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Quarterly news from Médecins Sans Frontières UK Issue no 41 Summer 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.**

# Abandoned to violence, disease and hunger

© Per-Anders Pettersson

"They arrived in huge numbers with nothing, sometimes without even any clothes. When the first groups came in a massive wave, we had to send a large number of them straight to hospital because they were in such an awful condition. We also noticed that there were very few children under the age of one. Being the most vulnerable, they had simply not survived their ordeal," explains Goedele Van Bavel, an MSF volunteer in Katanga.

Katanga, a vast province in the Democratic Republic of Congo, is currently experiencing a massive humanitarian crisis with very little attention from the outside world: in the last fifteen months over 90,000 people have fled their homes in fear and have lost everything. Thousands of families now live scattered in the bush or in hastily assembled camps.

"People arriving in [the town of] Dubie were in a really bad state as they had walked hundreds of kilometres to get here, half naked, with barely any food. Many mothers had given birth en route and some people did not survive. You just wouldn't believe such a situation exists unless you actually see it," says Megan Craven, an MSF nurse in Dubie.

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**The ongoing violence has had a devastating effect on the health of the population. Today food and medical care are a major concern. MSF works in nine locations throughout the province and provides healthcare through hospitals, health centres, mobile clinics, vaccination campaigns, nutrition centres, and emergency water and sanitation.**

© Bruno Berson

In Dubie, a town on the border of the territories controlled by rebel groups, the population has tripled to 28,000 people. Around 18,000 of them are sheltered in three camps constructed by MSF, where we provide basic healthcare, water and sanitation facilities. MSF also supports two hospitals (Kilwa and Dubie) and six local health centres.

Living in the bush has taken its toll. Without adequate shelter and no healthcare, many people have succumbed to diseases such as malaria and gastro-enteritis. Others were just not strong enough to survive the 150 kilometre walk to Dubie.

After the first wave of displaced people arrived, it soon became clear that the biggest need in the area was food. Local agriculture could just not provide for a population three times its normal size. For months people lived on the skins peeled from manioc roots, which would normally be discarded or fed to the pigs. There was nothing else to eat. In April, MSF started distributing food to people in the camps and has so far provided beans, flour and oil to 5,000 families.

MSF also opened a therapeutic feeding centre in order to treat the severely malnourished children arriving in a steady stream. “When I arrived here in April there were 80 severely malnourished children in the therapeutic feeding centre. Now after two months there are 30. Even though there are new admissions every week, the number has decreased which is encouraging news” says Dawn Taylor, an MSF water and sanitation engineer working in the camps.

In the last few months, the already catastrophic situation has deteriorated further after an offensive by the Congolese army against militia groups known as the ‘Mai Mai,’ which occupy large parts of northern Katanga. The Mai Mai, created by the former President of DRC in the late 1990s as a local resistance force against the invading Rwandan army, have since turned on the people they were supposed to protect. Despite efforts at national reconciliation (the first elections in 40 years are due in July) and the presence of a UN peacekeeping force, hundreds of villages are subjected to brutal harassment, pillage and even total destruction.

MSF carries out basic health consultations in the village of Nyonga next to lake Upemba, and organises mobile health clinics in some of the more isolated areas. 5,516 children were vaccinated against measles and items are being distributed to over 4,000 families.
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Médecins Sans Frontières nurse Megan Craven bringing relief to the displaced people in Dubie.
© Nicky Lewin

These people have often wandered for months in the bush before getting to Dubie. MSF provides these people with medical assistance, shelter and relief items.
© Andrea Pontiroli

**What is happening in Katanga receives very little attention from the outside world. MSF is one of the very few humanitarian organisations present on the ground and every day MSF volunteers witness the desperation of the people of this region.**

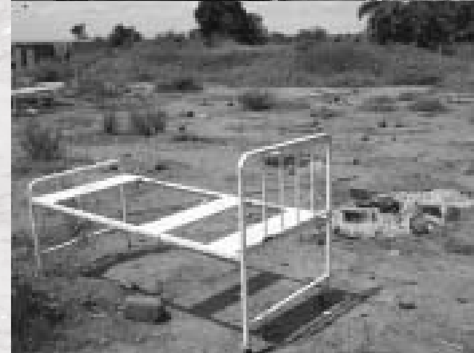
The fighting has been moving south-west pushing an estimated 35,000 displaced people to gather around the shores of Lake Upemba in south Katanga. People here live in squalid conditions in straw huts or on floating islets made of papyrus.

"I didn't expect people to be literally living on water," says David Cremoux, who has just returned to the UK from Katanga. "Inland is not safe because of the attacks. So if people stay on water, where they can fish, they can survive. But the hygiene is terrible because the river is being used for everything – as toilets as well as for cooking, cleaning and washing. My biggest fear is a cholera outbreak here. It would be catastrophic."

MSF has opened a healthcare centre and distributes basic supplies for displaced families, such as blankets and mosquito nets. But the security situation makes this difficult: "Sometimes we can't even distribute essential items to people for fear that this will attract looters," explains Jean-Guy Vataux, MSF's Head of Mission.

"Getting supplies in is also a nightmare. The roads are appalling and many freight companies won't come to the area."

What is happening in Katanga receives very little attention from the outside world. MSF is one of the very few humanitarian organisations present on the ground and every day MSF volunteers witness the desperation of the people of this region.



Above: MSF field staff rescue a pregnant woman who was caught in the crossfire between government troops and Mai Mai fighters in DRC. The woman was shot in the stomach. She was flown out in a rapidly improvised civilian plane from the fighting zone, and taken to a hospital 50 miles away.
© Nicky Lewin

**Katanga is neglected in almost all ways and the people there abandoned to hunger and preventable diseases. Apart from the work that MSF has been able to do, the organisation has also been trying to put pressure on the international community to step up its help to the region.**

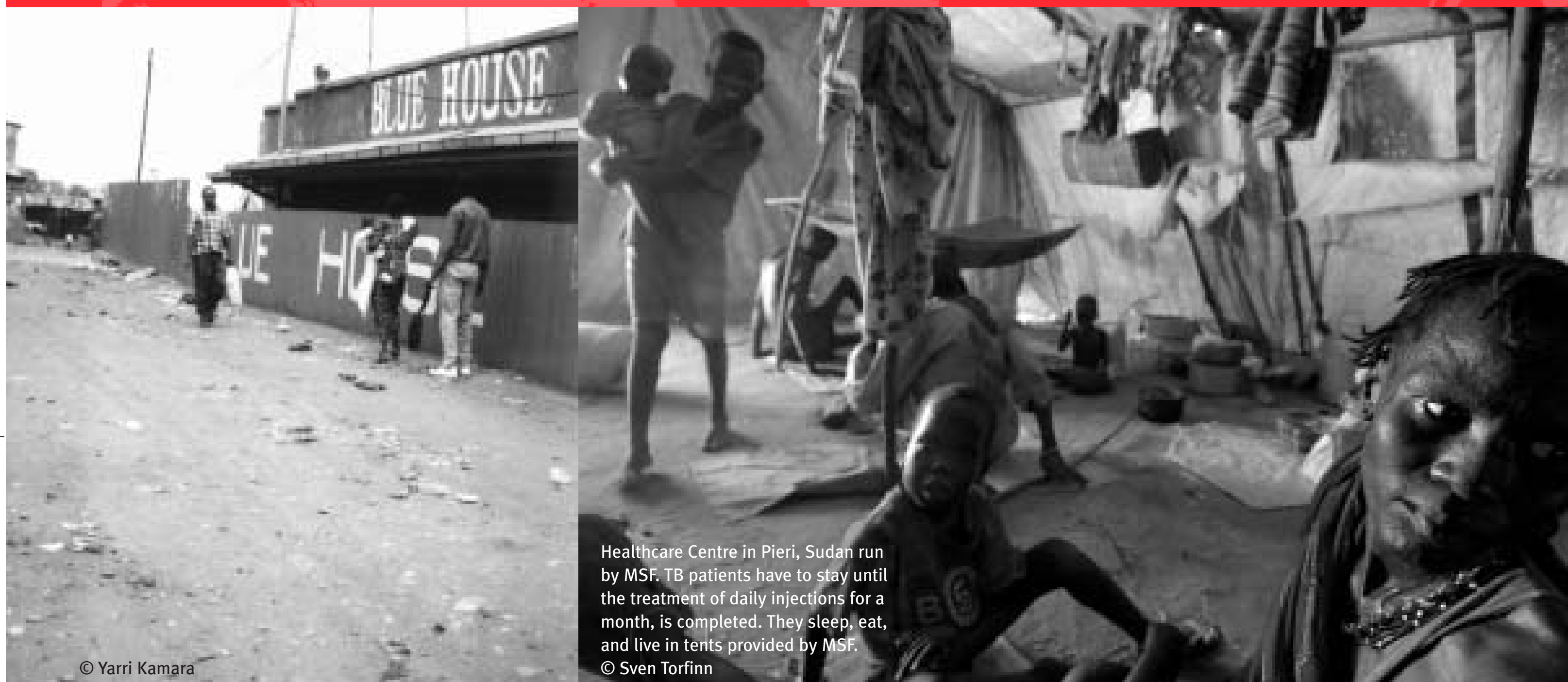
Tuberc

**"Bol, a six year old boy arrived at the clinic and was the most skeletal little boy you could imagine. He had a permanent fever and did not have the energy to sit up or even open his eyes,"**

explains Vanessa Hunt, who has been an MSF nurse in Pieri, south Sudan. "We quickly ruled out diseases such as Kala Azar, brucellosis, typhoid and malaria and decided to treat him for tuberculosis as a last-ditch attempt to get him better. He slowly started to recover and was soon beginning to walk – you just wouldn't recognise him. He's now like any other cheeky little boy and runs around causing havoc all day long. I still can't believe his transformation."

Many people in rich countries think of tuberculosis (TB) as a disease of the past. But TB is more than ever a global medical emergency: every year two million people die of it – almost four people a minute – and nine million people get sick, mainly in developing countries. Twenty per cent of the affected population are children, for whom TB is particularly deadly.

# a global disease




© Yarri Kamara

Healthcare Centre in Pieri, Sudan run by MSF. TB patients have to stay until the treatment of daily injections for a month, is completed. They sleep, eat, and live in tents provided by MSF.
© Sven Torfinn

## Tuberculosis and HIV

The Blue House is a TB and HIV clinic run by MSF in the Mathare Valley in Nairobi, Kenya, where about 250,000 people live, including a large number of refugees who have fled violence in neighbouring countries. Living conditions in Mathare are an ideal environment for a highly infectious airborne disease such as TB to flourish. Entire families live here, crammed in dark single rooms in packed shacks along congested dirt alleys.

Medicines are kept at the Blue House clinic to ensure that they are not sold to provide for other needs. Patients make regular trips to the Blue House to take their medicines, allowing medical workers to monitor their status.

Lydia is 28 and has one child. After her husband died of HIV/AIDS she left Uganda to look for a better life in Kenya. She settled with her son in Mathare, one of the most crowded slums of Nairobi, and her life got worse. When she arrived she felt sick. Every day her legs were aching, she could hardly walk and hardly see. "My eyes left me alone and I had to stop working as a house girl" she says.

"Then friends told me about the Blue House where you can get treated for free" she says. "The doctors told me I was HIV positive and had TB. I started taking TB tablets the same day and was given injections. I took three tablets every day for eight months. We thought I was cured but TB came back and I had to start treatment again. Now, after two years, I have recovered fully. I am working again and can take care of my child without the help of others. I am all right."

Because TB very often occurs with HIV, the Blue House, like many other MSF TB clinics, is dedicated to the treatment of both diseases. MSF is currently treating over 300 TB patients at the clinic, 225 of them also HIV positive.

One of the major problems is that diagnostic and treatment remain archaic. "To diagnose the disease we still rely on the microscope examination of sputum, a method developed more than 120 years ago and that only allows the detection of 45-65% of cases. This rate is even lower for patients infected by both HIV and TB," explains Marie-Eve Raguenaud, TB expert at MSF. Due to the inefficiency of the test, the treatment of half the patients in developing countries is often delayed or not started at all.

Bol was lucky. "TB is a fantastic disease when there is the capacity to diagnose and treat the patients, as there is often such a marked improvement in a relatively short space of time," says Vanessa. But very often TB is not detected because patients do not have access to health facilities and the disease continues to spread.

Despite alarming figures, TB remains low on governmental agendas. The disease is traditionally considered to be a disease of the poor. TB is often a major problem in countries affected by ongoing conflict, where national health systems have collapsed, road networks non-existent or insecure, and movements of populations occur. Transmission is accelerated by cramped housing conditions and infection facilitated by poor nutrition and hygiene.

The treatment for tuberculosis is long and complex: medication must be taken at regular, designated intervals for a period of up to eight months. Interrupting the treatment – even briefly – decreases its effectiveness, puts the patient in danger and can cause resistant strains of the disease to develop and spread.

Adherence to treatment is one of the major challenges and MSF tries to develop flexible approaches, with the help of social workers and community members.

## Drug resistant tuberculosis

This form of TB, caused by inadequate or incomplete treatment, has reached alarmingly high levels in many countries around the world. It is a particularly pressing emergency in Eastern Europe and Central Asia, but is now also on the march in Africa.

There are two million people with multi-drug resistant TB (MDR TB) and half a million new cases appear every year. MSF currently runs specific MDR TB clinics in Abkhazia, Armenia, Ivory Coast, Thailand and Uzbekistan.

MDR TB is more deadly and much harder to treat than ordinary TB. Diagnosis takes longer and requires more sophisticated technology. The drugs, which are much more expensive, are less effective and must be taken for two years. They are highly toxic and can cause serious side effects such as hepatitis, hallucinations and dizziness. The patients often have to be hospitalised for long periods, in isolation.

"Treatment is possible," explains MSF nurse Emma Diggle, working in an MDR TB project in Uzbekistan, "but it happens at a cost and demands a lot of effort."

"Isolating the patient while he is contagious, for example, can be very difficult. We are taking mothers away for up to two years. Or we are taking the family breadwinner away, and this, in a country that has no social service structure. We know that it is beneficial in the long-term, but it is very hard," says Emma.

**"We thought I was cured but TB came back and I had to start treatment again. Now, after two years, I have recovered fully. I am working again and can take care of my child without the help of others. I am all right."**

© Sven Torfinn

## WHAT IS TUBERCULOSIS?

Tuberculosis (TB) is an infectious disease caused by a bacteria, myco-bacterium tuberculosis which usually develops in the lungs, the main zone of infection. Major symptoms are: prolonged cough, bloody expectorations, chest pain, and alteration of the general health status. Actions like coughing, sneezing, talking and spitting can all spread the bacilli in the air where they can remain for several hours before being inhaled by another person.

According to the World Health Organisation (WHO), one third of the world population is infected and therefore at risk of developing the disease at some point in their life.

This is particularly true for people with weak immune system, such as people living with HIV or AIDS. Today 30% of the 40 million people living with HIV/AIDS worldwide are also infected with TB. It is the main cause of death among those infected.

In the last few decades, a more ferocious form of TB has developed. It is resistant to the drugs used to cure ordinary TB and is generally caused by interruption of treatment.

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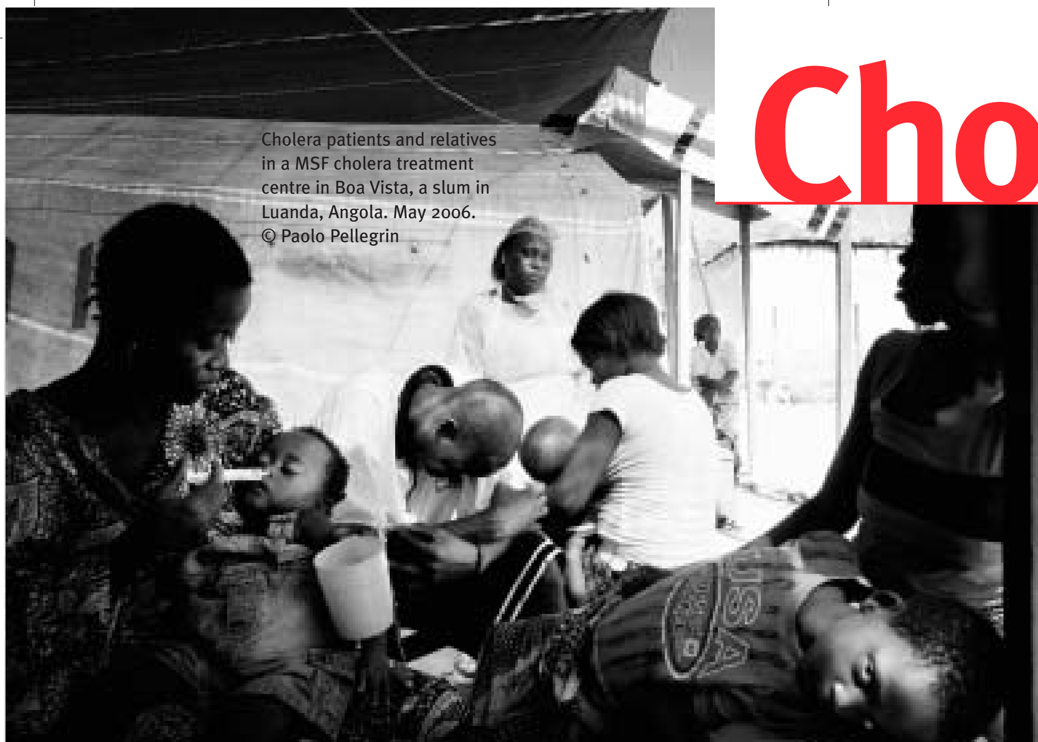

Cholera patients and relatives in a MSF cholera treatment centre in Boa Vista, a slum in Luanda, Angola. May 2006.
© Paolo Pellegrin

# Cholera: Angola's

## "Cholera does not dis is an outbreak every

People sick with cholera are brought to a cholera treatment centre run by MSF in Malanje, Angola. May 2006
© Paolo Pellegrin

A wom treatm © Pao

**The first cases of cholera for ten years were reported in Angola's capital, Luanda, in mid-February. MSF responded immediately, constructing cholera treatment centres in the worst affected areas. But cholera spreads very fast and the disease has since infected over 34,000 people throughout the country and claimed more than 1,200 lives. MSF communications officer, Susan Sandars, was in Angola in the early stages of the cholera epidemic.**

Cholera does not discriminate. When there is an outbreak everyone is vulnerable. I see a man sitting patiently in a public bus parked next to the disinfection area of the treatment centre. He is obviously waiting for someone inside the centre. It is only when I see the child-sized coffin on his knee that I realise who it is.

The atmosphere inside the centre is somewhat chaotic. All the beds are full and some patients have to share a bed. The staff are working flat out. During my visit logisticians are hastily putting up another tent, which will house twenty more beds, but the truth is that they are running out of space. The CTC itself seems quite basic: at the entrance there is a disinfection area where everyone is sprayed with chlorine, which kills the bacteria that causes cholera. Cholera is highly contagious so it's crucial that infected people are isolated and anyone who comes into contact with them is disinfected. There is also a triage area for newly arrived patients, a pharmacy, water points, latrines and several large tents which contain rows upon rows of beds. Each bed has a hole in the middle and two buckets underneath, one labelled 'vómito' the other 'excremento'.

It would be easy to be shocked by the indignity of it all, but in truth the only way to treat cholera is to allow the patient to flush the bacteria out of their body and to re-hydrate them as quickly as possible. For those who reach the centre in time recovery is quick. As patient Teresa Francisco says: "I started to feel ill yesterday morning. I had bad diarrhoea so I went to the local health centre and they gave me some paracetamol and some oral rehydration solution. They told me to go home and if I got worse I should go back to the centre. They didn't say anything about cholera. Then I started vomiting so I went back to the centre at about 8pm. They told me to come to the MSF clinic, but I had to walk as they did not give me a car or an ambulance. My brother-in-law came with me so I wasn't scared and now my mother is here looking after me. When I got here I was put on a drip straight away. I'm feeling much better now so the nurses have taken out the drip but they have told me to wait for a while to see if it's okay for me to go home." However rudimentary they may seem, these centres are the most effective way to save lives in a cholera outbreak.

**"The majority of people coming to the centre will be infected, with the most severely affected easily identifiable by what one nurse describes to me as 'cholera eyes' – sunken eyes that show no recognition of the people around them, or their surroundings."**

Most patients at the centre are put on intravenous drips containing ringer lactate fluid to rehydrate them. MSF staff work round the clock putting people on these drips, with one doctor telling me he has done about fifty IVs here that morning. Once patients are on the drips they must be constantly monitored, if too much is given to a young child there is the risk of flooding their lungs. If it is not given quickly enough to an adult they could die from dehydration.

When a cholera outbreak is first suspected stool samples are used to diagnose whether it is cholera or not. By the time that a CTC is set up such tests are hardly necessary. The majority of people coming to the centre will be infected, with the most severely affected easily identifiable by what one nurse describes to me as 'cholera eyes' – sunken eyes that show no recognition of the people around them, or their surroundings.

Most of the patients in the centre are from Boa Vista, one of Luanda's biggest slum areas where the cholera

# ola's latest scourge

## not discriminate. When there everyone is vulnerable."

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A women with cholera in a MSF run cholera treatment centre in Luanda, Angola. May 2006 © Paolo Pellegrin

outbreak has been most severe. With limited public transport, getting to the CTCs is not always easy. Florinda Mateus, whose five-year old son Nelo is receiving treatment, told me: "I saw the notices on TV about cholera so I knew to bring Nelo here, but the normal buses wouldn't take us so I had to call a taxi. They charged me 1,500 kwanza, much more than usual because they knew my son was ill." Other patients reported that they were too scared of being robbed to come to the centre at night, so each morning would see a surge in patient numbers. Often this delay means that patients are so dehydrated when they arrive at the centre that little could be done for them.

After leaving the centre I join Julia Parker, who helps organise the public health education part of the project – an essential element of any cholera response – and the Angolan student activists that MSF is working with to keep people informed about cholera prevention. Every day groups of volunteers walk around the slum areas of Luanda asking people if they know about cholera, what to do if they suspect they have the disease and if they know how to prevent it.

But preventing cholera from spreading is not just a question of knowledge. As Julia says: "The people we've been talking to in Luanda know that they should wash their hands and treat their water but the conditions here just don't favour good hygiene."

Sadly she is right. The number of cases in Luanda has continued to rise and the cholera has now spread to other parts of Angola and shows no signs of abating. Every day about ten people die from a disease that is easily preventable and easily treatable. Today MSF is running ten cholera centres in Luanda, with a total capacity of 700 beds. MSF has also set up cholera centres in Benguela, Bengo, Malanje, Biè, Huila, Huambo, Kuanza Norte and Uige.

# MSF UK volunteers currently in the field

**Angola** Karen Copsey *Pharmacist* Micaela Serafini *Doctor* Julia Parker *Epidemiologist* Birgit Hauffe *Doctor* **Armenia** Bryn Button *Logistician* **Bangladesh** Chris Hall *Logistician* Raymond Kelly *Logistician* **Burundi** Rob Delaney *Water and Sanitation Expert* Zelda Goad *Nurse* Timothy Boole *Financial Controller* Tara Brady *Doctor* Helen Mitchell *Nurse* **Cambodia** Christopher Peskett *Nurse/Medical Team Leader* **Central African Republic** William Askew *Doctor* Selena Brewer *Humanitarian Affairs Officer* **Chad** Robin Vincent-Smith *Logistician* **Colombia** Olivia Hill *Medical Co-ordinator* Paul McPhun *Head of Mission* April Ingeborg Baller *Doctor* **DRC** Rebecca Adlington *Doctor* Matthew Arnold *Logistician* Dawn Taylor *Water & Sanitation Expert* Emma Warwick *Financial Controller* Megan Craven *Nurse* Sally Tillett *Nurse* Jonathan Smithson *Doctor* Babak Kianifard *Surgeon* Marie Dubeau *Humanitarian Affairs Officer* Eleanor Holland *Nurse* **Ethiopia** Naomi Tilley *Nurse* Candy Barrett *Nurse* **Guinea** Laura Pomeroy *Nurse* **Haiti** Susannah Readett-Bayley *Project Co-ordinator* Lucy Reynolds *Project Co-ordinator* Tuppin Scrase *Doctor* Mesfin Senbeto *Medical Co-ordinator* Sarah Senbeto-Bush *Nurse/Midwife* **India** Bruce Russell *Logistical Co-ordinator/Project Co-ordinator* Katarzyna Russell *Nurse/Midwife* Margarita Riera Montes *Doctor* **Indonesia** Judith Kendell *Anaesthetist* **Ivory Coast** Howard Moore *Doctor* Sam Ramsay Smith *Surgeon* **Liberia** Tom Quinn *Head of Mission* Aileen Kitching *Doctor* Beryl Hutchison *Nurse* Anat Aharoni *Logistical Administrator* Clare Hommers *Anaesthetist* Elizabeth Moloney *Nurse/Midwife* **Malawi** Bibiana Angarita *Biomedical Scientist* Margaret Fitzgerald *Doctor* Daniel McLaughlin *Logistician* **Morocco** Huw Price *Doctor* **Mozambique** Emma Cartmell *Doctor* Nicky Shellens *Logistical Administrator* Rebecca Smith *Doctor* **Myanmar** Kalpana Sabapathy *Doctor* William Baylis *Logistician* Yasotharai Ariaratnam *Financial Controller* Aster Ayana *Doctor* Michael Patmore *Biomedical Scientist* Nicola Mackworth Gee *Doctor* Alastair McGregor *Doctor* Angela Bailey *Doctor* **Nepal** Richard Sturge *Doctor* **Nigeria** Gina Bark *Humanitarian Affairs Officer* Helen Bygrave *Doctor* Aloysius Bingi *Biomedical Scientist* Anna Bownes *Financial Controller* Marta Ramoneda Angles *Logistical Administrator* **Pakistan** Bryan Emery *Logistician* Jackie Butler *Nurse/Midwife* Stephen Cooper *Logistician* Gareth Crawford *Logistician* Luis Francisco Neira *Doctor* Mark Rolls *Financial Controller* Annas Alamudi *Logistician* Anne Findlay *Doctor* Amir Shroufi *Doctor* Andrew Henry *Surgeon* Georgina Brown *Midwife* **Palestinian Authority** Annabelle Williams *Field Co-ordinator* **Russia** Emma Bell *Regional Information Officer* **Sierra Leone** Jonathan Heffer *Head of Mission* Stephen Dalton *Surgeon* Emma Simpson *Project Co-ordinator* Syed Akmal Hussain *Doctor* Megan Dalton *Project Co-ordinator* Kevin Miles *Nurse* **Somalia** Colin McIlreavy *Head of Mission* Jacob McKnight *Logistician* Elrasheed Abdalla *Doctor* Kathleen Roberts *Nurse/Midwife* Rupert Miller *Logistician* **South Africa** Eric Stobbaerts *Consultant* **Sudan** Beverley Collin *Medical Co-ordinator* Paul Critchley *Project Co-ordinator* Cesar Erena *Doctor* Alyson Froud *Medical Co-ordinator* Michael Hering *Logistician* David Nott *Surgeon* Christopher Lockyear *Logistician* James Fuller *Doctor* Felix Over *Nurse* Margaret Baker *Nurse* Lynne Jones *Nurse* Alice Thomas *Nurse* Adam Thomas *Logistician* Fiona Laird *Midwife* Luke Arend *Logistician* Mairi Macleod *Logistician* Alison Jones *Nurse* Hilary Bower *Project Co-ordinator* Kate Done *Doctor* Simon Heuberger *Logistician* Lauren Pett *Logistician* Monica Arend-Trujillo *Doctor* Alvaro Mellado Dominguez *Nurse* Vanessa Hunt *Nurse* Vivienne Monaghan *Nurse* Jacqueline Ryan *Nurse* Freda Graf *Nurse* Tania Verdemato *Water & Sanitation Expert* Laura Rinchey *Doctor* Anna Hess *Nurse* **Tanzania** Tracy Crawford *Nurse* **Thailand** Paul Cawthorne *Project Co-ordinator* David Wilson *Doctor* Petrana Ford *Information Officer* Nathan Ford *Medical Advocacy Consultant* **Uganda** Fran Miller *Mental Health Officer* Charlie McQueen *Water & Sanitation Expert* Franklin Ackom *Medical Co-ordinator* Nathanael Jarrett *Logistician* Sidney Wong *Medical Team Leader* Victoria Treacy *Nurse* Catherine Pamplin *Logistical Administrator* Catherine McGarva *Mental Health Officer* Christopher Pritchard *Logistician* **Uzbekistan** David Axten *Nurse* **Zambia** Lucy Gardner *Mental Health Officer* Stephen Hide *Head of Mission* Cielo Rios *Medical Co-ordinator* 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

## Sudan

Clashes between armed groups and direct attacks on villages have been happening in the Upper Nile and Jonglei provinces of southern Sudan leading to the displacement, injury and death of many civilians. Threats of violence have forced MSF international staff to evacuate from Nasir and from clinics in Wudie, Lanken and Pieri. In Pieri, most of the patients in the MSF clinic, 120 of them being treated for tuberculosis, were forced to flee. Medical equipment, drugs and food for the patients were looted. This means that humanitarian assistance in the region, already way below what is needed, will be even poorer. MSF is one of the very few providers of health care in the Upper Nile region and access to essential medical care is now severely reduced.

In Darfur the situation remains unstable with clashes occurring in the north on a number of fronts and a high level of insecurity in the area bordering Chad. This has not caused significant changes to our operations there but a major concern is the reduction of food aid to displaced people by the World Food Program (WFP) due to lack of funding, with people now receiving only half daily rations. The 2.1 million displaced people in the region are entirely dependent on this and MSF calls on the international community to take emergency action to prevent a nutritional disaster.

## MSF supports reforms in medical research and development

As health ministers gathered in Geneva for the World Health Assembly (WHA) in May, MSF called on governments to overhaul the way medical research and development (R&D) is prioritised and financed. MSF supports a resolution put forward by Brazil and Kenya for a “Global Framework on essential health R&D.” The resolution represents an important step to ensure that medical R&D is driven by and prioritized according to real health needs, and not solely by commercial concerns.

The current R&D system provides greater rewards for developing drugs that sell well, rather than drugs that meet un-addressed needs, such as sleeping sickness, kala-azar and tuberculosis.

“Governments need to commit to changing the rules of the game, or people will continue to die because the diseases they suffer from don’t provide profits,” said Dr. Rowan Gillies, International President of MSF, speaking at a press conference in Geneva.

## MSF responds to Indonesia Earthquake

On Saturday 27 May an earthquake of 6.2 magnitude shook Java island in Indonesia. Initial estimates suggest that more than 5,000 people died, 20,000 people were injured and some 200,000 people left homeless.

MSF responded rapidly and at the time of writing, just three days after the disaster, 35 MSF staff were present in the area (surgeons, doctors, nurses, psychologists, logisticians, and water and sanitation experts).

After initial assessments the first MSF team decided to provide medical assistance in the heavily affected areas around Bantul, the epicentre of the earthquake. In that location, around 2,000 people died, 1,400 have been severely injured and 1,600 have moderate wounds. Other MSF activities have so far included the creation of three mobile teams to provide medical assistance to remote locations, and a mental health team has arrived to offer counselling.

MSF has donated drugs and medical material to local hospitals and to the Indonesian Red Cross and 35 tons of medical supplies, a field hospital, generators, tents, and relief items for about 2,000 families have been sent so far.

As the situation develops so will MSF’s response. To keep up to date with our activities please visit our website on www.uk.msf.org

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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

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