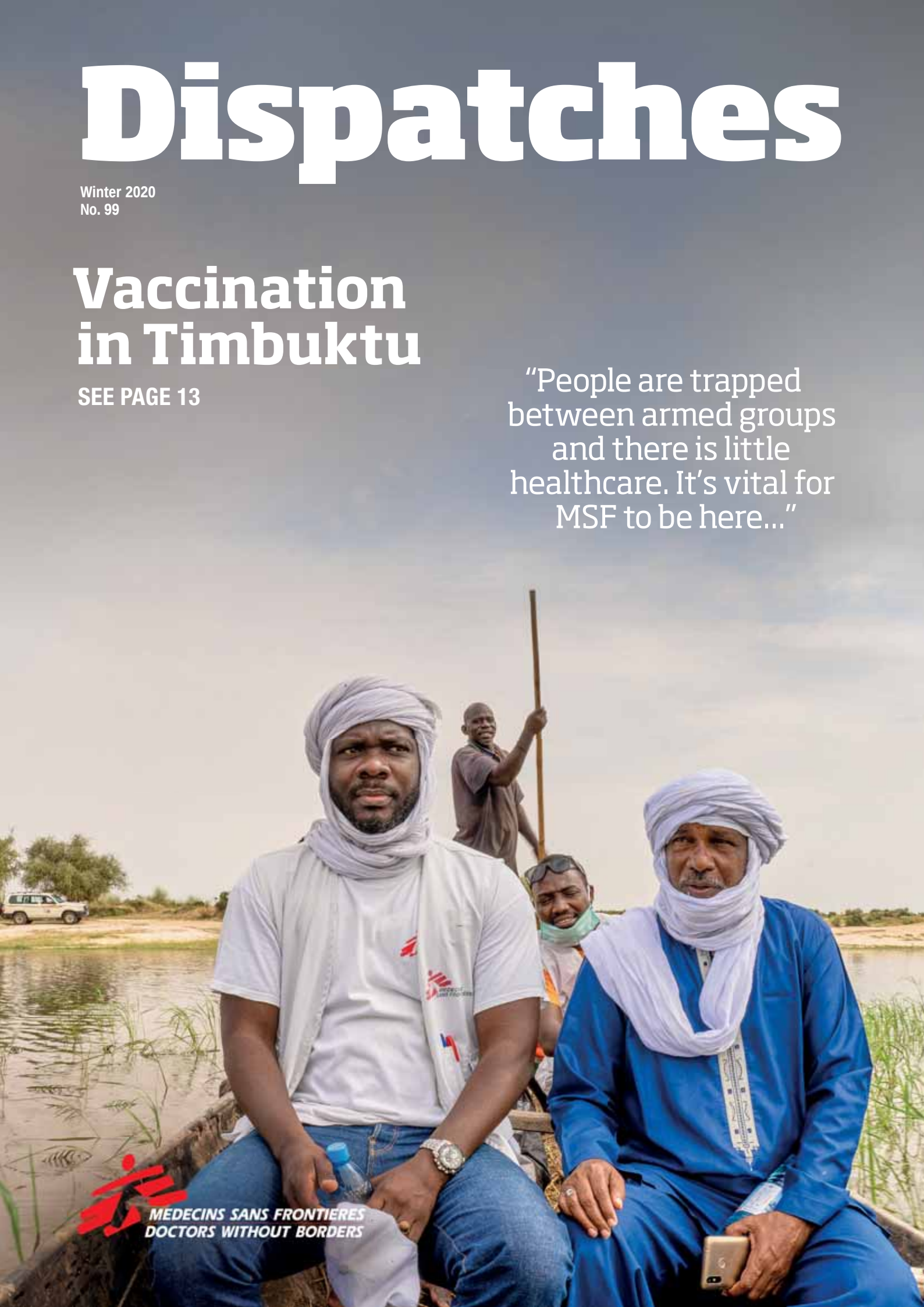
Dispatches

Winter 2020
No. 99

Vaccination in Timbuktu

SEE PAGE 13

"People are trapped between armed groups and there is little healthcare. It's vital for MSF to be here..."



MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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Front cover: The mobile MSF vaccination team travels by dug-out canoe to Arnassaye, Mali, where children aged between six months and 14 years will be vaccinated against measles. Photograph © Mohamed Dayfour/MSF

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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.

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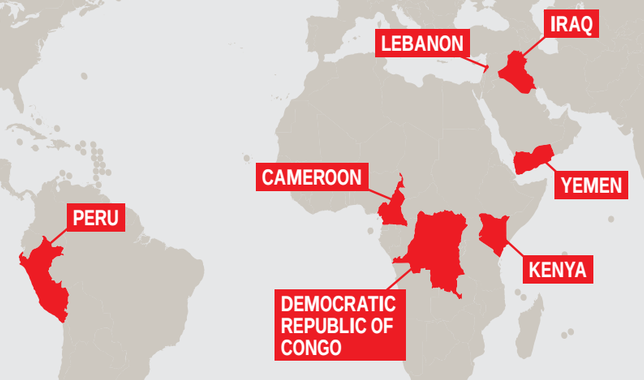
SITUATION REPORT



Diabetes: a hidden crisis

Diabetes is a disease that can be controlled with insulin, yet 100 years after its discovery, insulin is still only available to half the people around the world who need it.

Moussa, aged six, receives treatment for diabetes at MSF's clinic in Aarsal, Lebanon. Photograph © Jinane Saad/MSF

"I had to ration the little insulin that I had," says 23-year-old Viola Makore, from Mutare in Zimbabwe. "I would only inject a little bit so I could save it until we had some money."

In 2014, Viola received a diagnosis of type 1 diabetes. This form of the disease means the body cannot make insulin, so a daily top-up is vital. Without insulin, Viola would become severely unwell and possibly die within days.

Viola's story is not unusual. Across sub-Saharan Africa, many people diagnosed with diabetes cannot afford to manage their disease, while many others die before diagnosis. And in most of the countries where MSF works, insulin is not available either in public health facilities or private pharmacies.

THE CHALLENGES

Here are three reasons why the problem exists and three ways in which MSF is addressing the challenge.

1. The cold chain

"We can't give insulin if people don't have a fridge to store it in."

We hear this a lot in many of the countries we work in, where temperatures often exceed those recommended for storing insulin. Without a fridge, people have to travel to clinics more than once a day to receive their insulin.

However, MSF carried out a myth-busting study which found that insulin does stay stable and can be used effectively at temperatures higher than 25 degrees Celsius. Clay pots with a layer of charcoal sandwiched between them have also proved to be effective in keeping the temperature of insulin low and stable. This has made an enormous difference to MSF patients, who can now take their insulin home.

2. The complexity

Managing type 1 diabetes can be a complex endeavour. People with the disease need to inject themselves with insulin five to six times a day and constantly monitor their sugar levels.

New devices such as insulin pens, which make it easier to inject insulin, and glucose monitors, which eliminate the need for people to prick themselves multiple times a day to test the sugar levels in their blood, have the potential to change the lives of diabetics.

422 million
Number of people living with diabetes worldwide

20
Number of projects where diabetes is the most common non-communicable disease treated by MSF

However, these devices are not routinely available in many places due to cost. In Bekaa, Lebanon, MSF is subsidising and trialling the use of these new tools to improve our patients' quality of life.

3. The cost and competition

The cost of producing insulin is calculated at €61–€114 per patient per year. Currently, just three companies – Novo Nordisk, Eli Lilly and Sanofi – control 99 per cent of the insulin market, with manufacturers of generic alternatives facing huge challenges for their products to be approved and used.

MSF is working hard to address these costs while looking at ways to increase competition. MSF calls on insulin manufacturers to work together to bust the myth around insulin storage and to reduce the price of tools that will ensure diabetes treatment is accessible to all.

Find out more: msfaccess.org/diabetes

LEBANON

"I needed to make myself useful to overcome the panic"

Three-year-old Samar is treated for facial injuries and burns at an MSF clinic in Beirut, Lebanon, after a massive explosion which devastated the city on 4 August. Photograph © Mohamad Cheblak/MSF

MSF psychologist **Sara Tannouri** looks back at the blast which devastated her home city of Beirut two months ago and describes how MSF is providing ongoing support.

"4 August 2020 at 6.08 pm. I was just about to leave my house. I was already late and had said a perfunctory goodbye to my family on my way out. As soon as I closed the car door, I heard a loud noise and felt as if the air was being sucked out of the car. Seconds later, shattered glass and debris were falling like heavy rain. The blast had destroyed everything in sight.

I felt completely stuck to my seat. A few seconds of piercing silence were followed by a strange mix of alarms going off and screams of help and distress from neighbours, who I could see covered in blood, looks of confusion and fear on their faces. Amid the chaos, I could hear my mother screaming my name and finally I shook off my paralysis and ran back into the house to assure her I was alive.

Damaged hospitals

The day after the explosion, and after a sleepless night, I received a call from the MSF team in Beirut asking me to join them in the humanitarian response as a psychologist. I felt I needed to use whatever expertise I had to contribute to the response and to help my own community in its most dire times. As part of MSF's emergency team, I helped assess four of the most heavily damaged hospitals, conducted home visits and provided psychological first aid and mental health support to people affected by the blast.

These events come on top of an acute economic and financial crisis, which has left people struggling to provide for their families, as well as political instability in Lebanon. The flow of patients coming for consultations has been constant and the community, who had sometimes the tendency to stigmatise people with mental health issues, has expressed a real need for this service.

Rebuilding piece by piece

Being part of MSF's mental health response team has definitely helped me come to terms with how this crisis has affected me personally. Having been through a very similar experience to the patients has enforced a strong feeling of empathy from my side. I decided to channel my energy and expertise into providing as much aid and support as I could to those who needed it.

Almost everyone I know has been contributing, in one way or another, to rebuilding this shattered city, piece by piece. This has given me the strength to wake up tirelessly every day since the blast and to keep hold of hope."

Photograph © MSF

KENYA

A refugee waits outside MSF's mental health clinic in Dadaab refugee camp, where 200,000 people live in very challenging conditions.

msf.ie/kenya

Photograph © Solen Mourlon/MSF

DEMOCRATIC REPUBLIC OF CONGO

An MSF health worker helps distribute essential relief items to people displaced from their homes in Kambe, northeastern Democratic Republic of Congo.

msf.ie/DRC

Photograph © MSF

IRAQ

A nurse treats a COVID-19 patient in Al-Kindy hospital, Baghdad. Since July, MSF teams have been training staff in the respiratory care unit in the use of ventilators and specific techniques for treating patients with severe forms of COVID-19.

msf.ie/Iraq

CAMEROON

MSF treats ten victims of school shooting

Photograph © MSF

On 24 October, a school shooting occurred at the Mother Francisca International Bilingual Academy in Kumba, southwest Cameroon. MSF immediately put a mass casualty plan into action at the local hospital.

The MSF team received a total of ten injured children, aged from ten to 15. Of these, one was pronounced dead on arrival, four were treated in the hospital, and five were taken by ambulance to other hospitals for specialist treatment.

"As a medical humanitarian organisation, we lament the tragic loss of life in the Kumba community," says Jodra Marcos, MSF emergency coordinator in Cameroon. "This attack, which saw children gunned down while attending school, was a reprehensible and indecent act. Civilian structures, including schools and hospitals, must not be targets."

msf.ie/cameroon

Photograph © Kuki Mendonça/MSF

PERU

An MSF team member prepares to travel along the Amazon River to provide medical care in remote riverside villages. Peru has one of the world's highest mortality rates for COVID-19, with the isolated regions of the Amazon particularly affected. MSF has been supporting 23 health centres in this region to provide people with essential medical care.

IRAQ

An MSF technician conducts laboratory testing in Nablus hospital in west Mosul, Iraq. The city's health system is still recovering from the conflict of 2016-17. The emergency room of Nablus hospital receives an average of 100 patients a day.

msf.ie/Iraq

Photograph © Manhal Alkallak/MSF

Photograph © Majd Aljunaid/MSF

YEMEN

MSF nurse Cristina Martel Martin checks a patient's chest X-ray in Al-Sahul COVID-19 treatment centre in Ibb, Yemen. "I never considered before how many litres of oxygen a cylinder holds and how many cylinders a patient needs," she says. "In Ibb, I quickly learned that a patient with moderate to severe COVID-19 symptoms needs about six cylinders a day. Any interruption in the provision of oxygen can be deadly."

Visit msf.ie/yemen to find out more about our work in Yemen

‘They all had gunshot wounds’

When violence erupted in Pieri, South Sudan, killing 200 people and wounding 300 more, the MSF team at nearby Lankien hospital braced for a wave of severely injured patients. Medical team leader **Istifanus Chindong Damulak** coordinated the response.

“My wife has just given birth this morning and is still in the health facility. All the staff are now on the run to the bush for safety. I can see smoke from the burnt huts just across the airstrip.’

These were the first words I heard from our MSF health facility supervisor on the morning of 16 May. It was 6 am – an unusual time for our regular daily call. I knew, even before I picked up, that it must be an emergency.

“I told them we should remain in emergency mode… because the injured would inevitably arrive at our hospital…”

AN ERUPTION OF VIOLENCE

He told me violence had erupted in Pieri, a town about 50 km south of where I’m based, at the hospital in Lankien. By 7 am, the news had spread.

The safety of the team in Pieri was my biggest concern. What would happen to our staff who live there? There’s no bunker in Pieri. Would they run to the bush? Where would they go?

I called an emergency meeting and updated everyone in the MSF team, both medical and non-medical, that our mass casualty plan was being activated.

I told them we should remain in emergency mode and be prepared to act at any moment in the day, because the injured would inevitably arrive at our hospital…

THE ER

At 9 pm that night, I was called to the emergency room. Casualties had begun to arrive.

Straight away I saw six injured patients, each with several gunshot wounds, lying on the ER floor. I looked outside and saw three military trucks fully packed with injured people. Everyone was shouting for help.

Within a few minutes the ER was full of staff – most of whom had already finished for the day. We received 20 patients at once, all men with gunshot wounds, many with severe injuries.

One patient died on arrival and another – a man with a gunshot wound through the chest – died 20 minutes later during a blood transfusion. Of all the patients who were admitted, only two were well enough to be discharged that night.

INJURED STAFF

Over the following days, people who’d been injured in the violence continued to arrive. Our team treated 63 people in total, including two of our team members from Pieri. All had gunshot wounds.

Two days into the violence, some of our staff who had fled Pieri started to arrive in Lankien. Incredibly they got straight to work. They received and treated an additional 19 people with gunshot wounds.

One shared their own experience from Pieri:

‘My mother is old and she stayed with small children in Pieri. She cannot run. I went to save her, but I was ambushed. Several people were shot dead in front of me. I was trying to help some of the injured with first aid when someone told me I was bleeding. I had sustained two gunshot wounds. I was bleeding too much. I gave up, believing that I was going to die.’

THE AFTERMATH

More than 200 people died in this latest wave of violence. An estimated 300 more were injured.

Even after the violence had subsided, for days we continued to receive patients, many with septic wounds from abdominal gunshot injuries.

At times I felt very emotional and helpless, because our hospital is not equipped to do the kind of surgery these patients needed. Normally we would refer patients to another facility, but with concerns about COVID-19 community transmission, it was incredibly hard to refer patients. I saw our patients with abdominal wounds deteriorating and I couldn’t do anything to help.

For our team it was also very personal. One of our team members was killed in the violence. I had been with him just a week earlier and now he was gone. It was – and still is – incredibly traumatic for the team in Pieri.

The Pieri team is like one family; they are a community and very committed. It will take some time for the pain of losing a team member to ease.

“We received 20 patients at once, all men with gunshot wounds, many with severe injuries.”

Left: Anaesthetist Richard Bigabwa prepares a patient for surgery in Old Fangak, South Sudan, December 2017. Photograph © Frederic Noy/Cosmos.

Below: MSF nurse John Wicyual examines six-month-old Mathulak Jong who has acute pneumonia in Meer, South Sudan, December 2017. Photograph © Frederic Noy/Cosmos

RETURN TO PIERI

Five days after the attack, I went to Pieri. The town was empty, with only a few men and young people around.

It felt like a ghost town. Every woman and child was still in the bush, wary of another outbreak of violence.

I WON’T FORGET

I cannot forget the moment I fastened the seatbelt around the eighth patient on a tiny plane, all with severe abdominal gunshot wounds.

Although referrals were incredibly difficult, we’d been able to get agreement for this one. The patients were being airlifted to another hospital.

I knew full well that normally these patients would be on stretchers, not in seats. But the stretchers would take up more space on the plane, meaning we would have to reduce the number of people being evacuated, with no guarantees of another flight.

I won’t forget that moment.

But then there was the moment we welcomed these same patients back to Lankien, all discharged after successful treatment, all having recovered.

I won’t forget that either.”

Bentiu Protection of Civilians camp

Bentiu Protection of Civilians camp in South Sudan is home to some 100,000 people who have sought refuge from conflict. Residents live in temporary shelters made of corrugated metal, plant stalks, mud and plastic sheeting. These offer limited protection from the elements, especially during the rainy season when walkways become lanes of mud. People's medical needs are enormous.

MSF operates the main hospital in the UN-run camp, which provides general medical care, surgery, treatment for malaria, malnutrition and diseases linked to poor water and sanitation, along with treatment for tuberculosis and HIV.

"MSF is operating one of the only hospitals that has surgical services – not only in Bentiu, but in the wider region," says MSF surgeon John Buckles, who has returned to Bentiu five times to conduct surgeries. "Working here, you're faced with a broad spectrum of conditions, ranging from tropical diseases to surgical conditions that occur in any society where there are abdominal issues, through to emergency caesareans. All of these conditions have continued during the COVID-19 pandemic."

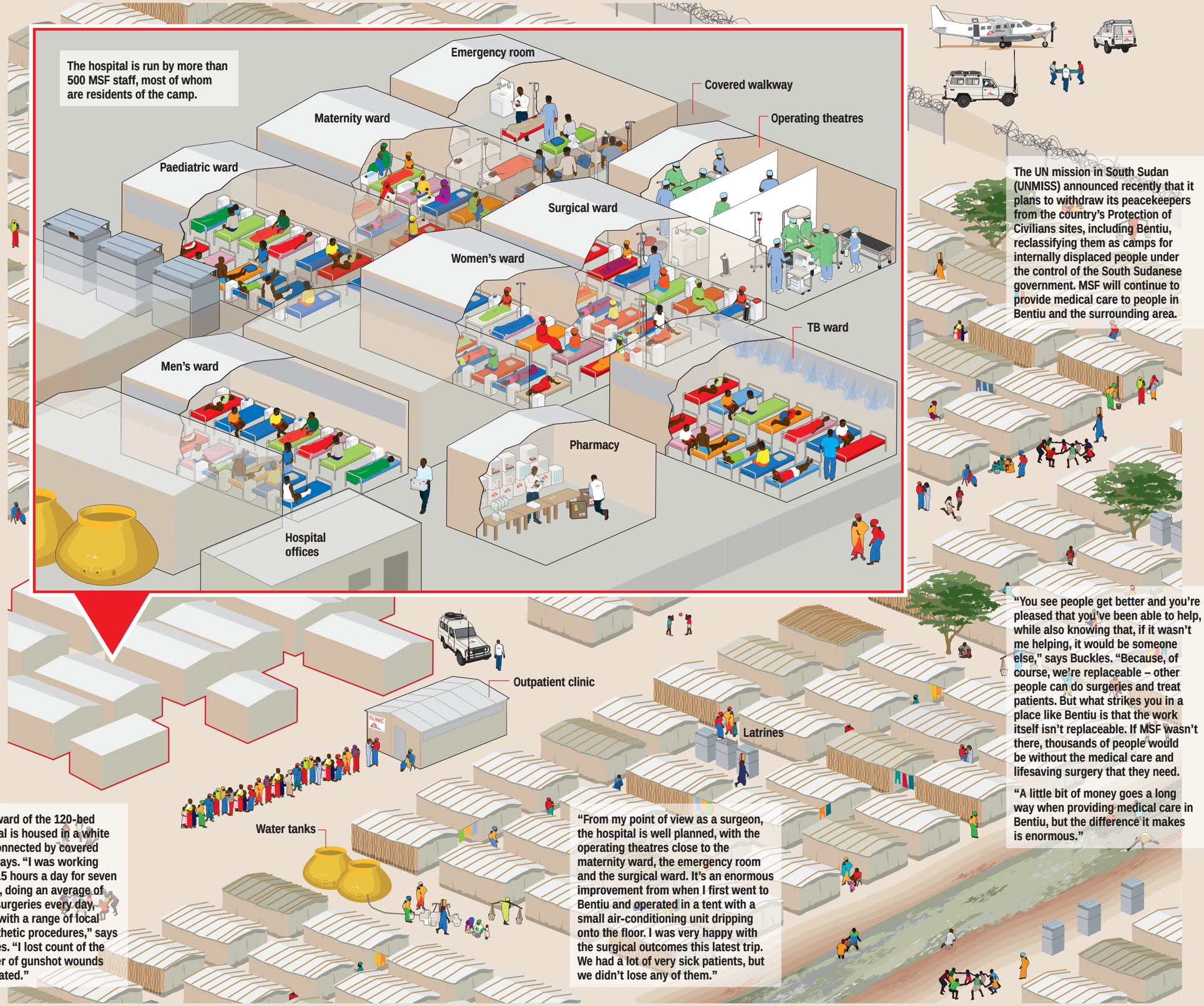


Illustration: Jenny Ridley

Fighting for treatment

Twenty years ago, MSF was involved in a revolution in South Africa that would save thousands of lives and forever change the way the world saw and treated HIV. MSF staff, alongside activists and people dying from AIDS, used mass protests and legal action, first against profiteering pharmaceutical companies and then against the South African government, to fight for free HIV treatment for all. From clandestinely bringing medicines into the country to providing large-scale treatment, this is the story of a healthcare revolution.

A CRUEL IRONY

In 1994, as South Africa celebrated its hard-won freedom from apartheid, the country descended into a chilling new crisis. An incurable disease called HIV – which destroys the body's immune system – was sweeping across the country. By 2000, an estimated 4.2 million South Africans were infected by HIV. Nearly 1,000 people were dying a day. Stigma was powerful and dangerous. Aside from the few who were privately insured, treatment was completely out of reach: a year's worth of branded antiretrovirals (ARVs) cost €8500–€10000. Pharmaceutical companies refused to lower the price.

"We were only seeing the sickest of the sick… people were brought in on stretchers or in wheelbarrows…"

Above: Pretoria, South Africa, 18 April 2001. Aids activists protest against pharmaceutical companies outside the High Court in Pretoria. Photograph © Lori Waselchuk

Promising scientific evidence from Thailand showed that a combination of ARVs, including AZT, cut transmission from an HIV-infected mother to her foetus by 50 per cent. However, in South Africa, the health minister had blocked the use of AZT for pregnant women in the public health system. In August 1999, MSF's Dr Eric Goemaere arrived in Johannesburg to find a partner clinic for a "simple prevention of mother-to-child transmission (PMTC) programme" – only to learn that nothing about it would be simple.

'PEOPLE WERE BROUGHT IN ON WHEELBARROWS'

As late as 2001, prominent people maintained that ARV treatment in poorer countries was impossible: that year, Andrew Natsios, director of the United States Agency for International Development (USAID), told the US House of Representatives' Committee on International Relations: "Rural Africans do not know what watches and clocks are. They use the sun." Since they wouldn't be able to take medicines properly, it was pointless trying to provide treatment.

The MSF team were anxious to prove to the scientific community that, contrary to accepted wisdom, ARVs could be safely administered to a poor African community, even outside a hospital setting. Against opposition, in February 2000, MSF and partners opened a clinic in Khayelitsha township, Cape Town, to treat infected mothers and their partners. The clinic was soon overflowing with patients.

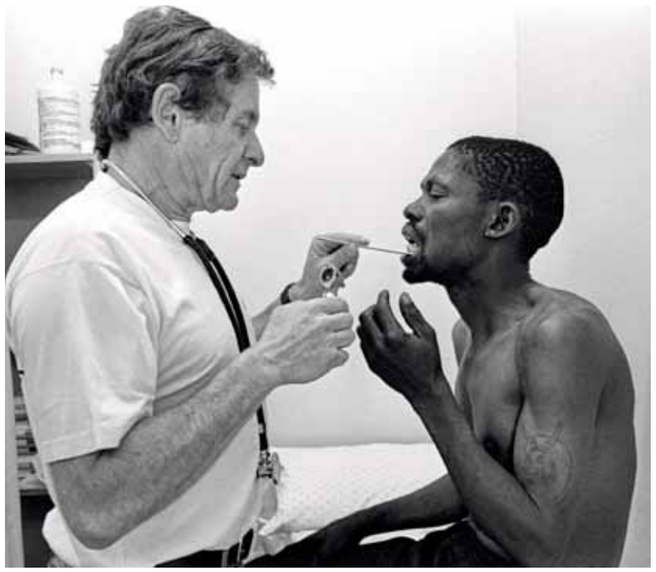
"By the middle of 2000, a few months after we had opened, we had registered several hundred people as HIV-positive," says Dr Goemaere. "We were only seeing the sickest of the sick – those who were absolutely desperate. People were brought in on stretchers or in wheelbarrows. The waiting room was packed. Stigma dropped very rapidly because suddenly people realised – it's not only me…"

A BRIEF ALLIANCE

In 1998, a group of 42 pharmaceutical companies took the South African government to court when it tried to adapt its patent laws to allow it to import low-cost generic drugs, mostly antibiotics. The case – Big Pharma vs Nelson Mandela – was stalled for three years until March 2001. A handful of HIV activists sprang into action to support the government, thinking this would open the gates for treatment for all South Africans. On 19 April, faced with a public relations disaster, Big Pharma announced they were dropping the case. The crowd was jubilant.

Above: Cape Town, 12 December 2002. Former South African president Nelson Mandela sports an activist T-shirt after visiting MSF's clinic in Khayelitsha. "We have created the impression that we don't care about the young people who are sick and dying," he said. "This is a war. It means that all of us should stand on our feet and mobilise the community." Photograph © Eric Miller

Below: Khayelitsha, October 2003. Dr Eric Goemaere treats 32-year-old Xolani Lantu at MSF's HIV clinic. Photograph © Francesco Zizola/Noor



"The court was filled with people and, while we were waiting for the judge, they started to sing," says Ellen 't Hoen, MSF's legal adviser. "Every hair on my body was standing on end. It was in the air that they were going to drop the case… When they did, the whole thing just broke out in one big dancing party. It was absolutely amazing."

However, the government soon made it clear it was not interested in bringing generic ARVs into the country.

AN UNDERCOVER DEAL

Despite being completely blocked by the Department of Health, MSF got local government approval for a full public ARV programme in Khayelitsha beginning in 2001 – the first in South Africa.

MSF just had to pay for the drugs. However, without generic ARVs this was financially impossible. At first, MSF could only put 180 people on branded ARVs. But thousands of people were ill. Clinic staff were forced to choose who would live and who would die. Desperate for generic ARVs, MSF struck an undercover deal with the Brazilian government. MSF Brazil would buy generic ARVs from the Brazilian government and then ship them to their colleagues in South Africa.

However, MSF couldn't wait for the generics to arrive. Goemaere's clinic had been running for a year by this time and the situation was dire.

"This must be among the greatest-ever public health achievements in the history of humankind."

BUYING OVER THE COUNTER

To buy enough drugs to keep patients on treatment, Goemaere visited one of the few pharmacies in Cape Town that supplied them. The dozen treatments he purchased that day cost more than the second-hand Toyota he was driving. However, it was enough to tide them over until the first consignment of Brazilian ARVs arrived secretly via DHL in November. The first group of patients was switched to generic drugs.

In 2002, the MSF team presented results from the Khayelitsha project at the Barcelona AIDS Conference. The findings were explosive: 91 per cent of patients were still on treatment and healthy. The denialists could no longer ignore scientific fact.

In early 2003, a landmark court case brought by the Treatment Action Campaign (TAC) found that two pharmaceutical companies had abused their dominant positions in the ARV market. Four Indian companies that produced generic ARVs were finally allowed into South Africa. On 8 August 2003, the South African government made the longed-for announcement that they were going to roll out free ARVs. The battle had been won.

Top: January 2002. A young boy prepares to take his HIV medication. Photograph © Gideon Mendel

Above: January 2002. An HIV patient has a medical consultation at MSF's clinic in Khayelitsha. Photograph © Sebastian Charles

A GRASSROOTS VICTORY

"Looking back at these events, I am struck by how far HIV care has progressed," says Dr Goemaere, who still works for MSF in South Africa. "What sounded like medical utopia in early 2000 is now the norm rather than the exception in most sub-Saharan countries.

"Once we struggled to treat 400 patients and faced the terrible dilemma of selecting who would live and who would die. What a relief for clinicians now to initiate any new patient on ARVs, some at their first visit, without having to worry about limited resources.

"This must be among the greatest-ever public health achievements in the history of humankind. It was a struggle in which the best of science joined forces with the best of political will to change the course of the pandemic. It was a grassroots victory, with people fighting for their rights and for human dignity, first against pharmaceutical companies and then, unexpectedly, against their own government."

Read the full story: The book, ***NO VALLEY WITHOUT SHADOWS, MSF and the fight for affordable ARVS in South Africa*** can be downloaded for free from: **https://msf.exposure.co/no-valley-without-shadows**

Vaccinating against measles in Timbuktu

In September, MSF and the Malian Ministry of Health launched a large-scale measles vaccination campaign in Timbuktu and the surrounding area. The aim: to reach 50,000 children aged between six months and 14 years.

Despite the official end of the war in 2015, Timbuktu and surrounding regions in northern Mali remain tense, with security incidents and criminality having a significant impact on healthcare. Vaccination coverage is low, especially among children.

The vaccination was done in three stages in 12 of the 19 zones of Timbuktu, with the teams basing themselves in health centres or turning schools or other buildings into vaccination sites for the day. The zones ranged from easy-to-access urban areas to rural areas on the opposite bank of the Niger River, where the backwaters, pools and lakes form a natural barrier.

Above: Mariam Maïga holds her son and his vaccination card after his measles vaccination in Arnassaye, one of the outlying vaccination sites.

Below left: A boatman crosses the Niger River in Timbuktu region, northern Mali.

Below right: Children play in front of Djingereber mosque in Timbuktu, built in the 14th century.

All images: Mohamed Dayfour/MSF

"It takes an hour to an hour and a half to get there in a dugout canoe," says Tuo Songoufolo, MSF's medical adviser for the project. "People tend to spread out over the area to graze livestock or to grow their crops. And that means we need to follow them to vaccinate."

"Mali is in a very difficult situation at the moment," says MSF health promoter Mohamed Camara. "There are many areas where there is little healthcare and where people are trapped between different armed groups. There are very few humanitarian organisations present because of the security situation. That's why it's so important for MSF to be here."

Healthcare on donkeys

Darfur has suffered throughout the past decade of conflict. The security situation remains volatile and violent clashes continue. Nasteh Shukri Mahamud is a nurse and MSF's medical team leader in Rokero, central Darfur, where providing medical care often means days spent on donkeys...

"Here in Rokero, we provide medical services at the local rural hospital, where we have inpatient wards, a maternity ward and an inpatient therapeutic feeding centre for malnourished children.

We've also opened a small and very basic healthcare centre in Umo, a remote area nestled between two mountains in the Jebel Marra range. The area is controlled by an armed rebel group that continues to fight government forces and other armed groups in the region. Around 50,000 people live there in dozens of villages scattered over the vast rocky terrain. Our team in Umo often treat injuries caused by the fighting. At night they hear gunfire.

The area has been cut off from outside assistance since 2008. The only means of transport in and out of Umo is by donkey or camel. There are no roads and no way in for cars or buses. It is a four-hour donkey ride from Rokero to Umo – a tiring and dangerous journey along rocky, slippery ground.

Below: The MSF team ride from Rokero to Umo on donkeys. Photograph © MSF

Right: An MSF team member and donkey prepare to journey to Umo. Photograph © MSF

When the MSF team arrived for the first time, the whole village – including elders, women and many children – welcomed us with excitement and anticipation. Since then, we have served this community six days a week, with a team of 20 experienced and dedicated Sudanese MSF staff. We can treat as many as 70 patients in a day.

'I SAT ON A DONKEY FOR EIGHT HOURS'

The journey to Umo is especially difficult now, during the rainy season, when the tracks become muddy and untrustworthy. I was glad I had learned to ride a horse in Ethiopia in 2012, when I worked in an MSF nutrition project that could only be reached by a one-hour ride. But on that day in Darfur, I sat on a donkey for eight hours. When I arrived back in Rokero that night, I had to walk around for 10 minutes just to feel my legs again.

I have enormous admiration for our drug dispenser Najmadin Aden Mahamed, who does the trip at least once a week to bring supplies and drugs.

It is difficult to imagine what a journey along those tracks would be like for a pregnant woman experiencing complications. The number of deaths among pregnant women and new mothers in Darfur is high. Community elders told us that some women lose their babies in the first trimester of their pregnancy because they ride donkeys and work too hard.

Our team are also very concerned about malnutrition among Umo's children. During our first month, the outpatient therapeutic feeding centre treated 60 severely malnourished children. I met a two-year-old girl currently being treated at the feeding centre, brought in by her mother seven days earlier. She had severe acute malnutrition and was weak and much too small for her age. But in that week she had changed so much. She was active and enjoyed eating again. Her mother could hardly believe how quickly she had improved. She was also surprised that our medical services were free of charge.

HOPE FOR THE FUTURE

Distances in this isolated region can be overwhelming and can make it impossible for some people to access timely emergency care. People die on the way to our health centre in Umo or reach Rokero hospital too late. In our first month, we lost two patients on the way to Rokero. As a medical professional, this is hard to accept. We also hear of sick people living in areas controlled by armed groups who are too afraid to seek healthcare.

But it's rewarding to work with such an experienced and dedicated team. All my colleagues know, from their own experiences, the hopes and worries of people in Darfur. They know all too well that many communities struggle to access the basics – like healthcare, clean water, education and protection. Some are cautiously optimistic about a recently signed peace agreement between the Sudanese transitional government and some armed groups. There is hope that it could be a first step towards peace, reconciliation and stability in Darfur, and a chance for the many hundreds of thousands of displaced people to return home.

I am proud to be a member of a team that responds to these health needs and helps save lives in a place that has been so long neglected."

MSF IRELAND'S FIELD STAFF

Afghanistan
Brigitta Gleeson, *Laboratory Manager*, Co. Roscommon
Jean Marie Majoro, *Logistician*, Co. Kildare
Laura McAndrew, *Communications Manager*, Co. Mayo

CAR
Eve Robinson, *Epidemiologist*, Co. Dublin

Chad
Nicodeme Zirora, *Finance Manager*, Co. Dublin

Iraq
Ahmed Barakat, *Infection Control Manager*, Co. Dublin
Alex Dunne, *Humanitarian Affairs Officer*, Co. Dublin
Simon Gubbins, *Medical Doctor*, Co. Galway

Kenya
Dana Krause, *Head of Mission*, Co.Dublin

Sierra Leone
Thomas Casey, *Communications Manager*, Co. Dublin

South Sudan
John Canty, *Project Coordinator*, Co. Cork

Yemen
Aoife Ní Mhurchú, *Mission Specalised Activity Manager*, Co. Cork

Gift in wills

THANKS TO YOU,

MSF will be ready to respond to the next emergency. Gifts left in Wills play a vital role in ensuring we have the funds to deliver medical care where and when it's needed.

For more information on how you can support MSF's work this way, please contact Ruth Hanahoe at **Ruth.hanahoe@dublin.msf.org** or **01 660 3337.**

‘Winter is going to be a nightmare’

In September, fires destroyed Moria refugee camp on the Greek island of Lesbos, leaving thousands without shelter. Irish MSF nurse **Niamh Burke** describes the after-effects of the disaster.

I arrived on Lesbos on the day that Moria refugee camp burned down, leaving over 12,000 men, women and children sleeping rough on the streets.

I quickly got to work with the rest of the MSF medical team, who were extremely busy treating people who had been affected by the disaster in our clinic across from the old burned out camp.

One morning shortly after I arrived, the authorities moved very suddenly to get everyone into the new camp.

Below: Floods at the new refugee camp on Lesbos island, Greece. Photograph © MSF

Most people moved in quietly, as they felt beaten, and that they had no choice.

CONDITIONS IN THE NEW CAMP ARE POOR

The new camp is very exposed, and right beside the sea, which is very dangerous for children. There’s no proper shelter from the weather conditions, which can be quite harsh in the wintertime. When it rains, it gets very muddy. It’s also very windy and cold and it’s a long walk from the entrance to the back of the camp.

There are no showers, which is very problematic from a public health point of view. We see a lot of problems with skin diseases such as scabies and lice, which we cannot treat effectively, because the patients need access to basic hygiene facilities like showers. Instead, many of the camp residents are forced to try and bathe in the sea, which has its own dangers. There are also too few toilets, and no wheelchair access. I have seen one man have to carry his disabled mother to the toilet.

As well as all this, there is serious overcrowding in the tents. As part of my job, I often accompany our patients back to the camp after their treatment at the MSF clinic. One gentleman I brought back was living with his three sons and his mother in a tent the size of a small utility room. It wasn’t off the ground in any way, and the floor was exposed to flooding. I felt terrible leaving them, as I was worried about how they are going to cope.

MENTAL HEALTH EFFECTS

This deterioration in refugees’ mental health can be directly linked to the containment policies that see them trapped in camps like Moria, which was built for 3,000 people, but was holding over 12,000 at the time of the fires. Some of the children we see are regressing, and experience night terrors. Some are terrified even to be looked at. As for the adults, anyone who already suffers from conditions such as anxiety, depression or PTSD, simply doesn’t feel safe in a camp environment where they must share their tent with strangers.

The long-term resolution to the situation is to move these people off Lesbos, to the mainland, where they can start living their lives. As nurses and doctors, we can only do so much before we must return to them to these awful conditions.

PEOPLE ARE LOSING HOPE

After the fire, the Greek and EU authorities said they ‘didn’t want another Moria’. They didn’t get another Moria; they got a worse camp. While the last camp was desperately overcrowded and unhygienic, basic facilities were in place, and people had access to some activities and could cook for themselves. Now, people are stuck in tents with very few outlets, and are losing hope.

Winter is going to be a nightmare – it was already very cold there in October. There have been a small number of evacuations since the fire to the Greek mainland and elsewhere in Europe, and there is a silent hope on the island. I worry that once these evacuations stop, that hope goes, and people are resigned to a sense of despair and hopelessness.

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