DISPATCHES

Médecins Sans Frontières 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.

On the cholera frontline

Inside an MSF clinic, pages 6-7

MSF staff begin IV treatment of cholera for a small child in a clinic in the Arbonite region of northern Haiti Photograph: © Aurelie Baumel/MSF, 2010

MEDECINS SANS FRONTIERES

Spring 2011
No 60

South Sudan
Maternal healthcare

With south Sudan recently voting in a referendum to secede from the north, one of MSF's priorities has been to prepare for possible emergencies, while continuing to provide medical assistance to a vulnerable population.

Midwife Katy Hutchinson describes the situation in Agok, where MSF runs the only hospital programme and where the maternity team is carrying out 60 to 80 deliveries per month.

"We've seen a lot of enthusiasm from women in the community around Agok to have their babies here, but it makes me worry about the villages that are two days' walk away where there is no MSF.

Before, our only option was to refer patients to a hospital two and a half hours' drive away. One woman who had an ectopic pregnancy arrived relatively stable but then deteriorated in the night, when it was too dangerous to drive her to

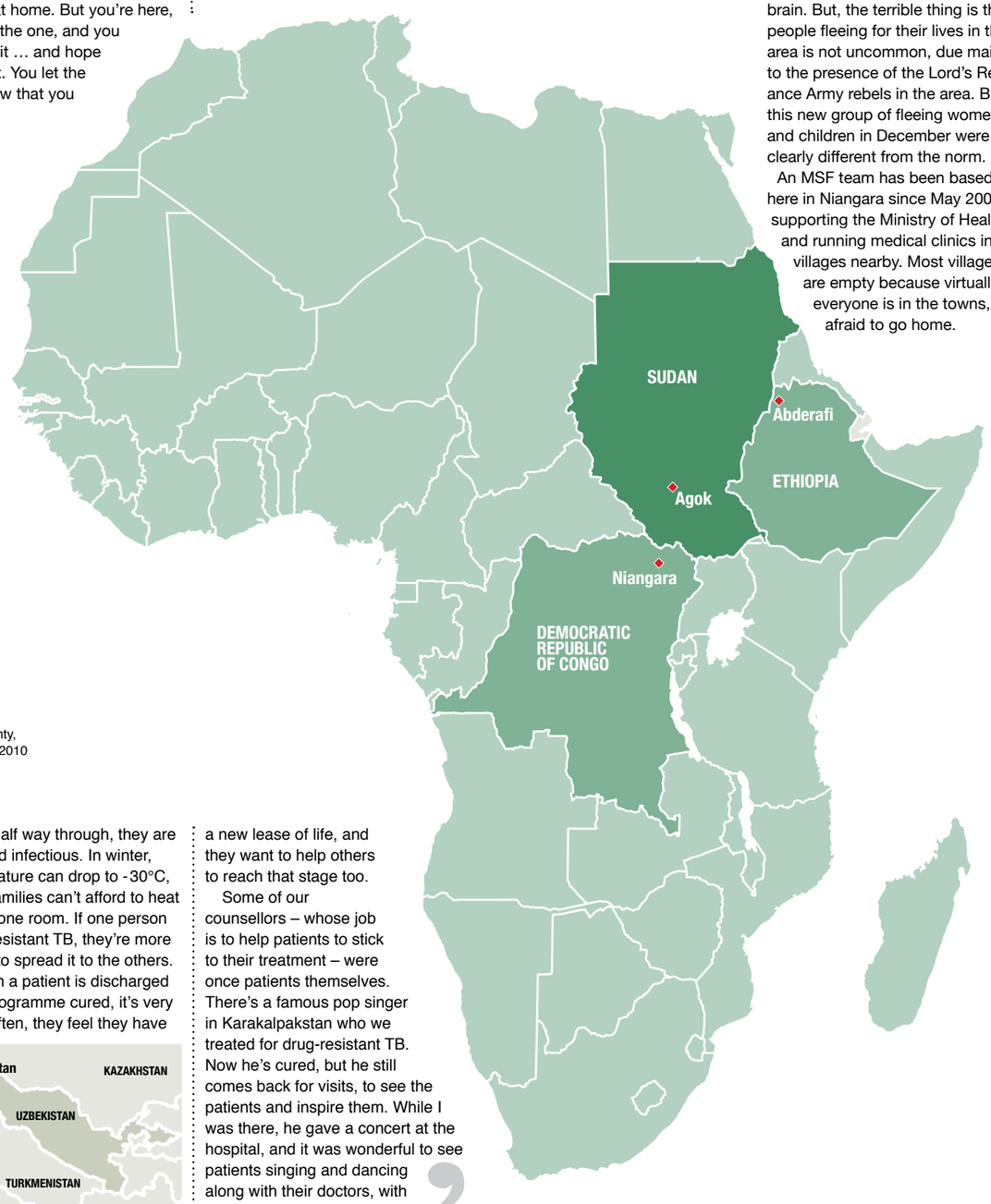
hospital. We decided to give her an auto transfusion: withdrawing her blood from her abdomen and giving it back through her veins. This is not something you would ever see in any western clinic, but when there is no blood donor, no surgery option, and the woman is dying in front of your eyes, you do what you have to. She survived until the morning and went off to the hospital – and came back to see us a couple of days later totally fine.

I have done other procedures that I would not expect to encounter at home: one of my most memorable patients was a woman who was not stable enough to be driven two and a half hours for a caesarean in hospital. Her baby was coming shoulder first and I had to put my hand inside her, to move the baby into the correct position. If I hadn't done so, she would have died.

There is no way I would have ever done that at home. But you're here, and you're the one, and you have to do it … and hope for the best. You let the patient know that you are going to do everything you can and then you do it. But it was a scary moment for me.

Every single week we save somebody's life and it makes me a little upset that not every woman in Sudan has the opportunity to have a safe delivery. But we haven't had a maternal death since I've been here, and I hope it will stay like that."

Photographs ©Kate Geraghty, south Sudan, 2010



Congo DRC
Refugee crisis

Azaad Alocco is the MSF project coordinator in Niangara, Democratic Republic of Congo.

"When 600 women and children suddenly set up camp outside a town in northern Congo, an alarm goes off in your brain. But, the terrible thing is that people fleeing for their lives in this area is not uncommon, due mainly to the presence of the Lord's Resistance Army rebels in the area. But this new group of fleeing women and children in December were clearly different from the norm.

An MSF team has been based here in Niangara since May 2009 supporting the Ministry of Health and running medical clinics in two villages nearby. Most villages are empty because virtually everyone is in the towns, too afraid to go home.

Photograph ©Natasha Mlakar/MSF, DRC, 2011

When this group suddenly arrived and started making makeshift shelters we discovered that they were Mbororos – nomadic herders who travel through central African countries. They told us that they had fled a neighbouring district to avoid being raped or kidnapped. Even for nomads used to a hard life, the conditions in their makeshift camp were bad, with no water or hygiene facilities.

Over the next three weeks the MSF team assessed 541 people and treated many severe malaria cases, intestinal parasitosis, respiratory infections, and skin infections.

One afternoon when we went to prepare for another clinical session we found the camp almost empty. Armed men had ordered them to leave, having seized their possessions and animals, except for the donkeys.

Just before nightfall, MSF found about 100 women and children by the roadside without any shelter and hurriedly organised an emergency distribution of food.

The nomads, plus several hundred Mbororo men, are now in the bush around Nambia, where MSF runs a medical clinic, but only when it is safe to do so. We are worried that they are now much more vulnerable to attacks than when they were here at Niangara. We can only hope that those who need medical attention can get themselves to our mobile clinics."

Uzbekistan
Drug-resistant TB

MSF's Tuberculosis Programmes Implementer, Dr Bern-Thomas Nyang'wa, has just returned from Central Asia, where drug-resistant TB is reaching epidemic proportions. He travelled to the remote Karakalpakstan region, where MSF is treating thousands of sufferers of this disease.

"Tuberculosis has been around for a long time, but these emerging strains are resistant to the two most potent TB drugs, and so are far more difficult to deal with. We've been treating patients in Uzbekistan with drug-resistant TB for the past eight years. There's been massive progress in this time: we've treated 1,500 people. But there are still difficulties to overcome.

The drugs that do work are still very expensive (over €3,000 for each person), and the treatment is gruelling. Patients have to take a cocktail of drugs - they might take up to 23 pills in the morning, and even more in the afternoon - and they have to keep this up for a minimum of two years. The side effects can be really debilitating, so it's a challenge to keep people on treatment.

The problem is, when someone drops out half way through, they are still sick and infectious. In winter, the temperature can drop to -30°C, and poor families can't afford to heat more than one room. If one person has drug-resistant TB, they're more than likely to spread it to the others.

But when a patient is discharged from the programme cured, it's very uplifting. Often, they feel they have a new lease of life, and they want to help others to reach that stage too.

Some of our counsellors – whose job is to help patients to stick to their treatment – were once patients themselves. There's a famous pop singer in Karakalpakstan who we treated for drug-resistant TB. Now he's cured, but he still comes back for visits, to see the patients and inspire them. While I was there, he gave a concert at the hospital, and it was wonderful to see patients singing and dancing along with their doctors, with their spirits lifted."

Ethiopia
Kala azar

Josie Emslie, pictured right, joined an MSF team at Abderafi, on the border between Ethiopia and Sudan.

"I am writing from our field hospital in Abderafi. It's about 40°C, which people here tell me is cool. We treat patients with malaria, TB, HIV and malnutrition and specialise in treating a much-neglected disease called kala azar. It is caused by a parasite transmitted by sand flies that attacks the immune system. Without treatment there is a 99% chance that someone with kala azar will die. At our hospital 94.5% of those we treat survive.

Yesterday I chatted to 39-year-old Awoke who we first saw three months ago. He has abdominal pains and headaches and is shockingly under-weight. We tested him and discovered that he is now co-infected with both kala azar and HIV, so started him on a course of antiretroviral drugs alongside his treatment for kala azar.

His course, a combination of multiple injections and tablets each day, is relatively pricey, costing about £300. But he is one of the lucky ones receiving treatment.

Every year thousands die of kala azar due to lack of access to treatment. In 2010, our project here screened 1,463 people and treated 395 (those who tested positive). Awoke wants to recover in order to return to his wife and children in the highlands. We're going to do everything in our power to help him do just that."

12m The number of people affected by kala azar worldwide

1.6m Number of people who die from tuberculosis worldwide each year

Floating clinic means a better life on the lagoon

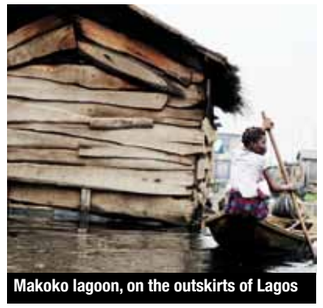
How do you improve healthcare when there's no land for a clinic and your patients live on water? In Makoko, a densely packed slum on the outskirts of Lagos, MSF has found the answer

It's 6am, the sun is already beating down and a crowd is gathering. There are mothers with children, pregnant women, old men and teenagers. For weeks now, word has been spreading that free medical services will be offered at the new building with the white walls, and nobody wants to miss out. By eight o'clock, there are scores of people on the veranda, on the steps and out the front.

Queuing here, however, requires more than just patience. What's also needed is sure footing, a touch of ingenuity and possibly a boat. For this is not just any medical clinic: this is a floating MSF clinic opening in the Makoko lagoon, a densely packed slum that sits on a large body of water on the outskirts of Lagos, Africa's fastest-growing city.

Here, wooden shacks perch on stilts over the brown water, linked by precarious wooden walkways. Men paddle by in handmade canoes, while children poke their heads out of windows, clamber up poles and shout to each other across the waterways.

In a city of 18 million people, the settlement on the lagoon is where some of the 2,000 daily arrivals from rural Nigeria and neighbouring countries end up. And it's here, where poverty and overcrowding are commonplace, and where some people have never even set foot on dry land, that MSF has opened its unique floating clinic.



Makoko lagoon, on the outskirts of Lagos

"It is an exciting challenge running a project in this huge megalopolis," says Daniele Cangemi, MSF's head of mission in Nigeria. "Here we're surrounded by so many different cultures and ethnic groups and by people who don't have access to free healthcare. The challenge for us was finding a way to work effectively in an environment like this."

Finding a way meant first acknowledging that most of these water-dwellers would be unable, realistically, to reach the clinic that MSF operates on land in a nearby slum. Many live so far out on the lagoon that it can take a long time to reach solid ground. Instead of expecting them to go to the clinic, MSF brought the clinic to them.

Since opening in January, the floating clinic, which sits on stilts and juts out onto one of the lagoon's main waterways, has already become a focal point for the community. This, despite the fact it almost sank the day it opened.

"We were overwhelmed with patients on the first day," says Pamela Bernard Sawyer, the MSF nurse in charge of the clinic. "Before we arrived we thought there would be a few patients and the numbers would grow as the weeks progressed. We were so shocked when we came up the canal on the boat and saw so many people."

With two rooms for consultations, a small pharmacy and a veranda, the clinic can only safely hold 40 people and eight staff at a time. "At one point there were so many people crowding onto the clinic we were really worried we would collapse into the water," says Pamela. "We had to stop everything and ask a group of people to leave and come back later."

With the clinic stabilised, the task of treating patients could begin. Many of those living on the Makoko lagoon are immigrants from neighbouring Benin. "Every year more people arrive here and they build on the lagoon because it is the only place they can settle," says Pamela. "In this area conditions are unsanitary. The river is very polluted. It's contaminated with human waste, animal waste, and every other type of waste."

Despite these difficulties, schools, shops, churches and a functioning community have been established. Healthcare, however, is virtually non-existent.

The new floating clinic is on one of the main waterways in the Makoko lagoon. The lagoon has shops, churches and schools but had little in the way of healthcare Photographs: © Silvia Fernàndez /MSF, 2010

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The cost of a medical drip

"People are coming to us with a whole range of conditions," says Pamela. "Infected wounds, malaria, respiratory tract infections, diarrhoea – everything." For serious emergency cases, there is a rapid referral service to larger clinics on land.

Sorting this out, however, was not straightforward. "First of all we had to work out what was the quickest exit off the lagoon, as there aren't many and it's like a maze out here," adds Pamela.

With the rapid exit route established, the team had to establish how they would get patients out. "It's just a boat with an engine, but we like to call it our ambulance," she says.

Maternal healthcare has been a particular focus for the clinic. Nigeria has one of the world's highest maternal mortality rates, as even women with difficult pregnancies usually give birth at home due to the high cost or unavailability of medical treatment. Out here on the lagoon, those problems are magnified.

"I have pregnant women turning up who are eight or even nine months pregnant and they have never had any antenatal care," says Pamela. "Many of them have lived on the water their whole life and come to us with urinary tract infections, malaria and other complications. It's great to be able to help them."

She laughs. "We haven't had a birth on the clinic yet. But it's coming. I can feel it."

Working in such a unique urban environment has thrown up new challenges for MSF. But with the majority of the world's population now residing in cities, innovative projects like the floating clinic in Lagos are an increasingly important part of MSF's work.

For the MSF team, it has meant forging a close relationship with the local community. "The first contacts we made on the lagoon were with the traditional leaders," says Manfred Murillo, the field logistician for the project. "It was the community that came up with the workers and it was the construction of the clinic that really helped us enter the community and be accepted.

'At first I was amazed that anyone could actually live here. But I soon became so impressed with the way people have adapted'
Pamela Bernard Sawyer, above

"The local crew were experts. They solidly lodged the wooden posts seven feet under ground and stabilised them with cross beams for a foundation. It's a simple structure, but it was amazing to see these guys work so skilfully in such difficult and wet conditions."

At the floating clinic, the day is drawing to a close and the team is loading up the boat ready to depart for dry land. A group of boys are kicking a ball to each other as they jump from boat to boat, oblivious of the water beneath them. This unstable, watery world is their natural environment, and they move as if on dry land.

"When I first came here, I was amazed that anybody could actually live here," says Pamela. "But I soon became so impressed with the way people have adapted. I really wanted to work somewhere where there was need, and as soon as I arrived here, I knew that this was the place.

"These people really need health services and MSF is providing those services." She looks around at the watery surroundings. "I'm glad we're here."

114 General consultations after two days of opening

20 years Estimated lifespan of the floating clinic structure

Key weapon in the fight against cholera

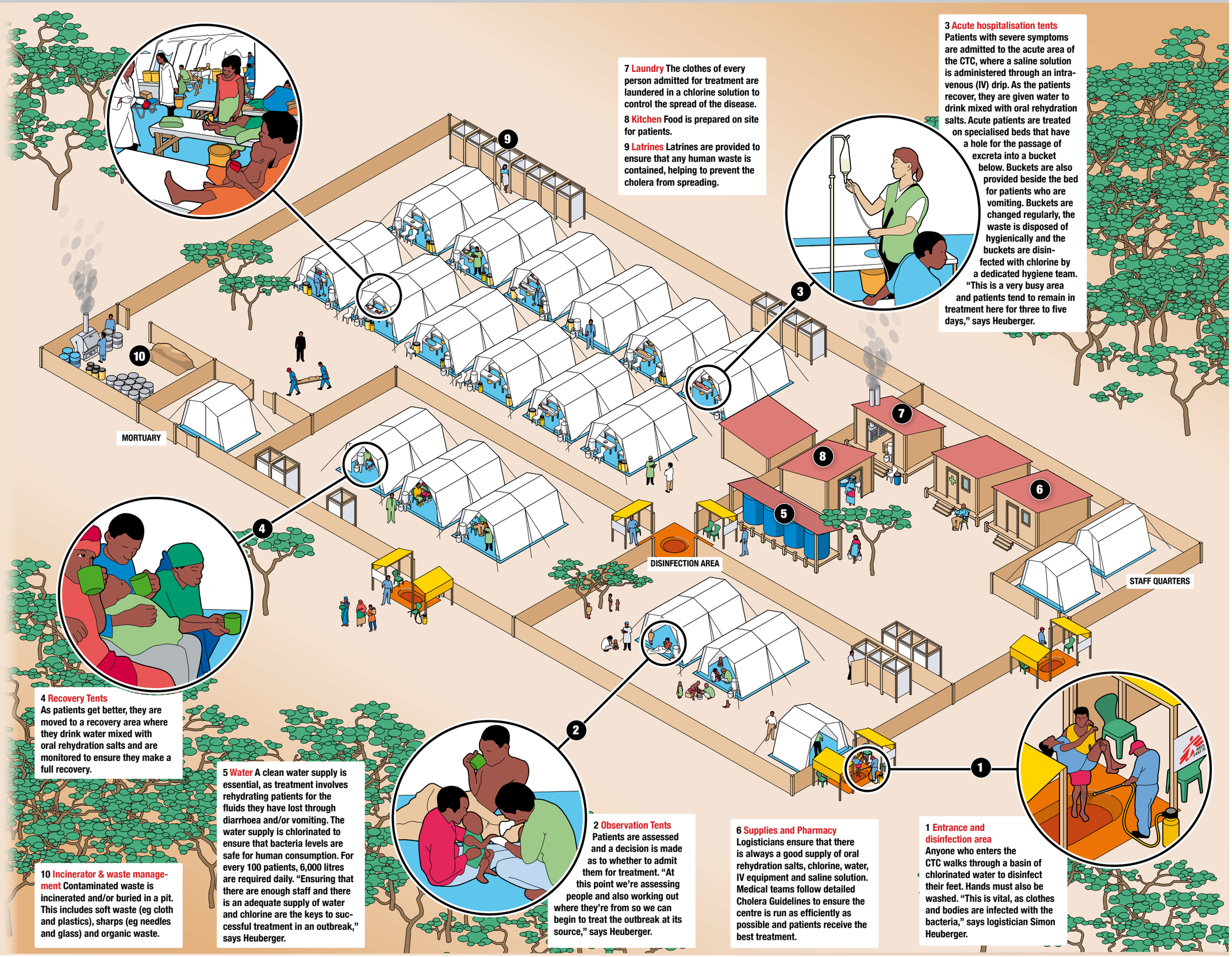
A Cholera Treatment Centre (CTC) is a specialised isolation ward designed to manage and treat cholera patients and prevent the spread of the disease. In cholera outbreaks around the world, MSF rapidly sets up these centres to combat and contain infection.

Treating cholera is a race against time. The onset of the disease is abrupt, with profuse diarrhoea and vomiting resulting in severe dehydration that can kill infected people within hours. Although it is an easily curable disease, it is vital that cases are detected and treated in a CTC as early as possible.

Treating cholera is a race against time

In the CTC, patients are given an oral rehydration solution that works to replace the massive amount of fluids and salts lost due to the disease. During this period, patients are isolated to prevent the further spread of infection.

In 2009, MSF treated 103,220 cholera cases around the world and in most outbreaks, was able to limit the fatality rate among patients to less than 1 percent. Since the cholera epidemic began in Haiti in late October 2010, MSF teams have treated more than 110,000 patients across the country.



7 Laundry The clothes of every person admitted for treatment are laundered in a chlorine solution to control the spread of the disease.

8 Kitchen Food is prepared on site for patients.

9 Latrines Latrines are provided to ensure that any human waste is contained, helping to prevent the cholera from spreading.

3 Acute hospitalisation tents Patients with severe symptoms are admitted to the acute area of the CTC, where a saline solution is administered through an intravenous (IV) drip. As the patients recover, they are given water to drink mixed with oral rehydration salts. Acute patients are treated on specialised beds that have a hole for the passage of excreta into a bucket below. Buckets are also provided beside the bed for patients who are vomiting. Buckets are changed regularly, the waste is disposed of hygienically and the buckets are disinfected with chlorine by a dedicated hygiene team. "This is a very busy area and patients tend to remain in treatment here for three to five days," says Heuberger.

4 Recovery Tents As patients get better, they are moved to a recovery area where they drink water mixed with oral rehydration salts and are monitored to ensure they make a full recovery.

10 Incinerator & waste management Contaminated waste is incinerated and/or buried in a pit. This includes soft waste (eg cloth and plastics), sharps (eg needles and glass) and organic waste.

5 Water A clean water supply is essential, as treatment involves rehydrating patients for the fluids they have lost through diarrhoea and/or vomiting. The water supply is chlorinated to ensure that bacteria levels are safe for human consumption. For every 100 patients, 6,000 litres are required daily. "Ensuring that there are enough staff and there is an adequate supply of water and chlorine are the keys to successful treatment in an outbreak," says Heuberger.

2 Observation Tents Patients are assessed and a decision is made as to whether to admit them for treatment. "At this point we're assessing people and also working out where they're from so we can begin to treat the outbreak at its source," says Heuberger.

6 Supplies and Pharmacy Logisticians ensure that there is always a good supply of oral rehydration salts, chlorine, water, IV equipment and saline solution. Medical teams follow detailed Cholera Guidelines to ensure the centre is run as efficiently as possible and patients receive the best treatment.

1 Entrance and disinfection area Anyone who enters the CTC walks through a basin of chlorinated water to disinfect their feet. Hands must also be washed. "This is vital, as clothes and bodies are infected with the bacteria," says logistician Simon Heuberger.

Watch videos of the Gaza clinic at msf.org.uk/gaza

New hope for children caught in the crossfire

Marcus Dunk visits an MSF clinic in Gaza City to see how the team there treat the mental and physical problems of children scarred by violence

On 13 May last year, six-year-old Mohammed was in the kitchen of his home in Gaza City. In the semi-darkness of yet another power cut, Mohammed's mother was kneeling to light a kerosene stove. Mohammed was next to her, holding a candle to help his mother see better.

When hot candle wax dripped onto his hand, he dropped the candle on the stove. It burst into flames and, within seconds, the whole kitchen was ablaze. The flames engulfed Mohammed, who suffered third-degree burns to 73 percent of his body, along with extensive inhalation burns. His injuries were so severe that doctors held out little hope for his survival at first.

Six months on, and Mohammed is now running up the steps of the MSF clinic in Gaza City. Bounding into the reception area, he's quickly surrounded by staff joking with him. A smile breaks out across his face. Despite the horrific scarring that covers much of his face and body, it's clear that this is a little boy with energy to spare.

"Mohammed's father told me last week that his son loves coming to the clinic," says MSF's Dr Rami Al Madhoun. "He has a real bond with the staff and he feels normal here. We make him feel comfortable."

Making Mohammed comfortable, physically and mentally, is a treatment priority for the staff at the clinic, many of whom have become used to attending to burns victims over the past two years. Due to the Israeli embargo, as well as to inter-Palestinian disagreements, lack of fuel has curtailed production at Gaza's only electric power plant, bringing daily power cuts that last from eight to twelve hours. The people of Gaza rely on generators, black-market gas cylinders, oil lamps and candles – all sources of serious accidents and burns.

Mohammed was luckier than many burns patients in Gaza. Due to the severity of his injuries, he was given permission to cross the heavily fortified border from Gaza into Israel to be treated by specialists at an Israeli hospital for three months. But after that, nobody – including the Palestinian Authority – was willing or able to continue paying for his $1,000-a-day treatment, so he was forced to return to Gaza. It was on his return that his father found out about the free services offered by MSF.

On a hospital bed, Mohammed jokes with physiotherapist Ihmoud Hejji as he gently puts pressure on Mohammed's arms and legs in order to reduce scarring and enable freer movement. Their bond is obvious. For nearly 23 hours a day, Mohammed wears a translucent plastic face mask — created for him in the MSF workshop — in order to reduce his facial scarring. But while he is here, he can take it off, and his relief at this sudden freedom is obvious.

It's a short-lived freedom – within minutes Ihmoud is helping him to insert into his mouth a strange tube-like device with two balloons attached to it.

"Because of the scarring and burns damage around his face and mouth he has been having trouble eating and talking," says Dr Mohammed Abu Alqumboz. "His mouth just isn't stretching wide enough. We don't have access to the latest equipment here, so we improvised and came up with this device. We insert the tubes and the balloons into his mouth and gradually inflate the balloons so they fill his cheeks. This will help expand the scar tissue and will help him when he eats and when he talks and when he smiles and laughs. It seems to be working."

Gaza in numbers

1.6m

people live in the Gaza Strip, a 25-mile long tranche of land

24ft

Height of the security wall around Gaza's land border. An Israeli-imposed embargo in force since 2007 restricts the entry and exit of people and goods,resulting in shortages of specialist medical items and delays in treatment

25%

of the 1,200 monthly requests to the authorities for permission to leave Gaza for specialist medical treatment are refused by the authorities or are granted too late

287

surgical consultations by MSF's new reconstructive surgery programme since August last year

Galep with the MSF psychologist Deborah Franco

Freed from the mask he has to wear for 23 hours a day to reduce scarring, Mohammed jokes with his physiotherapist Ihmoud Hejji Photographs: © Marcus Dunk/MSF, 2010

As Mohammed's cheeks inflate, Ihmoud passes him a red clown nose to put on, and Mohammed makes faces at us all.

Although he is all smiles today, the trauma has left its mark: Mohammed's parents say that he is anxious and aggressive to the point that they have withdrawn him from school.

While much of this can be attributed to his accident, Mohammed has also been shaped by the conflicts around him. The Israeli military offensive of 2008-9 and inter-Palestinian clashes have had a devastating impact on the psychological wellbeing of Gaza's children. Chronic bedwetting, anxiety and aggression are now endemic.

That is why, alongside the rehabilitation and post-operative care provided by MSF, psychologists also offer mental health support. In 2009, more than 70 percent of psychotherapy sessions conducted were with children.

"From a very early age, children in Gaza are exposed to violence, to death – the death of family, friends, people they love," says MSF psychologist Manuel Francisco Morantes. "Here, guns, shells, bombs, air raids and artillery fire don't just belong to the virtual world of video games. They're real and many children become their victims."

Across the road from the clinic, Mohammed is with clinical psychologist Jasser Salah. Due to the age of the patients, psychotherapy sessions with these children often take the form of drawing. Today, Mohammed is working on a picture of a fire. "This gives him a way to act out his feelings and to release some of the tension he feels," says Jasser. "He's had four sessions and we've already begun to see some behavioural improvements.

"It's short-term therapy. We can't do much about the difficult environment, but we can help them cope with what they're experiencing."

At the end of the session, Mohammed is keen to come over and shake my hand. "My one hope is that my son will recover," his father says. We both look down at Mohammed. He is still smiling.

'His father told me Mohammed loves coming to the clinic. He has a real bond with the staff and he feels normal here. We make him feel comfortable'

GALEP'S STORY

Galep, seven, suffers from recurring nightmares, insomnia and anxiety. His family home, close to a hospital and police station in Gaza City, was in the middle of the shelling during the Israeli 'Cast Lead' military offensive of 2008-09. He has also witnessed inter-Palestinian clashes and shootings.

"In the first session I had with Galep, his body was shaking, he couldn't focus on what he was doing," says MSF psychologist Deborah Franco. "He wouldn't utter a single word."

However, watching him today is to see a child slowly opening up. His drawing revolves around his recurring nightmare about a snake that is coming to eat him and his family.

But with the help of Deborah, he can draw and talk his way through the story and even construct a plan to kill the snake. At the end of the session, he smiles, puts his school backpack on and bounces out of the room into the sunshine of the Gaza street.

"He's made a big step today," Deborah smiles. "Even though he's still having bad dreams, he was able to draw and talk about it and even make a plan to deal with it. So if he dreams about the snake tomorrow, hopefully he'll remember his plan and he'll be able to go back to sleep. It's a way of helping him cope."

For Deborah, the work is difficult, but rewarding. "I'm so impressed by the children I've met here," she says. "When you hear what some of them have seen and lived through, it tears you apart. They should be playing with dolls and having fun, not dealing with these hard things. But they are resilient."

Number of psychological consultations in Gaza in 2010 **3,387**

33,036 Number of physiotherapy sessions in 2010

Read more at msf.org.uk

‘Such beautiful people deserve our very best’

Dr Ben Gupta is an anaesthetist working in Papua New Guinea’s Southern Highlands

Christmas Day 2010 will be one I’ll never forget.

I’d been invited to attend a traditional feast called a ‘mumu’ and, walking along the path towards the meeting area, I was struck once again by how beautiful this area is. Everywhere I looked, lush green hills were framed against a clear, blue sky. The sun was shining and the noise of exotic-sounding birds echoed around the valley. I’d been working as an anaesthetist for MSF here in the Southern Highlands of Papua New Guinea for five months already, but the scenery still had the power to leave me breathless. Think of the word ‘paradise’ and you’d probably picture a landscape something like this.

The mumu only added to this sense of well-being. Villagers from miles around Tari had turned out to celebrate, and we watched in amazement as 107 huge pigs were slaughtered and then cooked in a giant, narrow pit that stretched as long as a football pitch. There was dancing and celebration and, as we laughed and chatted, I felt it was a privilege to share in this experience with the local community.

Unfortunately, this wouldn’t turn out to be the most memorable aspect of the day. As I got back to the hospital around midday, Max, the MSF surgeon, came out to meet me with a grim look on his face.

“Sorry mate, we’ve got to go to theatre now,” he said. “A woman’s just been brought in. She’s been chopped.”

My heart sank. In the local Pidgin English, ‘chopped’ means attacked with a machete. I rushed inside and got changed.

Back in the UK, these sorts of injuries would be encountered only a few times throughout a career, if at all. But here in Papua New Guinea, they’re a daily occurrence. What’s just as shocking as the injuries themselves is the banality of the incidents that lead to them. Minor disputes about money, petty arguments and disagreements all too often lead to extreme violence. Between September 2009 and September 2010, 5,500 of the medical consultations MSF conducted in Tari were related to violence.

Hand in hand with this is the high incidence of sexual violence, particularly against women. According to the Papua New Guinea Law Reform Commission, 70 percent of women have been physically abused by their husbands; in some parts of the country the number reaches 100 percent.

Even after five months, dealing with the repercussions of this violence on a daily basis never felt normal. It had, however, become depressingly familiar. As I scrubbed up, I wondered how such extreme and endemic violence could exist in such an idyllic landscape, populated by such friendly, open people.

Lucy, one of the local theatre nurses, was attending to the woman as she lay quietly on one of the beds outside theatre. She had already applied pressure dressings to the woman’s arms and head and was talking to her gently. Despite all the bandages, I felt positive when I saw her. She was alert and answering questions from Lucy, a sign that she probably hadn’t lost too much blood. She also didn’t have any facial injuries that would leave her with permanent disfigurement. We took her through to the operating theatre and I put a local anaesthetic block in to numb her arm. While we waited for her arm to go numb, Lucy cleaned her head-wound and chatted to her in Huli, the local tribal language. She told us her story.

Patients in the triage area at Tari Hospital, in the Southern Highlands region of Papua New Guinea. Below, a survivor of family violence receives care from MSF Nurse Anita Gole Photographs: © Fiona Morris/MSF, 2010

‘There are no quick solutions or easy fixes for trauma like that’

It turns out she had been arguing with her brother about money when, without warning, he had taken a machete to her head and arms. Here was another example of people using extraordinarily violent means to resolve conflict. It was sudden. It was disproportionate. It was completely and utterly inexplicable.

The surgeon, Max, began removing the bandages from her numb arm while Lucy continued to translate. Suddenly he stopped what he was doing. I looked over and saw that, underneath the bandage, the woman’s hand was almost completely amputated, barely hanging on by a tiny strip of skin. There was a split second of silence before Max gently explained to the woman that her hand could not be saved. We then got on with the job of repairing what was left of her forearm. It took us a few hours, but we managed to repair much of the damage and tidy up some of the mess the machete had made. After the woman had been wheeled away to the ward, we cleaned up and left the theatre in silence. None of us felt like talking.

Over the next few days, however, we did begin to talk; not only about some of the patients we’d seen and the violence that seems to bubble away beneath the surface of everything here, but why it was happening. Theories were bandied about, explanations presented, but none of us could work out a reason for it. Months later, I’m still no nearer an explanation. But what I do know is that if MSF wasn’t in Tari providing emergency surgical care, then a lot of people who had been attacked, wounded and maimed in this area over the last few years would almost certainly have died.

People like the 16-year-old girl who collapsed outside the hospital with a ruptured spleen as a result of a beating from a member of her family. A half-hour longer and she would have died. But we rushed her to theatre for an emergency splenectomy and she made a full recovery.

People like the woman who had been ‘chopped’ in the face, leaving a hole in a major artery. After multiple trips to theatre and many blood transfusions, she also survived. As did the girl whose brother tried to chop her head off and the boy who was shot in the abdomen during a tribal fight and the baby that had been mauled by a wild pig. All these patients, and many more whose lives and limbs were saved, are still here because of the work that MSF is doing in Papua New Guinea. Their faces will stay with me for the rest of my life. Christmas and New Year came and went and, as the weeks went by, I saw more and more of the woman who had been attacked. Despite the horrific nature of her injuries, it was gratifying to see her slowly but surely making a full recovery. With the help of the professional psychological support provided by MSF, she also began to interact more with staff and even occasionally to smile.

Of course the real challenge for her will be when she leaves our hospital and has to learn to live not only with her disability, but also with the psychological impact of the attack.

There are no quick solutions or easy fixes for trauma like that, just as there aren’t any for a society where violence has become such an accepted part of daily life. But I hope that by being there, by providing much-needed medical care and by setting an example, we are helping to make a real difference here. Such a beautiful country and such beautiful people deserve the best we can give.

£418

Buys equipment and medicines for 100 operations

PAPUA NEW GUINEA

Number of psychological consultations given to survivors of violence in PNG in 2010 **572**

6,700 Survivors of family and sexual violence in PNG who have been treated by MSF since 2007

EPIC WALK

Nurse in 2,000-mile trek to raise funds for MSF

Intensive care nurse, Andy Dennis, is walking from Amsterdam to Barcelona to raise funds for MSF. Andy, who currently works at Harrogate District Hospital, expects to take six months to cover the 2,000-mile distance between the cities.

"I first worked for MSF in a displaced persons camp in northern Uganda in 2005," says Andy. "Three years later, I helped set up health clinics in south Sudan. Both missions were assisting populations terrorised by rebel group, the Lord's Resistance Army.

"My time with MSF has been an inspiration to me. I have seen how many people are denied access to medical care and I have seen MSF enhance people's lives by caring when no-one else does."

Andy is hoping to raise a total of £16,800, all of which will go to MSF. To follow his walk and donate via his project go to **www.walka2b.co.uk**

TB

New TB testing device to revolutionise treatments

A new TB testing device that can deliver fast and accurate results has been welcomed as a major step forward in fighting the disease.

"This will revolutionise TB treatment, " says Dr Eric Goemaere, MSF medical coordinator in South Africa. "We used to have to send patient samples to major hospitals and then wait six to eight weeks for an answer. For many patients that's too little, too late. This test will help save lives."

This molecular test uses a machine the size of a large backpack, which means it is ideal for use in remote locations. A sample of the patient's sputum is put onto a cartridge and slotted into the machine. Two hours later it produces a read out of the result. The new test makes it possible for people who live in remote and rural areas to start treatment immediately instead of waiting weeks for their results to be sent to city laboratories.

The Xpert MTB/RIF test, which is based on DNA analysis, has been trialled in MSF's Khayelitsha project in South Africa for over a year, and MSF plans to use the test in at least 19 other projects.

Andy Dennis in northern Uganda Photograph: © Andy Dennis

We rely on private contributions to supply our teams with the medicines, equipment and instruments they need to save lives. Thank you for your support

MSF UK VOLUNTEERS

Afghanistan Sophie Sabatier *Project coordinator*
Bangladesh Anna Kent *Nurse/midwife;* Imogen Eastwood *Nurse;* Sarah Boehm *Doctor*
Central African Republic Andrew Mews *Head of mission;* Georgia Seiti *Midwife;* Elaine Badrian *Nurse;* Niamh Ryan *Nurse;* Eve Mackinnon *Water and sanitation expert;* Eleanor Gray *HR coordinator;* Mark Blackford *Financial coordinator;* Matthew Health *Logistician;* Jane-Ann McKenna *Project coordinator;* Anna Carole Vareil *Administrator*
Chad Kathryn Johnstone *HR coordinator;* Emily Russell *Project coordinator;* Matteo Weindelmayer *Logistician;* Nichola Raper *Logistician;* John Morris *Doctor*
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Democratic Republic of Congo Anna Halford *Project coordinator;* Aileen Ni Chaoilte *Nurse;* Robin Meldrum *Communications officer;* Sam Perkins *Midwife;* Benjamin Caulfield *Water & sanitation expert;* Kathryn Richardson *Doctor;* Sonya Burke *Administrator;* Hosanna Fox *Logistician;* Orla Condren *Nurse;* Philippa Letchworth *Doctor*
Djibouti Mireia Coll Cuenca *Nurse*
Egypt Mario Stephan *Head of mission*
Ethiopia Elisa Cerrato *Health promoter;* Gillian Onions *Nurse;* Laura Todd *Doctor;* Elisabeth Westaway *Nutritionist;* Fiona Fisher *Doctor;* Frances Powell *Gynaecologist*
Haiti Carme Abello *Logistician;* Adam Younis *Water & sanitation expert;* Angelica Orjuela *Logistician;* Declan Overton *Logistician;* Rachael Craven *Anaesthetist;* Angeline Wee *Doctor;* Thibaut Mills *HR coordinator;* Mya Hornsby *Financial coordinator;* Danielle Ferris *Field coordinator;* Conor Prenderville *Logistician;* John Gray *Logistical coordinator;* Megan Craven *Medical team leader*
India Carolyn Lomas *Doctor;* Liza Harding *Project coordinator;* Kit Tranmer *Doctor*
Iraq Daniel Williamson *Project coordinator*
Kyrgyzstan Duncan Bell *Deputy head of mission;* Elizabeth Bell *Doctor*
Malawi Emma Diggle *Epidemiologist*
Myanmar Wai Ching Loke *Doctor;* Thomas How *Project coordinator;* Christopher Peskett *Nurse;* Mairi Macleod *Logistician;* Pawan Donaldson *Project coordinator*
Niger Claudia Garcia Diaz *Administrator*
Nigeria Natalie Thurtle *Doctor;* Catriona Carmichael *Field coordinator;* Sanjay Joshi *Logistician;* Christopher Houston *Logistician;* Gemma Davies *Deputy head of mission;* Alyson Froud *Medical coordinator;* Craig Bennett *Field coordinator;* Laura Smith *Financial coordinator*
Pakistan Matthew Lowing *Logistician;* Ailsa Stott *Medical Doctor;* Bree Cant *Midwife;* Catherine Sutherland *Doctor;* Simon Tyler *Field coordinator*
Papua New Guinea Jacqueline Ryan *Medical team leader;* Bryn Button *Logistician;* Emma Rugless *Nurse*
Russia Jonathan Heffer *Head of mission*
Somalia Joan Hargan *Nurse*
Somaliland Georgina Brown *Midwife;* Peter Camp *Logistician;* Harriet Rees-Forman *Midwife;* Donna Love *Nurse*
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South Korea Kiran Jobanputra *Doctor*
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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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CAN WE HELP?

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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