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Autumn 2021

Dispatches

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SITUATION REPORT

1. KENYA

Paul Odongo/MSF

A doctor and midwife check on a mother in the maternity ward at MSF's Dagahaley hospital in the Dadaab refugee camp. Over 200,000 people currently live in the camp. MSF has been providing medical care in the camp for most of its 30-year existence. "If the camp closes and there are no alternative solutions to ensure people can continue accessing healthcare, this could be disastrous," says project coordinator Jeroen Matthys.

2. SUDAN

Baby Dawit Yonas was born prematurely, weighing only 1.2 kg. His mother, Mebruit Muruts, gave birth at MSF's maternity clinic in Al-Tanideba camp, Sudan, where 20,000 people have sought refuge from the fighting in Tigray, Ethiopia.

Dalila Mahdawi/MSF

3. IRAQ

Ahmed Kaka/MSF

Saqr Badr stands outside MSF's al-Wahda hospital in East Mosul after being discharged. "I came back to Iraq and was finally able to walk," he says. Sadr was shot in the leg by a sniper as he tried to flee Mosul in 2017. He spent two months at al-Wahda hospital before being transferred to MSF's reconstructive surgery hospital in Amman, Jordan, to complete treatment. 1,112 people have been treated at the Mosul hospital since it opened in 2018.

4.SOMALIA

MSF

An MSF team distributes food in El Wakk, Jubbaland state, southern Somalia. Jubbaland is facing a deadly cascade of emergencies, including malnutrition, measles and water shortages. Over the past year, MSF teams have run measles vaccination campaigns, distributed water and treated children for severe malnutrition.

5. CENTRAL AFRICAN REPUBLIC

Four thousand people have taken refuge in and around a mosque in Bambari, Central African Republic, following renewed fighting. The security situation across Central African Republic has deteriorated over the past six months. MSF is working to improve health and hygiene conditions in the makeshift camp through a malaria treatment centre, temporary latrines and hand-washing points.

Jacob Kuehn/MSF

IN MEMORIAM

Tedros Gebremariam | Yohannes Halefom Reda | María Hernández

MSF is in mourning after the murder of three of our colleagues who were working in Tigray, Ethiopia.

Driver Tedros Gebremariam, assistant coordinator Yohannes Halefom and emergency coordinator María Hernández were travelling through central Tigray in an MSF vehicle on 24 June. All contact with the team was lost during the afternoon. The following morning, their vehicle was found empty and their lifeless bodies were found nearby.

No words can convey our sadness, shock and outrage at this horrific attack. Nor can words soothe the suffering of their families and loved ones, to whom we relay our deepest sympathy and condolences.

Tedros Gebremariam Gebremichael, aged 31 and from Ethiopia, had been a driver for MSF since May 2021. Yohannes Halefom Reda, aged 31 also from Ethiopia, joined MSF in February 2021. María Hernández, aged 35 and from Spain, started working for MSF in 2015, first in Central African Republic and later in Yemen, Mexico and Nigeria.

MSF condemns this brutal attack on our colleagues and has called for a full investigation into the killings.

"The murder of our colleagues – Tedros, Yohannes and María – is a tragic example of the complete disregard for human life that our teams have witnessed in this conflict," says MSF operations director Teresa Sancristoval. "The levels of violence against civilians and the atrocities committed in Tigray are utterly shocking."

MSF'S UK VOLUNTEERS

Afghanistan: Sarah Elizabeth Leahy, *Project coordinator*; Thomas Casey, *Field communications manager*

Bangladesh: Caroline Chestnutt, *Water & sanitation manager*; Sarah Cross, *Nurse*; Aine Lynch, *Project coordinator*; Jo Westwood, *Water & sanitation manager*

Central African Republic: Amy Mikhail, *Mobile implementer*; Hanna El Hafidi, *Pharmacist*

Chad: Nicodeme Zirora, *Finance coordinator*

Democratic Republic of Congo: Mark Blackford, *Finance coordinator*; Ruth Zwizwai, *Epidemiologist*; Marcus Wilson, *Hospital facilities manager*

Egypt: Elizabeth Wait, Health promoter

Ethiopia: Alastair Yeoh, *Doctor*; Daniel Fitzgerald, *Doctor*; Jenna Broome, *Doctor*; Alice Hooper, *Humanitarian affairs officer*; Rebecca Kerr, *Advocacy manager*

Guatemala: Benjamin Jeffs, *Medical team leader*

Haiti: Michael Barclay, *Project coordinator*

India: Sakib Burza, *Head of mission*; Simon Lee, *Doctor*

Iran: Timothy Hammond, *Medical team leader*

Iraq: Ciara McHugh, *Midwife*; Deirdre O'Donnell, *Paediatrician*; Stephen Davidson, *Nurse*

Kenya: Dana Krause, *Head of mission*

Lebanon: Leila Younes, *Health promoter*; Catherine McGarva, *Mental health manager*

Libya: Chloe Marshall-Denton, *Protection manager*

Malawi: Deidre O'Shea, *Lab manager*

Mozambique: Manja Leban, *Doctor*

Myanmar: Mohammad Sesay, *Humanitarian affairs officer*; Ben Small, *Field communications manager*

Netherlands: *Emergency team*

Richard Galpin, *Water & sanitation coordinator*

Nigeria: Davina Aidoo, *Mental health manager*

Pakistan: Serina Griffin, *Finance manager*

Palestinian Territories: Helen Ottens-Patterson, *Head of mission*; Mina Naguib, *Doctor*

Sierra Leone: Gareth Lock, *Obstetrician*; Jennifer Hurley, *Midwife*; Rachel Crozier, *Nurse manager*; Batje Flier, *Finance coordinator*

South Sudan: Kate Thompson, *Finance coordinator*; Anton Zhyzhyn, *Water & sanitation expert*; Melissa Perry, *Project coordinator*; Erin Lever, *Midwife*; Sofie Karlsson, *Midwife*; Katherine Smeaton-Russell, *Nurse*; Caterina Quagliani, *Nurse*; Jason Dunnett, *Finance manager*

Sudan: Daniel Roberts, *Doctor*; Cara Brooks, *Project coordinator*; Abdirashid Bulhan, *Water and sanitation manager*; Dalila Mahdawi, *Communications manager*

Syria: Lily Daintree, *Midwife*; Padraic McCluskey, *Project coordinator*

Ukraine: Andrew Burger-Seed, *Project coordinator*

United Kingdom: *Asylum seeker mental health project*

Keith Longbone, *Project coordinator*; Philippa Tagart, *Psychosocial facilitator*; Iva Said, *Cultural mediator*

Uzbekistan: Beatrice Blythe, *Anthropologist*

Venezuela: Davina Hayles, *Project coordinator*

Yemen: Isabel Wilson, *Paediatrician*; Adeyemi Lawal, *Medical coordinator*

SOUTH SUDAN

WORDS
BETHANY SAMPSON
PHOTOGRAPHY
NICOLA FLAMIGNI

Bumpy roads, bullets and bats in the bed

"I'm standing by the hospital gate watching the preparations for departure as bags are loaded and the final checks take place. A slight dampness from my MSF jacket soaks slowly through my T-shirt. I had to wash the jacket this morning to get the blood off the front and it still isn't dry. I've been up since 3 am helping the team in maternity treat a patient with severe bleeding after giving birth.

I flap my jacket a bit in the morning air. It's still cool, but as the sun continues to rise it will soon be burning hot. My jacket will be dry in less than half an hour.

We're making the first overnight visit of the year from our main hospital in Lankien to our clinic in Pieri, some 36 miles and a three-hour drive to the south.We have a briefing for the journey ahead. There are contingency plans for all eventualities, and I've prepared a medical bag containing equipment to stabilise someone with a severe illness or injury.

Eventually, everything is prepared and we set off, passing out of Lankien and into the countryside beyond. The journey goes smoothly as we bump our way down the dirt road, the car jolting up and down the ruts and tilting from side to side as we cross dried streams and riverbeds. The only drama comes half an hour in when one of our colleagues, reacting to the uneven road, has to get out and vomit in the grass.

From the air, this area looks almost deserted: a dense scrubland with areas of swamp where water has been left standing after the heavy floods of the rainy season. Close up, though, it's full of life. Groups of children run out and race after the car as we pass. David, one of our experienced local staff who is coming to help with carpentry and repairs, tells me that the smoking bundles the children carry means they're out hunting today for bees and honey.

The team in Pieri are waiting for us. They swing into action when we arrive, providing tea and something to eat while confirming plans for the day. Our outreach staff will travel onwards this afternoon to review our community-based medical care sites. Our carpenters will head off to repair the ceiling of the clinic's inpatient ward. And I'll stay here with the team to help develop their contingency plan for treating large numbers of injured patients, known as a 'mass casualty plan'.

In the dry season, fighting often flares up between different groups, while raids by young men attempting to capture cattle are common. Last year the clinic was so full of injured patients after an episode of fighting that some were sleeping outside on the ground. A helicopter was a common sight, travelling back and forth to pick up the severely injured patients needing surgery.

The team here are extremely dedicated and hardworking and it's nice for us to spend some time working together more closely. Most of my contact with the staff here is restricted to conversations over the temperamental satellite phone. As we're talking, a new patient is brought in – a two-year-old girl with severe malaria.

She's unconscious and starting to have a seizure. The team quickly spring into action, replacing her glucose, rehydrating her and giving her injected medication for malaria. Her mother holds her tightly as the team get the treatment started around them.

We sit in the evening having a cold drink from the market, watching as the birds settle into the trees to roost and the stars come out. There's no electricity here, no phone signal, no internet. It feels peaceful. As I go to the room where we're staying, I frighten the bats from where they've been sleeping and they stream out from the underside of the bed frame and up towards the ceiling.

As I drift off to sleep, I remember I was warned to put a sheet on top of my mosquito net to protect me from the bats in the night… but I'm too tired to get up now. I'll have to take my chances.

My eyes have barely closed when the supervisor comes to tell me that we have received an emergency call. We're expecting patients from a nearby area where there's been fighting. Someone called ahead to tell us they're on their way. Their conditions sound severe and we don't know exactly how many people are injured. Still, it will take some hours before they reach us along the uneven roads. Around midnight they call me on the radio – the injured patients have arrived.

The medical staff on-call have moved the patients inside and I join the team in the clinic's small emergency room. There are two patients: one with a gunshot injury to his thigh and one with a gunshot injury to the abdomen. The team quickly take their vital signs and assess the injuries. We have one torch between us. As we wrap the bandages, I discover that I can use both hands and the light from my phone (no electricity remember) if I perch it in my jacket pocket facing out.

Thankfully, both patients are relatively stable as the bullets missed their most critical organs. We get them started on intravenous antibiotics and fluids. Their relatives hover anxiously by their beds. I leave the on-call medic to continue their treatment and head back to bed for a few more hours of sleep.

In the morning, there's a cool bucket shower and some breakfast before I join the clinical team to start the day's work and review the patients. I'm worried about the man with the injury to his abdomen. We arrange to urgently transport both injured men by plane for surgery.

After lunch it's time for us to start our journey back to Lankien; we have to be back before dark. As we set off, I pass the child with malaria. She's sitting up munching happily on a biscuit her brother has given her. She's likely to make a full recovery. Then we're on the road again, bumping and jolting our way back north, kicking up a trail of dust behind us. Halfway through the journey, I'm nearly frightened out of my skin by a loud noise from under my seat. I peer under to find an enormous chicken staring back at me.

The guys find my fright hilarious and continue to laugh as the unfortunate chicken and I both squawk as we pass over the larger bumps. David proudly informs me it is his purchase and promises to be very delicious.

We arrive back, absolutely covered in the dust from the road, but the trip has been a success. Hopefully it's the first of many trips, as we try and support our remote sites before the rains come and the roads become impassable again.

Our water and sanitation expert insists I take a shower before I come into the kitchen and eat. I'll need to wash my jacket again to have it clean and ready for tomorrow."

Bethany Sampson *is a doctor based in Lankien, South Sudan*

READ MORE AT
MSF.ORG.UK/SOUTH-SUDAN

▶ An MSF team checks a child for malnutrition in Ulang, South Sudan.

ON THE RAZOR'S EDGE

MADAGASCAR

WORDS AND PHOTOGRAPHY
BENJAMIN LE DUDAL

DROUGHT AND POOR HARVESTS HAVE CAUSED A MALNUTRITION CRISIS ACROSS SOUTHERN MADAGASCAR. BENJAMIN LE DUDAL IS AN MSF NURSE RESPONDING TO THIS EMERGENCY.

◀ A guide leads the team to Maroforoha, southern Madagascar.

'We are tired, *vazaha*'. The young man is crouched down beside his motorbike, his eyes dark. He refuses to continue. We had recruited our two bikers in Tsivory town the day before. After fording several rivers and trudging through the tall grass, pushing and pulling the motorcycles up steep sandy banks, then riding through the savannah for nearly three hours, the two drivers want to turn around. They hadn't expected a journey like this.

I look at the GPS map and consult our guide. Both are clear: we have made it three-quarters of the way. Only five km still separate us from our goal, the small and isolated village of Ambatomanaky. Turning back when we are so close makes no sense and doesn't bode well for the rest of the week.

An exploratory trip is one of the most essential of MSF's activities. It mainly involves logisticians, water and sanitation specialists and medics. The principle is simple: send a small team to unfamiliar areas in order to bring back vital information: do people have clean drinking water? What are the security conditions, the main diseases, the state of the health facilities? Usually the team travels by 4x4 or motorbike and camps in the bush. ›

Our trip feels more urgent than most. We've heard alarming reports that people in this area are starting to starve. After two or three years of scarce rains, the cassava and sweet potato crops across southern Madagascar have shrunk. This year, the rainy season never arrived at all.

Acute malnutrition is on the rise. Food distributions have taken place, but mainly in larger villages, forcing people in remote hamlets to walk for several hours to collect their rations, which they then struggle to take home due to exhaustion.

Our mobile medical team hit the road with two 4x4s and eight motorcycles to run clinics in the remotest regions. Even with our own transport, getting around is far from straightforward…

Last week, we ran our first mobile clinic. It took six hours by motorbike to reach Ankamena, a small hamlet of wooden shacks at the foot of a magnificent mountain. With the closest health centre 25 km away, it's half a day's walk for mothers to take their children to be vaccinated against measles.

The task of our medical team was to identify the most malnourished and to provide treatment and therapeutic food. Our main focus was children under five, because they are the first to die of hunger and the infections that accompany malnutrition.

In no time, a crowd of mothers, children and the elderly gathered. We triaged the most severe cases and quickly admitted small children with bellies swollen by intestinal parasites. Nurses measured the children's mid-upper arm circumference – a useful indicator of malnutrition – as well as their weight and height. Then came the distribution of Plumpy'nut, a high-calorie therapeutic food. It won't solve the problem of crops wiped out by drought and locusts, but it will keep the weakest from starving until we return in two weeks' time.

As nursing manager, I oversee the mobile clinics and make sure everyone has what they need. While the logisticians erect a roof of leaves so that waiting families have shade, I distribute water and ensure everything is going smoothly, giving a hand with consultations when needed.

After two days of clinics, we headed towards the village of Ranobe. To do this, we had to cross the Mandraré river. Our team forded the river with water up to their chests. Having reached the opposite bank, we walked for 40 minutes under the blazing sun with 14-kg boxes on our shoulders.

In Ranobe, people flocked to our clinic by the hundreds, waiting in the heat until it was their turn.

"Our team forded the river with water up to their chests"

▲ Benjamin and the team meet with the mayor of Ebelo.

◀ The bikers on their way to Ambatomanaky.

A little girl played with a piece of wood carved in the shape of a human; an adolescent squatted, leaning on his spear.

A significant proportion of people in Ranobe had severe acute malnutrition. Whole families had nothing to eat apart from plants. Our mobile clinic team had become well-oiled and we worked continuously for five hours. In another village, we came across a 16-month-old boy who was dehydrated and severely malnourished. We took him to hospital in one of our vehicles for specialist care.

In theory, there's a network of basic health centres in the area, but in practice, not all of these are operational. Some are just a memory, while others continue to receive patients but lack equipment and supplies. If a patient's condition is worrying, they must go to a specialist centre, or else to the hospital in Tsivory. The cost of round-trip transport, not to mention accommodation and food, quickly becomes prohibitive. If MSF had not been there, it's a safe bet that the mother of this 16-month-old child could not have afforded the journey. How many children like this die for a lack of affordable healthcare?

While having my coffee that morning, I observed a funeral procession leave the village at first light, accompanied by lamentations and tears. A seven-month-old child had died the day before.

What makes the situation complicated is that the availability of food in villages just a few kilometres apart can vary from satisfactory to catastrophic, and neither government figures nor rumours can reliably predict ›

the situation. The only solution is to go and see for ourselves. Which is how I find myself miles from anywhere with two exhausted bikers who have gone on strike…

We'd set out in the early hours of the morning with the smell of gasoline from the freshly filled tanks. We are an MSF team of three: the medical advisor, the translator and me. The motorcycles travel smoothly on the paved road. On the verges, workers stop to watch us go by, spades slung over their shoulders and hands shading their eyes. We discover a landscape of hills, tall grass and unfamiliar trees, gilded with fine gold by the rays of the rising sun. Far to the north, a vast mountain range blocks the horizon.

Before venturing into the bush, we felt it was safest to hire a local guide. Even GPS maps are imprecise here. The road soon fades into a path just wide enough for an ox cart. Nature has patiently regained this road since independence and we slalom between giant termite mounds. We make our way through the tall grass, cross dying rivers and hoist the bikes with the strength of our arms to the tops of the banks, trying not to let our feet slip in the sand, before getting on them again, sometimes for just a few hundred yards, before a new obstacle arises. We progress at just five to seven km per hour.

We have almost reached our goal when the bikers go on strike. They are exhausted. We all are. I talk with them, say that we are a team and that we have to finish our trip as we started, together. One biker turns to his colleague: 'Courage!' he implores.

I promise them two very cold and well-earned beers once the trip is finished. They get back in the saddle. 'We go where others don't go'. This slightly pretentious MSF slogan seems to take on its full meaning as Ambatomanaky finally appears. The children stare at us with wide eyes: we are told that we are the first white people to come to the village.

We ask the chief about living conditions. He tells us that they manage to grow some peanuts, cassava and sweet potatoes, but crops are poor due to the lack of rain. For as long as anyone can remember, the climate here has been stingy with water and the region has experienced recurrent episodes of drought, but this drought has lasted for three years. The village has no pump or well. People drink water from the nearby river, whose colour is enough to explain why all the children here have big bellies. Many diseases, including intestinal parasitosis, are carried by water.

A few children are malnourished, but none appear to be in danger. Most are seen weekly at the health centre a four-hour walk away, where they are given Plumpy'nut – or at least they are when the health centre is stocked, which is not the case now. It's another four hour's walk under the sun to finally come back empty-handed.

Over the following days, we continue our reconnaissance of other isolated neighbourhoods. Everywhere it's the same situation: insufficient harvests, monthly rations which run out after 15 days, surface water that you must drink even if it makes you sick.

The chief of a hamlet asks me to intercede on his behalf so that his people get a well and maybe some food. I explain that this exceeds my decision-making powers, but I promise to pass on his request. Naina, one of the drivers, translates his final sentence: 'He says thank you for coming to see our little village, thank you for taking an interest in our lives.'

In the evening, Mélanie, the medical advisor, and I talk at length about the perspectives of these men and women who cling to their land no matter what. They are on a razor's edge and their health needs will have to be watched closely to ensure that their situation does not take an even darker turn.

On our return, we formulate our recommendations to our superiors: repair the out-of-service water pumps in Besakoa; rehabilitate Tsivory hospital, which is in a sorry state; deliver Plumpy'nut from the government to health centres so that they do not run out; and run a new mobile clinic in the region. This will be a patch on a colander, but it is still essential.

The next morning, I call the doctor caring for the 16-month-old child we took to hospital a few days earlier. He's out of danger.

▶ Crossing the Mandraré river to reach Ranobe.

▶ A woman stands by the Besakoa river, where villagers collect their drinking water.

◀ Musicians and dancers perform in the village square during a mobile clinic.

"Whole families had nothing to eat apart from plants"

Benjamin Le Dudal
worked as a nurse and volunteer firefighter before joining MSF

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RUNAWAY BACKPACK

People living in conflict-riven areas of South Sudan are often forced to flee new outbreaks of fighting at a moment's notice. To ensure that people on the run have access to a minimum of medical care, MSF developed the 'runaway backpack' to provide on-the-go medical treatment for common ailments and minor injuries.

Containing a range of supplies, from malaria test kits through to antibiotics and water purification tablets, the backpacks are designed so that community health workers with minimal medical training can use them even when they are miles from the nearest medical facility.

"The concept may seem simple," says Amor Chandoul of MSF's Nairobi Displacement Unit, which was tasked with redesigning the backpack. "But crafting a mobile form of healthcare that could move at the same pace as those fleeing the conflict's frontlines and that was more than just a first-aid kit was a process of trial and error."

An earlier version of the backpack proved to be of limited use when fighting broke out in Upper Nile state in late 2016, as it was too heavy and contained items that were either out of date or needed specialist medical training to use.

The backpacks have been simplified, with specialist items replaced by easier-to-use alternatives; for example, injectables swapped for oral drugs.

A list of essential items that each backpack should contain was agreed on, including malaria treatment, antibiotics, medication to reduce fevers, drugs for pain relief and wound care supplies.

"At first, we thought each backpack should also have space for orientation and telecommunications equipment," says MSF medical coordinator Dr Aziz Harouna. "However, we soon realised that a pack with high-tech kit like a satellite phone might put the wearer at risk of being targeted by an armed group, so we dropped both of those."

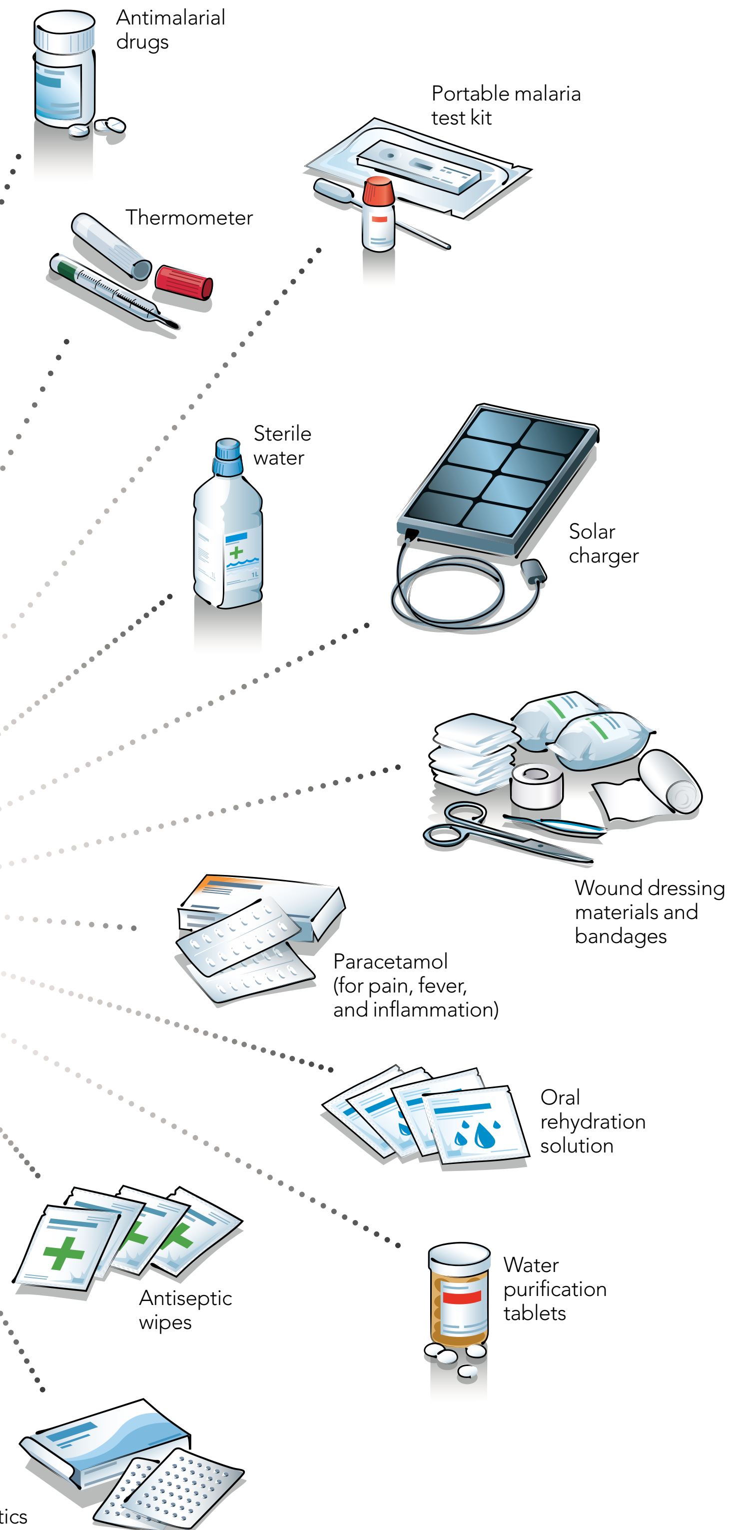
The waterproof backpacks were sourced in Juba, the South Sudanese capital, and look very ordinary. While most items of clothing worn by MSF staff are white, to make them stand out, these backpacks are plain black with a small MSF logo. Close up, they are identifiable as MSF, but without singling out the wearer as a target.

The decision to carry one of the backpacks is totally voluntary. People who put themselves forward are trained in how to use all the medicines and supplies. The backpacks are kept fully stocked, with all the drugs in date, so they are always ready to grab and go.

The new backpacks were first used successfully in April 2017 when an outbreak of fighting in Upper Nile state caused 25,000 people to flee. Among them were 29 health workers, each carrying a runaway backpack, who were able to provide people with emergency medical care.

SOUTH SUDAN

ILLUSTRATION
R. PALMER



8KG

Each backpack weighs 8kg, has space for the wearer's personal items and is designed to provide basic medical care for up to 20 people.

£109

Cost of one runaway backpack.

AFGHANISTAN

WORDS SARAH LEAHY
PHOTOGRAPHY TOM CASEY

‘In just one day we performed 20 surgeries’

SARAH LEAHY IS MSF’S PROJECT COORDINATOR IN HELMAND PROVINCE, SOUTHERN AFGHANISTAN. INTENSE FIGHTING IN THE REGION HAS LED TO AN INCREASE IN WAR-WOUNDED PATIENTS AND PUT EXTREME PRESSURE ON HEALTHCARE SERVICES.

▼A team perform surgery in one of three operating theatres at Boost hospital, Lashkar Gah, Helmand Province.

"Fighting in Afghanistan has been intense since May, but in August the clashes between the Afghan army and the Islamic Emirates of Afghanistan (also known as the Taliban) increased and moved into more urban areas such as Lashkar Gah city in Helmand Province. There has been relentless gunfire, air strikes and mortars in densely populated areas. Houses are being bombed and many people have suffered severe injuries.

Fighting within the city makes it harder for us to respond; our staff are part of the community and they, like many people, are afraid to leave their homes. Life is at a standstill. Some of our colleagues are staying overnight in the hospital as it’s safer, but also so they can keep on treating patients.

Despite the challenges, the MSF-supported Boost hospital remains operational and saw a marked increase in trauma needs during the fighting.

In just one day we performed 20 surgeries on people injured by violence, which is unheard of for MSF here as we are not Lashkar Gah’s main provider of trauma care. Beforehand, we had been operating on average on two war-wounded people per day.

Between 29 and 31 July alone, MSF treated 70 war-wounded patients. And in total from 3 May until 31 July, teams have treated 482 war-wounded, nearly all for injuries caused by shells and bullets and around a quarter aged under 18. The patients seen by MSF will be just a fraction of the true number injured by the violence.

People rely on the 300-bed Boost hospital, the only referral hospital in the province, for essential neonatal, paediatric, intensive care, maternity, and surgical services among others.

Since May, we’ve witnessed an alarming increase in the severity of illnesses when they arrive at the hospital. People described how they have been forced to wait at home until the fighting subsides or to take dangerous alternate routes.

One of the emergency room doctors explained that many patients have been caught in crossfires. On top of something like severe diarrhoea, they were also arriving at the hospital with a bullet in their shoulder or their leg.

The conflict leads people to think twice as to whether if they really want to make the journey. They delay until they can’t wait any more, when their relatives haven’t opened their eyes for two or three days, have shallow breathing and are unresponsive. From a medical perspective, that’s almost too late.

‘All my family depend on me,’ one patient with bullet wounds to both his arms told us. ‘but I feel like in the future I won’t be able to work because of my injuries. It’ll be very hard for me to feed my family. I’ve left my home and I cannot go back there.’

Medical staff around Afghanistan have faced fighting taking place in the streets around medical facilities, with little rest or respite; constantly worried about the families they have left at home. MSF teams here and across Afghanistan continue to provide much-needed healthcare, but these medical facilities must be respected by all."

READ THE LATEST UPDATES ABOUT OUR WORK IN AFGHANISTAN AT **MSF.ORG.UK/AFGHANISTAN**

YEMEN

WORDS HIND AHMAD MOHAMMAD HAIDAR
PHOTOGRAPHY NUHA HAIDER

‘WAR AFFECTS EVERYBODY HERE’

MSF midwife **Hind Ahmad Mohammad Haidar** has been living and working amid constant insecurity since the outbreak of Yemen’s brutal civil war. From a clinic in the city of Marib, she describes the importance of providing medical care after six years of conflict.

◀A child is vaccinated during a mobile clinic in Marib, Yemen.

“The situation here in Marib is bad. Nearly three million people have fled here to find refuge from the war; often they live in terrible conditions. Marib has the largest number of displaced people in the whole of Yemen and every week their numbers increase. There are enormous medical needs here. Even within Marib, people are forced to move from one place to another. For example, MSF used to support a rural hospital in an area called Madghal, but as the frontlines moved closer, the fighting there became too intense for people to stay. They were all forced to flee to a place called Al-Suwaida.

Even here at MSF’s clinic, we often hear the sound of rockets and shelling, but we just get on with what we’re doing. War affects everybody here, but particularly the children. I’m married with five children. My husband is a schoolteacher and before the war we lived in the capital, Sana’a. For me personally, the impact of the war is not so extreme and direct. It’s more the general sense of ongoing instability and the lack of safety that is difficult to deal with. When you see all the displaced people in Marib, and you witness their living conditions in the camps, it does affect you. But I’m glad I’m working with MSF and I’m happy we’re able to help people who are really in need.

Every day so many things happen. We treat a lot of patients. I remember one woman who came to us. She was 35 years old and had been displaced from her home five times. She was pregnant but had complications, including some blood problems. She needed to have a caesarean and we were able to care for her, refer her to a hospital for the procedure, and then, once she’d given birth, we provided her with postnatal care, gave vaccinations to her baby and offered her family planning, all for free. Everything went well for her. But if MSF wasn’t here, what would have happened to her?

There are a large number of migrants here in Marib, many of them women who crossed over from Africa trying to get to Saudi Arabia for work. They walked long distances to get here and many suffered abuse and rape on their journeys. MSF provides medical care to these women and a mental health team has been working closely with many of them. This is really important work.

To all our supporters, I would say thank you very, very much. You can rest assured that your support is not in vain. I’ve been working here with MSF for 16 months and I’ve seen the massive impact that we’ve had. So many people have benefited from the medical care that MSF provides. I’ve seen how MSF goes to the places affected by the war and helps the people who are most in need: those living in camps, displaced people, migrants and marginalised groups. I feel good being able to come to work and serve our patients.”

Médecins Sans Frontières/Doctors Without Borders (MSF) is a leading independent humanitarian organisation for emergency medical aid. In more than 70 countries worldwide, MSF provides relief to the victims of war, natural disasters and epidemics, irrespective of race, religion, gender or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

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Cover image: An MSF team journey towards Ambatomanaky in southern Madagascar where malnutrition is a growing concern. Photograph © Benjamin Le Dudal

ABOUT
Dispatches is written by MSF staff and sent out quarterly to our supporters to keep you informed about our medical work around the world, all of which is funded by you. Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. It is edited by Marcus Dunk. It is printed on recycled paper and costs £0.61 to produce, package and send using the cheapest form of post. It is an important source of income for MSF and raises three times what it costs to produce. We always welcome your feedback. Please contact us using the methods listed, or email: **dispatches.uk@london.msf.org**

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▲ Jean-Claude Bazibuhe is a water-seller in Goma, Democratic Republic of Congo. Since the eruption of the Nyiragongo volcano in May, water has become a scarce commodity in the city. "We are still living with the trauma of that night," he says. "When the night turned red, we rushed out of the house to escape the danger. Two of my children were injured and they are still in pain." MSF is providing medical care to people affected by the disaster and ensuring that those enrolled in the HIV programme have continued to receive treatments.

Moses Sawasawa