ARRIVING ALIVE
DELIVERING EMERGENCY CARE ON PERILOUS MIGRATION ROUTES

ALSO INSIDE:

SYRIA: Refugees from conflict struggle with chronic disease.
DEMOCRATIC REPUBLIC OF CONGO: Finding new ways to fight malaria.
HOW MSF WORKS: Building capacity to respond to natural disasters.
A CALL FOR COMPASSION
THE PEOPLE WHO RISK THEIR LIVES ON THE WORLD’S MIGRATION ROUTES DESERVE OUR HELP

Every year, thousands of people leave their homes in Central America and journey north in search of a better life. By the time they reach Mexico, many will have endured abuse, robbery, assault or rape — if they even get there at all: Murder rates along the migration routes are notoriously high.

But the criminal gang activity that makes these journeys so perilous is one of the reasons many are willing to make them in the first place. “I fled my country because of the threats of the gangs,” 62-year-old Miguel Angel Reyes of El Salvador told Doctors Without Borders/Médecins Sans Frontières (MSF) in Mexico. “I didn’t leave because of poverty but because of security.”

Miguel was speaking with MSF teams who treat migrants in need of medical care. As authorities in the United States and Mexico become increasingly heavy-handed in their attempts to discourage people from illegally entering the U.S., migrants hoping to escape lives of poverty and violence in Central America have been forced to travel via ever-more dangerous underground routes controlled by gangs. By the time many of them arrive in Mexico, they are suffering from injury, illness, hunger or weakness, but are often too afraid to seek medical help.

DANGEROUS UNDERTAKINGS

The route between Central and North America is not the only place where people run the risk of torture, illness or even death simply because they seek to build better lives for themselves. More than 1,800 people have died while trying to cross from North Africa to Europe on the Mediterranean Sea this year alone. Elsewhere, authorities in Malaysia have uncovered mass graves of migrant labourers killed by human traffickers. The search for new beginnings can be a dangerous and deadly undertaking in many parts of the world.

Migration has been a fundamental part of human existence throughout history, for as long as people have been moving to new places in order to flee persecution and pursue better lives. Today, many of the people who undertake these harrowing journeys are fleeing miserable situations. Some are economic migrants seeking real futures for their children, while others are refugees trying desperately to escape violence and misery.

Their plight is a humanitarian crisis that has no place in our globalized and interconnected world. MSF works in many of the countries where migrants start their journeys. We operate in refugee and displacement camps where people are forced to shelter due to war, conflict and violence, and we see first-hand the squallor and despair of life in such places — the conditions that drive so many people to seek some kind of hope and new beginning elsewhere.

AN ISSUE THAT CANNOT BE IGNORED

In many arrival countries, migration is a divisive issue. Public debate focuses on economic fears and deterrence. MSF does not have all the answers, but we are part of a global system that we can see is failing large numbers of people seeking to live free from violence, poverty and misery. That is why we treat patients along the migrant routes in Mexico, and why we launched our first maritime medical operations on the Mediterranean in the spring.

This is not a new topic for MSF. I wrote about the perils of the Central American migration routes in this very space two years ago, following a trip to Mexico during my first year as executive director of MSF Canada. What was an underreported story then is at last gaining more attention, but change must still come. Our approach to human migration is in need of a rethink.

On pages 6 and 7 of this issue of Dispatches, you will read what some of our patients themselves have to say about the journeys they’ve taken. It is a reminder of the individual human stories that lie behind the numbers and headlines. On page 7 you will also read excerpts from an interview with Dr. Simon Bryant, a physician from Canmore, Alberta, who works as a doctor aboard one of MSF’s search-and-rescue boats in the Mediterranean. Dr. Bryant has written elsewhere about why he wants to help those struggling to reach Europe: “It’s not about simply rescuing them from dehydration, hypothermia and drowning,” he has said, “but sharing one’s humanity. Giving a damn. About a couple of young men in our clinic, quietly weeping, telling a tale I can’t imagine living.”

Thousands are dying at sea, in detention and on the way to what they hope are better lives. They deserve more than our empathy, understanding and compassion. They also deserve — and need — a helping hand along the way, and a far more humane welcome than our world has so far been able to muster.
dispatches is the official magazine of doctors without borders/médecins sans frontières (msf) canada. it appears twice a year in print, and year-round online at msf.ca. in it, we bring you stories and updates about msf’s lifesaving work, as seen through the eyes of our staff, our patients and our donors — and especially from the perspectives of the many canadians working on the ground with msf around the world.

our magazine has been telling canadians about msf’s work and values for more than 20 years. but we want to know what you think: what do you read in dispatches and why? where do you read dispatches and how? what would you like to see in future issues, and where would you like to see it — in print, on a web browser or on the latest reader app on your phone?

msf exists in order to save lives, reduce suffering and deliver medical care where it is not available. but our mission is also to bear witness to the realities we see and experience, which requires us to tell the world about what we do, and about the people who need our help.

that’s why we need your help to tell us how we can best bring our stories to you. we’re asking our supporters to reach out and talk to us about what they value in dispatches, and what they’d like to hear about from msf canada in the future.

so please get in touch, and help us improve the way we tell canadians about msf. you can reach us in the following ways:

email: write to us at dispatches@msf.ca

twitter: follow @msf_canada, and talk to us directly using the hashtag #msfdispatches

facebook: like us at facebook.com/msf.english, and share your comments

post: reach us by mail at dispatches, c/o doctors without borders canada, 402-720 spadina avenue, toronto, ontario, m5s 2t9

we will collect all of your comments and publish a selection of them in the next issue of dispatches. we will also choose the top three pieces of feedback we receive about the magazine (in print or online), and send a new msf multilingual t-shirt (pictured) to the people who sent them — so don’t be afraid to tell us what you think!

we thank you for your ongoing support of msf’s lifesaving work; without you, it would not be possible. we’re grateful that you continue to take the time to learn about the people we treat and the challenges they face, and we look forward to sharing many more stories with you in future issues of this magazine.

Doctors Without Borders/Médecins Sans Frontières (MSF) currently treats around 2,000 patients with diabetes in Lebanon, many of them refugees from the brutal conflict in neighbouring Syria. I am a researcher from Canada studying what MSF can do to better help them. I also have a personal connection to my work, having lived with diabetes myself since childhood. At the age of 12, I was diagnosed with Type 1 diabetes. I was transferred to a major regional hospital, where I received a solid week of classes on how to live with diabetes. This foundation has enabled me to keep my blood-glucose mostly under control, allowing me to live what I consider a very fulfilling and healthy life.

**POOR ACCESS TO MEDICATION**

In present-day Lebanon, Syrian refugees living with diabetes are not as lucky as I was growing up in Canada. Some live with phenomenally poor management for their disease. Some received little education about diabetes in Syria; others are well-educated about it, but have gone days without insulin or other medications. Some patients used to be able to measure their blood glucose with a glucometer, but have now run out of money for test strips and have had to stop. Practically all had much better access to healthy food before the crisis.

Ideally, people with diabetes are given what is called self-management education and support. Essentially, the patient is trained on how to survive with diabetes and given help from time to time to fine-tune his or her routine. Trying to provide diabetes self-management education and support for refugees from the Syrian conflict, however, is quite challenging — to significantly understate things.

Take, for example, diet. Healthy food is a cornerstone of living well with diabetes. Eating regular portions at regular times and limiting starchy, carbohydrate-dense foods (breads, potatoes, rice) helps avoid blood-glucose “spikes,” and allows for better blood-glucose control.

**GREATER RISKS OF COMPLICATIONS**

One of our patients, Nadia (not her real name), was receiving insulin and needles for her Type 1 diabetes at one of MSF’s Bekaa Valley clinics. She is the same age as me, and had also been diagnosed with diabetes at the age of 12. However, while I can test my blood glucose whenever I want, she has to ration a few tests per week. While I have access to healthy food and a relatively stress-free life, she has to manage her diabetes while reusing needles and looking after her husband, two kids and extended family. And, although I met her when she was not experiencing any complications, blood tests have confirmed that her blood-glucose levels have worsened since she fled Syria.

This can have extreme consequences. If a near-normal blood-glucose level cannot be maintained, the risks of diabetes complications, and even death, sky-rocket. Some patients suffer from diabetes-related blindness. Others may die from kidney failure. I saw a 15-year-old girl with a diabetic foot wound — a complication that leads to amputation and is normally found in older adults who have had years of poor blood-glucose control.

Over the next year, MSF will be attempting to create a diabetes education program that makes sense in the conditions under which Syrian refugees in Lebanon currently live. Right now we are assessing the needs of patients through surveys and focus groups. Soon, the project will hire counsellors who will educate patients. However, there is still a lot more to do.

James Elliott
MSF medical researcher
NEPAL: READY TO REBUILD AFTER TWO DEVASTATING EARTHQUAKES

On April 25 of last spring, a 7.8-magnitude earthquake struck Nepal, northwest of the capital, Kathmandu. Then, on May 12, a second earthquake struck farther to the east. “In some areas, there was up to 90 per cent destruction,” said Dan Sermand, Doctors Without Borders/Médecins Sans Frontières (MSF)’s country director in Nepal. “Hospitals and health centres were damaged by the two quakes, leaving many people with no access even to the most basic healthcare.” MSF teams mobilized shortly after the first earthquake hit, beginning medical activities and distributing shelter and food by helicopter to people in isolated villages. Those teams were able to respond almost immediately following the second earthquake. In remote villages, MSF evacuated patients in critical condition to hospitals in Kathmandu, and provided medical and psychological services to those in need. The organization set up an inflatable hospital to treat serious cases, and implemented drug supply, medical training and a hospital referral system. MSF also distributed food, construction material and hygiene kits, and installed water and sanitation systems where needed. “I was humbled,” said MSF psychologist Renata Bernis after arriving in Nepal. “I visited villages that were completely destroyed, and I felt devastated on behalf of their inhabitants. But they positively shocked me when they told me, ‘We have lost, but we will rebuild.’ I’m confident that with this attitude, they will cope; they will rebuild. These are people, not victims.”

NIGER: POSITIVE NEWS FROM THE FRONT LINES OF A MENINGITIS EPIDEMIC

A meningitis epidemic in Niger recently showed welcome signs of slowing, with the total number of meningitis cases having decreased by nearly 98 per cent in the capital Niamey between May and June, from 279 admissions a day to four. But MSF staff, who worked with Niger’s Ministry of Health to treat patients, warned the epidemic is not over yet and vigilance must continue. “We have been through a very acute epidemic with a very rapid increase and decrease in the number of cases,” explained Bernadette Gergonne, an MSF epidemiologist. “It is unlikely that the cases will increase again in the country, but we must remain vigilant and continue the epidemiological surveillance.” MSF stressed that it had never faced such a huge epidemic of meningitis C before. “Now that this new strain is present in Niger, the risk of transmission will persist for the next dry seasons. We must therefore be ready to respond,” said Gergonne. In Niamey, MSF implemented a decentralization of healthcare sites, making the treatment of meningitis more accessible. Patients were diagnosed earlier, and received antibiotic doses directly in their neighbourhoods, with the most serious cases transferred immediately to the hospitals.

COLOMBIA: THE WORRYING SPREAD OF A LITTLE-KNOWN DISEASE

In Tumaco, Nariño Department, Colombia, MSF has responded to an increase in Chikungunya, a viral disease that causes fever and severe joint pain and is transmitted to humans by infected mosquitoes. The first cases were recorded in September last year, and since then the disease has already affected more than 200,000 people, according to the National Institutes of Health. MSF has responded by fumigating houses — spraying for vector control in the most vulnerable neighbourhoods, where the houses are built on stilts over water. This has been carried out in 10,000 homes, protecting about 50,000 people. In addition to the spraying, MSF has trained emergency medical personnel from several hospitals in clinical diagnosis, treatment and epidemiological reports. The MSF team has also explained to pharmacists the complications of mismanagement and the need to refer the sick to health centres. This disease creates a high social impact because of the large number of cases, and the sometimes long-term inability to work. Another element of MSF’s response has been the donation of 600 tests to help diagnose this emergent disease and help sufferers get the proper treatment. There is no specific antiviral drug treatment for Chikungunya, and no commercial vaccine.
Every year, millions of people around the world leave their home countries in search of new beginnings in new places. For citizens of wealthy, industrialized nations, the process can be relatively straightforward; for others, it is a decision fraught with risk.

Those fleeing persecution and poverty in authoritarian, under-developed or conflict-ridden countries often face overwhelming barriers to their movements. The most desperate are forced into underground human-smuggling networks, where they are at the mercy of the violent armed groups who control the people-smuggling trade.

The journeys are dangerous: Thousands have been killed this year alone, whether by drowning on the Mediterranean Sea or after suffering violent assault along the migrant routes of Central America, the Middle East or Southeast Asia. Many require urgent medical care for illness or injury, but have no access to health services; even those who survive their journeys are afraid to seek out care for fear of being deported or worse.

Doctors Without Borders/Médecins Sans Frontières (MSF) works on the migration routes along which many people travel, providing essential humanitarian care for those most at risk — on the Mediterranean, in Mexico, or in the reception centres of Europe. Here, some of the people we’ve encountered describe their journeys, and their hopes for the future, in their own words:

“In Medias Aguas [in Mexico] six police officers hit us. We had to go back to Ixtepec because I was feeling bad. We went to the hospital looking for health assistance but they didn’t want to help us as we were migrants. They told us we had to be accompanied by someone. My friend asked them to take care of me. I was lying on the floor for two hours wracked with pain and nobody took care of me. Finally, a woman who was in the waiting room angrily told the doctor: ‘Hey, this man is overwhelmed with pain, you are not going to assist him?’ Finally they took care of me.”

- Name withheld, 35 years old, from Nicaragua.

“They said they would take care of me, but I wasn’t there. They left me lying on the floor.”

- Sandra, from Nigeria; rescued on May 13 from an inflatable boat carrying 92 people across the Mediterranean — she was the only woman, and about eight months pregnant.

“Since 2011, when my father died, the first people to take care of me were you.”

- Golleh, 20 years old, from Gambia; from a letter written to the MSF physician who helped treat him upon his arrival at the Sicilian port of Pozallo.

“What I have seen has made me feel bad, really bad.”

- Raquel Julieth Hernandez, 19 years old, from Honduras; after arriving in Mexico she was assaulted and robbed by a group of men, but as a migrant was too frightened to seek medical help.

“I decided to leave Nigeria because my husband works in Libya and I wanted to take care of him. Staying in Libya is not easy, the fight is too much. You don’t sleep at night and people bust into your house, steal your possessions and rape your wife — they do horrible things. You can work but they will burst into your house and collect everything you worked for. It is not safe for we Nigerians, they kill many of us. ... We take the risk of entering into this water and going to Europe to look for a better life. We believe Europe is better than Libya. I hope my baby will have a better life but I know it’s going to be hard.”

- Sandra, from Nigeria; rescued on May 13 from an inflatable boat carrying 92 people across the Mediterranean — she was the only woman, and about eight months pregnant.

“It is a horrible experience. I don’t wish this on anyone.”

- Juan Ramón Salvador Moreno, Honduras; while moving north through Mexico with his three children and his brother, Juan Ramón (above, second from right) and his family were attacked, beaten, tied up and robbed by armed men.
"We go away from our country because we have no choice. We need to earn money for our families. We don’t want to get the Europeans tired of us, to overwhelm them, but we have no choice. We risk our lives to help our families, our neighbours, our friends, our parents and our brothers. That’s why we embark on this journey."

- Abdu, 34 years old, from Gambia; rescued on May 14 from a wooden fishing boat carrying 561 people on the Mediterranean.

"We were middle class, but we lost everything. Lots of Syrians get into Europe through smugglers, but it is very dangerous. And my family can’t afford it."

- Hasan Nasser, 42 years old, from Syria; living as a refugee in Turkey.

Q&A

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‘OPINIONS NEVER SAVED A DROWNING CHILD’: A CANADIAN DOCTOR ABOARD MSF’S MEDITERRANEAN MIGRANT RESCUE BOAT

Dr. Simon Bryant is a Canadian physician from Canmore, Alberta, and one of the first doctors to serve aboard the MY Phoenix, a search-and-rescue boat launched by Doctors Without Borders/Médecins Sans Frontières (MSF) last spring in response to the growing humanitarian crisis involving migrants crossing the Mediterranean Sea. Dr. Bryant shared his thoughts as the Phoenix first prepared to launch.

What is your role on MSF’s rescue boat?

I’m one of two physicians who, along with one nurse, comprise the MSF medical team on-board the Phoenix. We physicians will travel on the rigid inflatable boats to the migrant-carrying vessels, where we will conduct initial rapid medical assessments. We will ensure that the sickest and most vulnerable are brought onto the Phoenix without delay, where we will provide any needed medical care.

Why is MSF sending teams out on boats in the Mediterranean?

Quite simply, we are trying to minimize the suffering and deaths of migrants in the Mediterranean. In April, our team attended a candlelight vigil for the estimated 800 souls who perished in just one terrible incident. At one point we looked around and estimated we could see about that same number of people walking slowly along the waterfront. ”Imagine us all drowned,” somebody suggested, and we were silent. Nobody deserves to drown at sea.

What are the most urgent needs?

The Mediterranean migrants need immediate assistance to avoid death by drowning. After time at sea in smaller boats, migrants can be significantly dehydrated and therefore seriously ill with kidney failure and complications from previous conditions such as diabetes. There is of course absolutely no medical screening before departure from Libya, and some migrants are quite sick, injured, or in advanced stages of pregnancy before embarking on their voyages. Finally, there are increasing numbers of unaccompanied minors on these migrant boats.

Why do you think this is an important program for MSF to undertake?

The deaths of so many migrants already this year make it clear that this is a humanitarian crisis that cannot be ignored. MSF makes no distinction between the causes of human suffering; we just work to relieve it. These people are fleeing terrible situations in Eritrea, Ethiopia, Iraq, Libya and Syria, and likely undertake the Mediterranean crossing fully aware of the risks. Last year, the Italian search-and-rescue program Mare Nostrum rescued over 150,000 migrants, but it was cancelled in November due to lack of support from other European countries. Without this kind of program, Mediterranean migrants are doomed. There are many opinions about whether rescue encourages other migrants to set sail, and whether Europe can absorb more people, but opinions never saved a drowning child — so MSF will.
WHAT IS...
MALNUTRITION?

DOCTORS WITHOUT BORDERS/MÉDECINS SANS FRONTIÈRES (MSF) delivers lifesaving medical care in nearly 70 countries around the world. We respond to acute crises such as natural disasters and armed conflicts, as well as epidemics of disease and other health emergencies. MSF also provides healthcare in areas where chronic conditions result in reduced access to medical services, such as in refugee camps or places with little to no effective health infrastructure. Our work often takes place in remote or otherwise challenging environments, and requires an ability to deliver urgent medical intervention quickly and effectively, in response to a wide variety of needs.

To help bring these essential activities to life and to engage Canadians in a deeper understanding of the contexts where MSF works, we’ve launched The World is Our Emergency Room, an exhibit that explains different aspects of MSF’s operations in the field — from emergency care during disease epidemics to the treatment of deadly medical conditions. On the next page, you’ll find material from the exhibit that relates to MSF’s work in response to malnutrition — an ongoing health crisis that kills millions of children around the world every year. For more information, visit msf.ca/malnutrition; to learn more about The World is Our Emergency Room, visit msf.ca/exhibit.
WHAT IS MALNUTRITION?

• People become malnourished if they are unable to eat enough food, or if they are sick and their bodies can’t absorb the food they do eat. This can happen to patients with illnesses such as diarrhea, measles, HIV or tuberculosis.

• Malnutrition can affect anyone who lacks essential nutrients in his or her diet, but children are particularly at risk; pregnant or breastfeeding women, the elderly and the chronically ill are also highly vulnerable.

• More than 170 million children worldwide under the age of five are malnourished, and close to five million of them die every year.

WHAT ARE THE EFFECTS OF MALNUTRITION?

• For children under the age of two, lack of nourishment has a profound impact on physical and mental development. Malnourished children under the age of five have severely weakened immune systems and are less resistant to childhood diseases. That’s why a common cold or a bout of diarrhea can kill a malnourished child.

• Children who experience malnutrition as a chronic condition — who regularly suffer from an insufficient diet — will eventually stop growing and become stunted.

• At a certain point, a malnourished person’s body may begin to use its own tissue (for example, muscle tissue) to find the nutrients it needs. This is known as acute malnutrition, and it greatly increases the risk of death, especially in children.

DIAGNOSIS AND TREATMENT

• MSF treats hundreds of thousands of malnourished children every year.

• The fastest way for our medical teams to identify children at risk is to use a MUAC, a tape that measures a child’s mid-upper arm circumference. The tape is wrapped around a child’s arm, and the measurement will indicate whether he or she suffers from severe, moderate or early-stage malnutrition. Babies can be diagnosed using a portable weigh scale.

• MSF uses nutrition packets known as ready-to-use therapeutic foods (RUTFs) to treat malnutrition. They contain all the nutrients a child needs. RUTFs help reverse deficiencies and add weight; they also don’t require water for preparation, which eliminates the risk of contamination with water-borne diseases.

PREVENTING MALNUTRITION

• In some areas where MSF works, malnutrition rates rise at certain times of the year, usually in between traditional harvest periods. These “hunger gaps” require planned treatment programs to prevent malnutrition from occurring.

• MSF has developed a preventive health package that aims to reach children in areas susceptible to seasonal malnutrition. By distributing ready-to-use therapeutic foods to all children between the ages of six and 24 months, before the hunger gap period — and providing vaccinations, consultations and other medical assistance — our teams are able to significantly reduce malnutrition rates.

To learn more about MSF’s work on malnutrition and other critical medical issues, you can visit MSF Canada’s new exhibit, The World is Our Emergency Room, which will appear at select locations across Canada in 2015 and beyond. Visit msf.ca/exhibit for more information and to hear stories from our audio guide, in which Canadian MSF workers share their experiences from the field.
When Kim Danielle Noiseux began training community health workers in Democratic Republic of Congo to diagnose patients with malaria last year, she knew it was important for her trainees to practice their skills. What she didn’t expect was the impact this would have on her own personal health.

“I was sitting with a community health worker named Béatrice, and we had some time to review the steps she needed to take while testing someone for malaria,” recalls Noiseux, a Quebec City nurse who recently spent nine months working with Doctors Without Borders/Médecins Sans Frontières (MSF) in the province of South Kivu in Democratic Republic of Congo. “I asked her to show me how to do the bioline test [a simple and standard diagnostic method for malaria] by trying it out on me. When we looked at the results, she said, ‘Kim, it came back positive. You have malaria!’ ”

“I COULD SEE OUR PROGRAM WAS WORKING”

Being diagnosed with malaria is not usually good news — not only is it a brutal and difficult illness, but it also kills nearly half a million people around the world every year, most of them children. But Noiseux was happy to see her training efforts were having an impact.

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COMMUNITY ACTION

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The program in question was a community-based malaria treatment initiative, which MSF began at its Kimbi project in South Kivu last September in response to the high numbers of malaria-related deaths in the region.

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“We worked with community leaders in places where there were no health clinics, and identified people who were able to do simple math, and to read and write in French — and who were respected and trusted by people who lived in the community,” says Noiseux. “We then trained them to do the test to see if patients had malaria, and taught them how to give the treatment if it was just a simple case. If someone had a severe case, we would pay for a moto-taxi to bring them to the MSF health centre. Otherwise, MSF provided the medicine and other supplies, and the community health workers could help the people there.”

The results were significant. In the first four months, the community program held more than 20,000 consultations, nearly 80 per cent of which were with patients who tested positive for malaria. Of those, only 0.5 per cent were severe enough to require admission to the hospital. “These consultations were happening in villages that were far from the clinic, where people might not ever go to the hospital, either until they were very sick or not at all,” says Noiseux. “That’s more than 20,000 people who received medical help for a deadly disease, who might never have been treated otherwise.”

‘THE FIRST YEAR NO CHILDREN DIED OF MALARIA’

Most significantly, there were no malaria deaths in any of the villages where a community health worker was in place. “When I was evaluating this project after the first four months, all of the leaders from the rural villages where we had started the program met with me,” recalls Noiseux. “They all said this was the first year for as long as anyone could remember that no children died of malaria during the rainy season, and they were thanking MSF for it.”

As for her own case of malaria, Noiseux said her illness came with a silver lining. “I was so proud that it was one of our community health workers who was able to diagnose me,” she says. “It was a good sign.”

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MUSIC WITHOUT BORDERS

A GROUP OF STUDENTS CONNECTS ART WITH ADVOCACY IN SUPPORT OF MSF’S RESPONSE TO EBOLA IN WEST AFRICA

Last spring, a collection of young performers gathered in Toronto to celebrate the power of music. The group, which included award-winning violinist Emma Meinrenken (winner of the Junior Division of the 2013 Stradivarius International Violin Competition) and drumming group Bakudan Taiko, performed as part of a campaign to support the work of Doctors Without Borders/Médecins Sans Frontières (MSF) and its response to the Ebola epidemic in West Africa.

Aptly named Music Without Borders, the campaign was designed by a group of students — including artists, designers, musicians, programmers, writers and friends — from Bayview Glen School and the University of Toronto Schools. Conceived as a collective project drawing upon young people’s talents in order to better engage with global issues, Music Without Borders developed its name and theme based not only on the work of MSF, but on the notion that music has the ability to draw people together.

With that in mind, the young organizers developed their idea for a fundraising concert, along with a Music Without Borders creative blog (musicwithoutborder.com) with videos, poems, writing and music posted by the students, and a social media campaign on Twitter, Facebook and Instagram. In addition to Meinrenken and Bakudan Taiko, the concert also featured a keynote address by MSF Association member Emily Scott and a traditional chant provided by Carnatic musician Adithya Chakravarthy.

The concert was a success, as both a showcase for young musical talent and as a fundraising initiative. Music Without Borders student organizers and their parents dropped by MSF Canada’s Toronto offices not long after the event to present a cheque for over $13,000, all raised by the students’ efforts and all going to support MSF’s lifesaving medical work.

On the night of the concert, Carnatic musician Chakravarthy eloquently summed up the Music Without Borders mission, explaining how he hoped his music might help make a difference in the lives of MSF patients in West Africa and elsewhere. “The Ebola crisis has claimed thousands of African lives,” he said. “I have always believed that when people are suffering, we should do all that we can to alleviate their suffering.”

“The great Carnatic composers used music as a vehicle to express their thoughts,” he continued, “and as a result, many of these songs can contain some very profound messages. ... By being a part of Music Without Borders’ concert, I hope to contribute by raising awareness and funds to help fight for this noble cause.”

Tiffany Chiang
Donor relations representative

Thank you to the many individuals and groups who use their talents to raise money for MSF’s work. If you would like to organize a fundraiser of your own, please visit msf.ca/fundraise, where you will find a wealth of resources to help you in your efforts. For more information, or if you would like to discuss your fundraising idea with us, contact our Donor Relations team at 1-800-982-7903 or email us at donorrelations@msf.ca.
‘SHE WAS RIGHT AND WE WERE WRONG’
A CANADIAN MSF NURSE DESCRIBES A LIFE-CHANGING DIAGNOSIS FOR A PATIENT IN PAKISTAN

Eyes without a face.” Those were the first words I thought of when I looked at her. I was working as a nurse with Doctors Without Borders/ Médecins Sans Frontières (MSF) in Pakistan, near the western border with Afghanistan, and running through my mind were these lyrics to a Billy Idol song. Sometimes the biggest challenge is to make sense of what we see.

Her eyes — they were brown, sad and silent. She sat across from me. To her right was her husband. Her face was exposed in the presence of a man, uncommon in Kuchlak. The headscarf was usually the reason I saw only eyes, yet hers lay around her shoulders.

Her face was disfigured: Large, red, swollen lesions occupied the space where her smile should have been, as well as her cheekbones, her brow, her nose, her forehead and her chin. Her husband spoke to us in Pashto. She looked down and lifted her pant leg to show more lesions, then her sleeves. She was covered. She had been for months.

IN SEARCH OF HELP

The woman was in a state of despair, taken over by this illness. You could see the hope draining from her. She cried quietly as her husband told us about the numerous trips to doctors and clinics. Her illness was a mystery. The most recent diagnosis was leprosy. She had now come to the MSF clinic for help.

People travelled long distances to reach our clinic for free healthcare. This woman had come for more. She came for a reason to live. Her face was unrecognizable and so was her spirit. She had lost the desire to go on. Her husband spoke about how she wanted to die.

Our doctor also diagnosed it as leprosy, but the patient had not come to see the doctor — she was here to see the nurse. People called him Kaka. It means “uncle” in Pashto. Kaka was an older, experienced nurse. The community knew him, loved him, and had a great respect for his knowledge. The woman and her husband needed to hear what Kaka had to say.

‘HE’D NEVER SEEN ANYTHING LIKE IT’

The woman disagreed with the leprosy diagnosis, believing she had a parasite, cutaneous leishmaniasis (CL). It is common in this area of Pakistan and characterized by lesions on the face. It is carried and transmitted by sand flies, and is easily treated at the clinic with injections. MSF has one of the only CL projects in the area. Kaka ran the program, and he was considered the expert. He looked at me and explained the disease. This woman, he said, did not have CL. There were too many lesions. He’d never seen anything like it. But this woman needed hope and a reason to be there, so Kaka sent her for testing.

To us the news was shocking. The clinic had never seen a case so severe. To her the news meant a diagnosis, and a cure. The age limit for the program was 45 years old. Kaka and I thought she was much older. The lesions made it difficult to gauge. Proof of age or identification didn’t exist in this community. We admitted her regardless. Her injections began daily and so did her counselling.

NEW ENERGY AND A NEW SPIRIT

Months later, I was helping with the malnutrition program in Kuchlak. A child came in with its mother and another woman. As they were leaving, the woman came to me and took my face in her hands. She smiled with her eyes. She was young and happy. She said things in Pashto, as she looked at me kindly. Kaka asked me if I knew who she was. I did. I recognized her eyes.

She had been treated for the lesions and her depression, and had been discharged from the program. She looked like a new person, with a new energy, and a new spirit. The hope we put back in her life would last an eternity.

I saw her often around the clinic after that, and every time she would take my face in her hands. Among so many desperate eyes, hers were a grateful reminder of what we were doing.

Lisa Crellin
MSF nurse
When natural disasters such as floods or earthquakes happen anywhere around the world, Doctors Without Borders/Médecins Sans Frontières (MSF) is almost always among the first organizations on the ground, providing urgent medical care and relief in countries that cannot themselves sufficiently respond.

But how does an organization that already works to provide emergency medical care in nearly 70 countries prepare itself for the unexpected? One part of the answer lies in our approach to fundraising. MSF Canada fundraising manager Conan MacLean explains how we make sure MSF has the resources we need to respond to any emergency that requires our help — and how we stay flexible enough to always work wherever the needs are greatest.

Q: How does MSF fund its responses to emergencies such as natural disasters?

A: It’s crucial in any emergency situation that patient needs determine the funding we use, rather than having the amount of available funding define what needs we can meet.

Our funding model reflects the fact that we must be flexible and quick to respond in times of crisis. That’s why MSF depends on unrestricted contributions from private, individual donors. Private donations enable us to make decisions based on our own determination of immediate medical needs.

Q: What do you mean by unrestricted contributions?

A: Unless otherwise specified, contributions to MSF are directed to our general emergency fund, which is what we draw upon to deliver lifesaving healthcare wherever it’s needed around the world. Regular monthly or annual general donations — gifts that aren’t restricted to use in a specific context — are one of the best ways to support our work. Not only do such unrestricted and predictable funds allow us to plan ahead and effectively implement the thousands of medical interventions we conduct around the world every year, they also let us respond to unexpected crises and emergencies immediately.

Q: How did MSF respond to the recent earthquake in Nepal?

A: Within hours of the first quake on April 25, MSF teams and emergency supplies were already en route to Nepal, and were soon delivering essential care to those affected by the disaster, especially in areas that were otherwise cut off from any immediate assistance. Fourteen Canadian field workers were part of that emergency response effort, and MSF Canada also sent supplies, including specialized emergency tents that had been developed here in Canada.

It was thanks to our supporters, and the contributions they had already made to our general fund, that we were able to respond so immediately and effectively. Our medical teams were then able to assess the needs on the ground, and we determined it was not necessary to raise further designated funds in order to do our work. It was an example of the fund operating as it should, and of a successful emergency intervention that we — our teams in the field and our supporters here at home — were able to do together.

Q: Does MSF accept donations designated for specific emergencies?

A: There are some catastrophes so severe that we require additional support in order to maintain our response: The Ebola crisis in West Africa was an example of this, as was the Haiti earthquake in 2010. On these occasions, MSF launched specific fundraising appeals. In such cases, accepting designated funding allows us to scale up the resources necessary for a particularly overwhelming emergency without drawing resources away from other essential MSF programs around the world.

These are determined on a case-by-case basis, in response to needs and capacities. We won’t ask for additional support in a particular emergency until we can determine whether there is a need for our work. If designated support has not been explicitly requested, it is always best to visit the MSF website or contact us directly to find out if we are accepting donations for a specific crisis before making a restricted gift.
**PROFILE: A Q&A WITH AN EXPERT IN BEING PREPARED**

**Name:** David Johnston  
**Hometown:** Surrey, B.C.  
**Role with MSF:** Logistician

**Most recent posting:** “On board the *MY Phoenix* in the Mediterranean Sea as part of rescue operations for people attempting to reach Europe by boat from the coast of Libya.”

**One detail from that posting that made an impact on you:** “The mixture of relief and excitement shown by the rescued persons — relief at being rescued from a very precarious situation on the water and excitement to be starting on the next stage of their journey to what they must surely hope will be a better future.”

**What made you want to work for MSF?** “Perhaps a general feeling of wanting to help provide people with some of the medical care we take for granted. And knowing that I had a very supportive spouse as I headed off on my first mission.”

**What’s one piece of advice you would give to someone heading to the field with MSF for the first time?** “You’re talking to a logistician — there’s not one piece of advice! Take a small multi-meter (know how to use it!), a Leatherman (knockoff), and most certainly an ability to prioritize the very many requests (never accepted without a request form) you will get in any one hour.”

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**OF THE 125 FIELD WORKERS:**

- **66** Were medical personnel: Doctors, nurses, midwives, specialists
- **59** Were non-medical personnel: Administrators, engineers, logisticians, coordinators

**THEIR HOME PROVINCES ARE:**

- **48** Quebec  
- **39** Ontario  
- **24** British Columbia  
- **10** Alberta, Saskatchewan, & Manitoba  
- **2** Nova Scotia & New Brunswick  
- **2** Yukon & Northwest Territories

**125** CANADIANS ON MISSION as of June 2015
A GIFT IN YOUR WILL KNOWS NO BORDERS

ONE IN 10 OF OUR PATIENTS RECEIVES CARE THANKS TO LEGACY GIFTS

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

For information, please contact:
Tricia Khan
1-800-982-7903 ext. 4045
tricia.khan@msf.org

Please let us know if you’ve made a decision to include MSF in your will, so that we may thank you.

msf.ca/mylegacy