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Innovation has become a buzzword for any new technology that purports to save time and money while improving our well-being along the way. It’s a term often applied to new gizmos, gadgets and games, and while the speed with which these are evolving can be exhilarating, it’s also easy to be cynical about fads and distractions that fail to meaningfully deliver.

But innovation is about more than the latest technologies or toys. It is the ability to adapt to new contexts and the willingness to find better ways to solve the problems we face. For an emergency medical organization such as Médecins Sans Frontières (MSF), innovation lies at the core of our work: Our efforts to alleviate the suffering created by conflict, disaster or outbreaks of disease around the world mean we are continually confronted with new situations and challenges, and must constantly find better ways to reach our patients and improve the care on which they depend.

MSF Canada is at the forefront of this movement. Our office and our support networks across the country are made up of dedicated teams of practitioners, many of whom conduct program reviews and are engaged in helping bring new solutions to improve our field work around the world. This begins with an ability to take a critical look at our current activities. Only by being truly honest about the challenges we face can we hope to find and implement appropriate solutions, improvements and best practices.

Of course, in a world in which humanitarian emergencies remain distressingly plentiful and ongoing, the constant effort to improve our ability to respond can make it seem like we’re trying to fix the plane while it’s in the air. The funds we raise are intended to save lives in real time, and aid agencies such as MSF have limited resources for research and development. That in itself presents a challenge that requires new forms of innovation, forms that MSF Canada has been working to develop: By fostering new partnerships with other innovators and creating networks that connect us with ideas, we are finding ways to bring new solutions to difficult problems.

There are times when it becomes almost unethical not to use the latest advances in our work. We see this in efforts to develop potential Ebola treatments (Page 5) or find better ways of tracing disease outbreaks (Page 4).

I hope you will enjoy this look behind the scenes at the evolution of our humanitarian activities — all carried out with the singular focus of improving the delivery of emergency medical aid to where it is needed most.

Stephen Cornish
Executive director, MSF Canada
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The ice and snow of the Canadian Arctic and the sweltering interior of a Médecins Sans Frontières (MSF) treatment centre in Africa don’t seem like two environments with much in common. But a new project spearheaded by MSF Canada aims to use technology designed for one climate to help save lives in another — putting cold-weather ingenuity to work in the hot-weather regions where MSF often works.

The innovation starts with a simple form of technology: a tent. Tents are crucial pieces of equipment in many MSF emergency medical interventions, but they are not without drawbacks, especially in hot climates. Because they trap heat, tents can be problematic for the storage of temperature-sensitive medicines, and can cause discomfort for staff and patients alike. This last problem is especially striking when it comes to managing infectious diseases, such as the ongoing Ebola outbreak in West Africa or other highly contagious illnesses.

To cut the risk of viral transmission, patients must often be isolated and doctors required to wear hot and heavy personal protective equipment (PPE) at all times. As the Ebola response has shown, all that heat can have a direct impact on patient care.

“The problem is that you can only really spend at most 40 to 45 minutes dealing with patients before the heat in the suit gets too much and you start running the risk of making mistakes,” says Dr. Tim Jagatic, an MSF physician from Windsor, Ontario, who has been at the forefront of MSF’s Ebola response in Guinea and Sierra Leone. “At that point you have to leave the ward and remove your PPE, which seriously reduces the amount of effective time you can spend actually treating patients.”

FROM NORTH TO SOUTH

Enter Design Shelter Inc., a Canadian company that specializes in making insulated tents for use in the Arctic. The same principle that allows people inside the tents to stay warm in spite of frigid temperatures outside can also be applied in reverse to hot-weather climates — a notion that caught the attention of MSF’s Toronto office.

“The strict safety protocols MSF uses when responding to infectious disease outbreaks, like the ones in place at our Ebola treatment centres in West Africa, are designed to ensure there is as little chance as possible for viral transmission,” says Jonathan Jennings, the deputy executive director at MSF Canada. “That means our medical staff must wear full PPE at all times — the space suits you see in media coverage of the Ebola crisis — and in a field-hospital setting that heat can get overwhelming. If we can find a way to moderate those temperatures, it will have a direct impact on levels of care for our patients.”

While back in Canada recently, Dr. Jagatic observed a demonstration of Design Shelter’s tent in Mississauga, Ontario, and liked what he saw. Not only did the structures offer advanced thermal insulation, which can greatly improve temperature control in the field, but a modular design and lightweight material mean the tents can be expandable, transportable and possible to set up within 30 minutes — ideal for emergency settings. More significantly, the tents have the potential to be fully decontaminated, which would mark a great improvement over current practices.

“Right now the tents we’re using at our Ebola treatment centres have to be burned when we’re finished with them, because they can’t be entirely decontaminated,” says Jennings. “That’s a concern for a number of different reasons, which is why this technology is important for us to consider.”

NEW PARTNERS, NEW IDEAS

MSF Canada cultivated a unique partnership with a new donor willing to fund innovation work, and then customized the insulated tents to meet the medical needs in the type of contexts where MSF works. The next step will be to pilot the tents in an infectious disease scenario where MSF thinks they will have an immediate impact on their ability to respond to future disease outbreaks. By connecting with new partners and working with our donors, we can try to create new solutions that will improve our ability to save lives.”
When London, England, was struck by a cholera outbreak in 1854, British epidemiologist John Snow wrote down addresses of cholera victims, put them on a map, traced the outbreak and figured out its source: a contaminated water pump in Soho, which was then immediately shut down.

Fast-forward more than 150 years, to the 2010 cholera outbreak in Haiti: Canadian Ivan Gayton (pictured above with volunteers from the University of Lubumbashi, Democratic Republic of Congo), then head of mission for Médecins Sans Frontières (MSF) in Haiti, was surprised to find that the most accurate maps of the capital, Port-au-Prince, had only just been created following the earthquake of a few months earlier, by volunteers for the Humanitarian OpenStreetMap Team. Without those maps, MSF would not have been able to trace the cholera outbreak. “We were successful in mapping cholera in Haiti, but realized the staggering scale of the job required in order to do the same everywhere else,” recalls Gayton. “In the West, we take for granted that we have maps in order to practice public health. You will never be treated at a hospital in Canada without being asked your address. If we want to give the same level of care to people in resource-poor countries, we have to know where they are from.”

Accurate, up-to-date maps are essential tools for aid agencies responding to emergencies. But even in the age of satellite photography and Google Earth, many communities around the globe are literally not yet on the map. Inspired by his experience in Haiti, Gayton co-founded the Missing Maps Project, a collaboration between MSF, the Red Cross and the Humanitarian OpenStreetMap Team. The project’s ambitious goal is to map the world’s poorest and most vulnerable places within the next two years.

**THE MISSING MAPS PROJECT**

**MSF DRAWS ON A GLOBAL NETWORK OF VOLUNTEERS TO HELP PUT THE WORLD’S MOST VULNERABLE PLACES ON THE MAP**

**PREPARING FOR WHEN DISASTER STRIKES**

Missing Maps was officially launched in November 2014, when volunteers around the world started mapping settlements in West Africa affected by the recent Ebola outbreak. But while the Ebola mapping exercise was reactive, the ultimate goal of the project is to create maps proactively.
“Instead of waiting for the crowds to arrive when there is a CNN emergency, let’s use the names of MSF and the Red Cross to inspire people to create maps before a disaster strikes,” says Gayton. “We choose the vulnerable places, we map them, and when a disaster strikes we are ready.”

Currently, any given Missing Maps project begins with MSF or the Red Cross making a mapping request for a particular place; from that point, it takes about 20 days to create a map. The next step is to take satellite images, made openly available by sources such as the European Space Agency, and plug them into OpenStreetMap, an open-source mapping program. Teams of online volunteers around the world — often gathered together at so-called “mapathons” in cities such as London or Jakarta — then trace the outlines of buildings, roads, rivers or other landmarks on the satellite images to create digital base maps. Sections of these maps are then sent to local volunteers, who print out the pages and walk around the city to add street names and other details. All pages have a QR code, and when they are scanned and sent back to OpenStreetMap, the new information is automatically added. As a last step, data-entry parties are held to make sure all data are accurately entered into the map. Humanitarian organizations can then use the mapped information to plan risk-reduction and disaster-response activities.

MAPMAKERS OF THE WORLD UNITE

To create a map of Lubumbashi in the Democratic Republic of Congo, a town prone to cholera outbreaks where many streets remained undocumented, Gayton walked around the city with MSF staff and volunteers from the local university’s geography department. “During that time, we had mapathons in Germany, the UK, Canada, Hungary, Burkina Faso, Togo and Senegal that were supporting us,” he says. “If you look at the map of the southern part of Lubumbashi on OpenStreetMap now, it looks like downtown Manhattan. We had 17 people working in the field, and hundreds supporting us from abroad. That’s how you get it done.”

The first Canadian mapathon took place in Vancouver in November 2014. Almost 40 people participated, most of them gathering in one room to trace the outlines of a town in South Sudan. Participants were enthusiastic. “There were a lot of people who were really excited that they could contribute to something that is ongoing and be directly involved with an aid organization,” says Christian Hill, the organizer of the Vancouver event. “It’s really exciting to know that what you are doing directly affects what happens on the ground.” The digital volunteers in Vancouver plan to meet once a month to continue with their mapathons. Gayton hopes that more Canadians will join — particularly members from diaspora communities who can contribute to the creation of maps of their home countries.

Claudia Blume
Press officer

For more information on the Missing Maps project, visit msf.org.uk/missing-maps-project; to learn about the Humanitarian OpenStreetMap Team, visit hot.openstreetmap.org/.


TREATING EBOLA

A CLINICAL TRIAL FOR EXPERIMENTAL DRUGS IN LIBERIA ENCOUNTERS AN UNEXPECTED CHALLENGE

As the largest single medical responder to much of the Ebola outbreak in West Africa, Médecins Sans Frontières (MSF) is in a unique position to help with efforts to find effective treatment for the disease. In early 2015, the organization began hosting partnered clinical trials for a potential Ebola drug at ELWA 3, the Ebola Management Centre it runs in Liberia.

As it turned out, the project did not go as planned, but the reasons were not entirely negative: In February, MSF announced the halt of the trial due to a significant drop in Ebola case numbers at the centre.

“We’re relieved that there are fewer patients infected with the Ebola virus in Liberia,” said Dr. Bertrand Draguez, the MSF medical director overseeing the trials. “While it’s disappointing not to have a definite outcome, it is good news for the people of Liberia who have suffered Ebola for so long.”

Led by Oxford University, the trial had been aimed at determining if the anti-viral drug brincidofovir is a safe and effective treatment for Ebola. “We know that brincidofovir has been taken safely by over 1,000 people in clinical trials for other viral infections and we know that it has been shown to be effective in laboratory tests that use Ebola-infected cells. What we do not know yet is if it will be effective against Ebola in humans,” said Oxford’s Dr. Jake Dunning at the launch of the trial.

With the drop in patient numbers in the Liberian capital of Monrovia, however, the trial was unable to continue as planned — though MSF stated its resolve to continue efforts to help defeat Ebola in the region by whatever means possible. “The number of patients may be declining, but the epidemic certainly isn’t over yet,” said Dr. Draguez. “We are adapting our operational response to this new phase of the epidemic, with an increased focus on surveillance and contact tracing. At the same time, we remain dedicated to finding out as much as possible about potential treatments, vaccines and diagnostic tools, to prevent a repetition of the tragic loss of lives in this or any future outbreak.”
The Ebola crisis in West Africa has presented a number of challenges to agencies such as Médecins Sans Frontières (MSF) who have spent the last year working to stop the outbreak and to treat those affected by it. The virus was first identified in 1976, but it was not until the start of the current epidemic that Ebola began to receive widespread attention. Before then, MSF was one of the few organizations with significant hands-on experience treating the disease, and much of the practical knowledge about patient care and risk management in Ebola operations was held by those who had been previously involved in earlier outbreaks.

The unprecedented nature of the ongoing emergency in West Africa has exposed the limited extent to which that expertise has been shared. The sheer breadth of the outbreak has required more personnel in higher volumes than any previous response to the disease, and both the risks and the arduous nature of working in an Ebola context has meant that international healthcare workers must work for shorter rotations in the field. As the Ebola crisis developed over the summer of 2014, a potentially dangerous knowledge gap became evident — more people were desperately needed to help respond, but the risks of the disease made it necessary to ensure they were adequately trained about it.

Sharing Information

It was this knowledge gap that caught the attention of MSF Canada’s Program Unit, an innovation team based in the organization’s Toronto office. “Reports from the field were getting worse by the day,” says Fabien Schneider, the unit’s manager. “MSF’s human resources were under an immense strain, and there weren’t enough Ebola-experienced people to go to the field. It was a huge challenge for the organization. We wondered if we could help by finding a way to get more people effectively trained more quickly.”

Trainings for MSF field workers headed to the Ebola zone were already being conducted, but they could not be provided often enough to replenish the pool of qualified staff. The Program Unit began working with colleagues in Europe to develop an online briefing tool designed to address the shortfall.

“The overall vision was to adapt all the key information typically offered face-to-face to an online learning environment,” says Dominique Giguère, the unit’s senior instructional designer. The tool, known as an eBriefing, would not replace the existing face-to-face training, but would be used as a jump start, enabling staff to become familiar with Ebola safety protocols more quickly. It could also be used as a refresher for staff already in the field and a curriculum guide to equip staff trainers with knowledge they could share with colleagues and community members.

Given the pressures in the field, the development team knew time was of the essence. “The project plan had extremely tight delivery times for each step,” says Giguère. “We were all determined to deliver.”

Small Steps, Big Differences

By late October, the eBriefing was made available for the first time. Demand was immediate, not only from within MSF, but from other organizations on the ground in West Africa. USB drives containing the course material were shared with front-line response teams working in places where the internet was not available.

Patrick Robitaille, an MSF field coordinator from Montreal who recently returned from six weeks in Sierra Leone, where he was part of MSF’s Ebola response team in Freetown, was able to make use of the training tool before he left for Africa — something he says helped prepare him for work in a context that was unlike any of his previous MSF experiences. “I was much better prepared for the training I had in Europe,” he says. “I’m very grateful, because I had limited time to become familiar with a disease that many of us knew little about, one that requires expert management in the field because of the transmission risks.”

As Robitaille points out, small changes in the way MSF adapts to new crises such as Ebola can have an impact. “There is still a lot to be done in order to integrate the eBriefing model into our practices, but this tool has already made a difference in the field,” he says. “It’s a great way to increase knowledge, especially when training time is lacking. In an emergency such as Ebola, that knowledge is crucial.”

Stephen MacKay
Program unit coordinator

Visit the open learning resources at ecampus.msf.org to see more about MSF’s Ebola eBriefing.
ONE STEP AHEAD
STopping ebola in west africa requires knowing where the virus will go next, as one canadian epidemiologist learns

One day last fall in the north of Liberia, a woman in her early thirties was lying on a mattress in the bed of a pickup truck — the local version of an Ebola ambulance. Her name was Yassah, and her husband Jackson and their three sons, aged seven to 13, rode with her. She was being rushed for medical care at a Médecins Sans Frontières (MSF) Ebola Treatment Centre in the town of Foya.

Tragically, moments before arriving for medical treatment, Yassah succumbed to the Ebola virus and died. For Dr. Bruce Reeder, an MSF epidemiologist from Saskatoon whose job was to determine how Foya’s Ebola patients had become infected and where the paths of transmission might lead, the next moments were critical.

“We had to interview Yassah’s husband to determine when and where she became sick and with whom she’d been in contact,” Reeder says. “It’s crucial to follow up with every contact and monitor them for possible infection. That way transmission of the disease to others in the community can be minimized. As well, early diagnosis and provision of care can increase the patient’s odds of survival.”

WHERE WILL THE VIRUS GO NEXT?

Getting such information can prove essential to saving lives. But it also meant that Reeder often had to conduct interviews with people in difficult circumstances, such as Yassah’s husband. “Jackson was extremely upset after the passing of his wife, shaken with grief,” Reeder recalls. “But by interviewing him I was able to tell where the infection had come from, and to delineate who else may have been exposed.”

Jackson revealed that Yassah had recently visited relatives in the capital city of Monrovia before returning ill to her home village. The epidemiologist notified the health authorities in both the village and the capital so they could follow up and monitor each contact’s condition. Without such contact tracing, stopping an epidemic on the scale of the ongoing outbreak in West Africa will be nearly impossible. MSF has worked with the Liberian Ministry of Health and Social Welfare and called upon members of the international community to help meet those needs — with some success. “When the epidemic was escalating in August 2014, more effort was finally put into contact tracing,” says Reeder. “But it is a logistical challenge for the Ministry staff; it is still not as thorough as it should be.”

GETTING THE MESSAGE OUT

Another critical element of any effort to control the outbreak lies in spreading the message about the Ebola virus and how it works. Before the current epidemic, Ebola had never been seen in West Africa, and many who lived there were poorly informed about the disease. But Reeder saw evidence that the efforts of MSF and others to disseminate vital public health information was having some effect — something he saw even in the unfortunate case of Yassah and Jackson.

“Jackson told me he was just a simple farmer, but that he knew he had to protect his boys and the community from Ebola,” Reeder says. When Yassah first became sick, it took two days before an ambulance could bring her to the Ebola centre. In that time, Jackson kept visitors away, kept his children separated from their mother and wore plastic bags on his hands while tending to his ailing wife — all important ways of mitigating the transmission risk. “It was very brave, and he was doing all the right things with the resources at his disposal,” says Reeder.

Tragically, Jackson and his youngest son developed Ebola symptoms and died within a week of Yassah. But the remaining two boys survived — something Reeder says probably would not have happened without their father’s actions. “He very likely saved their lives,” Reeder says. “He knew he had to protect his boys, and he did so as best he could.”

Jacob Kuehn
Press officer

MSF withdrew from Foya in December 2014 after receiving no new cases at its Ebola Management Centre since the end of October. The success of MSF’s intervention in Lofa County, where there had previously been an overload of Ebola patients, has been attributed to the benefits of MSF’s comprehensive approach to treatment at its project there.
More than one year after the start of the emergency response to help refugees from the Central African Republic (CAR) who have been fleeing to the eastern part of Cameroon, the work of Médecins Sans Frontières (MSF) continues. These refugees remain vulnerable, with many suffering from psychological trauma.

In some centres, MSF’s conventional medical treatment for child malnutrition is being offered in conjunction with psychosocial support. This multi-disciplinary approach, which includes mental health activities for malnourished children and their families, promotes the recovery of the young patients. Mira Demachkié is a psychologist and mental health coordinator with MSF, and recently discussed the mental health aspect of MSF’s work with malnourished child refugees from CAR.

Why are mental health activities being combined with treatment for malnutrition?

MD: Helping malnourished children back to health entails much more than just giving them food. We know that a malnourished patient’s mental health can have a positive or negative impact on the progression of the condition. Physical and emotional stimulation are essential for proper child development. Malnourished children often suffer from apathy or a regression in motor skills. We aim to improve recovery by strengthening the parent or carer’s bond with the sick child.

At MSF, we are keen to increasingly integrate mental health activities with nutritional care. Indeed, mental health deserves attention in any context. Most of the patients admitted to our nutrition centres in the region are refugees who have fled from CAR. These families have experienced war and displacement. Some of them have witnessed friends and family being killed or tortured. These gruelling experiences trigger psychological reactions that deserve our full attention, as they can slow down the recovery of a patient’s health. Consequently, we also offer individual consultations to patients or family members who could benefit from them and are open to receiving our support.

What activities are being conducted?

MD: Besides individual consultations, we hold parent-child group sessions where we explain aspects of nutrition to the parents (or carers), highlight the importance of their roles and build up their self-esteem. These people are prominent in the lives of the young patients, and will help the youngsters grow and interact with the world around them.

During the sessions, we encourage emotional stimulation of the child and stress the importance of eye contact and touch. Working with the health promotion team, we organize role-plays, and we invite the parent to play with the child, or we encourage them to dance or draw together.

What are the effects on the health of the malnourished children?

MD: Children are very sensitive to what they get from their care givers. A sick child who is neglected has little will to survive. The World Health Organization has shown that giving psychosocial support during the treatment of malnutrition can have a positive effect on nutritional recovery.

Integrating mental health activities with medical care and health promotion improves the overall treatment of patients suffering from malnutrition; these activities need to go hand-in-hand. This is also an example of a great unit at the heart of the MSF teams, which highlights the benefits of — and the need for — mental health activities.

According to official figures, nearly 130,000 refugees from the Central African Republic have entered Cameroon since January 2014. MSF is working to support Cameroon’s Ministry of Health and is present in the east of the country, where the majority of the refugees have settled. Since February 2014, MSF has been addressing the needs of the refugees, providing medical consultations, treatment of moderate and severe malnutrition, referral of serious cases to the district hospitals, psychosocial support and activities linked to water and sanitation.
Travelling from Numbi to Minova, in eastern Democratic Republic of Congo (DRC), would be a dream ride for any motorcycle enthusiast. More than two hours of slopes, slippery surfaces and obstacles of all kinds make the journey a test of skill, as well as a chance to take in some beautiful scenery.

But for thousands of inhabitants of Numbi and the surrounding highlands, riding these roads has nothing to do with fun or the landscape. It is practically the only route to Lake Kivu and the city of Minova, and many sick or pregnant passengers rely on the skills of local motorcyclists to help them reach the only hospital in the area. In that case, driving a motorcycle with a patient as a passenger on the back is more than an adventure — it is quite a feat. “I have never encountered an impossible situation; you always find a way. But sometimes you have to cross yourself before accelerating,” explains Shabadé, a motorcycle driver who works for Médecins Sans Frontières (MSF) in the province of South Kivu.

Whether in exploratory missions to detect the needs of populations in remote areas or as a service to transport patients, these bikes help bring medical care to tens of thousands of people who otherwise would remain deprived of assistance. Lack of access to health care is a major problem in DRC, a country that has less than one hospital bed per thousand inhabitants and slightly more than one doctor per 10,000. These indicators are among the worst in the world.

“It’s a lot of pressure because you have to go fast but also carefully, because you are driving people in a delicate situation,” says Akonkwa, an MSF motorcyclist in Numbi.

Sometimes not even the expertise of these motorcyclists is enough to reach the health centre in time. “Recently we were driving a pregnant woman to the hospital but she started to have the baby. Luckily, the guy on the support bike had some experience and we were able to help the woman to give birth. Everything went well,” recalls Brimana, one of the newest MSF motorcyclists in Numbi.

**GOING WHERE CARS FEAR TO TREAD**

To manage routes like the one from Numbi to Minova — which, thanks to treacherous and uncertain terrain, cars only do in extreme cases and never in the rain — MSF has consolidated its network of motorcyclists with locals already making their living as part of the country’s vast network of mototaxis. And it’s not just in South Kivu that MSF uses motorbikes to reach patients. Oonagh Curry (pictured above left with MSF driver Gentil) is a Canadian who recently returned from Goma, on the other side of Lake Kivu from Minova, where she was MSF’s deputy head of mission. She says the bikes can be an essential tool for MSF’s work elsewhere in DRC. “We consistently use motorbikes in the remote areas surrounding two of our projects in North Kivu,” she says. “Populations who are most affected by violence, including those who are repeatedly on the run from fighting, are often located in some of the most remote and difficult to access areas of eastern DRC. Motorbikes help us reach patients in places where there aren’t any roads or where heavier vehicles can’t go because of heavy rains and landslides.”

The responsibilities of MSF drivers can also go beyond ferrying passengers and supplies. “As with all staff working with MSF, you need to be a humanitarian and driven to do what is necessary to reach patients in need of medical care,” says Curry of the motards, as MSF’s motorcyclists are known. “Once they’ve arrived and have had a chance to rest after several hours of rough road, they often take responsibility for whatever is necessary to make sure our medical activities go smoothly.”

For many of MSF’s motards sans frontières, working in such contexts can make their occupations about more than just income. “This job teaches you much more as a person,” says Brimana. “It gives you a better understanding of the society you live in.”
With a population of more than 100,000 people, the internally displaced persons camp that took shape last year at the M’Poko airport in Bangui, the capital of Central African Republic (CAR), was in many ways like a small city. People had come to the airport in search of safety following an explosion of violence in CAR in late 2013, but those who gathered amid the grounded planes had little access to basic services such as water supply. Many were trying to survive on less than one litre of water per day — far less than the amount required for survival in the first days of an emergency, and nowhere near the minimum of 20 litres per person a day called for by basic health and hygiene guidelines.

Martha Gartley (pictured above with the MSF water and sanitation team in Bangui), a Canadian water and sanitation specialist with Médecins Sans Frontières (MSF), recalls the organization’s efforts to find a way to address that shortfall. “The camp was close to the river,” she says. “MSF was able to run a water treatment plant that could supply enough water to provide people with six litres a day — not a lot, but at least the minimum to ensure survival.”

For Gartley, an engineer who worked on municipal infrastructure projects in Canada before joining MSF, the organization’s ability to create a functioning water supply system for so many people in such a short time was a moment of great satisfaction. “In many ways, supplying water to a camp like that is quite similar to the challenges of supplying water to towns in Canada — needs are needs and solutions must be found,” she says. “But in other ways, it’s quite different, because you don’t have any of the resources or basic systems in place. In this case, it was really impressive to see everyone come together quickly to develop a solution that had such an immediate impact on people’s lives.”

AN EXPERTISE IN HIGH DEMAND

Gartley’s time in CAR was just one of nine postings she has undertaken with MSF since 2010, when she travelled to Baraka,
in Democratic Republic of Congo (DRC), as a water and sanitation specialist — or “wat-san” in the standard MSF field terminology.

“I had finished my master’s degree in water resources engineering, and I was working in the private sector in Toronto,” she recalls, “when I met with a former colleague from my days as a treeplanter in Northern Ontario. She was working with MSF at the time, and she told me that watsans were a huge need in many of the places where MSF works.”

After visiting the recruitment section of the MSF Canada website, Gartley submitted an application; following her completion of the hiring process, she received her first MSF assignment, and soon found herself on the ground in DRC. “Baraka was a great first mission, because it was such a diverse project. I got to see so many different dimensions of MSF’s work,” she says. “Then, after my time in DRC, I went to Haiti, arriving shortly after the start of the cholera outbreak, and was able to see firsthand the needs in an acute emergency situation. Through both experiences I learned a lot, and have continued to be part of MSF emergency responses since then.”

Water and sanitation are essential components of MSF’s medical programs everywhere the organization works. Access to clean water for both drinking and hygiene, adequate sanitation to help control the spread of waterborne disease and properly managing waste are key ways of promoting basic health and preventing viral transmission. In many places where MSF operates, water supply systems and basic sanitation facilities are either inadequate or non-existent, so the organization must develop them in order to support its medical teams and the people they serve.

“A lot of people from my field are reluctant to apply because they think that MSF is just an organization for doctors and nurses,” Gartley says. “But there are so many different skills required. In my last mission, as part of the Ebola response, watsan made up over half of the staff we needed.”

Gartley recently returned from Kailahun, Sierra Leone, where MSF operates an Ebola treatment centre. Effective infection control measures, including water and sanitation systems, are vital to the successful management of the Ebola virus. Watsan teams are responsible not only for spraying, cleaning and other sanitation measures, but for removing the bodies of recently deceased patients — a critical and dangerous task, since that is when the virus is most likely to be transmitted.

“Those guys were just incredible,” Gartley says of the watsan team — made up of local Sierra Leonean staff — that she oversaw while in Kailahun. “I really had a lot to learn from them. They were the experts on the ground.”

With a capable team in place, Gartley found herself better able to focus on essential administrative support and direction — something not dissimilar to her professional experience in Canada. “Effective management is hugely important,” she says. “Whether you work for an engineering firm or are helping with an MSF Ebola project, it’s a necessary skill to have.”

For more information on working overseas with MSF, visit msf.ca/en/work-field.

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WALK WITHOUT BORDERS: CHALLENGE ACCEPTED

Thanks to Médecins Sans Frontières (MSF) Canada’s devoted and energetic supporters, the Walk Without Borders Challenge was an enormous success. Over six weeks of walking and fundraising in September and October 2014, you brought in more than $270,000 to help MSF provide medical care to people in need around the world.

The campaign was run entirely online at WalkWithoutBorders.ca and MarcheSansFrontieres.ca. More than 560 participants emailed, tweeted and sent Facebook appeals to friends, family members and acquaintances, yielding almost 4,000 donations.

We were pleased that many of you helped promote the campaign by photographing yourselves walking in solidarity: with Lorraine, the young HIV-positive mother from Zimbabwe; with Aboubacar, the father from Niger who walked to get healthcare for his malnourished daughter and pregnant wife; or with David, an MSF field worker from South Sudan who walked long distances to get medical care for his displaced patients.

The success of Walk Without Borders is all the more impressive considering how many other worthwhile fundraisers were competing for Canadians’ dollars and participation this past fall. It’s a testament to how much MSF’s medical humanitarian mission means to all of you. We’re grateful and inspired by your commitment.

We’re especially appreciative of the outstanding efforts made by Friends of MSF student groups at universities across Canada. Many of them organized group walks and runs that not only raised money but also helped raise awareness of MSF’s work.

The top Walk Without Borders fundraiser was Dr. Raghu Venugopal from Toronto. Some of you may recall his articles in previous issues of Dispatches, reporting back on his MSF missions around the world. Walking together with his young son, Raghu raised more than $20,000. He was inspired by the MSF teams working in West Africa to treat patients affected by the ongoing Ebola outbreak.

Writing from Pakistan, MSF physician and Walk Without Borders fundraiser Sarah Giles had this message for participants: “You have not just raised funds and awareness, but you have lifted the spirits of those of us in the field. I feel so amazingly supported by my fellow Canadians.”

This was MSF Canada’s first experiment with crowdsourced fundraising, and one that we plan to repeat in 2015. Start getting ready – we’ll be challenging you to surpass 2014’s results. And tell your international friends to prepare as well: Already, other MSF offices from around the world are calling to find out how to replicate Walk Without Borders in their countries.

Andrew Lingard is no newcomer to physical challenges. The 24-year-old is an avid runner and cyclist who once rode his bike from Niagara Falls to Montreal to raise money for his grandmother’s breakfast club.

So when Lingard decided last summer to find a way of supporting Médecins Sans Frontières (MSF)’s efforts to stop the Ebola outbreak in West Africa, the idea of raising money by riding the entire distance around Lake Ontario — some 800 kilometres in all — didn’t seem unreasonable. “Anyone can do it,” says Lingard modestly of his journey. “Biking is a low impact sport.”

The McGill University graduate, who recently completed his master’s degree in experimental medicines, was impressed by MSF’s response to the Ebola crisis this past year. “No one was talking about [the Ebola epidemic] in a constructive manner and MSF was throwing itself into it,” says Lingard.

Lingard visited communities around southern Ontario to find people willing to support his efforts. By September 23 last year, he was ready to begin his journey, leaving from Lewiston, N.Y. and heading east.

The ride itself was a mix of pleasurable views along the Erie Canal and painful experiences, including very long days and an ankle injury that almost made the cyclist give up in Picton, Ontario. But perseverance — and a great physiotherapist who donated his expertise to Lingard when he heard why he was riding around the lake — made it possible for him to finish his journey in his hometown of Niagara-on-the-Lake, Ontario, on September 28.

In all, Lingard managed to raise $6,500. “People were seeing Ebola on the news every night and they really wanted to do something,” he says. “They could see how much suffering there was, and they really wanted to reach out.”

Faith Leleu
Contributing writer
The conflict that erupted in South Sudan more than a year ago has left people more vulnerable to a deadly tropical disease known as kala azar (visceral leishmaniasis). The risk of infection increases as people are displaced by fighting into areas where the disease is prevalent and malnutrition lowers their ability to fight the infection. With many health facilities not functioning in conflict areas, getting treatment is more difficult.

Last year, Médecins Sans Frontières (MSF) treated over 6,700 cases of kala azar in South Sudan, more than double the number of cases it treated the year before. The majority of people treated were in Lankien, a dusty settlement in the conflict-affected state of Jonglei.

“For nearly 20 years, MSF has been running a clinic and hospital in Lankien, providing primary healthcare services and treatment for tropical diseases such as kala azar,” says Casey O’Connor, who oversees MSF’s activities there. “Early in 2014, it was evident that both the outpatient clinic and the hospital were overwhelmed by war-wounded patients, plus we were providing healthcare services to the growing number of people who had been displaced by the conflict.”

In Jonglei state, people have been uprooted from their homes by fighting and insecurity. Many have moved into acacia forests where sandflies, which help spread kala azar, breed. Sleeping out in the open, often without a mosquito net, increases the risk of infection.

THE COLLATERAL DAMAGE OF CONFLICT

Many health facilities used to offer testing and treatment for kala azar, but since the recent conflict started, most are no longer functioning, or are struggling to get medical supplies. This has lethal consequences, as without treatment the disease has a nearly 100 per cent fatality rate in eastern Africa.

“The outpatient clinic started overflowing with patients in June, with rising numbers testing positive for kala azar — much earlier in the season than anyone could remember and in numbers not seen before in Lankien,” says O’Connor.

The disease attacks organs such as the liver, spleen and bone marrow, and depletes the immune system, leaving patients vulnerable to serious infections. The treatment often takes 17 days and requires two daily injections. In severe cases, and for pregnant women or people with HIV, it requires admission to hospital and the administration of intravenous medications for five days.

“At one point we had five injection teams treating 800 patients per day. And no one likes the treatment — painful intra-muscular injections into the buttocks. Not just once, but for 17 painful days. All day you can hear the children crying from the pain of the injection,” says O’Connor.

From July to September last year, nearly 2,000 patients were on treatment for kala azar in Lankien. That rivals the worst outbreak there since data was first recorded in 1999. The outbreak has since slowed; numbers went down in late October and started to level off, but concern remains. “There is a critical shortage of drugs for treatment on a global level — some of them take six months to manufacture and the world-wide supply is under strain, as there is only one manufacturer,” says O’Connor. “Any rupture in the supply of medications means treatment is interrupted and the patient must start all over again with painful injections. But getting early and sufficient treatment means the difference between certain death and recovery — which comes with the possibility of life-long immunity to this disease.”

In South Sudan’s Jonglei state, MSF provides treatment for kala azar in Lankien, Chuil and Yuai. In neighbouring Upper Nile state, teams are responding in Malakal and Melut. In 2014, MSF treated a total of 6,754 kala azar cases in South Sudan, compared to 2,714 cases in 2013.
HOW MSF WORKS

THE RIGHT PEOPLE IN THE RIGHT PLACES
AN INTERVIEW WITH MSF FIELD HUMAN RESOURCES MANAGER CHRISTOPHE LEFEBVRE

Médecins Sans Frontières (MSF)’s ability to deliver emergency medical care in nearly 70 countries around the world requires the efforts of many dedicated people. In a new series called “How MSF Works,” we talk to some of those who help the organization reach the people who need its assistance most. In this instalment, we speak with MSF Canada’s field human resources manager Christophe Lefebvre.

How do you make those connections?

CL: We work with partners in the operational centres. Rather than hire people for specific positions in the field, we recruit them and place them within one of four different pools: medical, logistical, operational or administrative. A pool manager at the operations centre is in contact with the field and knows what positions are needed. So then we receive requests: There might be a need for a neonatal nurse to work in Haiti, for example. And if I know someone that fits that profile, I can contact them and make the recommendation.

Is it easy to make those matchups?

CL: There often have to be compromises between the needs in the field and who is available. But there is a really low rate of failure, because most people are flexible. You have to be flexible to work with MSF! That should be the headline of this article.

What impact has Ebola had on staffing pressures?

CL: There is always a time pressure in our work, because field requests often need filling ASAP, especially for MSF’s work in emergency contexts. With the Ebola crisis, the needs are immediate and the planning is still for the short term. The challenge is that, because of the specific risks of Ebola and the intensity of the work, the duration of expats’ field missions is only five to eight weeks. So each project is going through 30 expats or so every cycle. As a result, everyone needs to be extremely flexible — except that Ebola requires a certain amount of experience and professional knowledge, so only the most qualified are going.

Are expats from places like Canada the majority of MSF’s workers in the field?

CL: Not at all. Only one in 10 of our staff members are expats. The rest are national staff — people from the country where MSF is working. It is the national staff who do most of MSF’s hands-on work, and it’s for them that we are also focusing on training and development to help them in their careers.

Is it possible to have a long-term career with MSF?

CL: Yes! Extra trainings, whether internal or external, is one way to help our workers develop their own career paths within MSF. Part of our role is to identify those who will lead the organization tomorrow and to help them grow. We’re also developing mentoring programs to help people in this way.

What’s the best part of your job?

CL: The fact that we are so close to what’s happening in the field. We stay connected with the day-to-day activities and operations, and we can really see the impact we have. It can make you feel very proud.
AFGHANISTAN
Amal Ali Victoria, BC Nurse
William Prowlright
Gonzalo, BC Personnel development manager
Brenda Vittachi Dorval, AB Nurse

BANGLADESH
Pierre Labranche Montmagny, QC Project coordinator

CENTRAL AFRICAN REPUBLIC
Marthu Nicola Blanchard Vancouver, BC Logistics manager
Céline Lafortune Frelighsburg, QC Deputy medical coordinator
Henniette Huyrin Bordsson, QC Finance coordinator
Philippe Cottereau Montréal, QC Finance coordinator
Joseph Davidson Toronto, ON Flight manager
Olouf Eduord Domage Quebec, QC Doctor
Marc Forget Montréal, QC Project coordinator
Marlyn Gauvin Quebec, QC Nurse
Peter Heikamp Willowdale, ON Logistics coordinator
Brigitte Iserson-Vaslav Pointe-Claire, QC Nurse
Amine McNeill Shortt, QC Medical activity manager
Amy Nyland Montréal, QC Nurse
Lung Ji Pan Montréal, QC Nurse
Francis Pineault Montréal, QC Administrator
Elizabeth Starwary Lachute, QC Logistics coordinator
Stephanie Taylor Whitby, BC Project medical referent
Gennadi Velotkin North York, ON Mental health activity manager
Petraen Wouda Saint-Lambert, QC Head of mission

CHAD
Katherine Clark Toronto, ON Administrator
Meagan Cooper Mississauga, ON Nurse
Brigitte Iserson-Vaslav Pointe-Claire, QC Nurse

DEMOCRATIC REPUBLIC OF CONGO
Eboukeli Aka Mississauga, ON Pharmacist
Deanna Allan Toronto, ON Administrator
Colette Badjo Willowdale, ON Medical coordinator
Alexandra Carrier Saint-Anselme, QC Nurse
Lila Carroll Toronto, ON Logistician
Marlyne Bouchard Desjardins St-Jérome, QC Logistician
Patrick Boucher Guelph, ON Logistics coordinator
Abdelhamid Echabi Monté, QC Water and sanitation specialist
Bertha Fuchman-Small Saint-Isidore-de-Bellevue, QC Medical activity manager
Sébastien Gay Montréal, QC Logistics coordinator
Nicholas Gildersleeve Kirkfield, ON Logistics coordinator
Madeleine Hebert Montréal, QC Nurse
Vincent Hooge Ottawa, ON Logistician
Sarah Lamb Kanata, ON Project coordinator
Carolyn Anne Lettner Jasper, AB Logistician
Patrick McConnell Ottawa, ON Logistician
Richard Montmenestre London ON Logistician
Krystel Moussaly Saint-Laurent, QC Epidemiologist
Sideka Nariany Coaticook East, ON Nurse
Cynthia Nguyen Sault Ste Marie, ON Accountancy manager
Kim Danielle Noisette Quebec, QC Nurse
Todd Phillips Winnipeg, MB Logistics coordinator
Lettia Rose Vancouver, BC Nurse
Kalina Rivette Quebec, QC Project medical referent
Sandra Smiley Chilliwack, BC Communications manager
Jason Van Dyke Brockville, ON Logistician
Nathalia Guerrero Velez Montreal, QC HR coordinator
Sophie White Montreal, QC Deputy finance manager

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Brice Gamier Montreal, QC Deputy head of mission
Dominika Wanczyk Calgary, AB Nurse

GUINEA
Veronique Doubreloix Chibougouamou, QC Nurse
Jeffrey Cross Oshawa, ON Logistician
Tomislav Jagatic Vegacel, ON Doctor
Aishka Lobo Mississauga, ON Nurse
Niassa Natividade Montreal, QC Mental health activity manager

HAITI
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INDIA
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Adolphe Forto Montréal, QC Doctor
Emma Solar Trenton, ON Administrator

IRAQ
Maher Najer Montreal, QC Administrator

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Dallas Bulestik Calgary, AB Water and sanitation specialist
Fahreen Dosia Burnaby, BC Deputy Doctor
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Michael Mindely Belleville, ON Logistician
Andrew James Willis Sorna, ON Epidemiologist

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Alphonsine Mukanjeri Montreal, QC Doctor

MALI
Thierno Canadien Moctar, QC Medical and HR coordinator

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Amel Beni Toubabou, QC Head of mission

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YEMEN
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Abdelrahman Lawandy London, ON Doctor

ZIMBABWE
Dorly Lucien Legrand Montreal, QC Medical activity manager
A LEGACY THAT WILL KNOW NO BORDERS

LEAVE A GIFT IN YOUR WILL TO MSF

By remembering Médecins Sans Frontières/Doctors Without Borders with a gift in your will, you are making an extraordinary commitment to saving lives. Your legacy will help us continue to provide medical assistance to people in need, whoever and wherever they may be.

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1999 Nobel Peace Prize Laureate