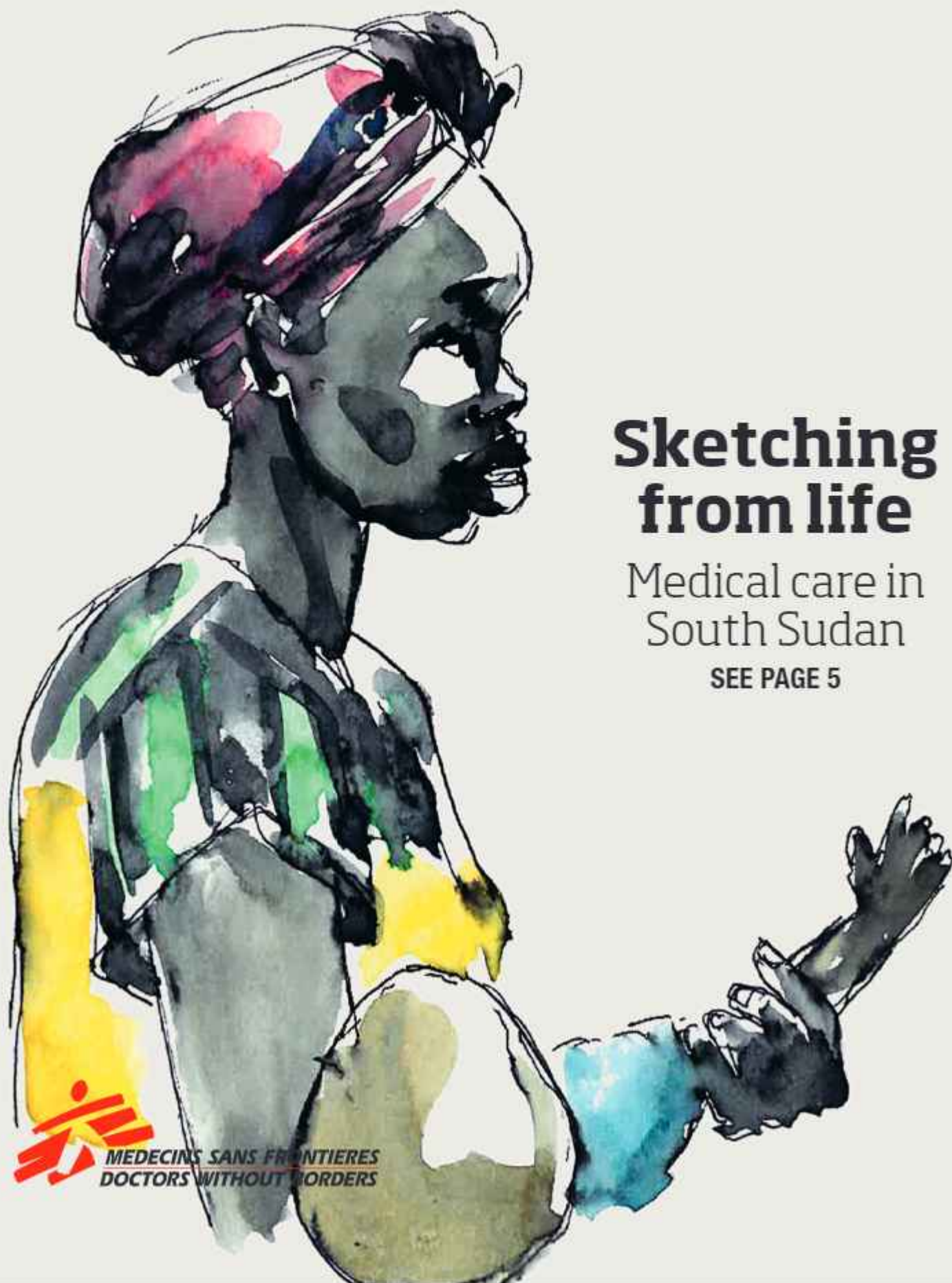


Dispatches

Winter 2019
No. 95



Sketching from life

Medical care in
South Sudan

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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Front cover: A mother in Aweil Hospital's emergency room in South Sudan. The hospital is the only secondary health care facility in a region with 1.5 million inhabitants.

Illustrations © Camille Quilichini/MSF.

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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About Dispatches

Dispatches is written by people working for MSF and sent out every three months to our supporters and to staff in the field. We send it to keep you informed about our activities and about how your money is spent.

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Antibiotic resistance: a global emergency

Doctors around the world are losing the ability to use antibiotics. What is MSF doing to tackle this emergency?

WHAT DO ANTIBIOTICS DO?

"Antibiotics kill the bacteria which cause life-threatening infections – which makes these drugs super-important," says Ernestina Repetto, MSF advisor on infectious diseases. "Without them, people can die of complications from common diseases or small wounds that become infected."

WHAT IS ANTIBIOTIC RESISTANCE?

Bacteria adapt to new environments. Every time they are exposed to antibiotics, there is a small chance that they will adapt and survive, acquiring resistance to the drugs. With the widespread use of antibiotics over recent decades, bacteria have had plenty of opportunities to increase their resistance.

WHERE IS IT HAPPENING?

It's a serious problem all around the world. In different locations, different types of bacteria have grown resistant to different antibiotics. In places with conflict it's even more complicated. Gunshots and explosions all cause dirty wounds, which often require multiple rounds of surgery –

making patients vulnerable to bacterial infections.

WHAT IS MSF DOING?

Setting up microbiology laboratories: Our lab teams can identify exactly which bacteria are causing an infection and which antibiotics they're resistant to, allowing doctors to decide which antibiotic will be most effective for each patient.

Ensuring antibiotics are used properly: "It's vital that there are strict rules on the sale of over-the-counter drugs at pharmacies and on antibiotic use," adds Ernestina Repetto. "But when a place is in the middle of conflict, it can be very difficult to implement or enforce these rules. That's why MSF tries to ensure that all our medical staff understand how antibiotics should be used, even in war-torn countries."

Preventing and controlling infections: "We have strict rules to avoid resistance spreading in hospitals," says Fatima Salim Younis, who supervises infection prevention and control at MSF's hospital in Mosul, Iraq. "Our approach involves: hand hygiene; cleaning and sterilising the environment and medical



devices; and controlling the channels by which infection can spread."

THE WAY FORWARD

"Tackling this is a huge challenge, and MSF can only address a small part," says Dr Jorgen Stassijns, coordinator of MSF's taskforce on antibiotic resistance. "We have very little influence on private healthcare providers, while the vast majority of antibiotics are used not in medicine but in livestock breeding and agriculture, over which we have no say."

Although more is needed to tackle the problem, MSF is trying to make a difference in its own medical facilities. Antibiotics are just too important – to our patients and to our doctors – for this fight to be lost.

A nurse prepares sterilised equipment for surgery at MSF's hospital in Mosul, Iraq. Photograph © Mario Fawaz/MSF

SOUTH SUDAN

“The only way to move around the hospital now is by boat”



The MSF team travel by canoe through flooded Pibor district to assess the damage.
Photograph © MSF

MSF medical team leader Benedetta Capelli is just back from Pibor, South Sudan, where rising floodwaters have forced MSF to relocate its hospital

“Our hospital in Pibor is about 100 metres from the River Gumuruk, with the river creating a loop around it.

Two weeks ago, the river suddenly started to rise. We moved the isolation area to higher ground, then the adult ward, children’s ward and therapeutic feeding centre.

When the water crept towards the operating theatre, we had to close it. We carried the most expensive equipment to an area we hoped would stay dry.

By now we were seriously worried. Every day the water rose by another 10 to 20 cm. For our South Sudanese staff, the distress was doubled. Just as our compound was disappearing underwater, their own homes were being flooded.

The moment we saw the water infiltrate the new ‘safe’ tents, we decided to look for another location for our hospital. We found a space in Pibor’s marketplace, and over the following days we dismantled the hospital and moved it, piece by piece. We created an area with tents for all the main medical activities.

Back in the MSF compound, the water was rising on all sides. On our final night

there we all slept together in the highest-up container. We had to paddle in a plastic boat to reach the toilets. In fact, the only way to move around the hospital now is by boat – the compound has literally become part of the river.

At the temporary site in the marketplace, our team is providing 60 consultations a day as well as antenatal care, deliveries and inpatient care.

The site has no electricity and is knee-deep in mud. We lost a lot of items to the flood – we now have just one oxygen concentrator. We have enough drugs to last a week. We are waiting for more from Juba, but transport – now only possible by helicopter – is challenging. The helicopter landing strip is just a thin strip of land.

Waterborne diseases are a major health concern – and cholera is the biggest fear. We also expect an increase in respiratory tract infections, malaria and snakebite.

We have no idea how long the floods will last and right now the water is still rising. Our next step is to find a location to install an emergency inflatable hospital.”

msf.ie/southsudan



DEMOCRATIC REPUBLIC OF CONGO

Women waiting for the Ebola vaccine have their questions answered by staff at a vaccination site in Beni to help address fears and rumours about the disease. MSF also runs an Ebola treatment centre in the city.



Photograph © Msya Abu Ata/MSF

IRAQ

Zeina touches the foot of her son Murtada, born at MSF’s maternity unit in West Mosul – a city struggling to get back on its feet after fierce fighting ended two years ago.



Photograph © Jeffrey Morris/MSF

LEBANON

Sami blows bubbles with four-year-old Abbas, who is being treated for the inherited blood condition thalassaemia, in Elias Hraoui hospital in Zahle. The hospital’s Kids’ Zone is a space to play during breaks in the treatment, which can last all day.



Photograph © Gregory Kenzo Saito/MSF

IRAQ

Dr Kate Goulding (left) and team assist a patient in Sinuni general hospital in Sinjar district, the ancestral home of the Yazidi people, who were subject to a genocidal campaign by Islamic State in 2014. Many survivors are traumatised by their experiences and the community is grappling with a severe mental health crisis.



SOUTH SUDAN

A mother brings her child to be vaccinated against measles at MSF's hospital in Aweil, as drawn by Camille Quilchini, an architect who spent seven months helping to construct a new hospital pharmacy.

See more illustrations and read Camille's blog at: msf.me/camille

Illustration © Camille Quilchini/MSF

Right: Syrians flee the town of Ain Issa, 20 miles south of the Turkish-Syrian border, after Turkish warplanes launched strikes on the area
Photograph © Jake Simkin

SYRIA

Northeast Syria conflict

MSF evacuates staff, launches medical programmes for fleeing refugees in Iraq

21 October – Following the launch of Turkish military operations in northeast Syria on 9 October, MSF was forced to suspend the majority of its activities and evacuate its international staff from the area.

The highly unpredictable nature of the conflict has made it impossible for MSF to negotiate safe access to deliver healthcare, leading to a situation where we can no longer guarantee the safety of our staff.

"It is with a heavy heart that MSF has taken the difficult decision to suspend the majority of its activities and evacuate its international staff from northeast Syria," says Robert Onus, MSF emergency manager for Syria. "We cannot operate at scale until we can gain the assurances and acceptance of all parties to the conflict that we can operate safely."

MSF teams continue to work in northwest Syria, providing healthcare in various facilities and via mobile clinics.

MSF LAUNCHES RESPONSE ACROSS BORDER

As people flee the conflict in northeast Syria, MSF has launched medical activities over the border in the Kurdistan region of Iraq.

Our teams are currently running two mobile clinics providing basic healthcare, psychological first aid and malnutrition screening at one reception site. Teams continue to prepare for a potential surge in the number of arrivals.

"Most of the people screened by our mental health team presented signs of depression and anxiety," says Marius Martinelli, MSF project manager.

More than 5,300 people have crossed the border from Syria into Iraq since the beginning of the conflict, with more than 500 new arrivals every day for the past six days.

Find out more: msf.ie/syria





Welcome to the emergency team



Being part of MSF's emergency team means travelling to conflict zones, disasters and epidemics at a moment's notice. Emergency doctor **Chris Hook** is part of the team

"Working for the emergency team means you have to be available to go pretty much anywhere in the world as soon as the call comes in. I've worked in Bangladesh, Yemen, Gaza and Nigeria in rapid succession, and I'm just about to head out to the Ebola outbreak in Democratic Republic of Congo.

When our regular teams need extra support, or when there's a new crisis occurring, we are often called in to help. In emergencies, things can spiral out of control very quickly unless you're on the ground, acting fast.

TROUBLESHOOTING IN NIGERIA

I was the medical team leader with the emergency team in Nigeria. We were a group of doctors, nurses and logisticians who monitored what was happening across the country, looking for signs of disease outbreaks, natural disasters or big population movements which showed people were being forced from their homes.

In emergencies, things can spiral out of control very quickly unless you're on the ground, acting fast.

Above: MSF health educator Charles Onanikem raises awareness about Lassa fever in Abakaliki, Nigeria. Photograph © Albert Masisa/MSF

When we saw or heard of something going on, we'd send a small team to do an 'explo' – an assessment of what was happening and whether we had the capacity to respond.

Last year we were called in to one of the largest cholera outbreaks in Nigeria's history in Bauchi. We set up a 100-bed cholera treatment centre in the middle of the city and established rehydration points where people with less severe cholera could go for treatment.

We also distributed chlorine tablets in an attempt to stop the spread of the disease.

We then organised an oral cholera vaccination campaign for 650,000 people within the city, which helped bring the outbreak under control.

Our job was basically troubleshooting. We were a mobile team, each with different skillsets – medical, logistical, water and sanitation – and we were a mixture of local and international staff. We'd move into an emergency situation, help to bring it under control, hand over to the relevant authorities and move on to the next incident. We were super-responsive and we were always busy.

WE ALL MUCKED IN

My role in the team was to make sure that everything happened. I ensured that we were

on time, with the right number of staff and with everything we needed.

I'm an emergency doctor, so I'd jump in and treat patients when the need arose, but I'd also be carrying boxes, running to the market to buy sugar to mix with the medicine, while liaising with the local army commander in the next town to make sure they were happy we were turning up. It was an interesting, hands-on role. You really had to do a bit of everything, and we all mucked in.

MALARIA EMERGENCY

Just before I left Nigeria, we were gearing up for the malaria season. We were based in the northeastern state of Borno, where violence and insecurity have left many people struggling to get medical care.

Fifty-thousand people were living in a camp in a town called Bama, and we distributed antimalarial drugs to all of the children under five – all 15,000 of them.

It was a massive undertaking. Each morning, we'd set up 15 sites throughout the camp and the town, bring in the nurses and get to work.

A nurse showed each child's mother how to administer the dose, and then we'd give her the remaining medicine for the following two days.

While this was going on, teams were going from house to house, telling people what was happening, reminding them where the sites were and encouraging people to bring their children along.

€4,171,655
worth of
emergency
supplies sent to
projects by our
emergency team
in 2018

THIS IS MY DREAM JOB

For me, working for the MSF emergency team is my dream job. I like problem-solving and I enjoy working in slightly hectic environments where things are constantly changing. One of the great things is turning up somewhere and seeing people so happy and welcoming, because they know that you're there to help. It's a real privilege to be part of that.

By the time you read this, I'll be in Democratic Republic of Congo where I'll be spending Christmas as part of the team working in the Ebola crisis. I'll be working in the treatment centres, wearing the full protective gear. This outbreak has been going on for over a year now and we have to do everything we can to assist."

Find out more

Find out more about the E-Team and support their work at msf.ie/eteam

Right: Medical staff dress in protective clothing before entering the high-risk zone of the Ebola transit centre in Bunia, Democratic Republic of Congo. Photograph © Pablo Garriga/MSF
Below: Local workers unload supplies on the runway at Old Fangak, South Sudan, which is reachable only by air or river. Photograph © Frederic Noy/Coemos



MSF EMERGENCY TEAM
The emergency team is made up of experienced MSF staff who are on call to respond rapidly to crises across the globe.
"Each year we identify doctors, nurses and logisticians based around the world who we think would be a good fit for the team," says Dr Chibuzo Okonta, an emergency team coordinator based in Paris. "We sign them up, give them the right training and keep them updated on events. When there's an emergency, we aim to get them on a plane within 24 hours."
In 2018 the emergency team deployed 2,444 staff delivering vital care in 25 emergency responses across six countries.



The NASG suit

Obstetric haemorrhage – where a woman bleeds heavily before, during or after giving birth – is the leading cause of maternal death in the world today, with the vast majority of deaths occurring in the world's least-developed countries.

The non-pneumatic anti-shock garment – or NASG suit – is a simple first aid device designed to keep women with an obstetric haemorrhage alive until they can receive the specialised treatment they need.

Dr Sonia Guinovart, MSF obstetrics and gynaecology advisor, is involved in MSF's pilot trials of the device in Sierra Leone and Democratic Republic of Congo.

"The NASG suit has been in use for a number of years, but MSF first used it in Sierra Leone," she says. "Sierra Leone has the highest maternal mortality rate in the world, mainly related to haemorrhages and uterine ruptures, so that made it an easy decision to trial it there. We wanted to see if it was suitable for use in the places where MSF works."

HOW DOES THE NASG SUIT WORK?

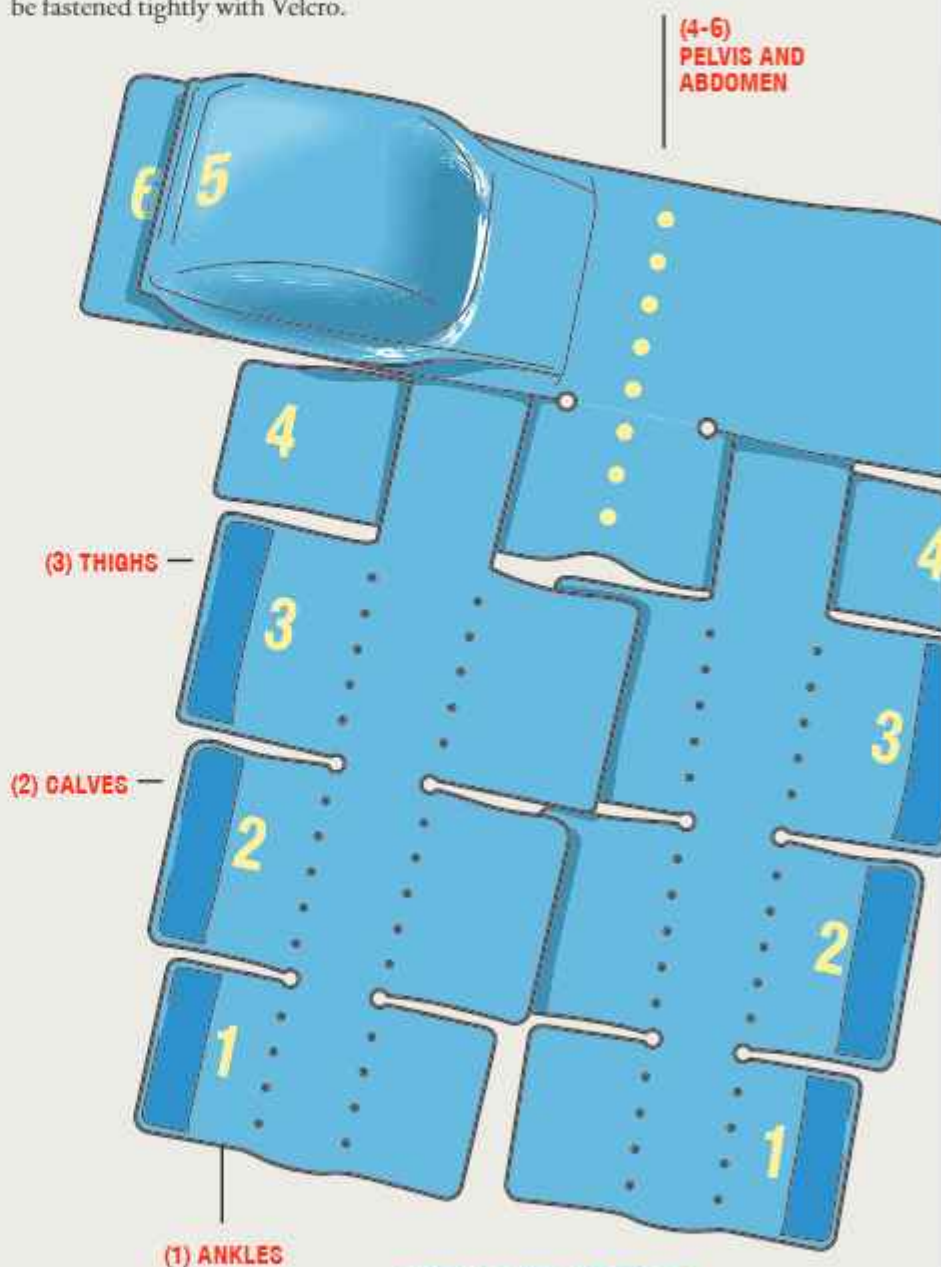
Resembling a wetsuit that has been cut into sections, the NASG suit is a compression suit that fits around the legs, pelvis and abdomen.

"The NASG provides compression. When a woman is bleeding from a postpartum haemorrhage, the amount of blood in the body decreases. This results in hypotension – or abnormally low blood pressure – and very soon the vital organs don't have enough blood or oxygen reaching them.

The suit applies pressure to the lower part of the body. As a result, blood is pumped into the central circulatory system, supplying vital organs such as the heart and brain with the blood and oxygen they need. The suit buys us time to stabilise the patient until we can provide definitive treatment, or can transport the patient to a place where that treatment is available."

SPECIFICATIONS

The NASG suit is made of neoprene and its five segments can be fastened tightly with Velcro.



HOW DO YOU PUT IT ON?

The suit is placed under the patient and the segments are closed and fastened in order, starting with the ankles (1) and proceeding to the calves (2), thighs (3), pelvis and abdomen (4-6).

COST €116

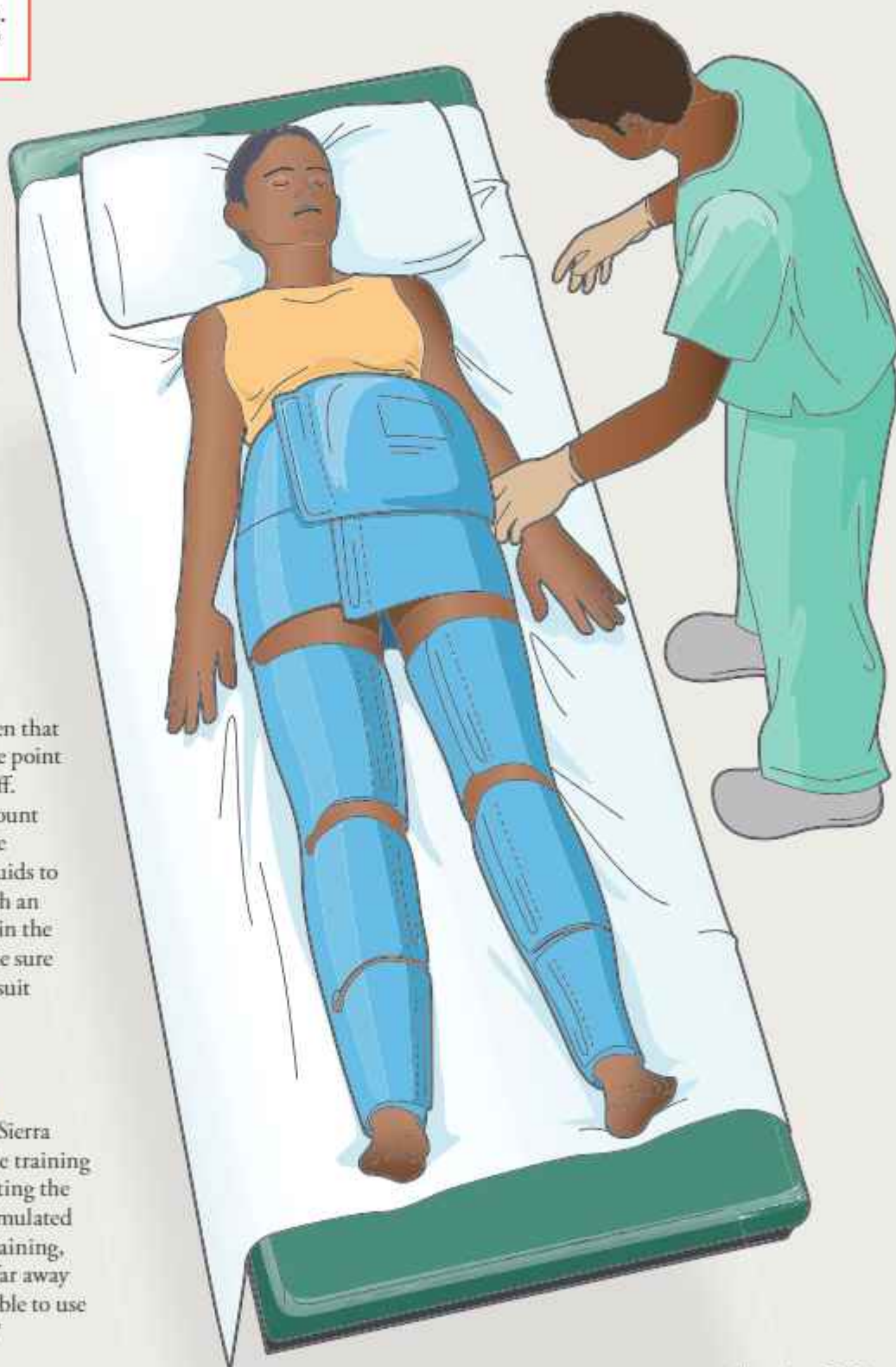
"The NASG suit costs about €116 and is multi-use. If it's disinfected and properly cleaned, it can be used 40 to 50 times. It's very cost-effective."

SURGERY

"What's game-changing about this device is that we can perform surgery without removing the suit completely. We can take the patient to the operating theatre, open just the abdominal segments of the NASG suit, perform the surgery, and then close it up again."

RESULTS

"The pilot went well and we're looking forward to trialling it in Democratic Republic of Congo. We'll be using it in several health centres that are accessible only by motorbike and on foot, so we'll be able to assess how the NASG suit works in those conditions. Our hope is that what we learn there will help us adapt it for use in other MSF projects."



SIDE EFFECTS

"The only side effects were complaints from some women that it was very hot to wear, to the point where some tried to take it off. We had to take that into account and ensure that patients were comfortable, with enough fluids to prevent dehydration and with an air conditioner or ventilator in the recovery room. We also made sure that women didn't wear the suit any longer than necessary."

HOW EASY IS IT TO USE?

"It's very straightforward. In Sierra Leone we conducted multiple training sessions with our teams, putting the suit on and removing it in simulated emergencies. With a bit of training, community health workers far away from a hospital will also be able to use it to help keep women alive."

Illustrations: R. Palmer

'How many grannies does it cost?'

You're far from help when the power in your ambulance mysteriously cuts out. Normally, that's an inconvenience. But when the power is needed to keep the oxygen concentrator working, a power failure can become a matter of life and death. Logician **Louis Dowse** tells the story...

"It's monsoon season in Cameroon and the rain is bucketing down – it's like a 30-degree version of Wales. MSF supports two local hospitals here, built in clearings in the dense tropical forest.

I'm a logistician and my job is to fix and maintain all the biomedical equipment, as well as making sure we have the power to run it all.

If I can't fix a problem, I get quite upset about it. Like the time I had to fix the electrics on an ambulance out in the middle of nowhere...

THE MYSTERY BEGINS

It all started when I got a call from the guys at Muyuka hospital. 'We've got a problem with the sockets in the ambulance – we can't charge the oxygen concentrator.'

Having no oxygen concentrator is a serious issue. If you're transporting a patient with respiratory problems, just one occasion when the equipment isn't working properly is

all it takes for someone to lose their life. We need to get this fixed today.

I go straight to the ambulance. There's a warning light on the control panel. I check the fuse box and behind the driver's seat but there's nothing obviously wrong.

I call the local mechanic and ask: 'Do you know anything about electrics in ambulances?' 'No idea, sorry,' comes the reply.

I decide to go back to base to see if there's a manual anywhere. Back at base, I can't find the manual or any sort of information.

THE MYSTERY DEEPENS

By now it's six in the evening and we're losing light. I grab a screwdriver and a head torch and head back to the first ambulance. 'Guess I'll have to work this one out for myself,' I say.

Examining the fuse box, I realise the fuse isn't tripping on and off – there's no current. Let's open the panel up. Oh, it's a star screwdriver... But I don't have a star screwdriver. So I get my Leatherman multi-tool – the best thing I brought with me to Cameroon, not counting my extra large jar of Marmite and my penny whistle.

I remove the trip fuses, thinking, 'Well, worst case, I'll go into the house at the base, take out one of the 16-amp fuse switches and switch them round.'

Back at the house, I can't find a 16-amp switch. Then Tim, the

Below: Anything could happen on the way to hospital, so the ambulance and all its kit need to be in perfect working order. Photograph © Yasuyoshi Chiba/Duckrabbitt





anaesthetist, takes an interest in what I'm doing. Tim knows a bit more about electrics than I do and he thinks we should check the batteries. We open the ambulance up and it has two batteries. But which battery powers the sockets and which is for the engine? We work it out, but we have no voltage reader to test where the current is broken.

We look at the fuses in the engine and in the side panel on the driver's side. None look burnt out. 'What about the cigarette lighter socket?' Tim asks. We check that and it works. At least this gives us a short-term solution for tonight. We plug an adapter into the cigarette lighter and then run the wires through to the back.

First thing next morning I go to the local petrol station and ask if they have a digital reader I can use. 'Oh, yes, I do actually,' says the guy. 'How much do I owe you?' 'Nothing.' In the end, I buy him a Fanta. He says: 'Bring it back when you're done. I don't need it anytime soon.' Super-nice guy.

TIME TO CONTACT BASE

Back at base, I check the different lines. I work out that the current is running as a DC current to an inverter. From the inverter to the fuses, there's some sort of power failure. Working out what could be wrong with an inverter is way above my pay grade, so I email the logistical advisors at headquarters in Barcelona. The email exchanges go on and on. Everyone gets involved.

'What model of inverter is it?' they ask. 'What's the serial number?' So I take out my mobile phone and take photos of the inverter and the control panel.

There I am, phone in hand, when it comes to me in a flash: 'When my iPhone freezes, I just turn it off and turn it back on again.'

On the control panel, I press power off and then power on.

That's it. Two days of real stress and frustration and all I had to do was power it off. I send an email to Barcelona saying: 'I've worked out what the problem is. Everything's okay.'



Top: January 2018: Falta Mohammad brings her children to an MSF clinic in Cameroon. © Sylvain Cherkouk/Cosmos
Above: MSF ambulances are made to multi-task – this ambulance in Malawi doubles as a mobile pharmacy. Photograph © Lucas Sola

HOW MANY GRANNIES?

I got very passionate about the electrical issues with the ambulance. In fact, I get very passionate about order and accountability in general.

I blame it on my granny. As someone whose grandmother started donating to MSF because her grandson joined MSF, I always think: 'How many grannies does it take to pay for that bit of technical equipment?' or: 'How many grannies does it take to justify my job?'

That ambulance is something that my granny paid for, or contributes towards, so I owe it to her to make sure that the ambulance, and everything inside it, is in perfect working order."

Healing along the water



Aurélie Rawinski's first posting as a nurse with MSF

takes her upriver into a remote part of Papua New Guinea. She is part of a unique team treating people suffering from tuberculosis in isolated villages

"I remember the moment when I received the email offering me a posting with MSF in Papua New Guinea. My heart was pounding – more so when I read the documents relating to the project, with their warnings about crocodiles and snakes.



I'm going to be working in Kerema, a remote town in Gulf province.

This is one of the most isolated parts of the country. It's not easy to recruit qualified staff here and many team members have relocated from the capital.

I make the journey and soon the fringes of the city give way to lush vegetation. The grey ribbon of the road winds between trees, interrupted by streams and the odd house balanced on stilts. As we arrive in Kerema, the green gives way to blue, with the ocean colouring the background.

Above: Team members plan the next day's journey. Photograph © Aurélie Rawinski

Left: The team cross a river to set up a mobile clinic in an isolated village. Photograph © Aurélie Rawinski



I'm part of a TB outreach team, meeting patients in their homes and communities and helping them to continue their difficult course of treatment. While TB is curable, the treatment is long (six to 20 months, depending on the type of TB) and must be followed scrupulously. It often comes with side-effects.

Instead of patients coming to us, we go to them. We have dedicated teams in three towns, assisted by members of the community, who distribute daily medication to the weakest and most isolated patients.

Left: Aurélie and the team head upriver. Photograph © Aurélie Rawinski

Right: Luisa Ure, 22, has been on treatment for TB for almost three years. "The treatment was very hard in the beginning," she says, "there are so many pills to take." She will complete the treatment in ten months. Photograph © Simon Ming/MSF



I'm on my way to the village of Popo Mikafiru. At 9 am, in heavy rain, I leave Kerema with two colleagues. Two hours later we arrive at the edge of a river and travel another hour by dinghy.

Our skipper is wearing a suit jacket that's too wide for him over an orange Hawaiian shirt. It's raining hard, he can see almost nothing and he's bailing out the dinghy with one hand while manoeuvring it with the other. We arrive soaked to the bone.

Above: Laiپی Isafi, 55, sits with his family outside his house. He is currently in the final stages of completing his treatment for TB. Photograph © Sara Bechstein/MSF

The villagers run to help us unload. We have TB drugs and weighing scales to help us adapt the treatment to each patient's weight, as well as to detect malnutrition. We'll supply each patient with a month's worth of TB medication and make sure that their symptoms are improving. Our monthly visits also give us an opportunity to spot possible new patients.

Before we know it, it's time to leave – for security reasons, we have to be back before sunset.

After all the rain, the sun is back, and I feel like Miss France, being greeted by all the people we pass on the shore!

Six hours of travelling for nine patients is exhausting but lives are saved. And isn't one of MSF's principles to go where nobody else will?

The next day, we continue our journey upriver for two hours before arriving in a village of about 30 houses.

So many of the children here are malnourished. We give them a therapeutic peanut-based food called Plumpy'Nut, which helps with moderate malnutrition.

Many people come to us with health problems. The nearest health centre is 90 minutes away by boat and the villagers have few opportunities to see a doctor. After two hours of consultations, the whole village has joined us. The children laugh when I take off my face mask with a grimace, and the dads bring us a dozen coconuts for the rest of our trip. We accept them gratefully – the sun hits hard and we still have a long day ahead of us!"

Find out more

msf.ie/tb

'This is why we are here'



In remote Old Fangak, a woman is in desperate need of

medical treatment. But with no surgical facilities and a runway too muddy to land a plane, time is running out for **Dr Tom Niccol** and the team...

"Emergency in maternity!"

The call pierces an otherwise silent period on the MSF radio.

I head towards the ward, uncertain what I'll find. Anything is possible in Old Fangak...

OLD FANGAK

Old Fangak is 500 km north of Juba, the capital of South Sudan. It's a swamp region with a population of around 50,000. There aren't any roads to Old Fangak. During the rainy season, when the runway turns to mud,

three helicopter flights and a boat trip are required to travel here from the capital.

I work at the small MSF hospital here, and today it is raining.

BLOOD ON THEIR SHOES

Arriving at the maternity ward, I see the midwife has blood on her shoes. This isn't wholly unusual, but I can read from her facial expression that the situation is serious.

The patient has given birth to a healthy baby girl. However, there have been complications and she is now haemorrhaging.

There's a river of blood flowing over the front of the bed, only partially captured by a nearly full bucket below.

Within a moment of my arrival, the patient loses consciousness.

NYAME

Crammed into the tiny delivery room, where the temperature must

be approaching 40°C, sweat is pouring from all the staff, their safety glasses fogging.

We squeeze fluid into drips in each of the patient's arms and I start her on a potent medication that raises blood pressure.

Within 10 minutes, the patient starts to groan. She is regaining consciousness.

I call her name: *Nyame*. (Nyame is not her real name, but a polite form of address in the local language, Nuer.)

SHE DESPERATELY NEEDS BLOOD

Nyame's condition requires surgical support. We don't have those facilities in Old Fangak, so we immediately begin the process to transfer her to another hospital.

In the meantime, Nyame desperately needs blood.

I gather all of her family members together and explain that Nyame is in a critical condition.

They tell me that Nyame has five children. If she doesn't survive, what will their future be?

Rapidly I tell the family we need blood donors, and out of the many volunteers, we find three with matching blood types.

EVERY POSSIBLE AVENUE

Throughout the night I stay with Nyame. Her family camps in the same room. Nobody sleeps.

At the same time, a team works to find a way to get her the surgery she desperately needs. But the runway is consumed by mud and, with planes unable to land, options are limited.

As dawn breaks, we still don't have an answer.

I check the clock and realise I've been in the hospital for 26 hours and with Nyame for 18. I hand over to another MSF doctor and take some rest.

WE WILL NOT STOP

I wake to learn that Nyame's haemoglobin levels are falling.

Children watch the MSF team return to their boat on the White Nile after running a mobile clinic in the village of Diehl. Photograph © Frederic Noy/Coamos

There's no visible bleeding, so we do an ultrasound.

Nyame is haemorrhaging into her uterus.

We are now close to 24 hours post-delivery. I update the family and explain that there's a high chance that Nyame will not survive, but that we will not stop treating her.

As the sun starts to set, we hear the most amazing news.

HOPE

The International Committee of the Red Cross (ICRC) will provide a helicopter to transport Nyame to Juba. In Juba, MSF will arrange and fund the surgical care.

I cannot even begin to express my gratitude. There aren't exactly many spare helicopters in South Sudan.

The earliest the helicopter can arrive is midday tomorrow.

We have no more blood for Nyame, but we have hope on our side.

I update the family and explain that there's a high chance that Nyame will not survive, but that we will not stop treating her'

GUARD OF HONOUR

The helicopter is waiting. I rig up a makeshift IV pole and make final adjustments to the infusions.

Around 30 people are gathered outside the maternity department, everyone wanting to offer a hand. It's like a guard of honour.

We all watch as the aircraft rises and flies towards the horizon.

A LIFE SAVED

Over the coming days, we frequently refresh our emails, eagerly awaiting an update.

Eventually we learn that Nyame is recovering well. She is expected to return to Old Fangak in the coming week.

Nyame is alive and Nyame's children still have their mother because of the commitment, passion and generosity of many. Humanitarian workers from different organisations came together for the same purpose: to save lives and reduce suffering.

"This is why we are here."

Find out more

msf.ie/southsudan

Below:
A patient
collects
pills
from the
pharmacy
at Old
Fangak
hospital.
Photograph
© Frederic
Noy/
Cosmos

MSF IRELAND'S FIELD STAFF

Bangladesh Jennifer Collins,
Nurse, Co Wicklow

CAR Eve Robinson,
Epidemiologist, Co Louth

Chad Jean-Marie Majoro,
Supply Logistician, Co. Kildare

Democratic Republic of Congo
Conor Moran, *Medical Doctor,*
Co. Galway

Iraq Alex Dunne, *Humanitarian*
Affairs Officer, Co Dublin

Jordan Eve Bruce, *Hospital*
Director, Co. Kerry

Kenya Dana Krause, *Head of*
Mission, Co. Dublin

Lebanon Declan Barry, *Medical*
Coordinator, Co. Longford;
Peter Garrett, *Medical Doctor,*
Co. Tyrone

Nigeria Nijole Slapsinskaite,
Nurse, Co Meath

Myanmar John Carty,
Project Coordinator, Co. Cork

Pakistan Aine Lynch,
Project Coordinator, Co Dublin

South Sudan Ismil Inan,
Logistics Team Leader, Co Dublin

Syria Thomas Fitzgerald, *Deputy*
Logistics Coordinator, Co. Dublin

Uzbekistan Birgitta Gleeson,
Biomedical Scientist,
Co. Roscommon

Yemen Kate Nolan, *Head of*
Mission, Co. Limerick



Gift in Wills

By leaving MSF a gift in your Will, you can help us save lives. To find out how you can continue your support for MSF's work this way, please contact Ruth Hanahoe at **01-2815184** or **ruth.hanahoe@dublin.msf.org**.

Treating transplant patients in Syria



Mohammad Al Youssef is a Syrian doctor who has worked with MSF for the past five years in northwest Syria providing lifesaving treatment for people with a condition that's often overlooked in conflict zones.

"Ten years ago, I underwent a kidney transplant. In that moment, I switched roles: I was not the doctor anymore, I became the patient. Today, I am one of the

only doctors in northern Syria providing treatment for patients who have undergone a kidney transplant.

Before the war broke out, treatment for these patients was straightforward. Everything was available and dialysis and medications were free of charge for kidney transplant patients.

WAR BREAKS OUT

But in 2011, everything changed. Checkpoints started to appear, and people could not receive treatment

Dr Mohammad now cares for almost 100 kidney transplant patients, with the help of medications provided by MSF. Illustrations © Lucille Favre/MSF

as they used to. You could get arrested or even killed.

People resorted to buying their own medicines or asking relatives abroad to ship them to Syria.

After a kidney transplant, patients have to take immunosuppressants for the rest of their lives in order for their body not to reject the new kidney. If they stop the medicine, patients go into kidney failure. That's why, in 2014, I decided to contact MSF. I told MSF that I knew 22 kidney transplant patients who were unable to afford their medications. MSF agreed to support these patients and to provide, free of charge, the treatment that would keep them alive.

This made me incredibly happy. I wanted to support these patients, to be there morally but also to help practically.

The number of patients in my care grew over the next few months and years. From 22 patients, I started to treat 45, then 73 and then almost 100!

Today, the war is far from over. The only thing I am sure of is that, for as long as my patients need treatment, I will not give up. I cannot abandon them. These people don't care about war; they just want to live a normal life. Providing this treatment is the only way to make this possible and to ensure their survival."



Find out more

msf.ie/syria

Spread the word about MSF! Pass your copy of Dispatches on.