A haven in the middle of a war zone – MSF’s work in Afghanistan
AFGHANISTAN

Afghanistan: where actions speak louder than words

“There were no drugs or healthcare available in my village,” says Nadeem*, a patient in Boost hospital in Lashkar Gah, capital of Helmand province. “The entire way here I thought I was going to die – not because of my disease, but because of the shelling and the landmines.”

Nadeem suffers from severe stomach problems and urgently needed treatment. He managed to leave Marjah in the middle of an armed offensive in a Red Crescent taxi. “My wife and my children are in Marjah. As soon as I get better, I need to go back there. But I am worried because it is very dangerous.”

MSF worked in Afghanistan from the mid-1980s until the targeted assassination of five staff members forced a complete withdrawal in 2004. In late 2008, Afghani refugees forced a complete withdrawal in the mid-1980s until the targeted assassination of five staff members forced a complete withdrawal in 2004. In late 2008, Afghani refugees started telling MSF medical teams in Iran about the horrific levels of violence they faced inside their country. Free and impartial medical assistance was a clear and urgent need and in 2009 MSF returned to Afghanistan, working in the Ahmed Shah Baba hospital in the outskirts of Kandahar, and in Boost hospital, the only public referral hospital for the one million people in Helmand province.

Dr Waliullah is an Afghan doctor who has been working with MSF in the areas of Pakistan since 2004 and is now MSF’s deputy medical coordinator in Afghanistan. He recalls the problems at Boost hospital when MSF started working there. “The hospital was almost empty because patients had to pay for medicine and treatment and many people in rural parts of Helmand cannot afford even a pack of paracetamol,” he says. “And the doctors were not around for much of the time – they had their own private practices to run and were not paying enough attention to the public hospital.”

“I particularly remember seeing five wounded patients together in a room, all from the same family. A mortar, they don’t know from which side, had landed in their house. The mother was badly burned and the children had broken arms and legs and two of them needed to have amputations. The nurses had found them outside the hospital one morning. They had no money and everything from the Ministry of Health had to be paid by patients, including treatment, medicines and fuels.”

“The hospital director told me he had to go out himself and ask rich people in the community if they would help. I think he found someone willing to pay, but I remember thinking it was not enough.”

MSF’s goal is not to take over Boost hospital. Instead, the objective is to ensure that high quality treatment is available free of charge, 24 hours a day. We are supplying essential drugs, medicines and international MSF staff needed in the hospital assisting in the maternity, paediatric, surgery and A&E departments.

“Word is getting around that this is now a safe place to come,” says head of mission Michiel Hofman. “When we started in November last year we had around 30 patients in the hospital, and now there’s an average of 100.”

“We have been meeting as many elders as possible from the surrounding area. We explain that we treat everyone for free and assure them that the hospital is safe because no weapons or military police are allowed inside. They normally reply that the proof is in the eating and they’ll wait and see.”

“If people come back to their village happy with their treatment and saying they were approached with respect, the elders say they’ll start to believe us. And of course this is quite understandable, because actions speak louder than words. It’s in our actions that we can really show our impartiality, that anyone can come to the hospital and be safe and have good free treatment.”

Dr Waliullah has seen the changes happening. “Things have got so much better. Before, the mortality rate was around 30 per cent, and now it is about four or five per cent. There’s much more work for the staff and they are always busy – the nursing staff complain that they don’t have time for tea breaks!”

“Day by day things are improving. But there is still a lot to do. If you’re going to provide the MSF standard of care, you need to hire more staff and in Helmand that’s hard because this is a war zone.”

“Even though the community is starting to trust us and the treatment is free, people still face enormous challenges getting medical care. ‘The war makes it extremely difficult for people to travel even short distances,’ says Hofman. ‘Often they have to detour through the desert because main roads are either the scene of fighting or have been mined by one side or other. It’s also a very costly and risky business because on some days you’ll come across a Taliban checkpoint where they have to pay and then further along they’ll find an Afghan army checkpoint where the soldiers will also demand money and maybe the next one will be an Afghan police checkpoint.’

“As a result people wait until the last minute before going to hospital and the patients who come are mostly very sick indeed. A hundred patients don’t seem like a lot, but a hundred patients in a really bad condition means that there’s a heavy workload for the doctors. ‘We see a lot of wounded people,’ he adds, ‘but I find the most terrible thing is the patients who have treatable conditions but who because they waited too long. It’s desperately sad that in the middle of a war zone people are dying from easily treatable things like measles, malaria or diarrhoea.’

“An essential aspect of MSF’s work in Boost has been to ensure that the hospital is a safe environment. This has been one of the greatest barriers to people who would otherwise seek medical care. Fatima*, who brought her five-month-old baby for treatment, says she is afraid to go to clinics near her town because armed people are staying there.”

“One of our top priorities here has been to work on the ‘no guns’ policy inside Boost hospital,” says Volker Lankow, project coordinator at Boost. “Every day, people tell me that they are suffering from the war raging in the province, and that they are afraid to enter a hospital full of people walking around with their guns. Every patient has the right to be treated and to recover in a safe place, and we are working hard to ensure that the no weapons policy is respected.”

At the entry gate of the hospital, a sign reading ‘no guns allowed’ stands next to guards who make sure that all patients and visitors leave their weapons behind.

Cost of MSF’s basic sterile dressing set £25.60
Cost of MSF’s compact amputation set, including the minimum essential kit to conduct safe sterile amputations £504.20

msf.org.uk/afghanistan

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THE ‘NO GUNS’ POLICY

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The Tall Yellow Lady and the boy from Manipur

Dr Fiona Fisher, known to her patients as The Tall Yellow Lady, left her work as a GP in Surrey for the north-east Indian state of Manipur, where MSF teams are combating TB and HIV.

I'm working in Manipur, a stunning part of north-east India that people sometimes forget exists. A low-intensity conflict between the authorities and several 'underground groups' means it's hard to get the required 'protected area permit' to enter the region, so there are few foreigners.

I don't know what people make of me. I am very tall - unusual for a woman here - and I'm also blond, so I'm known as 'The Tall Yellow Lady'. In the villages the children are really shy - they won't greet us, they'll just stop and stare, then they pluck up courage as we walk away and spurt out everything they know in English all at once: 'good morning, good night, hello I love you', before running off giggling.

My work is so different from what I was doing back home as a GP in Surrey. Though our main base in Churachandpur is quite far from the Myanmar border, we see lots of Burmese people who have travelled for days to get to our clinic because they've heard of our free care and our antiretroviral drugs.

We have four remote clinics out in the hills, reached by driving a 4x4 on mud-path roads on the edge of steep hills. There's little room for error. The clinics are基本 bamboo and mud buildings so we have to bring the bare essentials with us, like a microscope for the lab.

We employ a local nurse and registrar in each of the clinics so by the time we arrive they have begun registering the patients and queuing them up so that the most seriously ill are at the front of the line. Then the clinic just runs beautifully - the people wait patiently in turn and everyone is grateful because the treatment is all completely free, which is unusual here.

One of the biggest health problems here is the number of people with both HIV and tuberculosis. There's one little boy who's got both, and his story is so amazing that I took two photos to try and show his recovery. Vanlalsiam's parents and two siblings have died (we assume due to AIDS) and he's cared for by his grandmother. When we first saw him he was being treated for HIV/AIDS and TB by the Ministry of Health, but was not getting any better.

When we looked at his chest x-ray we could see a lot of fluid in the lungs and also big cavities where lung tissue had been eaten away by the TB. Listening with a stethoscope you could hear his breathing sounded harsh and rasping, which is a sign there's fluid in the lungs. He was really struggling to breathe; his shoulders would go up and down with each breath and you could see his rib cage working hard with the effort of sucking the air in and out.

It was hard for us to decide whether the problem was multidrug resistant TB or whether he had a drug-resistant form of HIV. He was so weak that it was difficult to get a sputum sample to test for multidrug resistant TB, but when his HIV viral load came back from the lab as extremely high we hedged our bets and went with HIV resistance. This meant changing his regime to unusual and expensive second line drugs.

I took the first picture on the day his special tablets arrived - the MSF coordination team in Delhi had gone to great lengths to get them for us. That's why I took the photo - I wanted to show them that they'd done this for a real human being and also in a way to say thank you to them for all that effort. But I didn't think that he would survive, because he was so ill.

He was taking three tablets for his HIV treatment and one combined tablet for his TB drugs (at first he had four months of daily injections for his TB), but on top of that he also needed iron supplements, and folic acid supplements, and he had thrush on his tongue so he had a tablet for that as well, and he was taking another tablet of vitamin supplements. So I said to him, 'what a switch-on boy.' Although it's a lot of drugs, together he and his grandma make sure he adheres to his treatment. We're sure he's swallowing all his tablets properly at home, and he comes to all of his appointments on time. His grandma is so grateful, and spoils him rotten (he was eating a big bag of crisps!). She now walks him several kilometres to school each day and waits there until after class to walk him home again. When I last saw him he was playing with his classmates like any healthy 11-year-old boy.

November 2009

Vanlalsiam, 10, with his grandmother, who is also his caregiver.

'His shoulders would go up and down with each breath and you could see his rib cage working hard with the effort of sucking the air in and out.'

April 2010

Vanlalsiam, now 11, after treatment for HIV and TB.

'When I took the second photo, I just couldn't believe he was the same child!'

Minimum cost to MSF of one year's regimen of second line HIV/AIDS drugs £415

31,000 Number of basic healthcare consultations in Manipur in 2009.

Photographs © Fiona Fisher/MSF; © Sami Siva, India, 2009.
HAMZA ATHUMI is a Ugandan doctor who has worked with MSF since 2003. Here he explains what made him want to join MSF.

There was a war in northern Uganda that lasted twenty years and I joined MSF in 2003 towards the end. I had finished my training in clinical medicine and public health and had started working with a missionary hospital near my hometown of Lira. At this point the war advanced so fast that thousands and thousands of people fled into Lira. People living in the war zones were destroyed and the only place where you could get cheap healthcare for the malnourished children was this missionary hospital.

We made a therapeutic food for the malnourished children using milk we bought from the dairy corporation mixed with groundnut paste, small fish, margarine and stuff like that. We were recording good results - children were improving, deaths went down - but we ran out of money.

I moved all our children to that programme in a local hospital. We were all out of options and we had 70 children on admission and we didn’t know what to do.

It was at this point that MSF came and did an assessment in the displaced people’s camps. They saw the needs and, among other things, they saw admission and we didn’t know what to do. We were all out of money.

For me the conviction was: OK, we have the tools. We made a therapeutic food for the malnourished children using milk we bought from the dairy corporation mixed with groundnut paste, small fish, margarine and stuff like that. We were recording good results - children were improving, deaths went down - but we ran out of money.

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CONGO

Fistula surgery ends post-childbirth ordeal

In the Democratic Republic of Congo, with few hospitals and maternal health services, prolonged obstructed labour can cause obstetric fistula. A hole (fistula) develops in the vagina when the blood supply is cut off, through which urine and/or bowel waste passes uncontrollably. Those women who survive the ordeal will be left with a permanent injury to their birth canal, and the smell caused by the continual leaking means they are often rejected by their husbands and the community.

MSF is currently running a fistula camp in Shamwana, Katanga province, where skilled fistula surgeon Dr Vöker Herzog is operating on 80 women to repair their internal injuries and provide a cure for their incontinence.

The surgical procedure usually lasts about one hour for a simple case but can take up to three hours for complicated cases. “The outcome is very successful with a cure rate of 90%,” said Dr Herzog. “These women have had their dignity returned to them and we hope to start a second camp later this year in Manono.

ZIMBABWE

Women footballers make winning respect their goal

“They thought we were just playing games,” says Meria Kabudura in MSF’s short film about a group of HIV positive women in Zimbabwe. “They would laugh at us and say: How can you sick people play football? How can you women play football?”

“Women in Zimbabwe don’t usually play football and HIV positive women are stigmatised so much that they are afraid to disclose their status even to close family members. But this group of women, from one of the poorest townships in Zimbabwe, decided to form a football team to show the world that they can be proud of themselves. The film follows the daily lives of four players during the build-up to the team’s first tournament. “I have to score, I have to score,” thinks team captain Annakilfields Phiri as the final hangs in the balance. “Our team has to win. We will show the whole world. They will never look down on us again!”

“We think this story about strength in the face of adversity is important and we would encourage you, our supporters, to order a free DVD of the film and lend it to any friends or colleagues you think might be interested. You can watch a trailer and order a DVD by entering your details and supporter number at msf.org.uk/positive

EUROPEAN UNION

Last chance for affordable life-saving medicines

India produces cheap generic versions of many essential medicines, including the AIDS medicines that MSF uses in 80 percent of its programmes.

A draft free trade agreement between the EU and India contains several alarming provisions on intellectual property that would alter India’s patent law and threaten the supply of such medicines. “The impact of this proposed agreement is truly global, as treatment will become considerably more expensive, and countries and funders may have to ration the number of people they can put on treatment,” says Ariane Bauernfeind, MSF HIV/AIDS programme manager.

The EU has indicated that it wants to conclude the negotiations ahead of the EU-India summit in October. MSF warns this is the last chance to remove provisions that will block access to life-saving medicines for people living in the developing world. To find out more and watch patients and healthcare workers in Kenya explain how essential generic drugs are for AIDS treatment, go to msf.org.uk/fta

HAITI UPDATE

Since the earthquake MSF has provided medical care to more than 92,000 people and performed nearly 5,000 surgeries, in 16 operating theatres at 19 health facilities.

Latest news at msf.org.uk/ haiti

Photograph © Brigitte Guerber- Cahuzac/MSF, 2010

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Dispatches is written by people working for MSF, sent out every three months to our supporters and volunteers in the field, and edited in London by Robin Meldrum.

It costs 8p per copy to produce and 22.5p to send, using Mailsort Three, the cheapest form of post. We send it to keep you informed about our latest activities and how your money is spent. Dispatches also gives our patients, staff and volunteers a voice to speak out about the conflicts, emergencies, and epidemics in which MSF works and about the plight of those we strive to help.

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