Dispatches

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No. 94

Ebola epidemic

Time for a new approach

SEE PAGE 5

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Contents

Front cover: An MSF health worker adjusts his goggles before entering the high-risk zone of an Ebola centre in Bunia, DRC. Photograph © Pablo Garrigos/MSF

REGULARS

FEATURES

Médecins Sans Frontières/Doctors Without Borders (MSF) is a leading independent humanitarian organisation for emergency medical aid. In more than 70 countries worldwide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion, gender or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

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Dispatches is written by MSF staff and sent out quarterly to our supporters to keep you informed about our medical work around the world, all of which is funded by you. Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. It is edited by Marcus Dunk. It costs £0.71 to produce, package and send using the cheapest form of post. It is an important source of income for MSF and raises three times what it costs to produce. We always welcome your feedback. Please contact us using the methods listed, or email: **dispatches.uk@london.msf.org**

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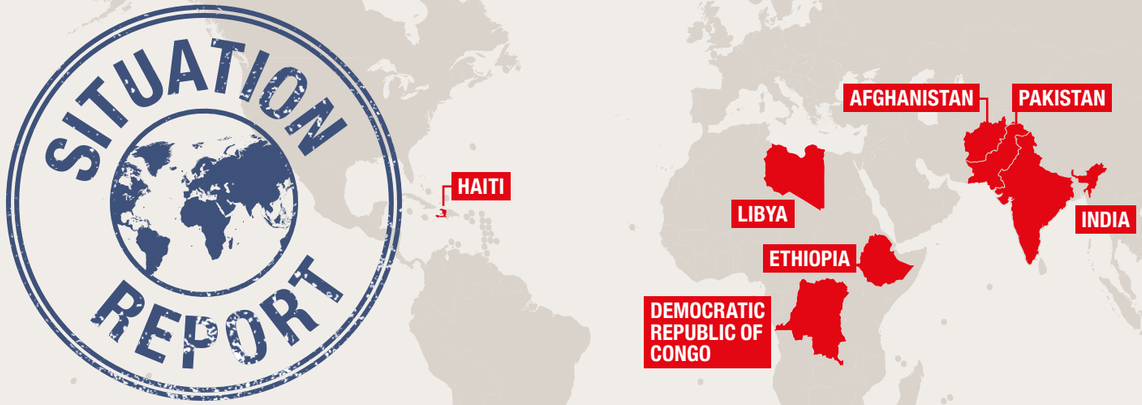


How MSF fights measles

In 2018, MSF vaccinated 1,479,800 people against measles in response to outbreaks. This is a huge figure, but the number of measles cases continues to increase.

The World Health Organization estimates that measles cases in Africa have risen 700 per cent since last year. MSF teams are currently fighting the disease in Democratic Republic of Congo (DRC), Niger, Nigeria, Chad and Yemen. However, responding to an epidemic is a race against time.

THE BASICS

“Measles is a viral disease that affects young children,” says MSF advisor Charlotte Nouette-Delorme. “If complications occur, it can be fatal. In developing countries, when measles is combined with malnutrition or malaria, its effects can be devastating.

But thanks to a safe, cheap and effective vaccine, measles is now a preventable disease. As a result, measles-related deaths have decreased by 84 per cent since 2000.

For the vaccine to protect a group of children, more than 90 per cent of them need to be vaccinated. This requires extensive, regular vaccination campaigns to avoid creating pools of unvaccinated children.”

SO WHAT’S THE PROBLEM?

“The problem is that this percentage is rarely reached,” says Charlotte. “It requires people’s support, which we know is declining in western countries, where some parents are refusing to have their children vaccinated. It also requires an effective vaccination campaign, and in the countries where we operate this isn’t always possible.”

In DRC, MSF teams contend with recurring measles outbreaks.

During the first five months of 2019, MSF teams vaccinated more than 360,000 children in DRC. However, in many parts of the country, the work is complicated by the large distances to be covered, a scattered population and the lack of medical facilities.

“To get the disease under control in these situations means making some fast, strategic decisions,” says Charlotte. “First, we have to rapidly establish which zones we’re going to vaccinate. Then we have to vaccinate the children who are most at risk. While doing this, we also need to treat the other diseases which aggravate the health of sick children.”

ADAPTABILITY IS KEY

“In Katanga, DRC, we have decided to vaccinate all children under five,” says Anne-Marie Pegg, MSF’s head of clinical epidemic response.

“This is the age group most affected by measles and vulnerable to complications. We are providing care not only to children with measles, but also to those who are malnourished or infected with malaria.”

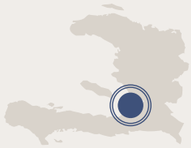
Adaptability is key in the fight against measles. “It’s vital to understand why the disease keeps coming back in certain areas,” says Charlotte. “The teams in Katanga have adapted their response to what they learned during the previous epidemic. Setting up early warning systems will also help them identify at-risk communities sooner, so they are not constantly chasing after recurring epidemics.”

msf.org.uk/measles

Above: Ingiya and three of her children arrive by bike at Pisa vaccination centre, Democratic Republic of Congo. Photograph © Joas Djekorkeme/MSF

HAITI

Health in danger as crisis worsens



Left: A protester blocks a street with burning tyres during a political demonstration in Port-au-Prince in June 2019. Photograph © Jeanty Junior Augustin/ MSF

Haiti is facing a major crisis as poverty, rising fuel prices and political scandals fuel a massive upsurge in violence.

The past year has seen a rise in violent demonstrations, coupled with a sharp rise in gun violence. In the first three months of 2019, MSF treated 237 patients for gunshot wounds at its emergency centre in Port-au-Prince's Martissant district – roughly twice as many as in the same period last year.

SURGE IN VIOLENCE

"Gun violence and street clashes are escalating," says Lindis Hurum, MSF head of mission in Haiti. "Barricades have been set up in the streets and on the main roads. Anger, fear and despair are palpable everywhere. The normally traffic-jammed streets of Port-au-Prince stand empty because people fear there could be an upsurge of violence at any moment. No one feels safe, including our medical teams, who have faced serious security incidents in recent days."

On 23 June, an MSF ambulance transporting a pregnant woman to hospital was stopped by a group of 20 armed men at a barricade. They threatened the team by pointing guns at their heads and forced them to turn back. On the same day, a patient leaving MSF's Martissant Centre was shot dead as he left the building, right outside the main entrance – a metal gate emblazoned with 'No Weapons'.

A FRAGILE HEALTH SITUATION

"The current crisis has further worsened the fragile health situation," says Hurum. "On one hand, you have a lack of doctors, drugs and essential supplies such as oxygen and electricity in public health facilities. On the other, you have an increase in patients who cannot afford to go to private hospitals. All the elements of a crisis are in sight."

MSF's Martissant Centre is one of just a few emergency rooms that function 24/7. The 26-bed centre provides lifesaving stabilisation and care to patients, free of charge, before transferring them to larger health facilities with advanced surgical capacity.

"We work day and night to save lives in a very stressful context," says Samira Loulidi, coordinator of the emergency centre. "When patients arrive, we stabilise them and give them first aid care, but we are not a hospital and we need a functioning referral system to assure more advanced medical care for polytrauma patients."

MSF is working to scale up its activities to respond to the crisis.

Photograph © Noor Ahmad Saleem/MSF

AFGHANISTAN

Dr Azada Barez examines a child in Kahdistan camp, Herat province, where 150,000 people are sheltering in desperate conditions after being forced from their homes by drought and conflict.

Photograph © Jan-Joseph Stok

INDIA

An MSF counsellor talks to Kim Kholling, who is being treated for multidrug-resistant tuberculosis at her home near Churachandpur, in Manipur state.

Photograph © Khaula Jamil

PAKISTAN

Two grandmothers celebrate the birth of their newest family member – a baby girl, the tenth child in her family, born with the help of MSF midwives at Dera Murad Jamali hospital in Baluchistan.

DEMOCRATIC REPUBLIC OF CONGO

Ebola epidemic

MSF operations director Isabelle Defourny answers three questions about Ebola in eastern Democratic Republic of Congo (DRC).

WHAT'S HAPPENING WITH THE EBOLA EPIDEMIC IN DRC?

"The Ebola epidemic is still not contained. More than 1,600 deaths have been reported since the outbreak was first declared. The end of April was the peak, with more than 120 cases a week. There are still a huge number of new cases – between 75 and 100 every week. In a context like this, it's extremely difficult to accurately track the epidemic's chains of transmission.

However, with the vaccines and experimental drugs available to us in 2019, we're now able to offer people the chance to protect themselves individually as well as to provide access to promising treatments."

HOW IS VACCINATION BEING CARRIED OUT?

"Right now, 'ring vaccination' is being used. This entails vaccinating everyone who has been in contact with someone infected with Ebola, as well as all of their contacts. The reasoning behind the method isn't bad *per se*, but it's time-consuming and challenging to implement – because identifying each person's individual contacts is problematic, and because it's not adapted to the insecurity affecting North Kivu. In addition, the number of people vaccinated is too small to contain the spread of the epidemic."

IS IT NECESSARY TO CHANGE STRATEGY IN ORDER TO CONTAIN THE EPIDEMIC?

"Absolutely. Until now, the main obstacle to implementing extended vaccinations has been the small stock of Merck vaccine – the only vaccine shown to be effective in an epidemic. According to the latest information from the World Health Organization, 600,000 Merck vaccine doses are now available. If this is the case, there's no longer any good reason for not stepping up vaccinations.

People in DRC understand the usefulness of vaccinations and, in fact, are asking to be immunised. However, with just 50 or so contacts vaccinated for each confirmed case of Ebola, it's likely that only one-quarter to one-third of those at risk are being protected from the virus.

DRC's stock of vaccines is extremely low, usually less than 1,000 doses. With only a sporadic supply of vaccines, and with problems tracing the contacts of Ebola victims, we're not yet able to say that this is an emergency response strategy.

While some people anticipate a rapid end to the epidemic, we see no signs to back up such predictions. Quite the contrary…"

msf.org.uk/ebola

Photograph © Pablo Garrigos/MSF

Photograph © Igor Barbero/MSF

ETHIOPIA

Hamisalech, 25, cares for her three-year-old son, Lominesh, who is recovering from malnutrition at the MSF-supported health centre in Banko Gotiti, in the Gedeo area of southern Ethiopia. Hamisalech fled her home in Guji after her village was attacked, and for the past year has lived in a camp for displaced people. Thousands of people have moved backwards and forwards between the Gedeo and Guji areas of southern Ethiopia since April 2018 following an outbreak of ethnic violence.

Photograph © Jérôme Tubiana/MSF

LIBYA

Refugees and migrants in Zintan detention centre, south of Tripoli, look out of the main gate. When an MSF team gained access to the centre in May, they found some 700 refugees and migrants locked in a hangar with just four toilets and no shower; the little water they had was unsuitable for drinking. In June, the detainees were moved to other buildings in the compound. MSF is providing medical care and food to people in detention centres and is working to improve water and sanitation. Between 5,000 and 6,000 refugees and migrants are being arbitrarily held in Libyan detention centres.

Sign our petition to end harmful detention policies in Libya: **stories.msf.org.uk/Libya**

‘I left my heart in Yemen’

Caroline Bwango is a London-based emergency doctor recently returned from MSF’s Mother and Child hospital near Taiz, southwest Yemen.

“I remember one young girl who was brought to us. She’d been out playing in the garden when she stepped on a landmine.

She arrived at the hospital with what we call ‘traumatic amputations’, which means that she’d lost limbs through the sheer force of the explosion. She was nine years old and she’d lost both of her legs.

Her family had rushed her to us. She was still awake and she was still breathing. It was our job to arrest the bleeding, restore her blood supply, stabilise her as best we could and keep her alive so that we could transfer her to MSF’s surgical hospital. We quickly assembled the team…

SAVING A GIRL’S LIFE

When the nine-year-old girl was brought to us, we had no warning. If we were in the UK, we’d have a pre-alert service, where the ambulance would call and say, ‘We’re coming in with such-and-such’ and we’d have time to gather the team, allocate roles and mentally prepare for what was about to happen.

But in Yemen, the ambulance system is barely functioning. People are picked up from the scene and loaded onto whatever transport is available – pick-up trucks, vans, private cars, motorbikes – and transported, sometimes for many hours, to us.

As a result, we’re always prepped and we’re always on alert. We know what our roles are and who is going to do what when a situation like this happens.

STAY CALM AND FOCUSED

There were six of us working on the girl. You start by quickly examining the patient from head to toe, checking airways, breathing and circulation, while others are working on the bleeding.

It’s always a frantic environment, but we stay calm and focused on what we’re doing. The girl was in great pain and was terrified, so we were also doing our best to soothe her and alleviate the pain.

Our job at this point is essentially damage control. We’re doing everything we can to stop the bleeding and to get her to the point where we can put her in a vehicle and rush her 20 minutes down the road for surgery.

“It’s always a frantic environment, but we stay calm and focused on what we’re doing.”

Top left: Emergency doctor Lupita Noria Garcia and her team at Al Salakhana hospital examine a patient injured in a road accident.

Middle right: MSF’s surgical team in Al Salakhana hospital peform a laparotomy on an 18-year-old man wounded in the abdomen by a stray bullet.

Far right: Helped by physiotherapist Farouk, 14-year-old Nasser learns to walk with crutches after his foot was blown off by a landmine.

All photographs © Agnes Varraine-Leca/MSF

I don’t know how long we worked on her, but we managed to stabilise her and get her to our surgical colleagues. They took care of her wounds and she survived. But she will live with a lifelong disability and faces a long road of rehabilitation. And all of this in a warzone.

A TERRIBLE INCIDENT

Landmines are violent and indiscriminate. There was one particularly terrible incident. Some children were out playing when they found a mine. They didn’t know what it was, so they picked it up and took it into the kitchen. Just as the parents were investigating what it was, it blew up and killed the entire family.

A CAMEL SAT ON ME

Amid all the suffering, there were moments when you’d catch yourself smiling. I remember one old man who hobbled into the hospital one day. When we asked him what was wrong, he told us that a camel had sat on him.

He’d been herding his camels down a hill and one of the camels had lost its footing and ended up sitting down backwards on him. He was a lovely guy in his 70s or 80s, proud to still be herding his camels. He seemed to think it was pretty funny as well.

1,019,679 emergency room patients treated by MSF in Yemen*

81,102 surgeries conducted by MSF in Yemen*

*March 2015 to December 2018

We patched him up and sent him on his way. I remember thinking, ‘That’s not something I’m ever likely to see in London…’

DOING MY BIT

I left my heart in Yemen. The patients that we treated and the Yemeni colleagues I worked with were amazing. Everybody you meet has been touched in some way by the war. But people get up and they keep going. Staff would have family members killed and would go to the funeral in the morning and then turn up to work the late shift afterwards. The dedication and the commitment of these people to serve their communities and to provide medical care was something to behold. It was humbling to work alongside them.

MSF is the only one providing free medical care in this area and each day was challenging and difficult. We had to make tough decisions and there were bad moments.

But I never once woke up in the morning thinking, ‘Oh no, I have to go to work’. Just being able to lend my support, do my bit and provide medical care to people who really needed it was a privilege.”

msf.org.uk/yemen

Cyclone Idai All Stars

When Cyclone Idai hit Mozambique in March, the coastal city of Beira was devastated. Homes, schools and health centres were destroyed, with almost 90 per cent of the city's buildings affected. Families were left homeless, without access to clean water or electricity. Worse was to come.

"We weren't expecting the cyclone. It has affected everyone; it destroyed almost everything."

Ten days after the cyclone struck, cholera broke out. People with cholera symptoms began making their way to Chingusura health centre, on the outskirts of the city, where an MSF team was assisting Ministry of Health staff. Within a day, the emergency room was full of cholera patients, with more arriving every hour. Something had to be done to reduce the risk of the disease spreading further.

MSF was tasked with setting up and running a cholera treatment centre where patients could be isolated and receive the medical care they needed. The first hurdle was finding a piece of land large enough for the series of medical tents that would make up the treatment centre.

"We heard that they were looking for land and our football pitch was suggested," says Silvia Emilio Augusto, also known by her football name of Tatiana. "We immediately said yes."

"A group of us got together and we walked from street to street to help clean up. We helped to put roofs back on the neighbours' houses."

As well as agreeing to let their football field be used, Tatiana rallied her team mates from the local women's football club, Cocoricoó, and together they pitched in to help MSF erect the field hospital tents that would form the basis of the cholera treatment centre.

Over the course of a hot day, the football team worked together to clear the ground, erect the tents and carry them into position, ready for the MSF team to disinfect them and fill them with beds and equipment.

Within a few days, the cholera treatment centre was fully operational and treating patients.

The generosity of the women's football team meant this vital cholera treatment service could be located just where it needed to be, and their efforts played a valuable part in bringing the outbreak under control.

Find out more

Watch the women's football team in action: msf.org.uk/allstars

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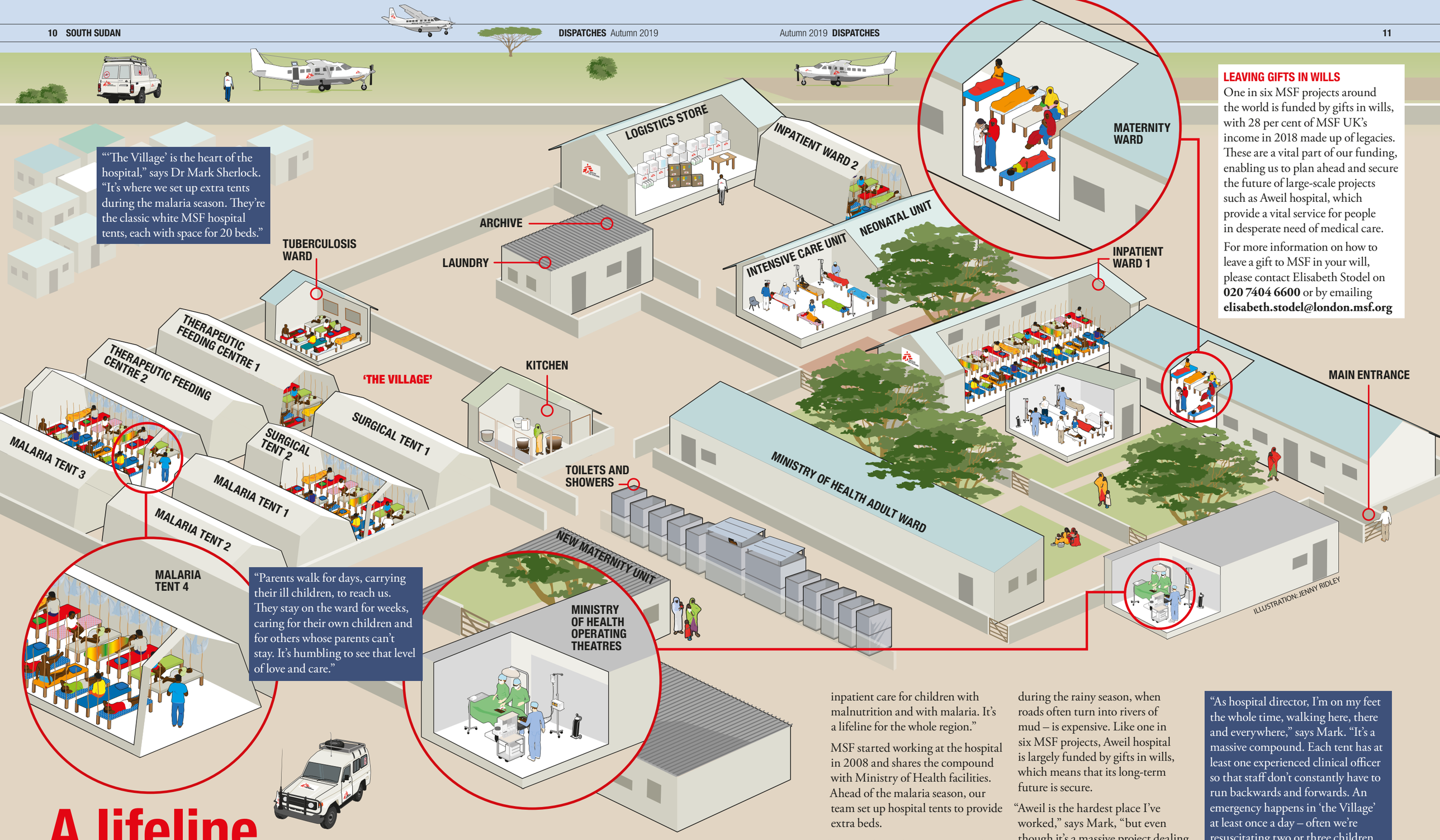

"'The Village' is the heart of the hospital," says Dr Mark Sherlock. "It's where we set up extra tents during the malaria season. They're the classic white MSF hospital tents, each with space for 20 beds."

"Parents walk for days, carrying their ill children, to reach us. They stay on the ward for weeks, caring for their own children and for others whose parents can't stay. It's humbling to see that level of love and care."

A lifeline in South Sudan

Aweil hospital in South Sudan is one of MSF's largest projects. Situated in the northeast of the country, the hospital is the only major health facility in the region and is the main provider of medical care for 1.5 million people.

"People literally walk for days to get here," says hospital director Dr Mark Sherlock. "It's the only place in the region providing proper surgery for children and safe deliveries for expectant mothers. It's also the only place providing inpatient care for children with malnutrition and with malaria. It's a lifeline for the whole region."

MSF started working at the hospital in 2008 and shares the compound with Ministry of Health facilities. Ahead of the malaria season, our team set up hospital tents to provide extra beds.

"During the malaria season we admit 120 to 200 patients every day," says Mark. "It's a huge influx and treating these patients is a huge undertaking. We usually hire an extra 100 to 200 staff members to cope."

Running such a large project – which can only be resupplied by air during the rainy season, when roads often turn into rivers of mud – is expensive. Like one in six MSF projects, Aweil hospital is largely funded by gifts in wills, which means that its long-term future is secure.

"Aweil is the hardest place I've worked," says Mark, "but even though it's a massive project dealing with overwhelming health needs, I quickly realised that by treating patients steadily, and by making small improvements to the way we run things day to day, we can have a big impact on people and their health."

"As hospital director, I'm on my feet the whole time, walking here, there and everywhere," says Mark. "It's a massive compound. Each tent has at least one experienced clinical officer so that staff don't constantly have to run backwards and forwards. An emergency happens in 'the Village' at least once a day – often we're resuscitating two or three children at the same time."

LEAVING GIFTS IN WILLS

One in six MSF projects around the world is funded by gifts in wills, with 28 per cent of MSF UK's income in 2018 made up of legacies. These are a vital part of our funding, enabling us to plan ahead and secure the future of large-scale projects such as Aweil hospital, which provide a vital service for people in desperate need of medical care.

For more information on how to leave a gift to MSF in your will, please contact Elisabeth Stodel on **020 7404 6600** or by emailing **elisabeth.stodel@london.msf.org**

Support us now at msf.org.uk

The backbone of MSF

Mårten Larsson is a Swedish paediatrician working at MSF's children's hospital in Maiduguri, Nigeria. Here he tells the story of Bukar, a dedicated Nigerian nurse who survived a violent attack and returned to treat his community.

"We don't do any major surgery that requires anaesthesia at MSF's paediatric hospital in Maiduguri. The children who require urgent surgical care are referred to the surgical unit at the teaching hospital in the city.

Nevertheless, we receive a lot of children with minor wounds, burns and skin infections, all needing minor surgical interventions that we do.

These patients are mainly treated by our excellent nurse aid Bukar, who specialises in wound dressings.

When I first arrived, I was impressed at how accurately he performed cleaning, disinfection, debridement, draining and suturing – also called stitching. This was all done with an impeccable 'aseptic technique', a process that helps prevent a wound from becoming contaminated.

BUKAR'S STORY

One day I asked him:

'How did you become this skilled with wound dressings?'

His eyes shone, and he started to tell his story…

'I have done this for three years now… It started when I worked in the emergency room and we received a lot of patients with burns and wounds.

I have learnt a lot from all the different doctors who have worked for MSF.

I always ask if there is something I can do differently to improve. That is how I learnt how important infection control is, and to dress with aseptic technique so as not to contaminate the wounds.

I also get a lot of practice. I do almost 1,000 dressings per year.'

'Wow, that's impressive,' I replied. 'How did you come to work for MSF?'

'Ah, it's a long story,' he said and smiled…

Above: MSF doctors check on a baby recovering from severe acute malnutrition in Maiduguri. Photograph © Ivan Muñoz/MSF

Right: Bukar hugs five-year-old Hafsat after removing the stitches from her forehead. Photograph © Mårten Larsson/MSF

VIOLENCE IN NGALA

'I come from a place 150 km from Maiduguri called Ngala,' began Bukar. 'I came here to study to become a nurse in 2013. After that, I returned home.

Then, in 2014, the conflict became drastically worse. An armed group came to my town and started to shoot at everything that moved. Men, women, children, chickens…

Everyone ran to avoid getting shot, but many didn't make it. It was horrible. I got separated from my family. Me and six others managed to escape and hiked for several days, always afraid of getting found by the armed men, but finally we reached Maiduguri.

Here, I was put in a camp for internally displaced people. It was a tough time. My family escaped over the border to Chad. My father died in Chad, but my mother and my brothers and sister have managed to move here. Now we have our own place.

CHOLERA OUTBREAK

One day in 2015, I was called by a doctor I knew from my studies who worked in a cholera hospital that MSF was running.

They had many severely dehydrated patients who needed intravenous rehydration. However, getting a cannula into their veins was very difficult.

The doctor knew from before that I am very skilled in this, so he asked me to come and help.

After two months, the manager of the hospital came and told me they thought I was working for the Ministry of Health, but they couldn't find me in their register.

I said that I didn't and that I was just there to help out.

The next day I had a meeting with the MSF project coordinator and signed my first temporary contract. I've worked for MSF ever since.'

'You are amazing, Bukar!' I told him.

AN INFECTION

Then one of the patients arrived.

A five-year-old girl, Hafsat, had fallen on a piece of metal and cut her forehead open. She had been sutured, but probably not with a clean technique because she arrived with an infection.

We removed the sutures, drained the pus and cleaned the wound, which healed and could be sutured again. Now she had returned to remove the stitches.

Bukar called me over. I thought he wanted me to review the scar, but he put a doll in my hand. I looked at him with a confused expression.

'I think you should give this to Hafsat,' he said and smiled.

I had been the one to inject the local anaesthetic the first time we cleaned her wound and she was not keen on me after that. I inspected the scar and, after confirming that it looked good, took the doll from my pocket.

The corners of her mouth almost reached to her ears as she broke into the biggest smile. Her eyes sparkled and her father laughed.

Bukar and I looked sideways at each other. These are the small things that really matter.

THE BACKBONE OF MSF

It is people like Bukar, who come from the community and work in the projects from start to end, who are the backbone of MSF. International staff like me come for short periods and contribute some expertise and guidance, but the real hard work is usually performed by people like Bukar.

Without devoted staff like him, MSF would not be the same."

MSF's UK volunteers

Afghanistan Daniel Crowell, *Water and sanitation expert*

Bangladesh Richard Maltman, *Logistics manager*; Kate Thompson, *Finance coordinator*; Mansur Abdulahi, *Water and sanitation expert*; Owen Bicknell, *Water and sanitation expert*; Jennifer Collins, *Nurse*

Burkina Faso Kate Nolan, *Head of mission*

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Uganda Julianna Smith, *Epidemiologist*

Uzbekistan Ffion Carlin, *Doctor*; Rebecca Roby, *Advocacy manager*; Gillian Fraser, *Doctor*

Venezuela Sunny La Valle, *Nurse*; Ana Teresa Saraiva Afonso, *Nurse*

Yemen Heather Barber-Dungavel, *Midwife*; Claire Kilbride, *Paediatrician*; Joan Hargan, *Medical advisor*

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A night on call in Nairobi

Medical emergencies can happen at any time of day or night. But in the Mathare and Eastleigh districts of the Kenyan capital Nairobi, poor security and few ambulances mean that people here struggle to reach medical care after the sun goes down.

To help fill the gap, staff at MSF's Lavender House clinic have set up two 24-hour toll-free hotlines with four ambulances on standby for immediate dispatch. This service is proving a lifeline for medical emergencies in eastern Nairobi, especially after dark.

6.45 PM

The night shift officially starts at 7 pm, but the clinic is already busy. Patient registers need to be filled, ambulances cleaned and re-stocked and caseloads tallied. A sense of relief mixes with expectation as watchmen, triage nurses, call centre team leaders, paramedics, ambulance drivers, clinical officers and counsellors huddle in each service area completing their handovers. The Lavender House clinic houses a 24-hour emergency room and a specialised sexual violence clinic.

7.28 PM

Team leader Ruth Symekher answers the phone. A man has just been struck by a speeding motorbike "down near the big roundabout" and is lying on the roadside, unresponsive. Zulu One heads east with its siren blaring, carving a path through the traffic. A crowd has gathered and several young men chat with ambulance driver Noah Imbugwa while the two paramedics administer tramadol and prepare a splint for the man's broken leg.

"We don't know what would have happened to him if you hadn't come," says one. When Noah tells them about MSF's free service, they plug the hotline number into their phones. The patient is eventually stabilised and ready for transfer to Mama Lucy Kibaki hospital's emergency room.

As Zulu One leaves 'Mama Lucy' just before 8.40 pm, Zulu Two and Three are driving in. It's been a busy start for everyone.

7.30 PM

A young woman calls the sexual assault hotline. Josphine Wanjoru, the community support assistant, answers the call. The woman is calling from the police station where she has just reported being raped. The attack involved a man she knew and trusted – a common theme among Lavender House patients. MSF supports another sexual violence service closer to the woman's location, so Josphine heads out with driver Joseph Omusi to take her there. She'll be counselled and medically checked by a trained nurse-counsellor, before being picked up by Josphine again and taken home. This outreach service is particularly valuable at night for survivors of sexual violence who might otherwise feel too unsafe to seek care.

9.40 PM

Driving through the heavily populated district of Mathare, it's easy to spot 'street families': children of all ages who have banded together to survive. They're highly vulnerable and are always received at Lavender House with an open door. The first to arrive tonight is a distressed young boy brought in by two friends, his clothes the same dirty brown from head to toe. He has been hit on the nose by a flying bottle and he writhes and cries out on the trauma room bed. Although nothing is broken, the team comfort him while he calms down.

Above MSF staff help a patient into one of four ambulances which are on standby around the clock for medical emergencies.
Photograph © Ahmed A Osman/MSF

Right An MSF team member carries her medical kit to a patient's home.
Photograph © Ahmed A Osman/MSF

Below: The team at Lavender House provide care to patients from some of Nairobi's most heavily populated areas.
Photograph © Ahmed A Osman/MSF

11.25 PM

Just before midnight, staff gather together to eat 'lunch'. Lavender House has just two 12-hour shifts per day, so that staff can safely travel in daylight, whether they're clocking on or off.

2.55 AM

In the courtyard, counsellor Zaina Ahmed is writing up notes for the two sexual violence cases she has dealt with so far.

3.27 AM

The night's first obstetric emergency is taking place in a nearby health centre, where a breech baby is causing trouble for her labouring mother. "By the time Zulu Two got there, both legs and the baby's bottom were out," says emergency medical technician Dennis Odour. "The mother kept pushing and was eventually able to deliver. The baby didn't make a sound at first but, to everyone's relief, she was soon crying."

5.35 AM

A young man staggers in with blood still flowing from a wound inflicted an hour before. He was in a fight at the casino, which ended with a bottle of beer being smashed over his head. "We see a cocktail of cases," says trauma nurse Isabella Jumba with a wry smile.

6.20 AM

Sunrise sees a critically-ill elderly woman being carried into the emergency room. Struggling with pneumonia, she lies limp on the bed as the trauma room staff prepare fluids, plus insulin for her diabetes. Her adult children hover worriedly. As a 'red case' – denoting the most critical patients – she'll be transferred for higher level care once she's been stabilised. She's the last patient seen in the night shift and, thankfully, the only red of the evening.

Find out more

Watch our YouTube series: **msf.org.uk/on-call**

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‘The love for your child is good’

How do you care for people’s mental health in the world’s largest refugee camp? MSF psychologist **Alison Fogg** shares her experience of treating Rohingya people inside the Kutupalong-Balukhali megacamp in southeast Bangladesh.

“Following Kamrul, one of the Bangladeshi mental health supervisors, I pause to catch my breath.

Men and boys pass me quickly, deftly negotiating the steep, bamboo-sided steps barefoot while balancing eight-foot bamboo poles on their shoulders, seemingly with ease in the 40-degree heat.

On either side of the narrow stairway, rows and rows of small makeshift plastic and bamboo tents cram the steep, muddy hillsides, providing little protection from the intense afternoon sun.

Reaching a ridge, we can see these precarious shelters spreading for miles in every direction. It feels even more overwhelming when you realise that each of the thousands of abodes represents a family of probably six to 10 people, each with their own story.

PLACE OF PEACE

It’s a daily privilege to work with the MSF team at Shanti Khana, or ‘place of peace’ – the name chosen for the mental health unit here – given the considerable emotional demands of the work.

Under the watchful eye of the senior clinicians, Sharif, Mofizul and Kamrul, the counsellors listen to story after story of trauma, multiple losses and ongoing fear and sadness.

THIS IS NOT YOUR FAULT

They support worried parents who bring in their children with an undiagnosed learning disability or autism, reassuring them: ‘No, this is not your fault or God’s punishment on you. Your care and love for your child is good.’

One of the happiest moments for the team is when they remove the chains binding some patients – often young men – when their concerned parents or siblings bring them in.

Living in flimsy and unlockable shelters, when their adult children are agitated and perhaps violent, relatives are often at a loss as to how to protect them from themselves and others.

I’ve seen how receiving a diagnosis – perhaps of psychosis or severe epilepsy – and appropriate medication, calms and stabilises a person. It provides the family with great relief and the patient with an opportunity for a new life.

OUR SHARED HUMANITY

Spending time in the project, the positive impact of the mental health team’s day-to-day efforts becomes clearly evident. Here, there is one particular Rohingya gentleman who is especially grateful for the care provided to his daughter by the team during an inpatient stay.

Above: Alison stops on a flight of steep, bamboo-sided steps in the Kutupalong-Balukhali megacamp.
Photograph © Alison Fogg/MSF

Following a suspected traumatic event, she starts to trust the counsellor who visits her bedside. She slowly begins to talk and eat again.

Her father visits the unit daily. One day, when his daughter’s progress is really becoming clear, he shows his gratitude by grasping me tightly around the waist in a side hug – I literally have to catch my breath at this point.

Standing in the patient waiting area, I am acutely conscious of the staff guidelines for culturally appropriate conduct, where women should under no circumstances have physical contact with men.

However, this is one of the many times my cultural assumptions are challenged, and a reminder, amid all the supposed differences, of our shared humanity.”

Find out more

Read more of Alison’s blog:
blogs.msf.org/bloggers/alison-fogg

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