MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Médecins Sans Frontières MSF (Doctors Without Borders) 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.

'At the moment, we're hoping for the best but preparing for the worst'

Two recent outbreaks of the deadly disease Ebola in east Africa – the first in Uganda, the second in neighbouring Democratic Republic of Congo (DRC) – have seen MSF emergency teams rushing to set up treatment centres and prevent the disease from spreading. The outbreaks are of different strains of the disease so appear to be unrelated.

While Ebola is very contagious, and the mortality rate can be high (from 25 to 90 percent, depending on the strain), it is not as fatal as most people fear, and many make a full recovery. A number of recovered patients are helping MSF to teach local communities to be less afraid of the disease.

The outbreak in western Uganda was centred on the town of Kagadi, where the first victim – a baby girl – died in late July; the disease spread quickly amongst the mourners who attended her funeral. Altogether 42 people were infected and 19 people died. In Isiro, in eastern Congo, 14 cases have been confirmed so far, but many more are suspected.

Henry Gray, logistics coordinator for the emergency team in Uganda, describes what MSF has been doing.

"We got to work fast. Usually, building a treatment centre for Ebola takes five to seven days, but within 72 hours of arriving, our team had cleaned and disinfected the hospital and set up a 30-bed centre within one of the wards.

Henry Gray helps a health worker put on the six layers of protective clothing necessary for entering the Ebola ward

Photograph © MSF, Uganda, 2012

'The patients we are treating are very frightened, for obvious reasons'

"Working on an Ebola outbreak isn't just about reacting to the physical challenges – educating people is also vital. Health workers are particularly susceptible to catching it so, along with treating patients, one of our main priorities is training local health staff to reduce the risk of them catching the disease whilst caring for patients. We have to put in place extremely rigorous safety procedures to ensure that no health workers are exposed to the virus – through contaminated material from patients or medical waste infected with Ebola.

"The general public is understandably concerned, because this isn't a disease that they regularly encounter. Ebola spreads quickly and can be deadly, so the social effects can be very severe. The patients we are treating are very frightened, for obvious reasons. Their families are also very scared, so as well as our treatment centre, we are setting up psychosocial support for the patients, their families and also our own staff, who may be traumatised by what is happening.

"Many people have stopped kissing or shaking hands when they greet each other – even though people are only actually infectious when they have Ebola symptoms.

"The symptoms can include fever, vomiting, sore throats and headaches and, in severe cases, internal or external bleeding. Unfortunately there is no specific treatment or vaccine for Ebola – several vaccines are in development, but it's likely to be several years before one is available.

"We will have the capacity to treat and care for between 50 and 60 patients at a time. At the moment we're hoping for the best but preparing for the worst."

We were overwhelmed by your messages of support for our team in Zimbabwe – thank you to everyone who wrote. We plan to publish a selection in our next issue.

YOUR SUPPORT

ABOUT DISPATCHES

Dispatches is written by people working for MSF and sent out every three months to our supporters and to staff in the field. It is edited in London by Marcus Dunk.

It costs 6p to produce, 7p to package and 22p to send, using Mailsort Three, the cheapest form of post. We send it to keep you informed about our activities and about how your money is spent.

Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. We welcome your feedback. Please contact us by the methods listed, or email:**marcus.dunk@london.msf.org**

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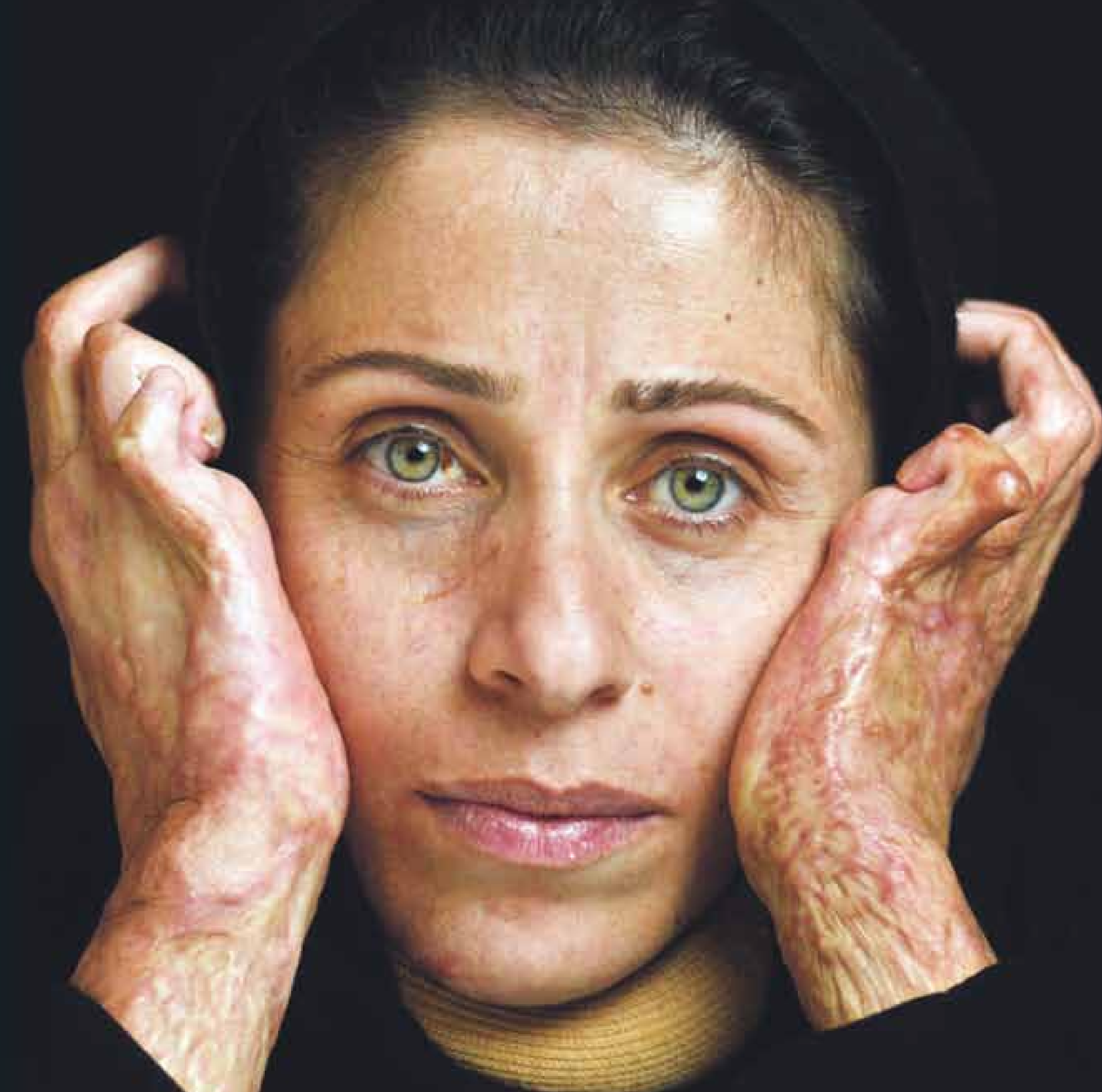
Have you thought of remembering MSF in your will? Any gift is welcome, however large or small. For more information, contact **joanna.corbin@london.msf.org** or call us on **0207 404 6600**.

CRISIS IN SOUTH SUDAN 'All these people in the camps are normal people who had normal lives. They're not rich people, but they had houses and clothes, and then one day they had to pack their things, leave their lives behind and start to walk ...' Find out more on pages 8-9

DISPATCHES



Restoring lives

How MSF helped Khanda and 1,500 others recover from their war injuries. Pages 6-7

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Autumn 2012
No 66

Mali
Aid in Timbuktu

MSF teams are working in Timbuktu's main hospital, providing medical care for the people of the city and its environs.

Timbuktu has been in the hands of Tuareg rebels and armed Islamist groups since the beginning of April. The city has seen pillaging, and much of the population has left: two-thirds of its 40,000 inhabitants have fled to other regions of Mali or to neighbouring countries.

In the city, sporadic fighting has flared up among armed groups and sacred sites around the city have been destroyed. In the surrounding villages, some health centres have been pillaged.

"Bringing aid to this region is a challenge, but it's also a necessity," says Dr Mego Terzian, MSF emergency desk manager. "The instability makes it difficult to work, and the north of Mali remains blocked to Westerners. Nonetheless, because the situation remains volatile and could deteriorate at any time, we are maintaining our presence in Timbuktu's hospital and in the surrounding villages."

'The instability makes it difficult to work, and the north remains blocked to Westerners'

MSF is one of the few humanitarian organisations working in this region. Five international MSF staff are working alongside local staff to provide medical care in the city hospital, and helping to supply the hospital with much-needed medicines.

An MSF worker hands out shelter kits to displaced people near Timbuktu

Many local health workers have fled the city, while those who remain are not paid regularly. Fuel shortages regularly disrupt water and electricity supplies, making it a challenge to keep the hospital running.

Over the past two months, more than 300 patients have been admitted to the hospital and over 1,500 consultations performed by our teams. In the surrounding area, MSF teams have conducted over 6,300 consultations, despite restrictions on movement outside the city.

Sierra Leone & Guinea
Cholera epidemic

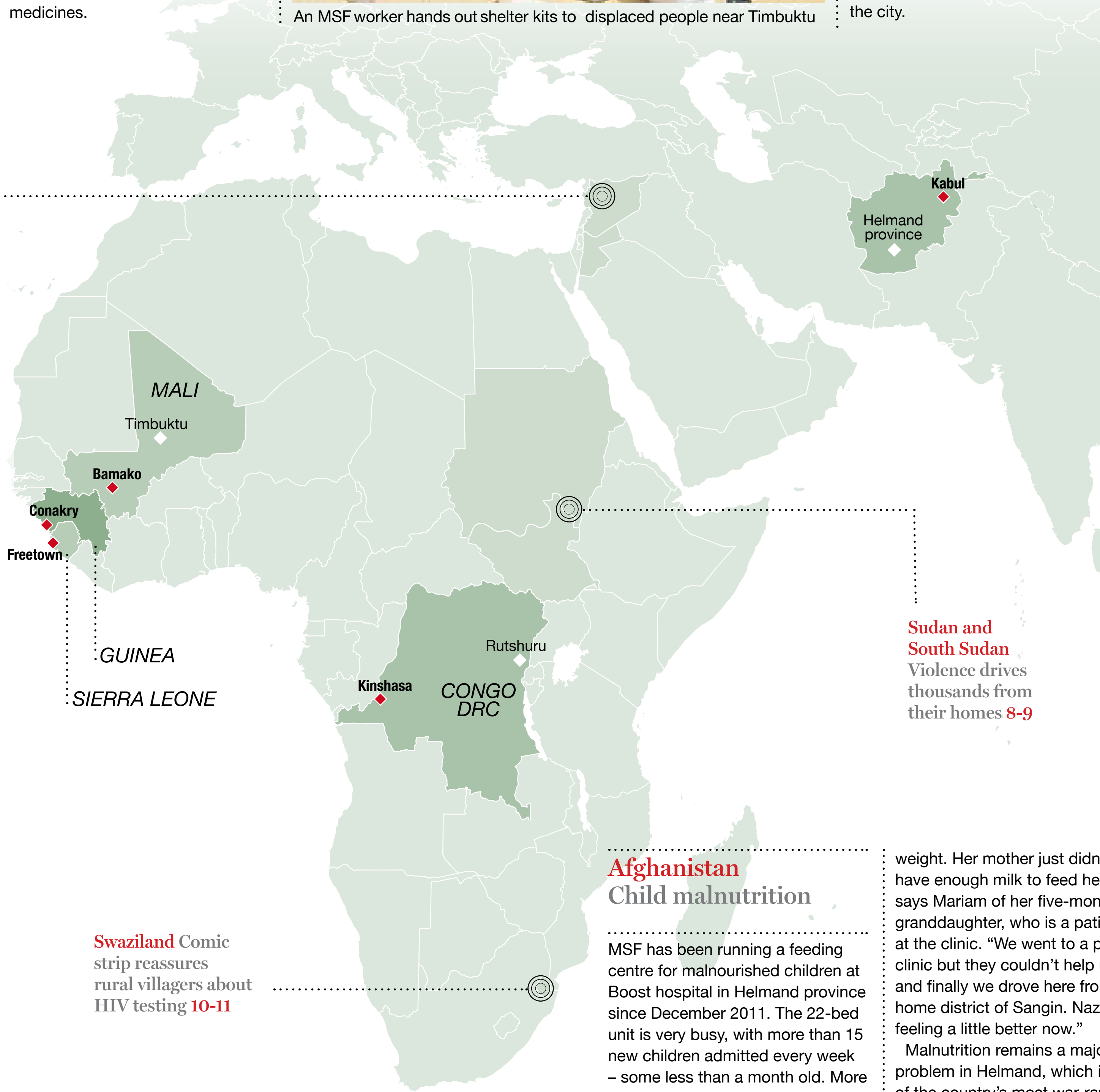
There has been an increase in the number of cases of cholera on both sides of the border between Sierra Leone and Guinea – made worse by the rainy season. The countries share a reservoir, which is a breeding ground for the disease. Once people are infected, the disease spreads quickly.

"This 'coastal cholera' has already killed some 250 people," says MSF epidemiologist Michel Van Herp.

More than 13,000 people have been admitted to hospital in the capitals, Freetown and Conakry, since February, when an epidemic was declared. MSF teams have opened cholera treatment centres and rehydration points on both sides of the border and treated nearly 4,600 patients.

In MSF's cholera treatment centre in the Mabella slum in Sierra Leone, the hardest-hit patients are visibly emaciated after days of diarrhoea and vomiting. "I want to die; I'm tired of this disease," says one patient.

Despite a slight increase of cholera cases in Sierra Leone generally, the number of cases in the capital is now falling. More than 99 percent of cholera patients treated by MSF make a full recovery from the disease.



Syria Clinic hidden in a house treats people who are too scared to go to hospitals for treatment 4-5

Sudan and South Sudan Violence drives thousands from their homes 8-9

Swaziland Comic strip reassures rural villagers about HIV testing 10-11

Congo DRC
Civilians in the crossfire

An MSF project has reopened in the east of the Democratic Republic of Congo (DRC) after heavy fighting forced it to close in July.

"We're working with communities that suffer an enormous level of violence," says Anna Halford, MSF project coordinator working near the Walikale project in Masisi.

"Widespread violence has become hopelessly commonplace; people here almost see it as normal to be robbed. People prepare for it – for example, they travel without taking all their kids with them so that they don't all get attacked at the same time."

Before the suspension MSF teams were treating more than a thousand cases of malaria each week in the emergency project.

But when the sound of gunfire began last month, people panicked and left the town.

"We had to flee," said a 28-year-old woman MSF is treating for malaria. "We took our four children and spent the night in the forest. We slept near a river and my youngest child was bitten by many mosquitoes." Her four-year-old daughter became sick a week later and is being treated for malaria.

People in and around Walikale remain severely affected by the ongoing conflict, continually forced to leave their homes in search of safety.

PHOTOGRAPH: © MSF, 2012

Two mothers bring their sick children to MSF's clinic in Walikale, DRC

Afghanistan
Child malnutrition

MSF has been running a feeding centre for malnourished children at Boost hospital in Helmand province since December 2011. The 22-bed unit is very busy, with more than 15 new children admitted every week – some less than a month old. More than 600 malnourished children have been treated so far this year.

"Nazia* was vomiting and had diarrhoea, and she kept losing weight. Her mother just didn't have enough milk to feed her," says Mariam of her five-month old granddaughter, who is a patient at the clinic. "We went to a private clinic but they couldn't help us, and finally we drove here from our home district of Sangin. Nazia is feeling a little better now."

Malnutrition remains a major problem in Helmand, which is one of the country's most war-ravaged provinces. Even when there is food for sale in the markets, many families cannot afford to buy what they need, resulting in mothers unable to produce enough milk to feed their babies.

"It is heartbreaking to see the condition some of the children are in because their mothers don't have enough to eat," says Christwish Wenyika, nurse supervisor of the feeding centre and the paediatric ward at Boost hospital. "We start with assisted feeding immediately, as soon as they arrive. The different supplements provide vital nutrients that the children are missing."

"I'll never forget one woman who came in with newborn triplets," says nurse supervisor Assadulah Muhamad Amim. "She was very attentive to her children, but at the same time realised she couldn't feed them all.

"She and the triplets ended up staying 20 days in the hospital, and it was incredible to see how healthy they were when they left. They still come back every two weeks for check-ups."

** Names have been changed.*

PHOTOGRAPH: © CAMILLE GILLARDEAU, 2012

A malnourished child is brought to MSF's feeding centre in Boost hospital, in Afghanistan's Helmand province.

The Syrian house that hides a secret clinic

Rachael Craven is a consultant anaesthetist at Bristol Royal Infirmary. This summer she spent her annual leave treating the wounded in a clandestine hospital set up by MSF in northern Syria

'MSF called me and said: 'Are you available to go in a week's time to Syria where we're running a hospital?' And I said yes.

We're working there illegally – the Syrian government doesn't want us there – so the international staff and all of the equipment have to be smuggled across the border. There are about seven international staff there at any one time and 50 Syrian doctors and nurses, who are fantastic.

We're in a house that's been donated to us by a local doctor. From the outside it's completely normal, but inside it's been converted into a hospital. Luckily it is not furnished with carpets like houses in the UK – this one has marble floors. The reception rooms downstairs are now an operating theatre, an emergency room and a recovery room; the kitchen's a sterilisation area for all the instruments; and the bedrooms upstairs have been converted into wards. The courtyard outside is the emergency room. And we sleep on the roof.

Accommodation is at a premium in northern Syria because of the influx of people from Aleppo. Every house has three or four families staying with them already.

We were at risk of shelling, but so far it has been a relatively safe area. I think a bigger risk is when the rain starts!

The situation – especially for civilians – is very difficult. Really large numbers of people have been killed and injured, but there are big problems for the injured in getting to hospitals, especially in rebel-held areas. Normally people would go to hospitals in the cities but, for the most part, those are under government control. People are scared to go and worried that they'll be taken for a rebel. So they're relying on small clinics that have been converted.

> 'People are scared to go to the hospitals in the cities ... worried they'll be taken for a rebel'

Every few days we had a mass casualty event, either when a battle had taken place near us and we saw a lot of rebel casualties, or after shelling attacks where the victims were civilians.

Near the end of my stay, an artillery barrage hit a market where villagers were stocking up on supplies. The local field clinic took care of most of the casualties, but it was an hour before anybody checked a nearby basement where 15 children had been playing. Shrapnel had come in through the ground level windows.

The children were all from one extended family and were from two to 18 years old. Five were killed outright, a few were taken to a local clinic, and the rest were brought to us. One was dead on arrival, another died with us, we were able to do surgery on two, and two were sent to Turkey.

There was one occasion when there was a push by government forces and we were aware that a set of tanks was heading very close to us. We were on standby to evacuate, but we had a patient who was critical and could not be transferred. It isn't something they really cover in medical training in the UK, the decision of whether to take a patient into theatre and so commit the rest of your team to stay.

Every day you had a mental tally in your head of which patients would have to come with you if you had to evacuate. We had one ambulance and one car that we could use.

MSF is very used to setting up surgical projects in this kind of situation, so although our equipment is basic, it's all designed to function in places where access to things like electricity can be an issue. It wasn't uncommon for the operating theatre to be plunged into darkness and then you lose your oxygen and that is dangerous. You need solid, simple tools.

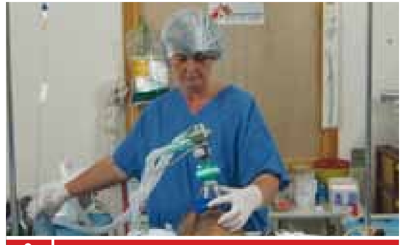
> 'If we were short of blood, the imam would put out a message at evening prayers for volunteers'

We are actually able to do quite complex surgery: we could do major abdominal surgery, laparotomies, tracheostomies – quite challenging cases. The vast majority were war wounded, about 98 percent either from gunshot or shelling wounds. We were seeing some absolutely massive injuries.

If we were ever short of blood, the imam would put out a message at evening prayers and there would be a queue of volunteers.

Because it's a relatively small hospital, we had to move patients on faster than we would normally, in order to take in new patients who were coming in the whole time. I was in Haiti after the earthquake, and within a week we were able to have a 200-bed inflatable hospital set up – and yet we're operating in Syria out of a 12-bed house. It is frustrating when you see the massive amount of need there, and the difficulties civilians have in travelling to hospitals and accessing healthcare.'

Inside the 12-bedroom house that has been transformed into a clinic. Complex operations are possible despite the very difficult conditions, and most involve treating gunshot or shelling wounds Photographs: © MSF, 2012



i IN THE CONFLICT ZONE

In June, MSF was finally able to put a team inside Syria to provide emergency medical care to people affected by the conflict. In the first few weeks we admitted more than 300 patients to the makeshift hospital and carried out over 150 surgeries. The injuries have been largely conflict-related, caused mostly by tank shelling, bombing and gunshot wounds.

A second emergency field hospital is being set up by MSF in the north of Syria and is scheduled to open as soon as the situation allows. As with the first hospital, the objective is to provide much-needed emergency medical care, including lifesaving surgery.

Patients needing complex reconstructive surgery are treated at MSF's specialist hospital in Amman, Jordan, and we are also providing primary healthcare and psychological support to Syrian refugees in Lebanon.

As well as our surgical projects, we are supplying drugs and other medical supplies in Syria. Despite the difficulties accessing the country, MSF remains ready to assist all victims of the conflict and we will continue to expand our activities in Syria and neighbouring countries.

Please note that the locations and exact activities of MSF inside Syria will not be shared for security reasons and, because of the uncertainty due to the conflict, MSF operations are subject to rapid change.

Since August 2006, Médecins Sans Frontières has been providing reconstructive surgical care to victims of violence through its programme in Amman. By late 2011, more than 1,500 victims of violence from Iraq but also Syria, Gaza, Yemen and Libya had been treated. The surgical programme offers free high quality surgical and medical care. Patients also receive physiotherapy and psycho-social activities and support.

Portraits by J.B. Russell

▲ Ali Amad Jabar, 15, suffered severe burns to his face, chest and arms after a car bomb exploded in a market in Basra, Iraq. He'd been at the market buying a bicycle with his brother.

◄ Khanda Faraj Mohammed, 27, suffered severe burns to her arms, hands and upper body when a car bomb exploded in a market in Kirkuk, Iraq. She was on her way to buy food for her three children.

▲ Hamid Mohammed, 15, was hit by a bullet while walking to school one morning in Anbar, Iraq. The bullet shattered the bones in his arm.

◄ Malak Qasim Mohammed, three, pictured here with her father, suffered severe injuries and burns to her face after their house was bombed during fighting between government and rebel forces in Yemen.

Waleed Azziz Mohammed, 26, suffered severe burns to his neck and face after a rocket struck his family home in Dahouk, Iraqi Kurdistan.

▲ Mazin Mustapha Mokhlf, aged one, and his father are from Kirkuk. Mazin's hand was badly burned in a domestic accident.

▼ Haider Ali Hussein, 12, suffered severe burns and internal injuries after a suicide bomber drove a car full of explosives into his school in Baghdad.

‘They had to leave their lives behind and start walking’

Fighting and bombing in Sudan’s Blue Nile state have forced more than 170,000 people to flee their homes since late 2011. These refugees are now camped in appalling conditions in a remote corner of neighbouring South Sudan.

Most have travelled on foot for weeks at a time, and many of the weakest have died en route. By the time they arrive at the camps, they are in a terrible physical state, and death rates are at twice the level considered an emergency.

In the four main refugee camps, resources are dwindling fast. There is little food, no natural shelter and safe drinking water has almost run out. Those who make it to the camps face the threat of malnutrition, dehydration and waterborne disease.

To add to this, heavy rains in recent weeks have left people stranded at temporary sites between the border and the camps.

MSF is running a massive aid response in the camps, with more than 180 international staff on the ground, and more on their way. Medical teams are providing emergency medical care to 5,000 people a week and working round the clock in desperate conditions in a bid to save lives.

Ruby Siddiqui (above), epidemiologist

‘It’s the silent ones you notice. In an outpatient department full of people and screaming children, the quiet ones stand out. Silence can mean something’s seriously wrong.

The hospital is swamped after we start our nutrition screening in the camp. All of our teams are referring children based on their mid-upper arm circumference (MUAC). MSF has created special bracelets, colour-coded green for safe, yellow for pay attention, orange for moderately malnourished, and red for severely malnourished. Anybody can be trained to wrap this bracelet round the arm of a child and assess the severity of malnutrition.

And our outreach teams have been finding a lot of malnourished children. The hospital staff are blaming me, but I know they’re just as pleased as me that we’re identifying these kids before they’re beyond medical care. And our outreach workers are enjoying helping kids to live rather than asking families about who died.

But as I wander around the ward, tears come to my eyes. I have never seen children this skinny and weak. Imagine an upper arm so far in the red zone that it’s basically just a bone wrapped in skin. It’s heartbreaking to see children suffering this way, a shadow of their former selves, unable to muster a smile. And on top of that some of them are hot to the touch or incredibly dehydrated. Malnutrition makes the children more susceptible to infections such as respiratory tract infections or diarrhoeal diseases (which can lead to dehydration). How much more can a child take?

So we have to be super-vigilant in triage, and pay particular attention to those kids who are not responding. The quiet ones. It’s such a relief to hear a child cry. It means they’ve still got some fight left in them.’

Read Ruby’s blog at:
blogs.msf.org/rubys

Chiara Burzio, nurse

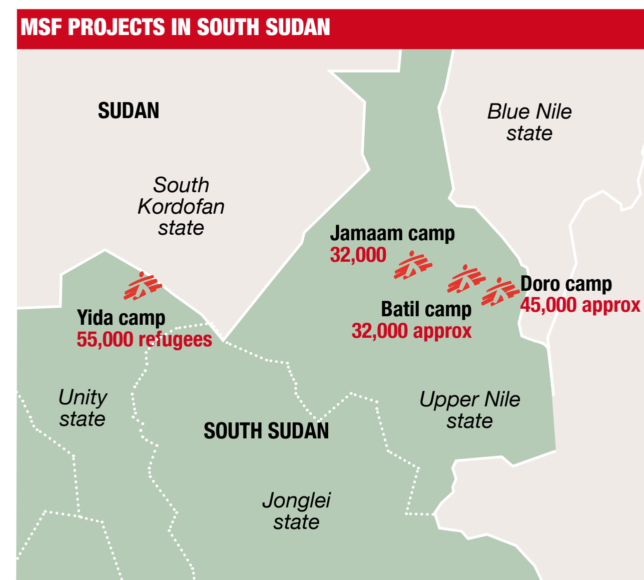
‘You see a lot of things here that are difficult to digest. When you’re driving in, you begin to see people scattered about, but then suddenly you’re confronted with a sea of people, most sitting down, sheltering under bits of plastic. I’ve never seen anything like it.

Most are dehydrated; many have diarrhoea. Everybody looks ill and exhausted. Many have just arrived after walking for 30 km [18.5 miles] or more on foot. You offer people a cup of water, and see how fast they are drinking; how eager they are for water — that is a heavy thing to see.

Malaria patient Gisma Hakim, 14, is comforted by her mother as she receives treatment at Jamaam camp earlier this year Photograph: © Paula Bronstein/Getty Images, 2012

The health of new arrivals is checked before they are taken to Batil camp

MSF PROJECTS IN SOUTH SUDAN



The bracelet used to check for malnutrition

> ‘As soon as the children start to gain weight, they start to laugh, they begin to play’
>
> Chiara Burzio, above

All these people have problems that are easily treatable. I work mainly with malnourished children here, and they’re like children everywhere. When they’re malnourished, they have these sad faces that never smile, but as soon as they start to gain weight, you can instantly see the transformation. They start to laugh, they begin to play and they’re like fun kids. All these people in the camps are normal people who had normal lives. They’re not rich people, but they had houses and clothes, and then one day they had to pack their things, leave their lives behind and start to walk. For weeks on end.

And if they were lucky enough and strong enough, they made it to one of these camps. And if they weren’t, then they died along the way.

People here need water. They need food. They need shelter. Most of them have just a piece of plastic sheet to cover them. During the night it’s cold, and if you’re sleeping outside without a blanket, the risk of pneumonia or worse is high.

To see people suffering is always difficult, but at least we are able to do something to help them. There are solutions for all these problems. It’s just that more needs to be done, fast.’

Find out more and donate to our South Sudan appeal at: msf.org.uk/southsudanappeal

Belgian cartoonist François Olislaeger travelled to the southern African kingdom of Swaziland to see first-hand how MSF is helping to combat the HIV/AIDS epidemic, and was inspired to tell the story of one particular patient

MSF UK VOLUNTEERS

Afghanistan Declan Barry *Doctor*; Anna Halford *Project coordinator*; Juliette Li Wan Po *Anaesthetist*

Bangladesh Judith Harvie *Doctor*; Stephen Sercombe *Financial coordinator*

Central African Republic Miriam Peters *Nurse*; Judith Starkulla *Midwife*; Philippa Tagart *Nurse*

Chad Orla Condren *Medical team leader*

Colombia Stephen Hide *Head of mission*; Conor Prenderville *Project coordinator*

Democratic Republic of Congo Victoria Hammond *Water and sanitation expert*; Geraldine Kelly *Midwife*; Andrew Mews *Head of mission*; Helen Rafferty *HR coordinator*; Harriet Rees-Forman *Midwife*; Timothy Tranter *Project coordinator*; Angeline Wee *Doctor*

Ethiopia Eleanor Hitchman *Mental health specialist*; Ailsa Stott *Medical team leader*; Yashovardhan *Logistician*

Guatemala Maria de los Llanos Ortiz Montero *Medical coordinator*

Guinea Benjamin Le Grand *Logistical coordinator*

Haiti Paolo Fresia *Financial coordinator*; Sunmi Kim *Logistics administrator*

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Kyrgyzstan Rebecca Roby *Administrator*

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Morocco Susan Sandars *Humanitarian affairs officer*

Myanmar Duncan Bell *Head of mission*; Jane Bell *Doctor;* Riccardo Donati *Logistician*; Victoria Hawkins *Deputy head of mission*

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Pakistan Jens Pagotto *Project coordinator*

Papua New Guinea Sarah Quinnell *Medical coordinator*

Republic of Sudan Sarah Smith *Field coordinator*

Russia James Lewis *Logistical coordinator*

Sierra Leone Alan Mackinnon *Doctor*

Somalia Eleanor Gray *HR coordinator*; Donna Love *Nurse*

South Sudan Robin Aherne *Construction logistician*; Alison Bishop *HR coordinator*; Georgina Brown *Midwife*; Alison Criado-Perez *Nurse*; Cormac Donnelly *Doctor*; Laura May Duggan *Nurse*; Josie Gilday *Nurse*; Niall Holland *Logistician*; Michael Kemsley *Logistician*; Zodiac Maslin-Hahn *Financial coordinator*; Marcin Ochal *Nurse*; Helen Ottens-Patterson *Medical coordinator*; Benjamin Pickering *Deputy head of mission*; Louise Roland-Gosselin *Humanitarian affairs officer*; Emma Rugless *Nurse*; Katie Theopold *Anaesthetist*; Simon Tyler *Project coordinator*; Steven Waters *Logistician.*

Syria Alvaro Mellado Dominguez *Project coordinator*

Thailand Paul Cawthorne *Consultant*

Uganda Henry Gray *Emergency team logistical coordinator*; Emma Kinghan *Doctor*

Uzbekistan Elsa Barbosa *Biomedical analyst*

Zimbabwe Tharwat Al-Attas *Deputy medical coordinator*; Paul Arobmoi *Biomedical analyst*; Paul Foreman *Head of mission*; Victoria Treacy Wong *Training officer*; Sidney Wong *Medical coordinator*

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Henry Gray helps a health worker put on the six layers of protective clothing necessary for entering the Ebola ward

'The patients we are treating are very frightened, for obvious reasons'

Photograph
© MSF, Uganda, 2012

"Working on an Ebola outbreak isn't just about reacting to the physical challenges – educating people is also vital. Health workers are particularly susceptible to catching it so, along with treating patients, one of our main priorities is training local health staff to reduce the risk of them catching the disease whilst caring for patients. We have to put in place extremely rigorous safety procedures to ensure that no health workers are exposed to the virus – through contaminated material from patients or medical waste infected with Ebola.

"The general public is understandably concerned, because this isn't a disease that they regularly encounter. Ebola spreads quickly and can be deadly, so the social effects can be very severe. The patients we are treating are very frightened, for obvious reasons. Their families are also very scared, so as well as our treatment centre, we are setting up psychosocial support for the patients, their families and also our own staff, who may be traumatised by what is happening.

"Many people have stopped kissing or shaking hands when they greet each other – even though people are only actually infectious when they have Ebola symptoms.

"The symptoms can include fever, vomiting, sore throats and headaches and, in severe cases, internal or external bleeding. Unfortunately there is no specific treatment or vaccine for Ebola – several vaccines are in development, but it's likely to be several years before one is available.

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