DISPATCHES

Photograph © Markel Redondo

Fighting a measles epidemic

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Summer 2017
No 85

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

INSIDE

MEXICO

An MSF team member talks to a woman in Acapulco about the help on offer for survivors of sexual violence. The presence of drug cartels and organised crime has resulted in this Mexican city being rated as the third-most-violent in the world. Since 2014, MSF has been providing psychological services and care for survivors of sexual violence. ***msf.org.uk/mexico*** *Photograph © Cristopher Rogel Blanquet/MSF*

GUINEA

Guinea: Containing a measles epidemic

MSF has just completed a mass vaccination campaign against measles in Conakry. Ibrahim Dialo, MSF's country manager in Guinea, explains how the campaign unfolded.

"Over 10 days, 649,000 children aged between six months and 10 years were vaccinated. Supporting the Ministry of Health, we mobilised 126 teams to 164 vaccination sites throughout the capital, including on some small islands off the coast.

Since the measles epidemic was declared on 8 February 2017, 3,906 measles cases have been confirmed, resulting in 20 deaths. These deaths are made all the worse when you consider that measles can easily be prevented with a vaccine.

Routine vaccination is vital

Now the most important thing is to improve the routine vaccination programmes in Guinea. When routine vaccination programmes work well, there's no need for expensive, logistically difficult catch-up campaigns.

It requires strong backing from international partners, especially in Guinea, where the perennially weak health system is still reeling from the devastating Ebola epidemic."

msf.org.uk/guinea

Children queue up to be vaccinated against measles in the Matoto area of the Guinean capital Conakry. *Photograph © Markel Redondo*

IRAQ

Mosul, Iraq: The patients we receive are the 'lucky ones'

As the fighting intensifies in and around Mosul, Jonathan Whittall has been working in MSF's newly-opened field trauma hospital in a village south of the city.

"Every day we see the worst of the worst injuries inflicted by this war. There is a near constant flow of patients and every single one comes with horrific stories...

An entire family were killed, except for one survivor. A father and his son were trapped under the rubble of their house for days after an airstrike and have only now reached us for help.

A little boy arrived with a gunshot wound to the head. Another boy's father tells us his son was shot by a sniper and was treated at home for days before reaching our hospital paralysed.

Red cases

We are set up to deal with what we call 'red cases'. These are the patients who often need immediate lifesaving surgery in order to survive. Our two operating theatres are almost always busy operating on these cases. MSF teams in and around Mosul have received more than 2,000 patients in need of lifesaving care in the past two months.

Nothing but the clothes on their back

We are seeing every kind of war injury you can imagine – multiple gunshot wounds, blast injuries, severe burns. We are trying our best to deal with the medical effects of a high-intensity urban war unleashed on a trapped population.

Beyond the extent of their injuries, the state in which our patients arrive is also extremely disconcerting. Many have been living under siege, trapped for months. Many have not eaten in days and are afraid and bewildered.

They often arrive barefoot and covered in mud after having walked in the rain and darkness across frontlines with literally nothing but the clothes on their backs.

Most of the patients we receive were wounded when the frontline moved through their neighbourhoods.We have seen patients with suspected sniper wounds to the back of the head and patients injured in airstrikes.

Great teamwork

Our hospital is surrounded by destroyed homes. Everyone has lost someone in this war. However, the hospital has one of the best team dynamics I have ever experienced.

The team come from many different parts of Iraq and from across the globe. Everyone works around the clock and is always on call, ready to adapt and to find solutions so that we can continue to save lives. We are all extremely proud of the work that is being done here."

msf.org.uk/iraq

CENTRAL AFRICAN REPUBLIC

MSF gynaecologist Katherina Pechtor and her team at Castor maternity hospital carry out an emergency caesarean on a woman experiencing complications in labour in Bangui, Central African Republic. MSF's 80-bed maternity hospital is the largest in the country, with some 600 babies born there each month. The hospital offers safe deliveries, surgery, neonatology and family planning services. It is part of a drive by MSF to increase the healthcare available for pregnant women, new mothers and their babies in Bangui. **msf.org.uk/CAR**
Photograph © Borja Ruiz Rodriguez/MSF

SOUTH SUDAN

South Sudan: Flying clinic saves lives

Three years of fighting in South Sudan has forced millions to flee their homes and paralysed agriculture – leaving the country facing a food crisis. In March, photographer Siegfried Modola joined our team in South Sudan.

"We took off early in the morning on an MSF plane full of medical supplies and other equipment needed for our eight-day stay in the bush.

I was joined on the eight-seater plane by MSF doctor Pippa Pett and security focal point Georg Geyer, our team leader for this assignment. Our flight would take approximately two hours to reach Thaker, in Leer county, South Sudan.

Desolation

Our plane lands on a dusty, windy space of open bush. Thaker is a scene of desolation. At a distance are several *tukuls* (mud huts), but few people can be seen.

Just two weeks prior to our arrival, skirmishes had erupted here between different armed groups. The plane takes off – MSF has few planes operating within the country, so they run to a tight schedule.

Minutes after our arrival, we are told there is a woman with serious pregnancy complications inside a hut nearby. Pippa examines the woman. She has been in labour for two days, the baby is stuck, and she hasn't felt it move for more than 24 hours. "She needs to be transferred to our hospital in Bentui," says Pippa.

The plane that flew off moments before is called back by radio, and the woman is flown to MSF's hospital in Bentiu for emergency treatment. That evening, we receive wonderful news – the mother is alive and well, and the baby has been born.

'We eat waterlilies to stay alive'

The team sets up the outdoor mobile clinic. There is a queuing area, where patients are given a medical card. Children are weighed and checked for fever and signs of malnutrition. Then patients proceed to the consultation area, where they are sent for urine tests, malaria tests or directly to the dispensary to receive medicines.

A woman arrives with her baby daughter, who shows signs of severe malnutrition. The baby looks much younger than her real age. An old woman arrives – she walks slowly, supported by a relative. Some of the people I meet have come a long distance for the chance to receive medical treatment.

Nyasunday, aged 25, is a mother of four. "We are all struggling here," she says. "We have to hide all the time as we fear for our lives.

"My husband is in Juba and he's not able to return as the road isn't safe. He's not here to help and I struggle to take care of my children. We are lacking food and I worry a lot for the future. We often eat waterlilies to stay alive. This is not a good life for my children. I hope for a better tomorrow."

* Names have been changed

Read the rest of Siegfried's report: msf.org.uk/flyingclinic

Dr Philippa (left) and James* (right) tend to a sick woman at an outdoor mobile clinic in Thaker, in South Sudan's Leer county. *Photograph © Siegfried Modola*

Mapping a crisis

Seven years of fighting between government forces and Boko Haram in northern Nigeria have forced 2.5 million people to flee their homes. Malnutrition rates are on the rise, and across the Lake Chad region, over four million people don't have enough to eat. Mapping specialist Sarah St Arnaud describes how MSF is using mapping technology to get on top of the crisis.

'In December I headed out to Maiduguri, the capital city in Borno State, northeast Nigeria. I was there to set up a project using GIS (geographic information systems) technology, in order to monitor the alarming rates of malnutrition.

I'm a geographer and cartographer by trade, and am currently working as MSF's GIS specialist. This means I'm often sent out in an emergency to map areas and to help discover where the most vulnerable are. I started working with MSF during the 2014 Ebola epidemic where we were able to map the spread of the outbreak using this technology.

The 'hunger gap' looms

Malnutrition rates in northeast Nigeria are already high, but we know the situation will only get worse as we approach the 'hunger gap' – the season between harvests, when food becomes scarce. The conflict in the region between Boko Haram and the Nigerian Government has only worsened the crisis.

Crops have been destroyed, homes burnt to the ground, and people have been forced to flee to Maiduguri and other regions. During the height of the hunger gap last year, countless children lost their lives. MSF remains the only organisation providing aid and lifesaving medical care in many villages outside the capital.

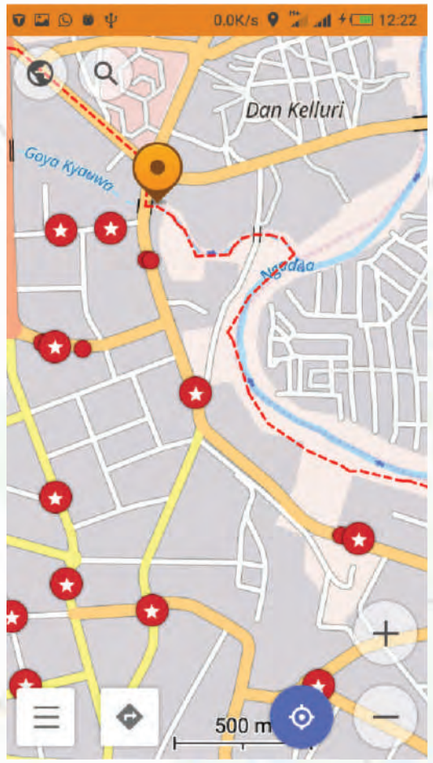
With the crisis looming once again, we have to be prepared. That's why this project was so important. In order to prevent more deaths, we needed to know where people were living, what their needs are, and who would be hit hardest as hunger levels rose.

There are more than one million displaced people living in Maiduguri in cramped and overcrowded conditions. Most of the refugees live scattered amongst the community – crowded together in compounds or houses with the local people, rather than in registered camps.

Door to door with a smartphone

So, how did we find these people? By going door to door and screening each household for malnutrition. It's a huge undertaking. We had 25 teams made up of two locally hired surveyors – one man and one woman. Every day, each team headed out to a different district of the city equipped with a smartphone, hospital referral forms, and MUAC (mid-upper arm circumference) bands which measure rates of malnutrition in children.

We use GIS mapping technology on the smartphones to monitor pockets of malnutrition and the areas where people are most vulnerable. The smartphone contains a digital assessment form and questionnaire. At every household we visit, we screen all children under 10 years old, and check babies for oedemas (the most severe form of malnutrition which causes a build-up of fluid in the body) and weight loss. We ask general questions about the household, how much food the family gets each week, if there is a steady income, as well as a section where we record the number of malnourished kids living there.



Sarah and an MSF team member consult a map of the local area. Both GPS and paper map reading were essential components of the team training. *Photograph © Sarah St Arnaud*

Each time we fill in the form on the smart phones, we also take down the GPS coordinates of the location. All forms are loaded onto the main server at the end of the day, where the data can be immediately analysed and mapped. Every night we can pull up the data in the form of a map and see where we need to distribute food. Food distribution is not something MSF usually does, but the crisis is so bad that we've scaled up our response significantly.

Building a village in the city

We also screen kids at schools and keep an eye on the price and availability of food at local markets. When people are not living in obvious refugee areas, it makes it much harder to find them and treat them. You'll have a wealthy area of the city and in the middle of it you'll have an empty compound with over 100 displaced people living there. The mapping project ensures that we can be proactive, find these people and prevent this malnutrition crisis from spiralling out of control.

It's amazing to see how resourceful people are. I remember one community I met who had rebuilt their village in the middle of the city, using grass and mud. They had arrived only four days previously, with just the clothes on their backs. They had decided not to separate from each other and go into the camps. So they spoke to the traditional leaders, took a vacant space and rebuilt their grass and mud huts all together. It was beautiful to see.

Laying the groundwork

"Before we could start the project, we spent three weeks 'base mapping' the city. This was a crucial part of the project. Most streets were already drawn, but we also needed to know the different divisions. We met with traditional leaders and explained what we were doing and why, and they showed us the boundaries of their areas. Each team would then map the district using smartphones and Google Maps. It was a bit like assembling different pieces of a puzzle. After the base mapping was finished, we could finally start the survey part of the project."

Above and below: Malnutrition assessment teams going door-to-door. *Photograph © Sarah St Arnaud*

We're ready

The teams did amazing work. They managed to screen around 1,100 households every day. At the end of my two months in the country, we had visited 34,790 households, and screened 73,746 children for malnutrition.

Now we have the data, the maps, as well as the hospital wards, the beds, the staff and the medication, we are prepared. When the hunger gap arrives, we will be able to respond immediately and save lives.'

LAKE CHAD EMERGENCY

More than four million people in the Lake Chad region are facing a malnutrition crisis. MSF is scaling up its work in the region to provide people with medical aid, including treatment for malnutrition. Find out more and give to our appeal at: **msf.org.uk/lakechad**

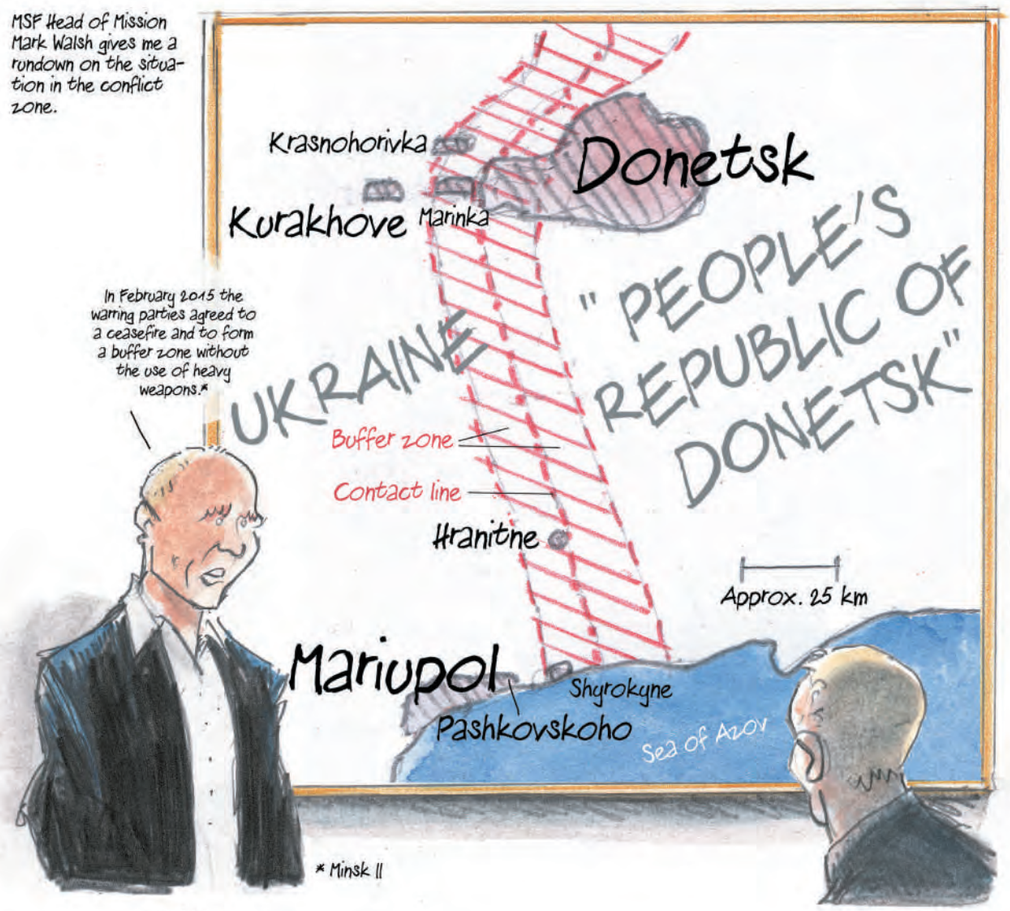
"Watching a malnourished child recover is like watching someone come back from the dead. When they arrive, they're so weak it's like their bodies and brains have shut down as they try to use as little energy as possible. But you give them antibiotics and you start some feeding and you slowly see their energy returning. They start sitting up, they start smiling, and then that natural playfulness that children have suddenly returns, and you can tickle them and they make faces at you. It's such a moving thing to witness. I'm so glad that MSF is here doing this work. You can see lives are being saved."

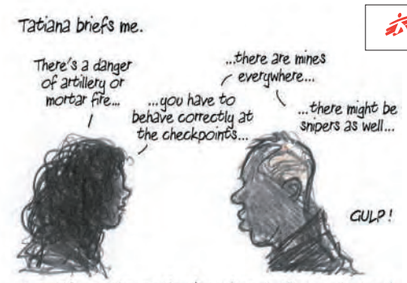
Dr Laura Heavey, MSF paediatrician

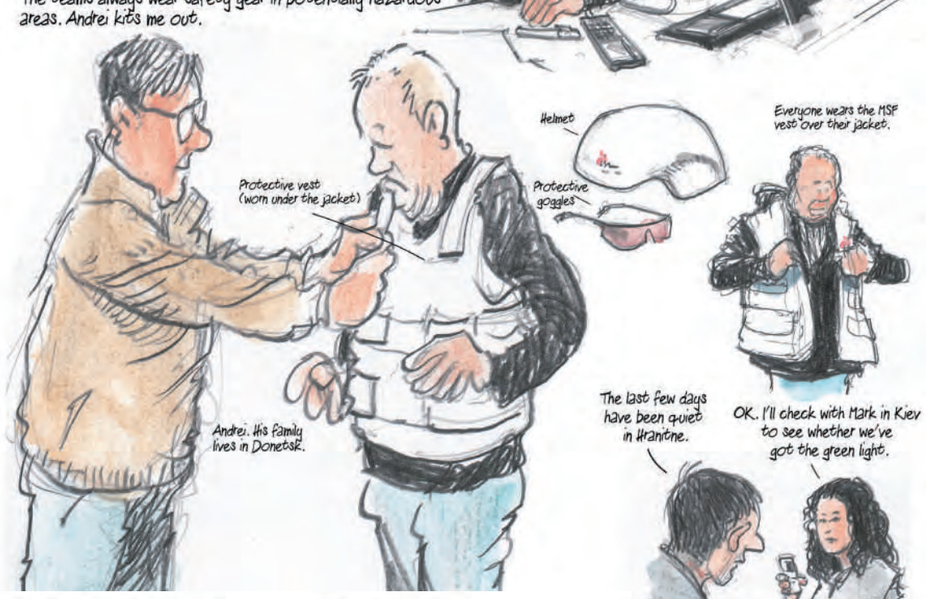
Illustrating conflict

The conflict in eastern Ukraine continues, taking a heavy toll on both sides. Political attempts to find a solution are making little progress, and those living along the frontline bear the brunt of the violence.

MSF runs mobile clinics along the frontline, providing psychological and medical support to people living in the areas controlled by the Ukrainian government. In February 2017, Swiss cartoonist Felix Schaad travelled with MSF to eastern Ukraine to document our work.







Find out what happens next at msf.org.uk/ukraine

Surgery in a civil war

Hella and her team perform surgery on an injured patient in the operating theatre of Khameer hospital, northern Yemen. *Photograph © Hella Hultin*

Hella Hultin is a Swedish surgeon working in Khameer, Yemen, where a civil war has been raging for more than two years. Here she describes her team's fight to save the life of a three-year-old girl.

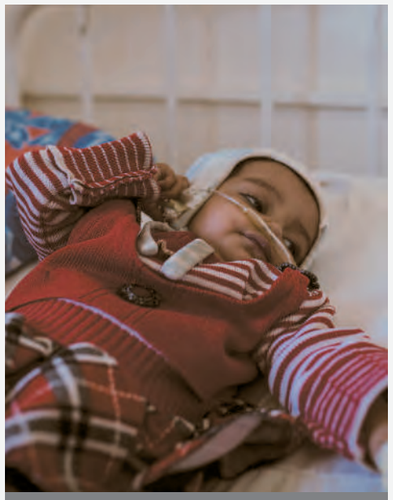
1

"It's our day off here in Yemen. Normally we just do rounds in the afternoon, unless there's something urgent. And sometimes there is.

I was in the hospital at around 2 pm when a call came from the emergency room: a man had arrived who had just been shot. He was in a critical condition.

From then on, it never stopped – we received one patient after another who required emergency care, and we had to forget about our day off.

But the fact is, by the end of the day I felt pretty good! After dealing with our last patient, I went home at 10 pm with a hopeful feeling inside.



10 April, 2017: Two-year-old Sumaya recieves treatment for rickets at Al Salam hospital. *Photograph © Florian Seriex/MSF*

Emergency surgery

The last patient was a three-year-old girl who arrived in a serious condition: she was dehydrated, feverish and had a grotesquely swollen belly. She was almost unconscious and her blood pressure was barely measurable.

The cause of her fatal condition was 'volvulus': her small intestine had twisted in the umbilical region and 50 cm of it was pitch-black and dead. A few more hours and she would have died from the toxic substances in the dead tissue.

As quickly as we could, we cut away the damaged part of her small intestine and sewed the healthy part back together. During surgery, she started getting better: her blood pressure normalised and her kidneys started to produce urine.

We couldn't sew the abdominal wall properly because the intestines were so bloated, but we sewed the skin and bandaged her properly.

After we finished surgery, we stayed with her for a long time in the operating room to warm her with our great inflatable thermal blanket, and to give her more fluids to replace everything she had lost.

Eventually, even her little feet became warm again.

In a few days, when hopefully the swelling in her intestines will have subsided, we will sedate her again and repair the abdominal wall completely. For now, I keep my fingers crossed!

2

Oh no, my little girl is worse!

We were about to sedate her again today to finally sew up the abdominal wall, because everything looked so good.

She had started drinking juice and water and had even eaten a little, and her stomach had become less swollen. Her parents were excited and grateful and everything felt very positive.

We were only planning to do this one small operation, which should only take half an hour. I was in the operating room, pre-washed prior to surgery, while my fellow doctor sedated the girl.

However, with the anaesthesia, things declined: the girl developed acute respiratory problems and was unable to oxygenate herself.

Her oxygen levels fell to appallingly low levels and the atmosphere in the operating room became tense.

After a period of time, which seemed very long but probably only lasted a few minutes, the situation improved. However, when we tried to insert a breathing tube again, the same thing happened.

Crossing my fingers

She experienced a bronchospasm, which means that the small airways of her lungs cramped together, making it impossible for her to oxygenate her blood.

We decided to postpone the surgery, wake her up and start bronchodilator treatment. She improved quickly but still needed a little oxygen to thrive.

I and my colleague Ivonne, an anaesthetist from Chile, now look after her constantly.

Tomorrow we are going to make soap solution and teach her how to blow bubbles. She needs both to play a little bit and work on her lungs. I'm now crossing my fingers even harder!

3

Today I discharged the little girl. The time she'd spent in intensive care had made her lethargic and weak, and it took her a while to get her appetite back. Moving out of the intensive care unit improved the situation, but it was hard to get her to walk by herself and start playing again.

She still screams when she sees me, as I'm usually the one who hurts her.

Her mother and I are friends, however, and she understands how important it is for her daughter to get back to normal again.

Today I managed to get a picture of her where she wasn't crying, and it feels like a victory to be able to wave goodbye to her and her mother.

Time for goodbye

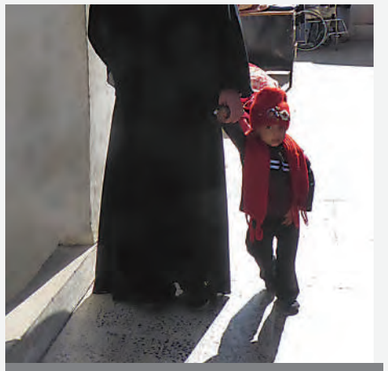
It is also time for me to go home. Tomorrow will be my last day working in Khameer.

A month in Yemen has felt very long, and at the same time it has disappeared instantly – so much has happened! So many new people I got to know, so many life stories to tell.

I'm returning to Sweden where it is clinically clean, with our senseless waste of everything which is so desperately lacking in Yemen – water, electricity, food, medical supplies of all kinds. It feels unreal.

I know that for several weeks I will jump every time there's a loud noise, and get palpitations when I hear the sound of aircraft, but I also know that it will pass.

I can only sincerely wish that, in time, it will be the same for the people of Yemen."



'I managed to get a picture of her where she wasn't crying...' *Photograph © Hella Hultin*

MSF IN YEMEN

Yemen is in the midst of a civil war. Since March 2015, a Saudi-led coalition has been fighting anti-government Houthi forces, resulting in bombing, gun battles and widespread destruction. Ordinary people are bearing the brunt of an increasingly brutal conflict.

Many clinics and hospitals have been destroyed, and those that are still functioning are in urgent need of more medical supplies.

MSF teams are operating in 13 hospitals and health centres across the country and are supporting a further 18.

Since conflict broke out, MSF has treated more than 50,000 people for conflict-related injuries. Find out more:

msf.org.uk/yemen

MSF'S UK VOLUNTEERS

Afghanistan Colin Fuller, *Project coordinator;* Jane-Ann McKenna, *Head of mission;* Federica Kumasaka Crickmar, *HR manager*
Bangladesh Madeleine Kingston, *Project coordinator*
Burundi Benilde Perez Amez, *Nurse*
Central African Republic Thomas Crellen, *Epidemiologist;* Dana El-Hilu, *HR Manager;* Nicole Claire Nyu Hart, *Medical team leader;* Iain Bisset, *Logistician;* Robin Scanlon, *Logistician;* Rennie Urquhart, *Gynaecologist;* Athanasios Koukoutsakis, *Logistician*
Chad Victoria Neville, *HR manager;* Aileen Ni Chaoilte, *Medical team leader;* Sarah Wookey, *Doctor*
Democratic Republic of Congo Anna Halford, *Deputy head of mission;* Claire Simpson, *Pharmacist;* Neal Russell, *Doctor;* Sergio Scro, *Project coordinator;* Juan Andres Abellaneda, *Logistician*
Ethiopia Isla Gow, *Midwife;* Georgina Brown, *Midwife;* William Pooley, *Nurse;* Kate Nolan, *Head of mission*
European migrant and refugee mission Jane Grimes, *Psychologist (Greece);* Declan Barry, *Medical coordinator (Greece);* Lauren Cape-Davenhill, *Project coordinator (Greece);* Catherine Thorne, *Translator (Greece)* Shahrzad Amoli, *Cultural mediator (Greece);* Jacklyne Scarbolo, *Midwife (Italy);* William Turner, *Head of mission (Netherlands);* Andrea Contenta, *Humanitarian affairs officer (Serbia)*
Guinea-Bissau Francesca Phelan Bosowski, *Nurse*
Haiti Robin Aherne, *Construction supervisor*
India Ian Cross, *Doctor;* Sakib Burza, *Medical coordinator*
Iraq Valerie Boutineau, *HR support;* Ciaran Laughlin, *Doctor* Basil Maillet, *Finance coordinator;* Cristina Ceroli, *Midwife*
Jordan Kate Baldwin, *Lab scientist;* Peter Garrett, *Doctor;* Sunmi Kim, *Logistician*
Kenya Mark Sherlock, *Doctor;* Eamonn Faller, *Doctor*
Kyrgyzstan Rebecca Welfare, *Project coordinator*
Lebanon Micheil Hofman, *Head of mission*
Liberia Joshua Ward, *Doctor*
Libya Jean-Marie Karikurubu, *Head of mission*
Malawi Simon Lee, *Doctor*
Malaysia Martina Caplis, *Midwife*
Mozambique Andrew Connery, *Doctor*
Nigeria Clifford Kendall, *Doctor;* Gabriella Gray, *Logistician* Aimen Sattar, *Logistician;* Ann Lomole, *Finance coordinator;* Niamh O'Brien, *Doctor;* Ann Marie Crosse, *Pharmacist;* Catherine McGarva, *Mental health officer*
Pakistan Keith Longbone, *Project coordinator;* Kenneth MacGruer, *Doctor;* Jennifer Benson, *Logistics manager*
Papua New Guinea Wendell Junia, *Lab scientist*
Philippines Shobha Singh, *Psychologist*
Sierra Leone Christopher Sweeney, *Nurse;* Melanie Villarreal, *Communications officer;* Laura Doriguzzi Bozzo, *Training officer* Claudia Patricia Soares Dias, *Nurse;* Hazel Morrison, *Doctor*
South Africa Amir Shroufi, *Medical coordinator;* Rebecca O'Connell, *Doctor*
South Sudan Ilio Franconi, *Construction manager;* Philip Andrews, *Nurse;* Karl Flynn, *Logisitican;* Melissa Perry, *Deputy finance coordinator;* Elizabeth Harding, *Head of mission;* Adam Ruffell, *Project coordinator;* Daniel Perez Martin, *Nurse;* Juliet Hull, *Doctor;* Carl Rendora, *Water and sanitation expert*
Swaziland Maria Verdecchia, *Epidemiologist;* Shona Horter, *Researcher*
Turkey Samuel Turner, *Project coordinator;* Alvaro Dominguez, *Humanitarian affairs officer;* Alvin Sornum, *Medical team leader*
Uganda Haydn Williams, *Head of mission;* Jacob Goldberg, *Deputy medical coordinator;* Jeanette Cilliers, *Water and sanitation expert ;* Melissa Buxton, *Nurse* Cara Brooks, *HR coordinator;* John Guzek, *Epidemiologist*
Ukraine Eleanor Davis, *Communications manager;* Julianna Smith, *Epidemiologist*
Uzbekistan Monica Moschioni, *Head of mission;* Mansa Mbenga, *Medical coordinator*
Zimbabwe Fadumo Omar Mohamed, *Mental health officer;* Daniela Stein, *Nurse*

A day in the life

Above: 'Mweso is misty and mountainous...' **Emily and the team make their way along a rugged track;** ***Below:*** **The team relax on a Sunday afternoon.** *Photographs © Emily Gilbert/MSF*

Emily Gilbert is a project coordinator for MSF in Democratic Republic of Congo (DRC). She is on call 24-hours a day, managing the team, dealing with security situations and keeping in contact with armed groups. With so much to do, field workers like Emily have to make the most of every moment, even during a rare day off…

"I often get woken at 5 am – sometimes earlier – either by various unfamiliar noises or by the phone ringing.

Here in Mweso, in eastern Democratic Republic of Congo, it isn't uncommon for people to have to climb a mountain for hours just to get a phone signal, so I know it's something important. Usually it's a staff member in one of our health posts updating me on the security situation, or it might be the leader of an armed group giving me information about a certain area we are planning to travel to. I try to get a few minutes to sit outside our house in the compound in the early mornings. Mweso is misty and mountainous – jumper and sock weather – so if there is sunshine, I try to enjoy it. When you're living in a base with up to 21 people, it's also nice to get some quiet time with a coffee.

"The armed group leader can't meet today; can we rearrange for Saturday?"

At 7.30 am it's the morning meeting, then I go to my office, which looks like a wooden cabin in the Alps – apart from the view, which is of barbed wire and a stone fence. I sometimes think that it should have a rotating door for the constant stream of people coming in and out.

On the wall are maps and a board tracking all the international and Congolese staff I am responsible for. Every week we plan the transport. Each time a team leaves to go anywhere, I call all the armed groups and government officials in the area to find out the security situation and ask for guarantees that our team will be safe. This can take anything from 15 mins to 1.5 hours.

For the rest of my day, my to-do list is never shorter than four A4 pages. I love the interaction with different people on different issues and having to solve problems that would sound entirely ridiculous in the 'real world': "A woman's just given birth in the field next to our base, can we send the car out to take her to the hospital?"... "People are fleeing from the camp we're in, should we evacuate?"..."This armed group leader can't meet you today, can we rearrange for Saturday?".

Hunting the elusive cafetière

As in most MSF assignments, we work five and a half to six days a week. But Sunday is, in theory, a day off. On Sundays, if I'm not woken early with security issues to deal with, then I wake up at 6 am with the church bells ringing – something I actually enjoy, not just because of their gentle chiming, but also because of the feeling that instead of having to get up, I can roll over and go back to sleep.

At 9 am I drag myself out of bed and go to greet the guards. They are the only team members working on the base on a Sunday, so I like to wish them a "bon dimanche" as I go to the cauldron of heated water to fill my empty bucket for a shower.

Then it's time for coffee. Sounds simple. But with up to 21 staff members sharing the base, finding the one cafetière that isn't missing its rubber seal or handle is a morning challenge that few are up for. The same goes for locating some matches to light the gas.

Then I join the other staff in the *paillotte*, the traditional Congolese hut, for a natter. This for me is like a Sunday morning in the UK, and makes me feel just that little bit closer to home.

Creative cooking under curfew

At 10.30 am it's time for yoga. Maybe. The intention is there but, in reality, it doesn't always happen. There's an area of the base that we call "the garden", with grass and some flowers growing. It's calm, surrounded by trees, and, if I turn my yoga mat away from the barbed-wire fencing, it's easy to forget that we are, in fact, in the middle of a conflict zone, with armed groups patrolling and violence occurring in the vicinity daily.

In the afternoon, I spend hours playing Settlers of Catan. It's a board game for four people, a cross between Monopoly and Game of Thrones, and either I have to beg people to join me or we all fight over who gets to play. There is also lots of guitar playing and singing.

During this time, a staff member often goes for a walk into town to get fresh vegetables from the market and comes back to make a feast. We have some talented cooks in this project. The last few weeks' artisan surprises have included dumplings, curry and dahl, ravioli, and vegetable tempura with cucumber yogurt – it's amazing how creative people can get with few resources, stuck on a base with a 6 pm curfew.

Armed robberies, gunshots and clashes

Sometimes a bunch of us go for a walk up the hill opposite our compound. This is probably the closest thing to normal life that we can do here. It's very beautiful, and when we're up there it's easy to forget where we are.

But the thing about being on an MSF assignment is that there isn't really any proper downtime. As a project coordinator, I have my radio with me at all times and am on call 24/7. There are few Sundays when I'm not abruptly removed from my day-off mentality by the sudden sweet melody of the Nokia ringtone – usually to update me about an armed robbery on one of the surrounding roads, a gunshot wound that has been received in the hospital, or the current state of clashes near one of our health posts.

In fact, I don't think I can say I have ever been truly relaxed on any day of the week in an MSF project, including Sundays. This is one of the reasons why MSF missions are, on average, six to nine months' maximum. Any more and your brain and body start yelling out for a break, and you start noticing yourself becoming more tired, more irritable and less effective at your job.

This is normal and happens every time I am in the last few weeks of a contract in the field. In just less than a month though, I should be back home, with my family, ready to recharge for wherever in the world MSF sends me next."

'I often get woken at 5am by the phone ringing...' *Photograph © Emily Gilbert/MSF*

MEDECINS SANS FRONTIERES
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Médecins Sans Frontières/Doctors Without Borders (MSF) 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, gender or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

Rapid response in Congo

Dr Justin Healy spent six months in Democratic Republic of Congo (DRC) as part of the Emergency Pool – MSF's team of rapid responders.

What were you doing in DRC?

I was with the 'pool d'urgence' – a team based in Kinshasa who respond to different emergencies throughout Congo: a bit of cholera, some population displacements, vaccination, malnutrition and so on. It was different every week. We travelled around the country on motorbikes, boats, planes, the works.

DRC is a big country…

It's enormous! It's the size of western Europe and I only saw a tiny fraction of it. Every few years a cholera epidemic goes up and down the Congo river, so we spent a lot of time on the river in tiny canoes. Once, we'd had reports of cholera in certain villages, so a team of six of us with a load of equipment and tents and beds piled into a canoe and went about 120 kilometres downstream.

We got there and MSF had already been in that town before with a measles outbreak, so we'd already built a temporary ward. With a bit of rapid repurposing, we had a space to keep patients isolated. We just got to work.

Is it a difficult disease to treat?

Without medical care, the death rate can be 30-40%, sometimes higher. But with treatment, it drops down to almost nothing. Nobody should die from cholera – it's all about getting people into treatment before it's too late. Unfortunately, some people did arrive too late.

That must be tough.

It's always awful when people die. But some people who arrive looking like they're not going to make it will often respond rapidly to treatment. It's an astonishing thing to witness. People who are barely conscious and look shrunken will undergo this incredible transformation once you give them fluids. It's like one of those toys you have as a kid when, if you add water, it suddenly fills out and transforms. I've never seen anything as dramatic or striking as a cholera victim even a couple of hours after being on a drip. It's wonderful.

Where else did you go?

We spent a bit of time up on the South Sudan border where 10,000 people had been displaced due to fighting. Even getting there was intense. We had to load everything onto ten motorbikes then travel 80 miles through thick jungle, through mud and water, across rivers and broken bridges – the works. It took us three days to get there.

When we arrived, we set up a rapid health survey to assess what the main medical needs were and then gave advice regarding an intervention.

Sounds like a very hands-on mission?

It was. I think it's important for doctors to stay connected to patients. It keeps you grounded and focussed on what you need to do. It's quite easy to retreat behind spreadsheets and patient data, and to lose that proximity.

What would you say to an MSF supporter about the work in DRC?

Thanks! MSF really does go places nobody else goes to. In DRC, if MSF wasn't there dealing with stuff like cholera and measles, many more people would die. I've seen it first-hand and I know the impact that MSF is having. So thank you for your support.

Read more of Justin's interview at msf.org.uk/justin


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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 by Marcus Dunk. It costs 8.6p to produce, 2.3p to package and 31p 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: *dispatches.uk@london.msf.org*

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