DISPATCHES

A YEAR ON THE EMERGENCY FRONTLINES

Henry Gray on 12 months spent aiding people in Haiti, Congo, Ivory Coast, Libya, Afghanistan ... pages 10-11

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No 64

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

INSIDE

Libya
Detainees denied care

Detainees in the Libyan city of Misrata are being tortured and denied urgent medical care, leading MSF to suspend its operations in detention centres in the city.

MSF teams began treating war-wounded detainees in Misrata's detention centres in August 2011. Since then, MSF doctors have been increasingly confronted with patients who have suffered injuries caused by torture during interrogation sessions that had been held outside the detention centres. In total, MSF treated 115 people with torture-related wounds and reported all cases to the relevant authorities.

"Some officials have sought to exploit and obstruct MSF's medical work," says MSF General Director Christopher Stokes. "Patients were brought to us for medical care between interrogation sessions, so that they would be fit for further interrogation. This is unacceptable. Our role is to provide medical care to war casualties and sick detainees, not to repeatedly treat the same patients between torture sessions."

Physiotherapy for a complex leg injury in a Misrata hospital

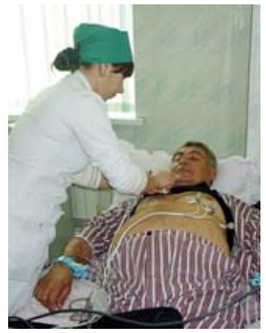
MSF met with relevant authorities to demand an immediate stop to the ill treatment of detainees. "No concrete action has been taken," says Stokes. "Instead, our team received four new torture cases. We have therefore come to the decision to suspend our medical activities in the detention centres."

MSF will maintain the rest of its operations in Libya, where it has been working since February 2011.

Chechnya
Healthier hearts

MSF has launched a programme targeted at cardiac emergencies in Grozny, Chechnya. The stress of years of war combined with smoking, poor diet, lack of exercise, hypertension, and diabetes have resulted in Chechens being more susceptible to cardiovascular disease, which affects one person in six.

Working in partnership with the Republic Emergency Hospital in Grozny, MSF devoted the first few months to developing equipment, improving supplies, and training staff. Since consultations began, over 700 admissions have been recorded, with more than 100 patients resuscitated using defibrillators. "This is a highly specialised medical activity and is the first time MSF has implemented a project for cardiac emergencies," says Vladimir Najman, MSF head of mission in Russia. "Based on preliminary results, it's a success."



A cardiovascular intensive care unit in Grozny

By the end of 2011, the mortality rate in the hospital had fallen to 7.82 per cent.

Niger
Refugee crisis

MSF is working in the Tillabéry region of Niger, where violence has forced 10,000 people to flee from neighbouring Mali.

"Refugees currently have no access to drinking water, food, latrines or proper shelter, and have no access to basic healthcare," says Benoît Kayembé, MSF's head of mission in Niger.

"We're in emergency mode. The Tillabéry region was already facing an uncertain situation in terms of food security, and this is being exacerbated by the arrival of thousands of refugees."

MSF has responded by sending an emergency team to respond to medical needs in the town of Tchinagodar, in collaboration with local authorities and the Ministry of Health.

The team will provide primary healthcare and referrals, screening and treatment for malnutrition, vaccinations for children and care for pregnant women.

"Our emergency response will evolve and adapt depending on the involvement of other humanitarian organisations in the region," says Kayembé.

The aftermath of the typhoon and subsequent flooding in Mindanao, the second largest island of the Philippines

Philippines
Aftermath of typhoon

On 16 December, a typhoon hit Mindanao Island in the Philippines, resulting in many deaths, flooding and widespread damage. An MSF team was assessing emergency health needs on the conflict-affected island when the typhoon struck. They immediately swung into action. Pier-Luigi Testa, MSF's deputy emergency programme manager, describes what happened:

"The rivers overflowed their banks and flooded entire villages and neighbourhoods, and water and mud carried off and destroyed houses. Many people fled and took shelter in evacuation centres that the authorities set up in schools.

The needs in these centres are comparable to what we generally see in refugee camps. Several international NGOs arrived right away to provide aid, deliver basic supplies and food and build latrines.

But MSF is the only one able to provide health care in cooperation with the Ministry of Health.

"Our team is training local staff to carry out medical consultations at the sites housing the victims from Cagayan de Oro (21,000 people divided among 22 centres) and Iligan (14,000 among 20 centres). We have already identified the main medical issues, which are watery diarrhoea and respiratory infections. However, we have also detected suspected cases of Weil's disease (leptospirosis) and tetanus that will be closely monitored.

"The team will also be monitoring the victims' living conditions and their situation. Tent camps have been set up to relieve the evacuation centres and, in particular, the schools, which must be available for the students, who will return soon."

A mother and child at an evacuation centre

In memoriam
Philippe Havet and Andrias Karel 'Kace' Keiluhu

On 29 December 2011, two of our colleagues, Philippe Havet *(right)* and Andrias Karel 'Kace' Keiluhu *(left)*, were killed in a shooting incident in the MSF compound in Mogadishu, Somalia.

Despite stringent security rules – including the use of metal detectors – an MSF Somali logistics assistant managed to smuggle a gun into the compound, which he then used to open fire inside the MSF office. Philippe died immediately, Kace later in the evening following surgery. We believe the shooting was a result of the non-renewal of the MSF Somali staff member's contract, following evidence of theft.

Philippe, 53, from Belgium, was an experienced emergency coordinator who had been working with MSF since 2000 in countries including Angola, the Democratic Republic of Congo, Indonesia, Lebanon, Sierra Leone, South Africa and Somalia.

Andrias Karel Keiluhu, better known as 'Kace', was a 44-year-old medical doctor who had worked with MSF since 1998 in his native Indonesia as well as in Ethiopia, Thailand and Somalia.

Both Philippe and Kace were in Mogadishu working with MSF teams to provide emergency medical assistance to displaced persons and residents of the city.

We are deeply shocked by this tragic event and we will greatly miss Philippe and Kace and their energy, humour and commitment. We extend our heartfelt sympathy and condolences to their families and friends.

While we grieve for Kace and Philippe, we continue to press for the release of Montserrat Serra and Blanca Thiebaut, our MSF colleagues kidnapped on 13 October 2011 in Dadaab, Kenya, and currently thought to be in held in Somalia.

148,000 Number of malnourished children treated by MSF in Niger in 2010

2,600 Number of consultations carried out by MSF in Misrata since April 2011

‘I was lucky. They didn’t find my family when I was shot’

In South Sudan, thousands of civilians have been forced to flee their homes by armed groups. Here, MSF staff speak about the impact of the violence and MSF field coordinator Karel Janssens talks about working in Pibor, one of the areas hit hardest

In the state of Jonglei in South Sudan, civilians continue to bear the brunt of inter-communal fighting. Wounded patients were still arriving at the MSF hospital in Pibor three weeks after a violent attack on the town and its outlying villages. Thousands remained in hiding in the bush.

“We’re seeing a cycle of attacks and reprisals throughout this area of Jonglei,” says MSF head of mission Jose Hulsenbek. “For the civilians in this part of South Sudan, the fear of having to flee their homes or being killed is very real.”

MSF is extremely concerned for the health and well being of civilians forced to flee from the fighting. People are hiding out in the bush with little shelter, limited access to food and a high chance of becoming ill. On their return, many find only ashes where their homes once stood.

Armed groups on all sides have attacked hospitals, health clinics and water sources, suggesting a tactic of deliberately targeting people’s basic life essentials.

“After these attacks many women and children are coming to us shot, stabbed, beaten,” says Colette Gadenne, MSF operations coordinator. “They try to keep safe by hiding in the bush, but it seems that even running away is not enough.”

MSF medical teams are treating serious wound infections, some several weeks old. Since re-launching emergency medical activities, MSF has treated 47 patients with gunshot wounds, including 16 women and eight children. A further 43 patients have been treated for stab wounds, beatings or wounds sustained while fleeing in the bush.

Karel Janssens:
“Here in Pibor county, MSF is providing the only access to healthcare for 160,000 people.

‘We found our clinic burnt out. It’s a total mess’

Karel Janssens, below

“Our team was forced to evacuate on 23 December after learning about an imminent attack. On Christmas Day, Lekongole was attacked, and a couple of days later Pibor was attacked as well.

“On 7 January the MSF team returned to Pibor and restarted medical activities, and on 13 January, we returned to Lekongole. We found our clinic completely burnt out. It’s a total mess.

“The whole place is a ghost town, completely burnt to the ground with not a single hut still standing. It’s a sinister landscape, with only stray dogs and a few people wandering about.

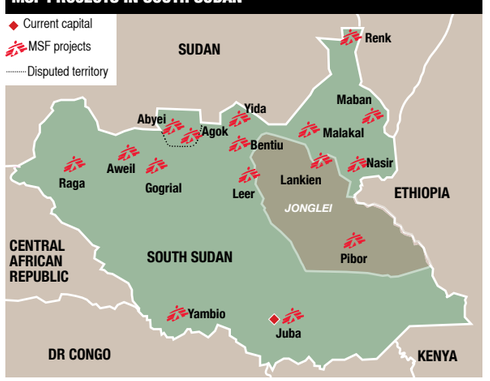
“We’ve been doing medical consultations for the people in surrounding areas, because they don’t dare return to town. They’re afraid of other attacks and there’s nothing left there anyway. People have come from the surrounding bush for food and medical care.

“Three weeks after the attacks we’re still seeing patients with gunshot wounds, but also a lot of malaria cases – people have been scattered in the bush and sleeping outdoors without mosquito nets, and we’re seeing the consequences of that.”

Left, a child is treated at the hospital in Pibor. Above, the burnt out MSF clinic at Pieri, in Jonglei state, where hundreds of people were killed during a series of raids last summer
Photographs: © Liang Zi, 2012/ MSF, 2011

Above, a baby is weighed at the outpatient paediatric unit in Pibor. Left, a boy who had to have his leg amputated after a snakebite because of the lack of medical care across Jonglei state
Photographs: © Cédric Gerbehaye/ Magnum Foundation Emergency Fund, 2011

MSF PROJECTS IN SOUTH SUDAN



‘IF MSF WEREN’T HERE, MAYBE I WOULD HAVE DIED’

A 39-year-old man shot in the arm in the attack on Pibor on 31 December 2011 tells his story

“When the attack happened, we fled into the bush with no food, just water for the small children. I was shot in the arm and hid in the bush for eight days. So much blood was coming out, sometimes I would just sleep without knowing it. At night it was so painful I couldn’t sleep. It took me three days to walk to the hospital.

“I was lucky. They didn’t find my family when I was shot because they ran ahead and hid in the river, keeping their mouths open out of the water to breathe. In my community some have been killed, many are missing. We don’t know if they’re dead or not.

“My home has been burnt to the ground, all of it, everything. I don’t know if I can go back.

“We’re very happy MSF is here – we were afraid you would not come back after everything was looted. If MSF weren’t here, maybe I would have died.”

Simplest treatments that make all the difference

Lindsey Mackenzie visits the bustling slum of Kibera, in Nairobi, to see the work of doctors at an MSF clinic

We're walking through the narrow mud pathways of Kibera, one of Africa's largest slums, in the heart of Nairobi, Kenya. There are people everywhere, and the smell of sewage and rubbish mixes in the air with the noise from ghetto blasters. Every dwelling we pass seems to house a small cottage industry: there are shoes being polished, men baking chapattis and donuts; there are hairdressers, tailors, charcoal sellers

Above and left, Esther is treated for burns by Dr Aden in the clinic Photographs: © Lindsey Mackenzie/MSF, 2012

and butchers. Even bed frames are on sale, although I've no idea how they would fit into the tiny mud and corrugated-tin shacks that people call home.

We're on our way to one of the three clinics MSF runs in this massive labyrinth that houses an estimated 300,000 people. With more than half of the world's population now living in cities, it's in environments like this that MSF is doing more of its work.

As we arrive at the distinctive light-blue clinic, we see a crying girl being carried in by her distraught mother. Her legs have been burnt and painful-looking blisters cover the skin.

Nurses rush the little girl, called Esther, into the dressing room and, within moments, Dr Aden has arrived to treat the wound. The story emerges. Earlier today, Esther's mother, Mary, went to work washing clothes, leaving ten-year-old Esther in their one-room mud shack to look after her four younger siblings. Esther was cooking porridge when one of her younger sisters knocked the boiling pot and its contents onto Esther's legs. Her screams brought her mother rushing home and, within minutes, she had carried her daughter to the free MSF clinic.

Although this type of burn is very painful, with the right dressing and care, the little girl should be back to normal within weeks

Dr Aden calms Esther and her mother as he cleans and dresses the burns. He reassures them that, although this type of burn is very painful, the damage is only superficial. With the right dressing and care, the little girl should be back to normal within weeks.

To help distract Esther, we play with my camera. She shyly takes photos of Dr Aden and her mother, smiling at the results on the screen and, before she knows it, her legs are dressed and bandaged. She tells me she is upset she will have to miss a few weeks of school where her favourite subject is maths.

As she carefully swings round on the bed and comes to a standing position, I can see just how painful the burn is, and how difficult moving will be for her until it heals.

She walks stiffly and cautiously to her mother. She'll be back tomorrow afternoon to have the wound re-dressed and Dr Aden will monitor her over the coming week to ensure there are no signs of infection.

It's a positive result, and a good example of solid, simple and undramatic healthcare. Yet for Esther and her mother, and for the people of Kibera, it's exactly this sort of simple healthcare that makes such a difference. For them, it's the difference between sickness and health, between life and death. It's the reason why MSF is here.

Number of pregnant women in Kibera MSF referred and sponsored to have safe deliveries in 2010 **1,674**

Dr Chris Bird is a paediatrician working for MSF. Here he talks about one little girl, Beatrice, who arrived at the hospital in Lulimba, a small town in the Democratic Republic of Congo.

Dr Chris Bird treats a child in the inpatient therapeutic feeding centre

Beatrice is not her real name but I want you, the reader, to know that this little girl, two years and seven months old, had a name. Beatrice arrived just as I was about to leave for the day. A quick glance at the prostrate child in the dim circle of light cast by the tent's single bulb and I guessed she was another malaria case. Steve, the nurse, shook his head. "No doctor. This is a new malnutrition case."

I quickly felt the child's feet – icy cold. A careful look at Beatrice showed that all the curves and dimples of a healthy child's face had shrunk, leaving the forbidding lines of a woodblock print. Beatrice was alert but silent. There was a glint of anxiety in her rheumy eyes.

'All the curves and dimples of a healthy child's face had shrunk, leaving the forbidding lines of a woodblock print'

I gently pulled back the cotton wrap. The malnutrition had ravaged her skin, causing it to flake off, leaving behind weeping sores across her arms, legs and chest.

The nursing staff went into action. They gave her glucose to prevent low blood sugar, antibiotics through the drip to fight off infection; they advised her mother to keep her warm. Careful fluid management and gentle re-feeding was started: give too little and the child will succumb to dehydration and shock; too much and the child will die of heart failure.

Treating a malnourished child is complex. It is not simply a matter of doling out cups of milk and packets of peanut paste when a child like Beatrice finds her way into our tent, tied to her mother's back after she has walked a day to get to our hospital.

The grand-sounding inpatient therapeutic feeding centre (ITFC) is my favourite part of the hospital. In a tent set apart from other patients you get to see these little waifs, with so much stacked against them, gradually put on weight, start to smile and play with their parents.

Dr Chris Bird with a colleague at Lulimba hospital in Eastern Congo

But Beatrice arrived before our ITFC had been established. That night there were only two frazzled nurses in our paediatric tent. It was rainy season so it meant malaria cases were high and in our hospital this meant the occupancy rate was 250 per cent.

After gently warming her by placing her close to her mother and monitoring the dosing of the initial fluids, Steve began her feeds. He tended to her skin and then, when she began to have difficulty breathing, he put her on the hospital's only oxygen concentrator, the maximum level of care for our most severely ill children.

But when I was called to see her later the next morning, her heart already had stopped. The anxiety in her eyes had gone.

Beatrice's mother sobbed as we wrapped her daughter in the green cotton cloth in which she was brought. Her father lifted her easily in his arms and left the hospital, his face immobile. Her mother walked, crying, behind him, stopping on the dirt road from time to time as she doubled up in grief. An elderly man going the other way, a Red Cross armband on his left arm, dismounted his bicycle and gave a formal salute to the family as they walked past.

You won't read about malnutrition in Congo because it doesn't fit the dustbowl paradigms that govern the concept of starvation or malnourishment. Where I am in Eastern Congo it is green and lush, but after years of war, insecurity and economic collapse, all the children in our tent are malnourished to some degree.

An estimated 9.7 million children under the age of five will die this year of largely preventable illnesses. Malnutrition is estimated to contribute to half of these deaths. What do numbers like these really mean?

I hope to you it means a small, fragile girl like Beatrice, whose parents loved her, who left us as quietly as she arrived.

£52.50 Cost of providing a child suffering from malnutrition with three packets of ready-to-use therapeutic food for 60 days

‘Tiring and uplifting’: my year in the disaster zones

When a disaster strikes or conflict breaks out, the MSF emergency teams are often the first on the scene. Here, emergency coordinator and water and sanitation expert Henry Gray looks back on a year of emergencies with the team

I remember leaving for my first mission as a member of the emergency team. I was at my friend Fiona’s funeral when the call came through, and I left immediately afterwards. I didn’t even have a chance to sign my contract before I was on a plane heading for the cholera outbreak in Haiti.

For the next month, I worked 17-hour days without a day off. It was an intense introduction to what my life would be like for the next year. When you join the emergency team, you sign up for a year and you’re then at the beck and call of MSF to go wherever the need is.

When I arrived in Haiti, I turned up at the hospital and looked around and thought, ‘Where on earth do I start?’ There were people lying on the floor, bodies everywhere – it was terrible.

It’s very easy to feel overwhelmed in situations like that, but you have to put that aside and make a start. Cholera demands a rapid response, and that’s what we were there to do.

We had fantastic support. Working for MSF, you know that when you’re on the plane heading into some disaster zone, there will be people working around the clock making sure that supplies will be on the next flight. You know that even if there are just two or three of you there on day one, by day three more manpower and support will have arrived.

By week four or five, the deaths in our cholera treatment centres were much lower, as more people were getting the messages about the disease and the staff we had trained began to do more of the work. It was a terrible situation, but we were able to help people who needed help. It’s vital amid the stress and pressures of an emergency that you don’t forget why you’re there. You’re there for the patients.

In Haiti, one of my tasks early on was dealing with the people we weren’t able to save. I don’t remember how many people I personally had to put in body bags during the first few weeks of the outbreak, but it was a lot.

That’s a strange thing to deal with. You do have to distance yourself a bit, because you’re no use if you’re a blubbing mess. But, personally, I feel that the moment I begin to feel too detached, it becomes dangerous. You have to remind yourself why you’re there. You’re there to help, and if you just deal with people and bodies as numbers, then you start to lose your way and your legitimacy for being there. If you stop caring, you stop doing your job properly.

In March I was sent to Ivory Coast during the civil war. I had a difficult mission. I started out in the west and then moved to the capital, Abidjan, just before the fighting reached there. At one point the violence surrounding us meant that some of the team were blocked in the hospital and the rest of us were holed up in our office, both teams unable to move for about ten days because it was too dangerous. We had to harvest water from the air conditioning units in order to have something to drink. We were in Abidjan for six weeks and, by the time things had calmed down, the decision was made to bring us out and send in a fresh team.

©Aurelie Baumel/MSF, 2010

Haiti Cholera treatment in Sarthe, Port-au-Prince

‘In Haiti, I thought “Where on earth do I start?” There were bodies lying everywhere’

©Raphael Ottagalli, DRC, 2009

DR Congo An Ebola decontamination area in Kasai

‘Hyperventilating in a spacesuit in an Ebola infection control area is bad news’

Photograph, right ©Nicola Vigilanti, Sierra Leone, 2011

Ivory Coast remains the mission where I have been the most frightened whilst wearing an MSF t-shirt. We all have a close relationship with MSF’s stress management team and they’re always on hand for emotional debriefs.

I’m British and the genetic recipient of a stiff upper lip, but early on I took some advice from a friend who is in the military. He told me that if the support is on offer, it’s there for a reason, so use it. Don’t be big and brave. If you’re being shot at, it’s frightening, and anybody who says they’re not frightened is either an idiot or a liar.

So I took his advice when I got back and had a good debrief with the stress team. It was very useful.

Three weeks later I was on a fishing boat being smuggled into Misrata in Libya. The city was under siege and being shelled daily. We knew there were medical needs there and had had a team on the ground for a few months. The only way in was by sea. A team of five of us flew out to Malta and boarded an Egyptian fishing boat for the 30-hour crossing.

The boat dropped us off and then it was gone, taking my colleagues back to Malta for a well-earned rest. The atmosphere was very tense. The city was being shelled every day, and at night you’d often be woken with the cry of ‘Take cover!’ You’d roll to your safe place, wait for the shelling to stop, and then try and go back to sleep.

Ivory Coast The gates of the hospital at Duékoué

My job there was to help get the water treatment plant working properly again. With our support the Libyan guys running the plant were able to produce 100 million litres a day of chlorinated water. Extremely satisfying and well received.

In May I was on my way to Uganda for an Ebola outbreak. Fortunately it was a small outbreak, but you treat Ebola very seriously. It can kill up to 90 per cent of the people who catch the severe type and it’s a full-on disease to deal with. Psychologically, it’s very intense, both for staff and patients. For patients, they are scared of the disease, but also of the staff, who are dressed up in a protective suit which looks like an astronaut’s outfit.

‘A friend said don’t be big and brave. If you’re being shot at, it’s frightening, and anybody who says they’re not frightened is either an idiot or a liar’

©Michael Goldfarb, Afghanistan, 2011

Afghanistan Treatment at the trauma centre in Kunduz

For the staff it’s stressful because there are very strict rules that must be followed. You drill it into the people you’re training: this is how we operate, this is how you put your protective kit on, this is how you take it off, this is what you do in the isolation zone.

There is no room for error. You train people to work in pairs and to keep an eye on each other, because hyperventilating in a spacesuit in an Ebola infection control area is bad news. I’ve seen that before, and it’s very scary.

Wearing one of those suits when it’s hot is draining. The first Ebola I did was in Congo a few years back. It was 40 degrees outside, 45 degrees inside, and then you put the spacesuit on.

After 45 minutes I had a litre and a half of sweat in each boot. It was the last time my body weight dropped below 80kg!

‘They know we’re out on a limb being in north Afghanistan and they appreciate it’

Afghanistan Henry Gray in Kunduz

©Benoit Finck, Libya, 2011

Libya Rebels in Misrata

When you’re dealing with the worst cases of Ebola, a lot of the time it’s just palliative care – making people comfortable – because really there’s nothing else you can do. There’s no cure. There’s no vaccine. It is difficult.

I finished off the year in Afghanistan, where I became the hospital director at a fantastic project in Kunduz, in the north of the country. There are over 200 staff, and it was thrilling to be part of something that is making such an immediate impact on people’s lives.

We’re the only trauma centre in the north of the country offering free trauma care, and people are flocking to it. They know we’re out on a limb being there, and they appreciate it.

It has been an interesting, turbulent and exhausting year. It has passed in a flash but, all in all, I have a sense of satisfaction. Not everything went well (rarely possible in the type of environment in which the emergency team works) but along the way I like to think we did our bit, and I have memories, both good and bad, that will live with me for a lifetime.

And the future? Well, my contract has finished, but I’m not quite done. I have extended it and will be out in the field again before too long...

MSF UK VOLUNTEERS

Afghanistan Declan Barry *Doctor;* Juan de Dios Robinson *Anaesthetist*
Bangladesh Judith Nicholas *Midwife;* Stephen Sercombe *Financial coordinator*
Central African Republic Victoria Hammond *Water and sanitation expert;* Matthew Heath *Logistical coordinator;* William Turner *Logistician;* Warwick Strong *Logistical administrator;* Mark Robson *HR coordinator*
Colombia Stephen Hide *Logistical coordinator;* Ronan O’Mhaoinigh *Financial coordinator;* Conor Prendergville *Logistical administrator;* Carme Abello *Logistical administrator*
Democratic Republic of Congo Andrew Mews *Head of Mission;* Sarah Maynard *Logistical Coordinator;* Orla Condren *Medical Team Leader;* Laura Gregoire *Doctor;* Julian Barber *Water & sanitation expert;* Christopher Bird *Doctor;* Robert Malies *Logistician;* Oliver McGrath *Water & sanitation expert;* Helen Rafferty *HR coordinator;* Elaine Badrian *Medical team leader;* Angeline Wee *Doctor;* Lynsey Davies *Doctor*
Dubai Michiel Hofman *Head of Mission-mentor*
Egypt Mario Stephan *Head of Mission*
Emergency team Henry Gray *Logistical coordinator*
Ethiopia Emily Stenke *Doctor;* Ebbe Thingaard *Doctor;* Peter Camp *Logistician;* Christopher Houston *Project Coordinator;* Yashovardhan *Logistician;* Niall Holland *Logistician;* Claudia Garcia Diaz *Financial administrator*
Guatemala Maria de los Llanos Ortiz Monero *Medical coordinator*
Haiti Benjamin Caulfield *Logistician;* Caroline King *HR coordinator;* Sylvia Garry *Doctor;* Paolo Fresia *Financial coordinator*
India Emily Goodwin *Field Coordinator;* Sakib Burza *Medical Coordinator;* Alistair Iveson *Logistician;* Colin Hermann *Logistician;* Yasotharai Ariaratnam *Financial coordinator*
Kenya Nell Gray *HR coordinator*
Kyrgyzstan Juma Khudonazarov *Medical team leader*
Lebanon Alison Jones *Medical Coordinator*
Malawi Michael Patmore *Biomedical analyst*
Mozambique Doriana Santos *Biomedical analyst*
Myanmar Victoria Hawkins *Deputy Head of Mission;* Thomas How *Project coordinator;* Pawan Donaldson *Project Coordinator;* Duncan Bell *Head of Mission;* Riccardo Donati *Logistician;* Jane Bell *Doctor;*
Niger Angelica Orjuela *Logistician*
Nigeria Estelle McLean *Epidemiologist;* James Lewis *Logistical Coordinator;* Claire Hudson *Nurse;* Emma Diggle *Reporting officer;* Carolyn Henry *Nurse*
Pakistan Forbes Sharp *Logistician;* Marianne Stephen *Doctor;* Miroslav Stavel *Doctor;* *Leanne Sellers Emergency pool; Mesfin Senbeto Doctor; Clara Annibal Midwife; Jens Pagotto Logistical administrator; Georgina Brown Midwife; Andrew Moscrop Doctor*
Papua New Guinea David Dalrymple *Financial coordinator;* Catriona Duncan *Anaesthetist;* Shaun Richards *Logistician;* Diane Robertson-Bell *Nurse*
Philippines Natalie Roberts *Doctor*
Russia Jonathan Heffer *Head of Mission*
Sierra Leone Philippa Letchworth *Doctor*
Somaliland Timothy Tranter *Logistical coordinator;* Adam Thomas *Head of Mission;* Harriet Rees-Forman *Midwife;* Carole Pye *Nurse;* Lesley Wills *Midwife;* Sohur Mire *Doctor*
South Africa Rebecca Welfare *HIV/TB integration implementer*
South Sudan Angela Cave *Nurse;* Jean-Marc Jacobs *Deputy Head of Mission;* Andrea Warwick *Surgeon;* Helen Ottens-Patterson *Field coordinator;* Kirrily de Polnay *Doctor;* Vivian Lee *Administrator;* Haydn Williams *Logistical administrator;* Louise Roland-Gosselin *Humanitarian affairs officer;* Simon Tyler *Project coordinator;* Alison Bishop *HR coordinator;* Sarah Geoghegan *Doctor;* Josie Gilday *Nurse;* Siama Latif *Medical team leader;* Danielle Wellington *Medical team leader*
Sri Lanka Eleanor Hitchman *Mental health officer*
Sudan Joan Hargan *Medical team leader;* Jose Hulsenbek *Head of mission;* Kate Reid *Midwife*
Swaziland Kiran Jobanputra *Medical supervisor*
Tajikistan Kartik Chandaria *Doctor*
Thailand Paul Cawthorne *Consultant*
Uganda Anna Carole Vareil *Field administrator*
Uzbekistan Elsa Barbosa *Biomedical scientist*
Zimbabwe Tharwat Al-Attas *Deputy medical coordinator;* Amir Shroufi *Epidemiologist;* Paul Foreman *Head of Mission;* Kiersten Simmons *Doctor;* Johannes McGavin *Doctor;* Paul Arobmoi *Biomedical analyst*

Number of patients with cholera symptoms treated by MSF in Haiti, October 2010–November 2011 **70,000**

95,000 Number of people in Ivory Coast provided with medical care during the crisis

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.

Clockwise from top left: a child in a hospital in Kabo, Central African Republic, where thousands of people have been displaced by fighting; a scientist working with a prototype tool for measuring the viral load of HIV in Malawi; reading Dispatches in Kenya; women in South Sudan, where the new country is beset by inter-communal violence

SCIENTIFIC DAY

MSF Scientific Day 2012

25 May, London

MSF's annual Scientific Day presents medical and scientific research from our field programmes around the world.

This year, we want everyone with an interest in global and humanitarian health and research to take part. We will be streaming the event live online and hosting a real-time Twitter discussion.

For more information about the day and videos from 2011 go to msf.org.uk/Scientific_Day.aspx Follow us on twitter @MSF_UK and #MSFSD

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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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If you have any questions about your support of MSF's work we would be delighted to hear from you. Please contact us by the methods listed or email **anne.farragher@london.msf.org**

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