

DOCTORS WORLDWIDE

HELPING THE SICK FEEL HUMAN AGAIN . HELPING THE SICK FEEL HUMAN AGAIN . HELPING THE SICK FEEL HUMAN AGAIN

2007



Photo Credit
Dr Perihan Torun

CHAIRMAN'S MESSAGE

It has been a busy year for Doctors Worldwide, with new challenges emerging, while old ones remain. This is the reality of an organization that remains true to the ideals of volunteerism, partnership and the preservation of human values and dignity. There continues to be a need for an organization such as ours that works at a grassroots level, and recognizes the worth and wealth of progress that can be achieved by shared experiences and learning. This approach is not without its obstacles. Nevertheless, this reflects the growing maturity of organizational thinking and development in terms of managing volunteers and setting up new projects. It may be said that many a charity and organization would have come down a similar path as an organic, volunteer-based movement. However, we are one of the few that occupies this niche and have continued to be successful in achieving its objectives.

For this we need to be thankful to our supporters and donors, as well as our volunteers and partners. Without the human resources upon which we are based, we would have struggled to maintain our support for existing projects or indeed endeavor to initiate new ones. Once again, a sincere thank you to all those that have supported and worked with us. In addition, I urge you all to continue to be involved with Doctors Worldwide in order to grow this organization into a truly global movement and an organization of reference. Not only do we need your participation at multiple levels in ensuring that we are an organization that learns from your experiences, but also in facilitating changes required.

It goes without saying that in most parts of the globe, the suffering continues in the wake of poverty, policy as well as due to natural and man-made disasters. Governments, national and international, continue to struggle and fail in their commitments to serve humanity, and there is as yet no proven blueprint for success. The response of Doctors Worldwide has been to venture into new territories, while maintaining our input into previous projects. Work has continued in Pakistan, Bangladesh, DR Congo

and Niger, in addition to new projects in Ghana and Kenya. Moreover, we have further developed our training courses to better equip our volunteers with our philosophy and prepare them for work abroad. In addition we have seen an increasing role for us in collaboration with other agencies both within the UK as well as internationally.

The following pages reflect our efforts, although it does not do justice to those who have volunteered their help, or to those who have facilitated the programmes, and most importantly to those who received help from us and who have made this work so worthwhile and rewarding.

I hope that you enjoy reading through this report, and feel inspired to join us on this journey where we truly believe in making a difference to people's lives, and in helping the sick feel human again.

Dr Najeeb Rahman
Chairman Doctors Worldwide

TRAINING DAY

My first contact with Doctors Worldwide was in 2001. I was an A&E SHO in my first post-registration job with a vague interest in public health and overseas work. I went to a meeting and, though I can't remember much about what was said in the meeting, I lodged DWW somewhere in my brain and went off to gain more clinical experience.

Six years later, in between leaving general practice and entering public health, it seemed a good time to make contact with Doctors Worldwide again. This time I decided to attend a one-day training course held in London. It was the second such course run by Doctors Worldwide. The first had been held in Birmingham a few months earlier and the third was held in Manchester this April.

The course was designed to provide potential volunteers with a general introduction to relief work. The majority of those attending had not volunteered abroad but had an interest in finding out more. About thirty people attended and most were qualified doctors.

Thankfully the first few sessions were lectures, given by the Doctors Worldwide team on topics including: ethics; motivation for relief work and preparing to go abroad.

After a warm-up coffee break and a bit of chit chat, we broke off into discussion groups. The first discussion was about preparation to be a volunteer. My group dived in with plans to do needs assessments, set up clinics, find local staff and then we ran out of steam. Our facilitator brought us down to earth by reminding us that there were more practical matters close to home that we had forgotten – arranging work cover, visas, accommodation, insurance, ensuring families and finances were looked after in our absence and planning our trip as safely as possible.

Lunch was followed by more lectures and discussions and finally a big group scenario at the

end of the day. Each group had to take on the role of a nominated international organisation and between us we had the task of coordinating a massive emergency relief effort. It was an effective way to illustrate the difficulties that organisations face in working together to deal with catastrophe.

A short time later, I joined the DWW team and my first task was to obtain feedback from those who had attended the course. The feedback was overwhelmingly positive and the sentiments expressed reflected my own feelings after the course. Overall a good balance was achieved between showing the benefits of relief work, both for the volunteer and for the communities that the volunteers go to, and reminding us of the difficulties in doing this type of work and of the importance of ensuring that one is physically, mentally and emotionally prepared.

In addition, many felt, as I did, that a large part of the benefit gained from the course was in meeting the Doctors Worldwide team, having an opportunity to ask those questions that we were most worried about, and getting a feel for the vision and methodology of Doctors Worldwide. I liked what I saw, particularly the friendliness of the team and their down-to-earth and humble approach to the work. A year and half later, I'm very involved with the work of Doctors Worldwide and still very enthusiastic about that vision and methodology.

Coming to a course does not commit you to being a volunteer, but it does provide a good way in to Doctors Worldwide, to find out what projects are going on, where you could go, and who you could go with. It enables you to start to think about whether or not relief work is something that you would like to do in the future. It allows us to share our vision with you and it allows you to see the bigger picture that you might one day decide to become a part of.

Dr Sonya Ahmed

Photo Credit
Dr Perihan Torun



D.R. CONGO

Following national elections Congo is continuing its recovery from a deadly civil war costing the lives of 3 million people. DWW has been working in Katanga region in the south for the past 4 years, our concentration being on the long term development of the health care system in this area. Previously DWW had built 1 hospital and 2 maternity centres, this year saw DWW complete 3 further maternity centres; all of them are in rural areas with little or no surrounding health facilities. One is in Lumata, 55 km south of Lubumbashi (the regional capital) and is part of DWW's "villages of hope" project.

Villages of Hope: This is a holistic approach to development issues, providing a comprehensive relief package. The main health issues in this area are;

- Maternal and infant mortality
- Malaria
- Waterborne diseases
- HIV/AIDS

Lumata has a population of around 15,000. By providing access to maternity and child care, food supplementation to some children, safe drinking water through the provision of four bore hole water wells and the distribution of mosquito nets; DWW hopes to impact on all four major causes of ill health in this area.

Hospital and Maternities: This year 1176 babies were successfully delivered at the DWW hospital and maternity clinics. 7215 patients were treated at these health facilities, including severe cases of malaria in children and a total of 2974 children have been vaccinated. The health care is provided at minimal cost and is free for those who cannot even afford this.

Circumcision: Over 30,000 males between the ages of 3 months to 15 years have been circumcised again this year. WHO (World Health Organisation) research has shown that circumcision provides 60% prevention for contracting HIV. Operations are performed at minimal cost by local surgeons and

nurses of our partner organisation RADEM. Although the circumcision campaign was set up initially in response to local cultural demand, it now forms an incredibly cheap tool in our HIV prevention strategy compared to medication and future vaccination programmes.

Food Aid: DWW provides a regular supplemental food supply, particularly for poor vulnerable children. Over 2500 children received regular food parcels throughout the year, this nutritional support should help reduce their susceptibility to illness, to qualify for this food aid the children must also attend full time education, which has helped to increase the number of kids enrolled in government schools. DWW also distributed meat to the poor as part of the Muslims Eid ul Adha festival. Over 40,000 families received meat from DWW this year.

Emergency medical aid: DWW and its partner organisation RADEM were asked by the government and UN to help in two emergencies, one was following a cholera outbreak in Katanga region, the other was a measles outbreak in an area called Malemba some distance from our base in Lubumbashi. In both cases teams of doctors, nurses and medicines were dispatched, in the measles outbreak nursing staff used bicycles to access out of the way villages. Prior to intervention 8-10 children a day were dying from Measles complications, in the immediate two weeks after the arrival of the teams only three children were lost in the entire period.

Education and training: One of the main aims of the Congo project was to improve health capacity; training of health staff inevitably plays a part in this. At our clinics in Lubumbashi, trainees in different health specialties were given hands on experience and training. DWW volunteers have also given lectures at the medical school and hospitals in Lubumbashi to students and medical staff.

Photo Credit
Dr Nurdan Ozyilmaz



KENYA

August of this year saw DWW starting a new project in Kenya, based in Rabai village, a rural area, a few miles from Mombasa is the Khahija centre run by a local and UK based NGO. The centre is essentially a school for under-served children, providing education in all subjects. DWW were asked to help set up a primary care clinic in the grounds, a small area within the existing buildings was utilised and a clinic initiated. Initially running once a week the centre staffed by a clinical medical officer and a nurse was slowly expanded as demand increased. A water bore hole with tank has also been partly funded to help provide clean drinking water for the village and surrounding areas. The plan in 2008 will be to improve the running of the clinic and to send volunteer doctors to work at the clinic and to help

train the medical staff. An assessment of a charitable hospital in Mombasa will also be undertaken.

The PRP (poverty reduction programme) currently only run in Congo was extended to Kenya, food is being provided for children at the Khadija centre and for three orphanages in Mombasa, this has helped to provide additional nutrition for the children to help improve both their physical and mental well-being; but also to help prevent their susceptibility to disease. 2008 should see the start of regular health screening provided by medical teams for all the children and staff of the four institutions. In total 300 children a day are aided through the PRP initiative.

Although the project into addressing obstetric fistula and maternal health was initiated by DWW UK, it has been our Turkish chapter which for this year took the leading role.

In addition to sending surgical teams to assist in fistula repair and training of local staff, activities also looked into supporting the local maternal health infrastructure at Maradi, a town in the heart of Niger.

However, as with many health issues in such countries, obstetric fistula merely represents the proverbial tip of an iceberg in relation to the challenges in addressing maternal health in this

region. Extreme poverty, poor education, adverse cultural practices, a lack of trained staff and available facilities conspire together to result in the tragedy that befalls women in Niger.

Nevertheless, we hope to continue to refine, develop and reinforce our efforts tackling obstetric fistula in Niger, and remain committed to building partnerships to address an issue which is oft neglected, but reflects so much more in terms of the reality of a people suffering.

NIGER

Photo Credit
Dr Ripon Ahmed



PAKISTAN

June 2007 saw President Musharraf laying the foundation stone for the New Balakot city, located 20 miles south west of the original earthquake devastated original along the WPI highway. The plans are to build 5000 new homes, enough for all the original occupants plus 800 more homes for other residents from surrounding areas. Despite some local opposition to the moving of the original city work has indeed begun, many still live in prefabricated housing but the plans laid by EESE, of a new modern city, with urban planning considerations, began. Whether it will be completed within the three year projected plan remains to be seen. This town, some 970m above sea level certainly has a dramatic backdrop, and visiting the area undoubtedly shows a high degree of activity with signs from countless national and international NGOs and government bodies attesting to this.

For our own part Doctors Worldwide bought land along the main highway, with the plan to build a small fully equipped paediatric hospital with training facilities. The year has seen progress with soil

testing, topography and architectural plans completed. A remaining frustration but necessity is the procedural paperwork and official approval required. That said, preliminary work has begun on planting trees and preparing the land. A start date for construction work has been set for November 2008.

In addition to the paediatric hospital a rural clinic and dispensary in the area of Ugi has been discussed and agreed with local people and leaders who DWW are encouraging to partner in the project as local ownership and shared decision making is essential to its success and longevity. This clinic will also be started and completed in 2008/9.

BANGLADESH

16th Nov saw cyclone Sidr cause widespread destruction to crops, buildings, livelihoods, water sources and unfortunately lives. The almost annual cyclone/flooding in the South of Bangladesh further undermines the already poor infrastructure and tentative livelihoods of millions of the poorest people in the world. There were no immediate medical needs in the areas around Daulat Khan where the DWW/Green Crescent primary care clinic is situated so some funds were used to build two new water pumps for villages effected by the cyclone.

The year generally saw a consolidation of the clinic with a regular weekly surgery run by a local doctor, two paramedics acting as triage co-ordinators. With the clinic now well known and frequented by the local villages the plan for next year is to send volunteers to look at improving the running of the clinic and small dispensary, to expand the number of surgeries run at the clinic and possibly look at plans to extend the clinic to allow more consultations a day and a midwife led ante-natal programme.

GHANA

“To meet a people who have never seen clean drinking water in their lives, and whose daily task is to find enough water to survive is truly a humbling experience”

Dr Imran Najmi and I met in Birmingham early one June morning as we started the first leg of our journey to Ghana, to undertake an assessment visit on behalf of Doctors Worldwide. Neither of us had travelled to sub Saharan Africa, before, and as such we were unsure of exactly what to expect. In preparation we had familiarised ourselves with a plethora of exotic and wonderful medical conditions we might come across, including guineaworm which is endemic in the region.

At Accra airport we were met by a representative of the local partner NGO, Northern Ghana Aid, and we rested in the city overnight, preparing for the long drive to Tamale, the capital of the Northern Region the next morning. Arriving in Tamale we were both surprised by how underdeveloped the city was, more so as it is regarded as the principal city of the Northern Regions. Northern Ghana is a very deprived region, and this stems from a disproportionate concentration of education and resources in the south of the country, mostly around Accra and the Ashanti region. In addition basic amenities like clean water and electricity were in short supply, and it was not uncommon for us to come out of our hotel balcony at night and see the whole city covered in a blanket of darkness as another power cut enveloped Tamale. Finding water in Ghana is a real challenge, and it seems to get more difficult the closer you get to Tamale. Guinea worm is most endemic in those areas where water is short, and in places where bore holes have been drilled but have gone on to dry up. As a result many people still collect and drink rain water which collects in local dams. Less than 10% of the population will filter and boil the water they collect, and this exposes a large section of the community to water borne diseases such as guineaworm. During our visit we met with the local governmental body tasked with tackling this

problem, and a stream of work was initiated which will, we hope, lead to the provision of clean drinking water to several communities in the region. This intervention is vital as part of the strategy to eradicate guineaworm in Ghana, and generally to improve health and prevent disease.

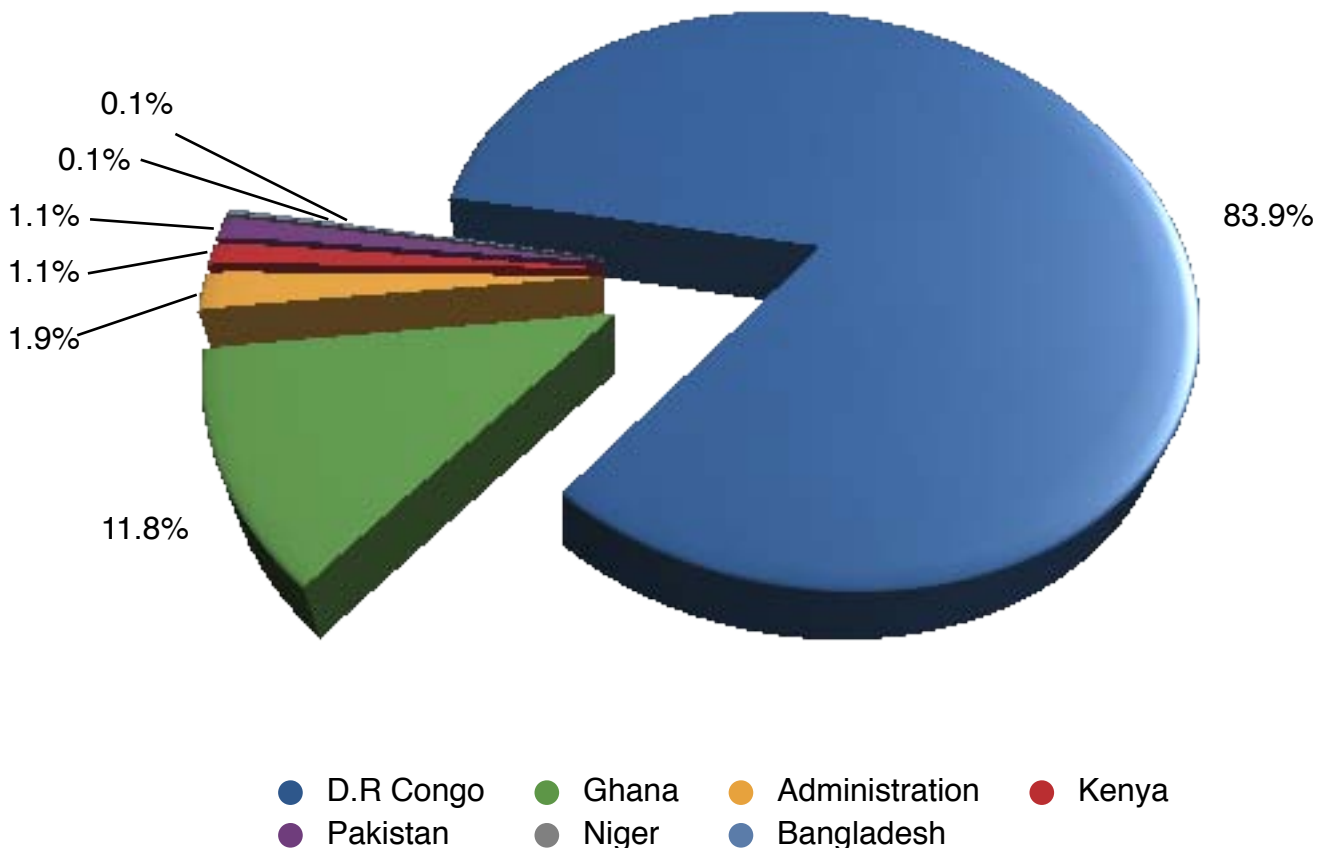
Another objective of our visit was to build links with local NGOs and healthcare facilities in order to identify short to long term goals we could work towards to help improve the level and quality of healthcare provided to the people of Northern Ghana. A crucial potential partner in this was the Tamale Teaching Hospital, a large tertiary referral centre which serves several million people in Northern Ghana. Our visits to this institute made us realise the acute shortage of trained professionals available to offer healthcare in the region, which has historically been attributed to the migration of doctors to better paid jobs in the South, and that has led to a situation where only 20 qualified doctors provide healthcare for a population of two million people. On a practical level this has meant that most care is delivered by allied professionals, and it became clear during our visit that developing the skills and education of this group of individuals is a large area of work that needs to be addressed. During our visit we had the opportunity to deliver a half day workshop on basic trauma management and this was well received with over 15 delegates attending. We aim to develop this programme over the next year and hope to offer a comprehensive package of teaching and training which will be delivered by our volunteers.

The coming months are an exciting time for both us and our local partners, and we are confident that our programme of works can have a beneficial and long lasting impact on the people of Northern Ghana. The path ahead may well be challenging, but we have at least taken the first few steps along it.

Dr Ibrar Majid

SUMMARY OF ACCOUNTS

Period 01/02/2007 to 31/01/2008	£
TOTAL INCOME	1,175,884
EXPENDITURE	655,543
D.R. CONGO	549,166
GHANA	76,997
KENYA	7,476
PAKISTAN	7,445
BANGLADESH	800
NIGER	923
ADMINISTRATION	12,736
SURPLUS	520,341



THE TEAM

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Dr Saddaf Alam

Mr Khalil Rehman

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