Quarterly news from Médecins Sans Frontières UK Issue no 40 Spring 2006

DISPATCHES

Charity no 1026588

Médecins Sans Frontières is a leading independent organisation for emergency medical aid. In over 80 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.

Displaced Chechens in one of the temporary dwellings built in an abandoned factory in the Aki Yurt region of Ingushetia.
© Simon C Roberts

Forgotten in Chechnya

"Each day we have to travel for about one hour from Grozny into the coutryside. Many of the places we visit are in very beautiful surroundings – set among mountains and with pure forests all around – but most houses are either destroyed or 'wounded' by years of war. Anaemia is very frequent in our patients, as you would expect where living conditions are bad, unemployment is high and nutrition is inadequate. We've been living in a constant state of alarm in Chechnya for so long that it ages and exhausts us and our physical health suffers," says Aiza Masaeva*, an MSF gynaecologist working in Chechnya.

The conflict in Chechnya, which started in 1990, officially ended in 1999. But under the facade of normalisation, the fighting continues. The Chechen people, traumatized by years of conflict, are still exposed to ongoing physical violence and harassment.

"People continue to live in fear," says Andrew Cunningham, head of mission for MSF operations in Chechnya and for the projects in neighbouring Ingushetia, where Chechens have fled for relative safety.

"Quality of life remains harsh, with extremely high rates of unemployment, poor housing and lack of the most basic services, such as sewerage and water delivery, let alone access to health care. A feeling of hopelessness pervades the Chechen population."

* Her hame has been changed

A young child being examined by a doctor in an MSF mobile clinic in the Malgobek region of Ingushetia.
© Simon C Roberts

"Our patients express real, heartfelt gratitude for our presence. I don't think that they fully understand what MSF is, but they often say 'thanks to you and those that sent you'"

Tens of thousands of people are still afraid or unable to go back to their homes. They find it hard to get medical care, and the state services, especially in rural areas, remain totally inadequate.

The people who have stayed in Ingushetia are now gathered in what are called sheltered spontaneous settlements or kompaktniki. Although a slight improvement from the tented camps, conditions are still very difficult with many living in overcrowded, dank, dilapidated buildings that enable diseases like tuberculosis and pneumonia to flourish. MSF continues to work there to improve the people's access to health care.

In most projects around the world, MSF international volunteers work closely with national staff colleagues, but in Chechnya the threat of kidnapping for foreign aid workers mean that our daily work is conducted almost entirely by national staff teams. "MSF has put into place an impressive cadre of medical staff who are deeply committed to providing medical assistance to their compatriots," says Andrew. Aiza Masaeva, a Chechen gynaecologist, is one of them.

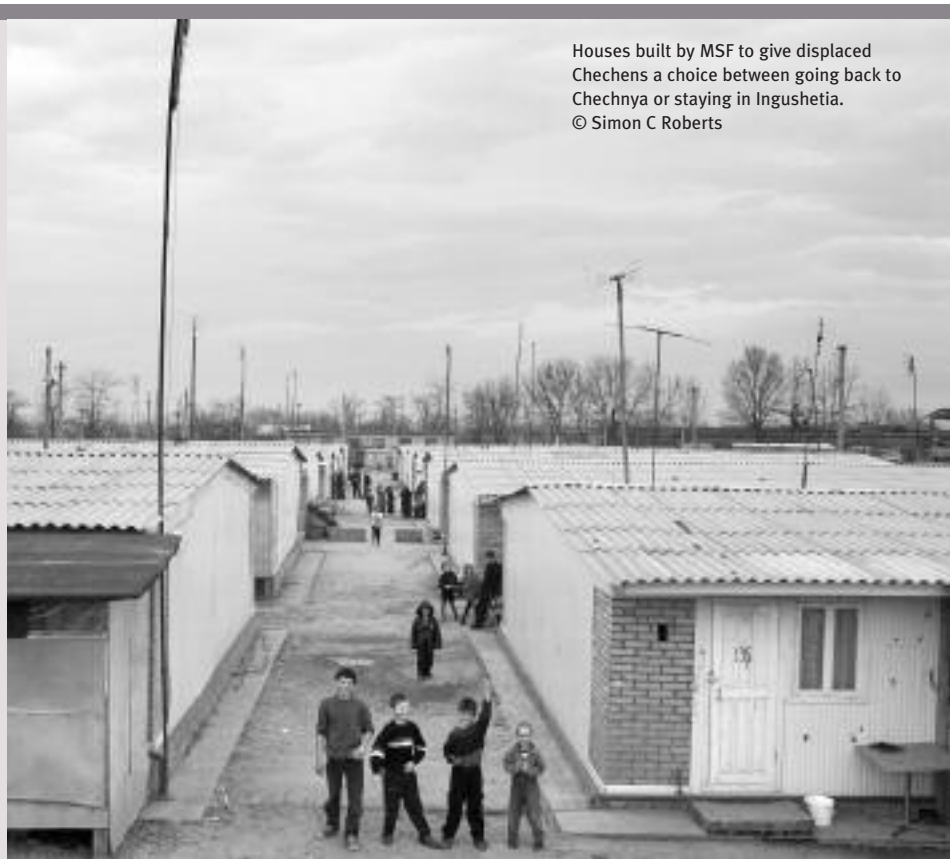
Aiza travels each day with a paediatrician, nurses, general practitioner and mental health counsellor for their weekly visit to five different locations in a rural area of Chechnya, where people have little access to medical care. MSF opened its first rural mobile clinics in July 2005 and will soon expand its mobile team to cover another four settlements.

"We normally arrive to find a queue of people, and the feldsher (practioner nurse), waiting for us. We work closely with the feldshers, who, despite not being highly trained, are made wise through their years of practical experience. They know all the ins and outs of the history

Mobile medicine

Many of those who have returned to Chechnya from Ingushetia are homeless because their houses have been destroyed. The most destitute are housed in temporary accommodation centres (TACs) run by local authorities, the majority of them in or near the capital, Grozny. The people living in those TACs, 36,000 of them, almost three times as many as in 2002, have to put up with grim and unhealthy conditions. MSF is trying to improve access to healthcare in those settlements with a special focus on mental health, since many suffer severely from the pervasive climate of fear and violence. This is generally through the mobile teams, like the one that Aiza works for. Three of them care for some 1,200 patients each month in Grozny and another two go out into the surrounding rural areas to serve nine settlements.

In Ingushetia, the mobile medical teams, active since 2000, continue to work in Malgobeck, an area with about 5,000 displaced people and no local medical doctors.



Houses built by MSF to give displaced Chechens a choice between going back to Chechnya or staying in Ingushetia.
© Simon C Roberts

Doctors treating a patient for burns in Grozny. MSF supports the burn wounds unit by donating drugs and medical equipment and by giving logistical support. © Denis Lemasson

of their local patients – we sometimes say that you don't need the patient's medical card, you can just ask the feldsher. They help us prioritise the sick, and ask us for advice and prescriptions.

"I also see lots of pregnant women – did you know that Chechnya has one of the highest birth rates in Russia?

"Our work only really scratches the surface. We know that lots of the ill people who come to us need extensive tests and in-patient care. But often they have no money, and I know that if I tell them to go to hospital they won't. So I try to do my best, and at least make sure that, if I can't cure someone, I can prevent them getting worse.

"Our patients express real, heartfelt gratitude for our presence. I don't think that they fully understand what MSF is, but they often say 'thanks to you and those that sent you'. One of my regular patients, a man who has had a very hard life and been in prison, even wrote a poetic tribute to our work.

"People sometimes ask me why I stayed in Chechnya and didn't leave. But these hard times have, if anything, made my love for Chechnya stronger."

Ten years of violence, fear and deprivation

The conflict between the Russian Federation and the Chechen armed rebels, now in its eleventh year, has all but disappeared from the international political agenda. But it has not stopped inflicting enormous strain and physical injury on the Chechen people. The guerrilla attacks of the rebels and the counter-insurgency strikes of the Russian forces sustain an atmosphere of extreme threat and random violence.

Russian officials claim the situation in Chechnya has 'normalised' and that Chechnya now has a legitimate administration. Moscow has been pushing for Chechen refugees to return home and all the tented camps of displaced people in neighbouring Ingushetia were closed in 2004. The majority of the displaced have returned to Chechnya.

But 26,000 displaced people still live in Ingushetia – some beginning their sixth year in exile – in very difficult conditions.

In Chechnya, traumatised civilians continue to bear the brunt of the conflict. Frequent sweep operations to round up suspected rebels, landmine accidents, disappearances and violence perpetrated by local militias are still far too common.

The international aid response in the region is extremely limited because of the violence and threats of kidnapping of foreign aid workers.

MSF has been working in the region since 1999, bringing medical support to the most vulnerable groups. They include those suffering from psycho-social trauma after years of violence; those in need of surgery after gunshots or landmine incidents; the rural population which lacks access to health care and those suffering from tuberculosis.

In total, MSF provides medical care to around 290 patients a day in Chechnya and Ingushetia.

Treating tuberculosis patients

"The two wars brought the destruction of the TB healthcare network and a subsequent sharp increase in TB incidence in Chechnya. Without international support the TB system would remain dysfunctional," says Gabit Ismailov, MSF medical co-ordinator for Chechnya.

MSF started its TB programme in the Chechen republic in 2004 and is currently supporting what is known as directly observed treatment programmes, DOTS, in four TB hospitals, serving the population of around 300,000 people.

TB is particularly difficult to deal with in conflict settings, where people are more likely to have problems sustaining the treatment. There is also the associated threat of multi-drug resistant TB, which is a problem in many parts of the former Soviet Union.

"In addition to medicines, MSF provides food, as well as mental health counselling, for patients in the inpatient phase of treatment. The out-of-hospital continuation phase of the treatment requires patients to visit 'DOTS corners', or local outpatient health centres run by local health authorities, and supervised by MSF teams. MSF actively monitors the adherence to the treatment during that phase," explains Ismailov. "To encourage patients to stick to the treatment, MSF also distributes food baskets, in collaboration with WFP. MSF also employs health educators to go and visit those who are defaulting the treatment. We are currently preparing a range of TB health education materials, such as posters and leaflets, to be distributed in the community."

MSF has treated over 600 tuberculosis patients since 2004.

Polyclinic no.5 in Grozny where MSF provides consultations and basic health care to women.

Pediatric consultations in Polyclinic no.3.

© Denis Lemasson

Maternity ward at the Choscal hopital in Cité Soleil. © Gael Turine

Cité Soleil:

Treating bullet wounds and

The people of Cite Soleil are trapped. Since the ousting of President Aristide in 2004, civilians have been caught in the middle of widespread politically motivated and criminal violence. Armed gangs control the streets and are fighting each other as well as the UN peacekeeping force (MINUSTAH).

The consultations in the slum's Choscal Hospital, reopened by MSF in August 2005, are testimony to the daily violence.

> "The number of people who come to us for care is growing rapidly and shows just how crucial it is that we provide medical care in Cité Soleil"

"In November alone, we saw 380 patients in the emergency room," says Loris de Filippi, Head of Mission for MSF in Haiti. "More than one-third of them had injuries resulting from violence: gun shots or stabbing." Among the wounded, 50 per cent are women, children and the elderly. Overall there are an average of 3,500 medical consultations carried out each month.

"Our ability to work in Cité-Soleil is precarious," says De Filippi. "We never know how much access we will have from one week to the next. But we found it simply unacceptable that a population of a quarter million, the equivalent of a small European city, would be cut off from medical care. Our experience since starting work in Choscal Hospital shows clearly how great the health needs are and how urgent the need to provide care."

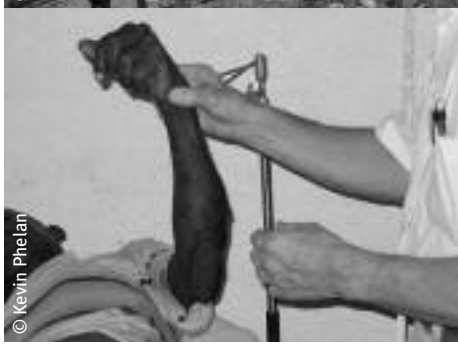
But the violence on the streets doesn't spare the hospitals, as Claudine, a nurse working with MSF at the Choscal hospital explains: "It happened the night of 19 February: we were assisting the babies in the pediatric ward, there were ten or fifteen babies sleeping in their beds. Suddenly we heard a huge noise. I closed my eyes. When I reopened them I saw an incredible scene: a bullet had broken the wall, passed through the window and got stuck in another wall. A baby was standing below the hole in the wall. I was shocked. Babies started crying and screaming. We decided to evacuate immediately the paediatric ward to the ground floor."

In addition to providing emergency trauma care, the teams have been busy providing maternal services. There are around 150 deliveries, a quarter of them involving life-saving caesarian sections, every month. Some women are now coming from outside the slum to get the peri-natal care they need.

"Haiti national's health system is based on a cost-recovery model. As a result, a woman is charged more than 50 US dollars for a caesarean section. This is simply unaffordable for much of the population we are assisting; generally they have to survive on less than a dollar per

"...a bullet had broken the wall, passed through the window and got stuck in another wall. A baby was standing below the hole in the wall."

Cité Soleil is one of the biggest slums in Port-au-Prince, Haiti's capital city. Around 250,000 people live here, in a precarious situation of poverty, violence and social instability. Until MSF started to work in the area last August, there was virtually no health care available.



An MSF surgeon examines a gunshot victim at the MSF trauma centre at St Joseph Hospital, Port-au-Prince.

delivering babies

day," concludes Loris De Filippi. "The number of people who come to us for care is growing rapidly and shows just how crucial it is that we provide medical care in Cité Soleil."

MSF works in other areas of Port-au-Prince. In December 2004, MSF opened a 56-bed trauma centre at St. Joseph's Hospital to provide free emergency medical and surgical services to the growing number of injured people who had little or no access to health care. Since opening, MSF teams have treated nearly 8,000 patients. Again, half of the people treated for violence-related injuries are women, children or elderly. MSF also offers post-surgical physiotherapy at a nearby rehabilitation centre.

Since April 2005, MSF has also been working in Decayette, another part of the capital, providing free basic health care, with a special focus on women and children. There, the MSF team carries out about 150 consultations a day.

MSF is now opening the Jude Anne Hospital in Port au Prince to help women living in the most violent parts of the city. The hospital will provide antenatal and post natal consultations for pregnancies, which are threatening for the mother and the child. Emergency obstetric care services will be available around the clock, including surgical capacity for caesarian sections. There is also a component aimed at decreasing the prevalence of the HIV virus among the infant population.

A doctor examines a mother at the maternity ward of the MSF Choscal hospital.

In the months before the presidential elections of February, the first since Aristide's departure in 2004, MSF teams in Haiti witnessed an alarming increase of people needing treatment for violence-related injuries, including a growing number of gunshot and knifing victims.

In February, the long-awaited presidential election finally took place and Rene Preval was elected. At the time of writing, in the direct aftermath of the election, Port-au-Prince seems calmer and the hospitals where MSF work seem, at last, to be getting fewer casualties.

MSF has worked in Haiti since 1991, focusing on primary health care, surgery, maternal and reproductive health.

Not many people have heard of the buruli ulcer. Yet the disease has been reported in 30 countries worldwide. It is the third most common mycobacterial infection in the world after tuberculosis and leprosy, but of the three diseases it is the most poorly understood.

A doctor changes the dressing on the leg of a young cameroonian affected by the buruli ulcer.

All pics © MSF

Buruli ulcer: a crippling di

Vinciane Sizaire is an MSF specialist on the ulcer and has recently been visiting the MSF buruli clinic in Cameroon. "The disease often starts as a painless swelling of the skin and, in absence of treatment, develops in large painless necrotic ulcers affecting most often the limbs. The usual outcome is horrible scares and the crippling consequences of skin retraction, joints stiffening and, sometimes, amputation. The ulcer destroys skin, underlying tissues and causes deformities. Many people lose their limbs." Although the disease is not life threatening and is treatable, it has a huge impact on affected communities and is a major public health issue.

The buruli ulcer has been reported in Australia and South America, but West Africa is the most affected region. According to WHO all countries along the Gulf of Guinea are now affected (see map). Although still largely unreported, there has been a large increase in the detection rate of the disease since 1980. In Ivory Coast, for example, some 15,000 cases have been detected since 1978 and prevalence reaches 16-20 % in a number of local communities; in some villages in Ghana, 22% of people are affected. Fifty to seventy percent of those affected are children under 15.

The disease often occurs in remote rural areas where populations have limited access to medical care and it is often detected at a late stage. The infection is known to be linked to contaminated water points – making women and children particularly vulnerable – but the mode of transmission is not yet fully understood. The role of insects is increasingly suspected.

If detected early, the lesion can be removed through simple and rapid surgery and have no long-term consequence. But if untreated, the lesion grows and scarring process starts, which can lead to paralysis due to the stiffening of the joints. This often means the patient loses the use of his arms or legs or amputation is needed.

Tania* is a young Cameroonian athlete who suddenly found out she had buruli. "It all started with a little spot on my left ankle. It was in the middle of competition and I did not want to get distracted or stressed. But weeks passed and the spot became bigger and purulent. I decided to go and see a 'mother', a traditional healer. She informed me that it was 'onwondo', the buruli ulcer. I was shocked. It was a terrible blow to my family, my coach and me. After two years of being treated by traditional medicine and the local nurses, and after another nodule appeared on my left elbow, I found out about MSF and decided to go and visit them at the buruli department of the

* Her hame has been changed

Treating Buruli patients in Cameroon

Buruli ulcer is considered a major health problem in Cameroon. MSF started working in the Akonolinga district in 2002, where the disease affected 0.4% of the population. With a population of 79,000 people, this means 250 cases a year are likely to be detected. MSF works in conjunction with national and local medical authorities to promote awareness of the disease, in villages and schools for example, and increase early detection, as well as providing effective treatment.

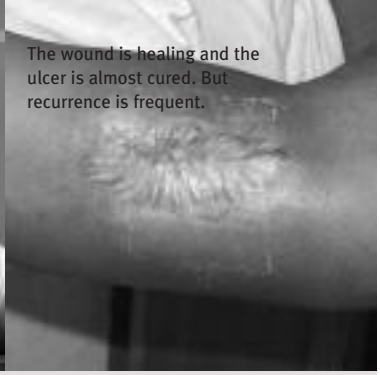
That includes surgical treatment, dressing and monitoring of the patients, on-the-job staff training, provision of equipment and the rehabilitation of infrastructure.

Patients suffering from Buruli ulcer receive eight weeks of antibiotics (Rifampicin and Streptomycin) in addition to the standard treatment of dressing and surgery. Although initial results of the antibiotic treatment seem to reduce the need for surgery, MSF believes more evidence is needed before concluding to the effectiveness of the treatment.

At present, the majority of patients enrolled in treatment are in advanced forms of disease (large ulcers).

Since 2002, over 350 patients have been registered. Fifty nine percent have recovered without recurrence.

The dressing applied to the wound needs to be changed regularly.



The wound is healing and the ulcer is almost cured. But recurrence is frequent.

"Today, after five years, I am smiling again. I know I will be able to have a normal life and I'm so thankful to those who helped me."

sease

Akonolinga hospital. I had to have an operation and the nurses looked after me day after day, cleaning and changing the dressing. Today, after five years, I am smiling again. I know I will be able to have a normal life and I'm so thankful to those who helped me. But I want to tell those affected by the ulcer: please do not wait, go and visit the buruli ward at Akonolinga as early as possible."

Lack of awareness of the Buruli ulcer by health workers and affected communities means that cases are usually detected at a late stage. Other reasons for not seeking medical advice are lack of money, concern that the treatment does not work, fear of surgery and anaesthesia, or superstition and stigma.

"This delayed recourse to surgery –the main treatment to the ulcer – is much more traumatic than if carried out early, when it is highly effective. At a later stage, wide excisions – or removal of the affected skin area – including healthy tissues are recommended to stop the infection and prevent recurrence or relapse at the same site. It requires skin grafting, and means a long stay in hospital," explains Vinciane.

Vinciane Sizaire and Eric Comte, Medical advisors with MSF, have contributed to an article reviewing the current status of control, diagnosis and treatment of the Buruli Ulcer for the Lancet. We expect it to be published shortly.

West Africa and the spread of Buruli

MSF UK volunteers currently in the field

Angola Karen Copsey *Project Co-ordinator* Julia Parker *Information Education Officer* Armenia Bryn Button *Logistician* Bangladesh Chris Hall *Logistical Co-ordinator* Raymond Kelly *Logistician* Burundi Rob Delaney *Water and Sanitation Expert* Ian David Atkinson *Logistician* Sonia March *Nurse* Central African Republic Simon Collins *Doctor* Chad Robin Vincent-Smith *Logistical Co-ordinator* China Wai Ching Loke *Doctor* Colombia Paul McPhun *Head of Mission* Olivia Hill *Medical Co-ordinator* DRC Paul Foreman *HOM* Megan Craven *Nurse* Anise Sacranie *Financial Controller* Sally Tillett *Nurse* Jonathan Smithson *Doctor* Doriana Santos *Laboratory Technician* Sara Moelwyn-Hughes *Nurse* Rebecca Adlington *Doctor* Matthew Arnold Mobile *Water and Sanitation Expert* Ethiopia Carolyn Gee *Doctor* Thomas How *Logistical Co-ordinator* Naomi Tilley *Nurse* Candy Barrett *Nurse* Morpheus Causing *Doctor* Guinea Laura Pomeroy *Nurse* Haiti Susan Chadney *Project Co-ordinator* Susannah Readett-Bayley *Financial Administrator* Mesfin Senbeto *Surgeon* Sarah Senbeto-Bush *Nurse/Midwife* Rachael Craven *Anaesthetist* India Margarita Montes *Doctor* Neeti Ghanekar *Medical Co-ordinator* Indonesia Judith Kendell *Anaesthetist* Robin Aherne *Logistician* Israel Annabelle Williams *Field Co-ordinator* Ivory Coast Howard Moore *Doctor* Liberia Alison Lindner *Nurse/Midwife* Claire Parker *Midwife* Tom Quinn *Head of Mission* Aileen Kitching *Doctor* Beryl Hutchison *Nurse* Anat Aharoni *Logistical Administrator* Malawi Margaret Fitzgerald *Doctor* Daniel McLaughlin *Financial Controller* Bibiana Angarita *Labatory Technician* Morocco Huw Price *Doctor* Mozambique Nicky Shellens *Administrator* Rebecca Smith *Doctor* Emma Cartmell *Doctor* Myanmar Anthony Munster *Logistician* Michael Patmore *Laboratory Technician* Nicola Mackworth Gee *Doctor* Alastair McGregor *Doctor* Seok Woo Kim *Doctor* Kalpana Sabapathy *Doctor* Yasotharai Ariaratnam *Financial Controller* Aster Ayana *Doctor* Nepal Richard Sturge *Doctor* Nigeria Helen Bygrave *Doctor* Aloysius Bingi *Labatory Technician* Paula Brennan *Logistician* Marta Angles *Logistical Administrator* Pakistan Stephen Cooper *Logistician* Gareth Crawford *Logistician* Dougal Hargreaves *Doctor* Paul Jawor *Project Co-ordinator* Elin Jones *Nurse* Mark Rolls *Project Co-ordinator* Ross Duffy *Project Co-ordinator* Tracey Leslie *Water and Sanitation Expert* Roger Anthony *Water and Sanitation Expert* Andrew Noden *Doctor* Miriam Bord *Nurse* Annas Alamudi *HRM Officer* Anne Findlay *Doctor* Paul Verth *Logistical Co-ordinator* Jackie Butler *Nurse* Russia Emma Bell *Information Officer* Sierra Leone Maria Dominguez *Doctor* Stephen Dalton *Surgeon* Emma Simpson *Project Co-ordinator* Syed Hussain *Doctor* Megan Dalton *Project Co-ordinator* Jonathan Heffer *Head of Mission* Somalia Colin McIlreavy *Head of Mission* Stephen Reid *Nurse* Jacob McKnight *Logistician* Arran Gaunt *Doctor* Elrasheed Abdalla *Doctor* Kathleen Roberts *Midwife* South Africa Eric Stobbaerts *Consultant* Sudan Beverley Collin *Medical Co-ordinator* Paul Critchley *Project Co-ordinator* Cesar Erena *Doctor* Meriel Rosser *Assistant Head of Mission* Boris Stringer *Logistician* Jacob Stringer *Assistant Head of Mission* Monica Arend-Trujillo *Doctor* Maria Siemer *Logistical Administrator* Jonathan Henry *Logistical Administrator* James Fuller *Doctor* Felix Over *Nurse* Margaret Baker *Nurse* Lisa Linpower *Nurse* Lynne Jones *Nurse* Vanessa Hunt *Nurse* Alice Thomas *Nurse* Adam Thomas *Logistician* Fiona Laird *Midwife* Luke Arend *Logistician* Gareth Barrett *Medical Co-ordinator* Maria Doyle *Nurse* Simon Heuberger *Logistician* Samuel Jones *Doctor* Lianne Barnett *Nurse* Alvaro Dominguez *Nurse* David Cook *Logistician* Vivienne Monaghan *Nurse* Tanzania Tracy Crawford *Nurse* Thailand Oscar Montoro De Antonio *Doctor* David Wilson *Doctor* Petrana Ford *Communications* Nathan Ford *Access to Medicines Co-ordinator* Paul Cawthorne *Project Co-ordinator* Uganda Lindsey Grimshaw *Logistical Co-ordinator* Christopher Smith *Doctor* Catherine Pamplin *Logistical Administrator* Christopher Pritchard *Logistician* Fran Miller *Mental Health Officer* Franklin Ackom *Medical Co-ordinator* Uzbekistan David Axten *Nurse* Zambia Susan Gibbons *Mental Health Officer* Zimbabwe Lucy Gardner *Mental Health Officer* Stephen Hide *Head of Mission* Cielo Rios *Doctor* Caroline Soi *Doctor*

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

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In brief

Kashmir Earthquake update

The snows came relatively late this winter but when they did arrive the relief activities in the areas devastated by the October earthquake in Pakistan became more difficult and made remote communities harder to reach. In some areas, road access has become totally impossible and MSF is using helicopters to transport staff and relief items, especially in the Muzzaffarabad and Bagh districts.

Four months after the disaster, which killed at least 73,000 people and left between two and three million homeless, the priority is to provide shelter from the cold and medical care to the displaced people, to help reconstruct hospitals and health centres and provide basic water and sanitation facilities.

Three temporary hospitals and health centres in ten locations have been set up. MSF has been using specialised inflatable tents, which are equipped with heating, electricity and sanitary facilities and enables medical staff to provide quality care in a difficult environment. MSF medical teams are providing 1,000 consultations a day. We are also doing mental health counselling to those traumatised by the earthquake and its aftershocks. So far, MSF has vaccinated 25,000 children against measles and other diseases. On the supply side, MSF has distributed 14,000 family tents, 182,000 blankets, 18,000 cooking kits and 15,000 construction kits.

MSF's inflatable hospital tents in Manserha, Pakistan.

Continuing violence in DRC

The ongoing violence in the Democratic Republic of Congo (DRC) continues to force people out of their homes and increase their vulnerability to disease, malnutrition and mental trauma in areas where emergency relief is almost entirely absent. In Katanga, people are still trapped between Rwandan-supported RCD-Goma forces, the Congolese Government army, and Mai-Mai militias. Where MSF is working, providing medical care, shelter, water and sanitation, we saw a total of 92,000 people displaced last year. In the last three months alone, 15,000 have taken refuge around the shores of Lake Upembe. MSF is concerned about the many people who may still be trapped in the bush, too frightened to move. The number of children under five in MSF therapeutic feeding centres continues to rise. In Mukubu, MSF has admitted between 15-20 severely malnourished children each week for the last six months. There has also been a cholera outbreak and MSF has set up two treatment centres in Mangui and Kikondja.

In North Kivu, renewed fighting has caused the temporary evacuation of MSF teams and led to 80,000 people being displaced either within the region or across the border as refugees in Uganda.

Cholera outbreak in Sudan

MSF has set up cholera treatment facilities in the town of Juba in Southern Sudan to respond to a severe outbreak. More than 1,800 cases, and 45 deaths, were recorded in February. The first cases appeared in another town, Yei, in January and MSF started working there shortly afterwards. Juba is a substantial town, the new capital of the Southern administration with more than 250,000 inhabitants. The MSF response is aimed first at reducing mortality in infected cases and trying to cut the spread of the disease. The epidemic is affecting a non-endemic, urban area, where people rely heavily on polluted water from the River Nile. MSF currently has 18 international staff working on the ground. More than 70 tonnes of medical and logistics material have been sent to Juba.

If you wish to support MSF's life-saving work in the field, post the coupon to: Médecins Sans Frontières, FREEPOST NAT20938, West Malling, Kent, ME19 4BR

Alternatively call us free on **0800 731 6732** or donate online at **www.uk.msf.org**

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