat patients at the clinic, MSF is strongly advocating publicly and at the highest levels with governments and international agencies to seek a durable and dignified solution for the unregistered Burmese refugees.

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MÉDECINS SANS FRONTIÈRES

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