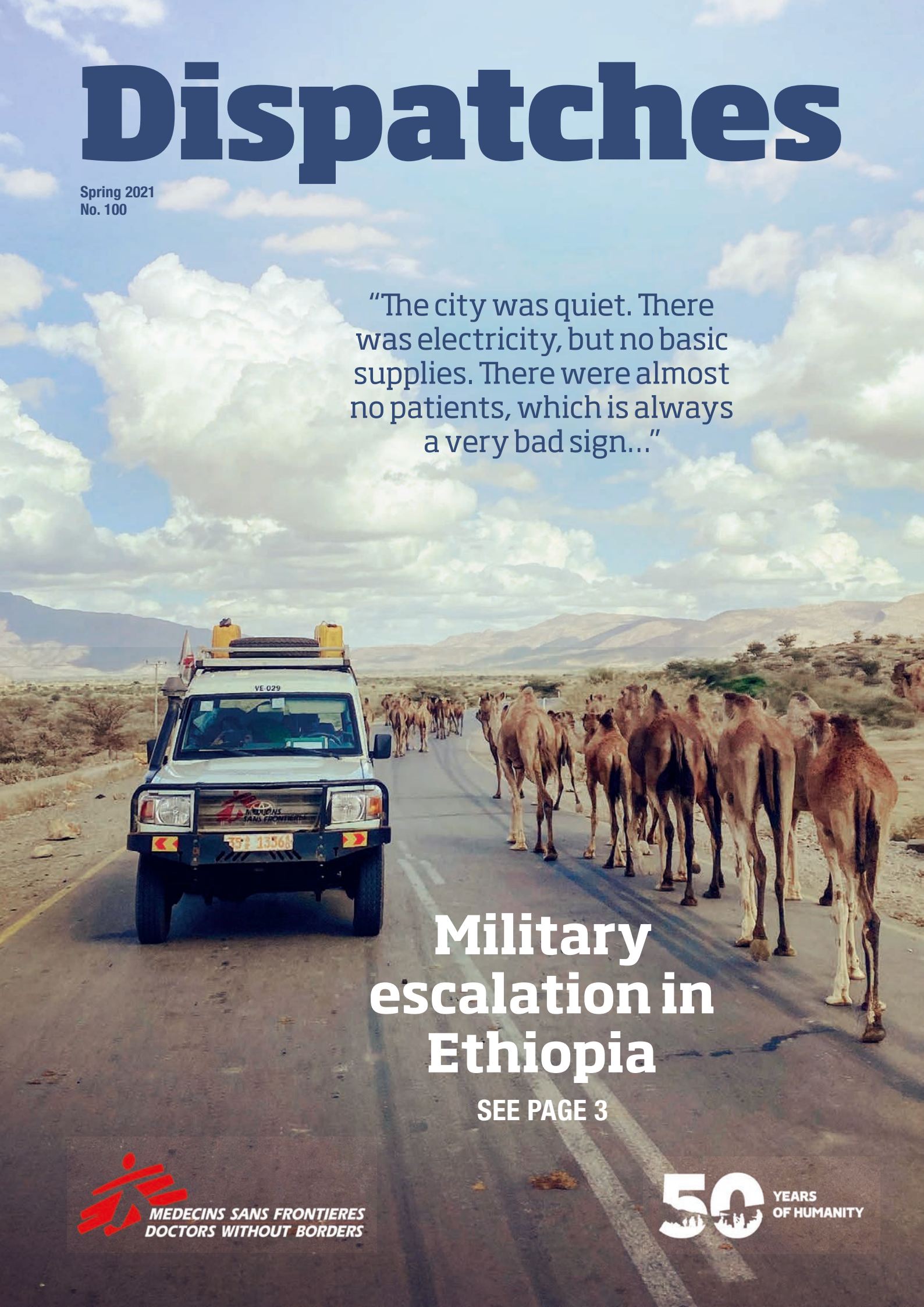
Dispatches

Spring 2021
No. 100

"The city was quiet. There was electricity, but no basic supplies. There were almost no patients, which is always a very bad sign..."



Military escalation in Ethiopia

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

50 YEARS OF HUMANITY

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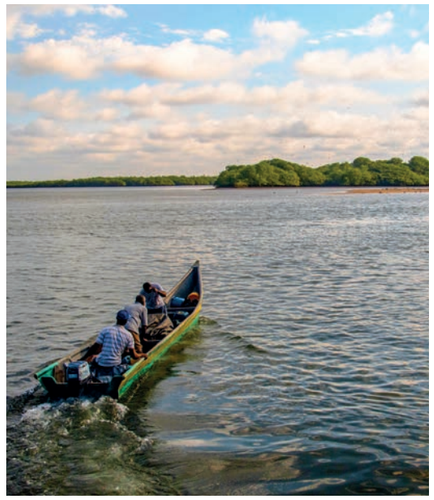
50 YEARS OF HUMANITY

Médecins Sans Frontières
1971-2021: 50 years of humanity

Front cover: An MSF Land Cruiser passes a caravan of camels in an area of Tigray, northern Ethiopia.
Photograph © Matt Hotchkiss/MSF

FEATURES



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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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 costs approximately 52c to produce each issue and 66c to 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 Lia Paul at **lia.paul@dublin.msf.org** or call **01 660 3337**

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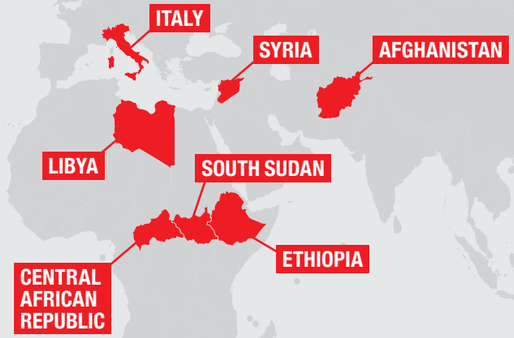
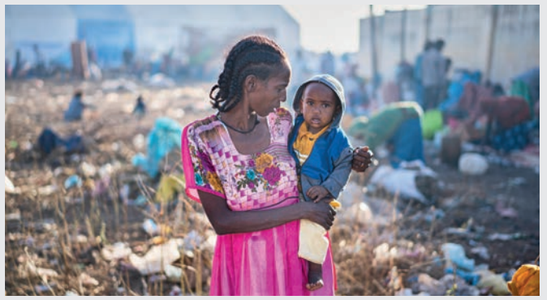


NORTHERN ETHIOPIA

"Our presence brings a certain feeling of protection"

Hundreds of thousands of people have been forced to leave their homes in the Tigray region of northern Ethiopia after fighting broke out in November last year.



More than 60,000 people* have crossed to Sudan as refugees, while many others are displaced within the region, staying in towns, remote areas or trapped between localised outbreaks of fighting. MSF teams have been providing medical care to refugees in Sudan since November and to affected people in Tigray since mid-December. **Albert Viñas** has been involved in almost 50 emergency responses for MSF and is the emergency coordinator in Tigray.

"After several attempts, we finally entered the capital of Tigray, Mekele, with a first MSF team on 16 December, more than a month after the violence started. The city was quiet. There was electricity, but no basic supplies. The local hospital was running at 30 to 40 per cent, with very little medication. There were almost no patients, which is always a very bad sign. We evaluated the hospital, with the idea of referring patients there as soon as possible.

We arrived in Adigrat, the second most populous city, on 19 December. The situation was very tense and the hospital was in a terrible condition. Most of the health staff had left, there were hardly any medicines and there was no food and no water. Some patients who had been admitted with trauma injuries were malnourished.

We supplied the hospital with medicines and bought emergency food in the markets that were still open. Together with the remaining hospital staff, we cleaned the building and organised the collection of waste. Little by little we rehabilitated the hospital so that it could function as another referral centre.

NO TELEPHONES

Beyond the hospitals, around 80 or 90 per cent of the health centres that we visited were not functional. In every place, we saw patients arriving late. One woman had been in labour for seven days without being able to give birth. Her life was saved because we were able to transport her to Mekele. I saw people arrive at hospital on bicycles carrying a patient from 30 km away. And those were the ones who managed to get to hospital… The impact of the violence is visible in the buildings and in the cars with bullet holes. We saw a population locked in their homes and living in great fear. Everyone gave us pieces of paper with phone numbers written on them and asked us to convey messages to their families. People don't even know if their relatives and loved ones are okay because in many places there are still no telephones or telecommunications.

MOBILE MEDICAL TEAMS

We are very concerned about what may be happening in rural areas. We still haven't been able to go to many places. But we know, because community elders and traditional authorities have told us, that the situation in these places is very bad.

Our mobile medical teams have started visiting areas outside the main cities and we are reopening some health centres. Our presence brings a certain feeling of protection. We have seen some health staff returning to work. Beyond medical activities, you feel that you offer people some hope: the feeling that things can improve after two months without good news."

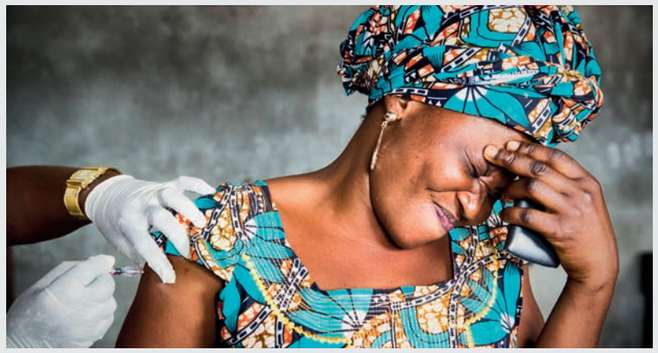
**UNHCR figure*

Read or watch Albert's full account at msf.ie/albert-vinas

A woman holds her child at Hamdayet crossing point, Sudan, after fleeing violence in the Tigray region of Ethiopia.
Photograph © Olivier Jobard/MYOP

YELLOW FEVER VACCINE

MSF research could save five times as many lives



A woman receives a yellow fever vaccination in Kinshasa, Democratic Republic of Congo. Photograph © Dieter Telemans

A new clinical trial has found that giving people just one-fifth of a yellow fever vaccine is as effective as the full dose. Implementing this finding means that more lives can now be saved during outbreaks of the deadly disease.

The study was led by Epicentre – the research arm of MSF – with the findings published in the medical journal *The Lancet*.

Results showed that reducing the standard yellow fever vaccine dose was both effective and safe, prompting the World Health Organization (WHO) to change its official guidelines on the disease.

WHAT IS YELLOW FEVER?

Yellow fever is a mosquito-borne acute viral haemorrhagic fever. It causes 30,000 deaths a year, most of which occur in Africa, where the virus is endemic to 34 countries.

While the infection is asymptomatic or causes only mild symptoms in many people, a small percentage of those infected experience a more toxic stage of the disease that can cause internal bleeding and severe damage to the liver and kidneys. Sadly, around half the people who enter this stage of yellow fever die within a few days.

Since 2000, MSF teams have responded to yellow fever epidemics in Angola, Democratic Republic of Congo, Guinea, Sudan, Sierra Leone, Central African Republic and Chad.

A VITAL VACCINE

There's no cure for yellow fever, so prevention is extremely important. A single dose of the vaccine can protect a person for life.

"When big yellow fever epidemics hit, countries and MSF need to access vaccines urgently," says Myriam Henkens, MSF international medical coordinator.

"Vaccination is the most important measure for preventing the disease. This study means that treatment providers can now rest assured that giving people smaller doses of any of the WHO prequalified yellow fever vaccines will protect the person in front of them while helping to keep even more people safe."

A LIFESAVING STUDY

The Epicentre study, in collaboration with the Kenya Medical Research Institute, Institut Pasteur de Dakar, and the WHO, took place in Uganda and Kenya between November 2017 and February 2018.

"More than a billion people currently live in areas of the world where yellow fever is common," says Isabelle Defourny, MSF director of operations.

"At a time when the world is fighting so many other health threats, it's encouraging to know that research like this will directly result in more lives being saved."

Photograph © Francesca Volpi

ITALY

This winter hundreds of migrants and refugees are travelling the 'Balkan route' on foot to reach Italy. The only assistance they receive at the Italian border is from volunteer groups who are supported by MSF.

Photograph © MSF

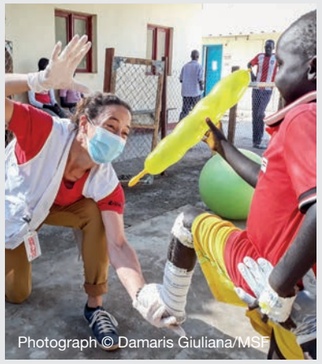
LIBYA

An MSF staff member distributes winter clothing and supplies to refugees and asylum seekers at Dhar Al-Jebel detention centre, where over 250 people are being held at the centre indefinitely. MSF has been providing medical care and humanitarian assistance to detainees since May 2019.

Photograph © Omar Haj Kadour/MSF

SYRIA

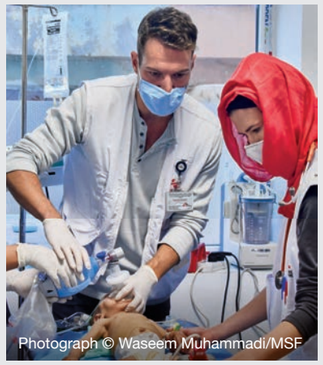
An MSF nurse checks a patient's blood pressure inside a COVID-19 isolation and treatment centre in northwest Syria, December 2020.



Photograph © Damaris Giuliana/MSF

SOUTH SUDAN

MSF physiotherapist Birgit Schönharting plays with five-year-old Anyar, who was bitten by a snake while playing outside his house. Physiotherapy is a vital rehabilitation tool for many snakebite survivors.



Photograph © Waseem Muhammadi/MSF

AFGHANISTAN

MSF doctor Bart and nurse Marzia perform CPR on a malnourished child in the emergency room of Herat hospital. Persistent insecurity, as well as long distances and the high cost of travel, prevent many Afghans from getting medical care.

CENTRAL AFRICAN REPUBLIC

MSF teams ramp up support as violence escalates

The situation continues to deteriorate in Central African Republic, as clashes escalate between coalition armed groups and government forces.

Following weeks of conflict across the country, fighting broke out on the outskirts of the capital, Bangui, on 13 January. MSF teams in Bangui treated 12 people for injuries.

Beyond the direct victims of violence, people across the country find themselves with reduced access to essential medical services as a result of the growing insecurity.

On 13 January, just 14 pregnant women arrived at Bangui's Castor maternity hospital, where MSF teams provide emergency obstetric care, compared to a daily average of more than 30.

MASSIVE INFLUX OF REFUGEES

Tens of thousands of people have been displaced from their homes by the latest cycle of violence, which started in December.

In the southeast, more than 10,000 people fled Bangassou during an offensive on the city on 3 January and crossed the Mbomou River to find refuge in the village of Ndu, Democratic Republic of Congo.

An MSF team cross the Mbomou River from Bangassou, in Central African Republic, to Ndu, in Democratic Republic of Congo, where thousands of people have sought refuge from fighting in and around Bangassou. Photograph © Dale Koninckx/MSF

"With the massive influx of refugees in Ndu, we immediately increased our support to the health centre by bringing in extra medicines, vaccines and additional staff," says MSF project coordinator Marco Doneda.

"The number of medical consultations has exploded, with more than 110 patients seen each day, mainly women and children suffering from malaria, diarrhoea and respiratory infections."

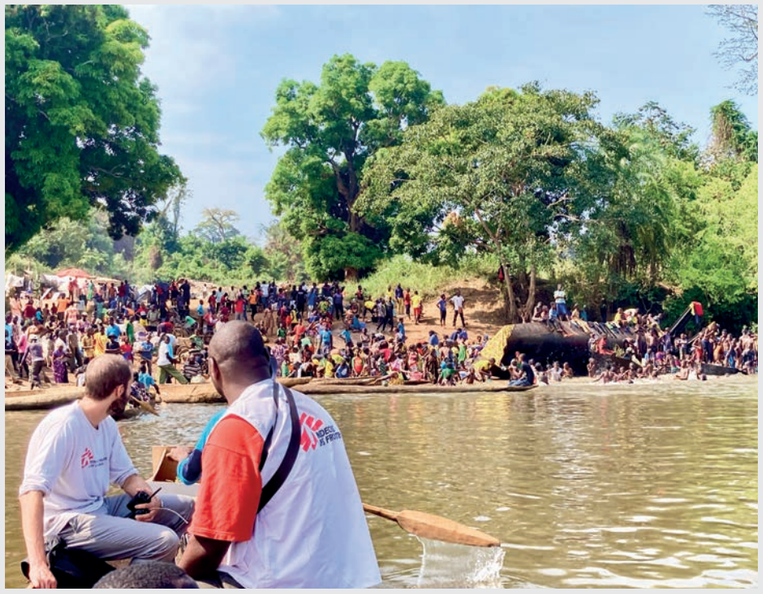
EIGHT YEARS OF CIVIL WAR

In a country already hard-hit by eight years of civil war, where people live in a situation of chronic medical crisis, the current insecurity is further exacerbating their vulnerability.

As well as MSF's emergency response, MSF teams continue to provide vital medical care in Bangui, Bambari, Bria, Bangassou, Batangafo, Bossangoa, Boguila, Carnot, Kabo, Paoua and Zemio.

msf.ie/car

Co Louth epidemiologist Eve Robinson describes her recent work in CAR on pg. 6.



10,000

people fled Bangassou during an offensive on the city on 3 January and crossed the Mbomou River to find refuge

Digging deeper into the Central African Republic's "silent crisis"

MSF is active in providing healthcare for communities in the Central African Republic, a country which has some of the worst health outcomes in the world. Louth-based **Eve Robinson** recently returned from CAR after a research project into high mortality rates in its rural areas.

I had never heard of the Central African Republic, often shorted to CAR, until I started working for Médecins Sans Frontières (MSF). For many years, MSF and other organisations have described CAR as being in a state of "silent crisis". Despite it being one of the poorest countries in the world, enduring a brutal civil war in 2013/2014, and coming bottom of the table for most health statistics worldwide, CAR remains largely unknown internationally.

MSF surveyors walk through a village in the prefecture of Ouaka, Central African Republic, as part of a MSF healthcare study in 2020.
Photo: Eve Robinson/ MSF

I arrived in CAR to work as an epidemiologist with MSF in in September 2019. One of my main roles was to help understand the health problems in the areas where MSF work.

CAR has the lowest life expectancy in the world – just 52 years. Because deaths are not officially registered in CAR, we didn't know what the death rate was, or what the biggest causes of death were in the community.

WE NEEDED TO KNOW MORE

I analysed data from our clinics and hospitals regularly, but this only told us so much. We knew that many people couldn't attend healthcare services because they are too far away, they are too sick to travel, or because of lack of security due to the presence of armed groups across the country.

We wanted to know if we were responding adequately to the needs of the population. Between February and June 2020, we would do several studies across the country to compare areas to have a picture of the national situation. I was responsible for the first study in a region called Ouaka.

We spent months planning. In a country as fragile as CAR, with a looming presidential election, there was a real threat that factions might seek to discredit the results for political reasons, so we had to ensure our methods would withstand any scrutiny. In Ouaka, we randomly selected the villages to visit.

Even our sturdy land cruisers could only manage 20km per hour on bumpy dirt roads. Some bridges were broken and not passable, and some of the villages in the bush could only be reached by motorbike. We planned for how and when we would tell the armed groups which controlled the region what we were doing – early enough that they could tell their troops on the ground to let us pass safely, but not too early to give any malevolent factions time to plan anything against us. We didn't plan for the emergence of a global pandemic.

ARRIVAL OF THE PANDEMIC

We were halfway through the survey in Ouaka when the first case of COVID-19 was detected in CAR. Could we continue? We didn't want our study team to unknowingly introduce the virus to the remote villages we were visiting, undoing the protection their isolation might give them against COVID-19.

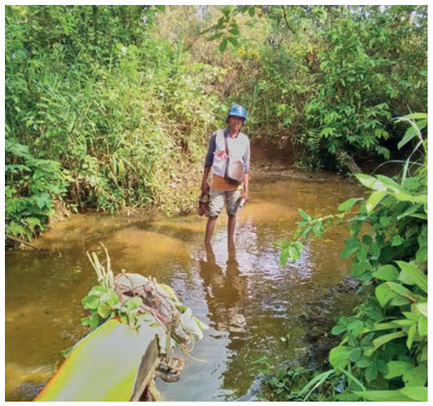
On the other hand, our preliminary results were indicating that the deathrate was much higher than expected. How important was it to continue to document how bad the situation was? If we waited until after COVID-19, would people say the high deathrate was because of COVID-19, and not believe the severity of the underlying crisis? We eventually decided to continue for as long as it was safe for the community and for us.

We politely refused outstretched hands when greeting village leaders, awkwardly offering an elbow bump, and trying to soften any perceived rebuff by explaining why. It got easier as news of the pandemic spread to even the remotest villages through old transistor radios hooked up to solar panels, or travellers passing through. People were desperate for information about the virus and how to protect themselves. We explained the importance of hand washing, cough etiquette and physical distancing. Some of it seemed inane; soap was an unattainable luxury for many, and even those who could afford it before told us the price had gone up.

Below left: An MSF surveyor navigates difficult terrain to access a survey point.

Below Right: Epidemiologist Eve Robinson consults with MSF colleagues during a survey at a village in rural Ouaka.

Photos: Eve Robinson/ MSF



GROWING INSECURITY

In the end we didn't get to visit all the villages we had planned, but not because of COVID-19. By the time we finished, less than a handful of cases had been detected, all in the capital city. A hijacking of another NGO by unidentified men, and the killing of a UN soldier along the roads to the last remaining villages, meant it just wasn't safe.

We also had to postpone the studies in the other regions. For now, we only have the results for Ouaka, but they are stark. The death rate is far higher than what would be considered an 'emergency'. Children are dying from illnesses that are either preventable or easily treatable, such as malaria, diarrhoea, pneumonia, and measles.

"SILENT CRISIS" WORSENS

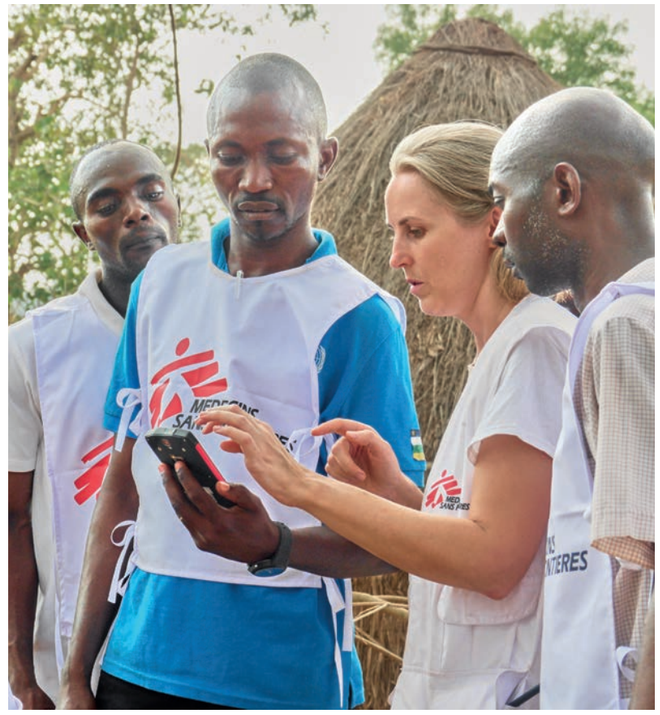
As of early 2021, CAR, hasn't been as badly impacted by COVID-19 as was feared. A lack of testing and barriers to accessing healthcare probably veil the true picture.

At times, over the last few months, as I see second and third waves of COVID-19 hit Ireland and elsewhere, I have thought to myself how lucky CAR is to have been spared. But then I think of Ouaka, and all the villagers that told us they don't have clean water to drink.

I think of the grandmothers who told us they found it hard to feed their grandchildren since they've been orphaned. I think of the family that lost two children to measles. I think of the villages that are afraid of being attacked by armed actors. I also think of my MSF colleague from Ouaka, who was killed on 28th December after being caught in crossfire as a new wave of violence hit the country linked to the presidential election.

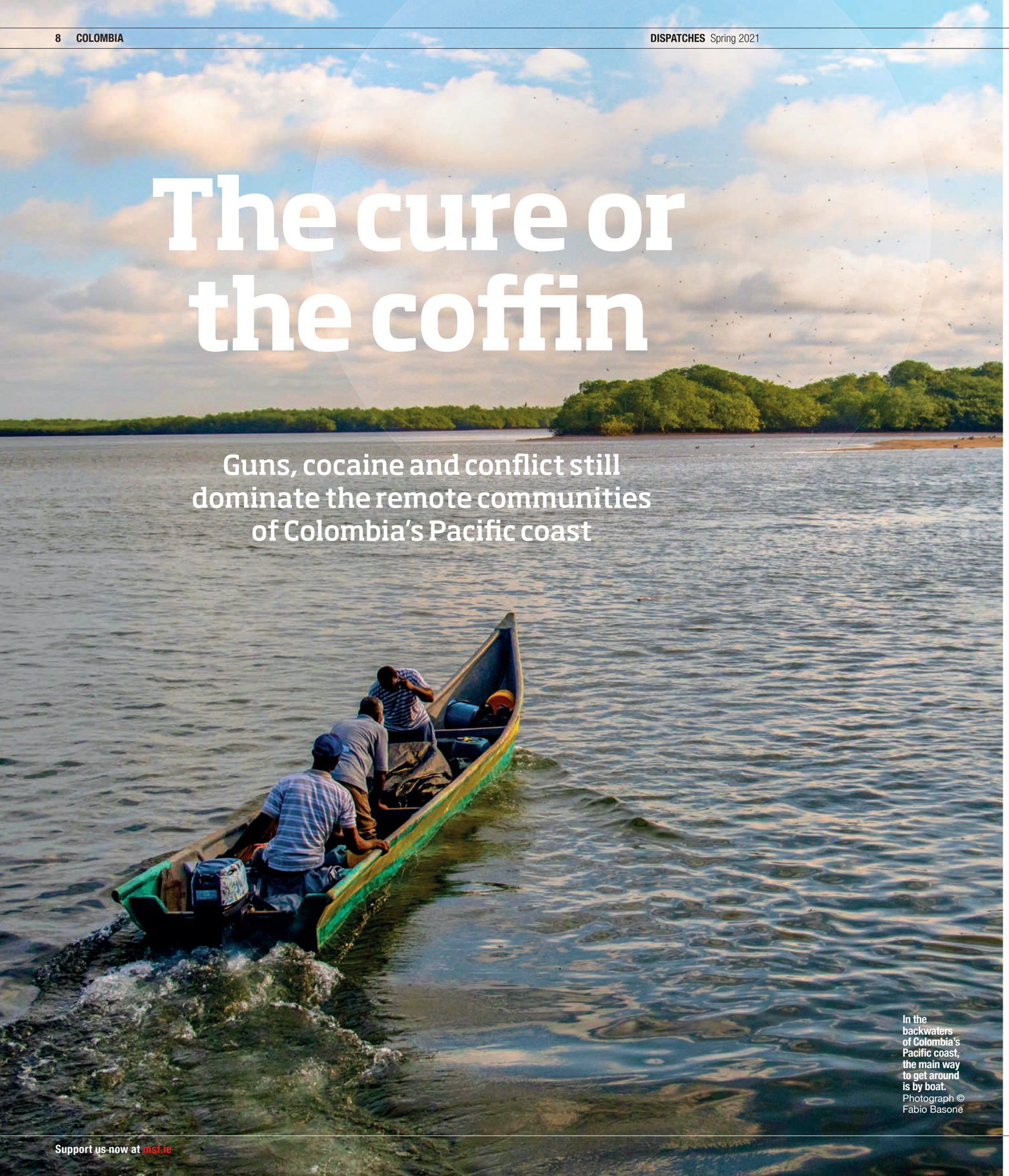
CAR is not a lucky country. The "silent crisis" not only continues but worsens.

We hope to restart our study in the other regions of CAR next year. In the meantime, MSF will use the results from Ouaka to improve our response in the region and to continue to advocate for the people of CAR.



The cure or the coffin

Guns, cocaine and conflict still dominate the remote communities of Colombia's Pacific coast



In the backwaters of Colombia's Pacific coast, the main way to get around is by boat. Photograph © Fabio Basone

MSF head of mission **Steve Hide** joins a medical team as they travel upriver to communities still in the grip of armed conflict.

"In the backwaters of Colombia's Pacific coast, the local remedy for a venomous snakebite costs the same as a coffin.

'You can choose: the cure or the coffin. Either way, you'll pay,' explains Francine, an elderly *curandera*, or traditional healer, sitting on her wooden porch.

The house is by a brown river which flows to the grey Pacific Ocean, at least one day's journey downstream in a canoe with outboard motor.

In many parts of the river the banks are covered in small bushes – seedlings for the coca plantations that spread far into the surrounding flat land – dotted among jungle and plantains and yams. Coca farmers stroll along the riverbank carrying sacks of seedlings and swinging machetes.

Meanwhile, on her porch, Francine continues with a list of snakes that bite people working on the small farms: the *verrugosa*, South America's largest venomous snake; the *talla equis*, a smaller but equally dangerous viper; and the *papagayo*, which likes to hide in trees.

Her herbal recipes are family secrets strictly guarded over generations. Clearly people trust her enough to take the cure.

THE TRIPLE WHAMMY

Francine's business relies, to some degree, on the fact that there are few health alternatives in this remote corner of Colombia. The nearest health post is six hours away by canoe with outboard motor. Petrol is scarce, or expensive, and even if you can get a ride, armed groups patrol the backwaters and might not let you leave.

This is the triple whammy that affects Afro-Colombian communities in the coastal lowlands of the Nariño department: years of institutional neglect, seemingly endless jungle and winding rivers, and the risk of guys with guns around every bend.

THE HORNET'S NEST

It has taken me two days to get here: one day in a car over rutted, muddy roads, then two canoe journeys and a walk through the jungle.

I am here working with MSF as part of a medical team bringing healthcare to the villages along the riverbanks. The doctors and nurses are busy in an improvised clinic set up in an abandoned school building… but only after a group discussion on the multitude of hornet's nests dangling from the ceiling.

The MSF team and our local fixers seem to be in two camps: ignore the hornets, which are now flying around us, or smoke them out.

'Leave them alone and they won't sting,' says someone. We adopt that strategy and spend the next few days with the large brown insects flying around us.

The next day, new faces appear in the village: a group of tough-looking guys sitting on plastic chairs on an empty lot. I invite myself to join them and talk about health.

At first they seem uncomfortable, but soon we are chatting about local food sources and *borojó*, a jungle fruit that is widely sold as an aphrodisiac in Colombian cities but is a vitamin-rich staple in local communities.

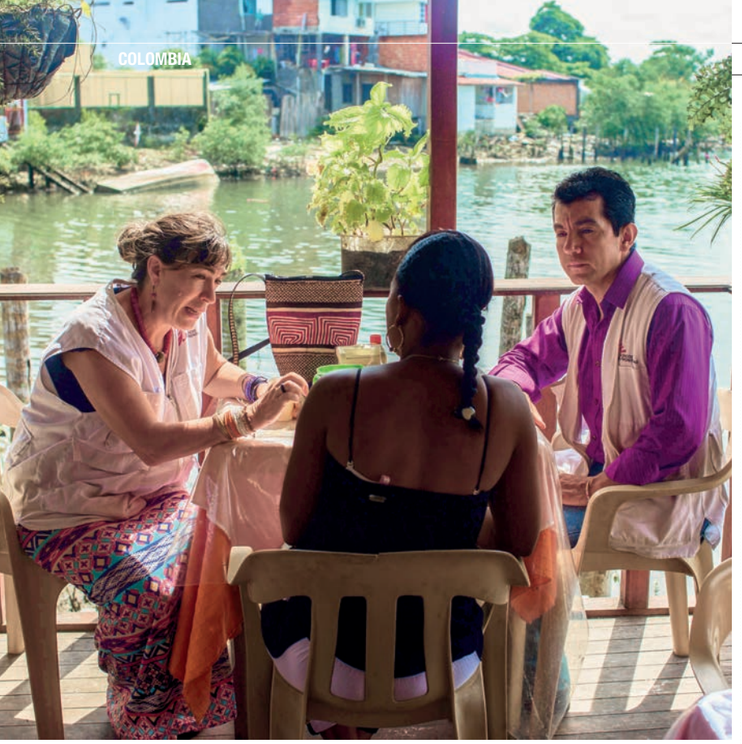
Later that evening I see the same focus group sat in the same chairs, now draped in machine guns. Clearly an armed group. Oops. Have I stirred up a hornet's nest?

After dinner we pass by their hangout on our way to wash in the river. The fighters yell a cheery '*buenas noches*'. So far so good.

PLANTATIONS AND HIDDEN COCAINE LABS

These gunmen seem at home in the village, but it is hard to gauge how the locals regard them. Their presence is related to the coca plantations, which at intervals are forcibly eradicated by state troops who arrive suddenly by helicopter. The gunmen are also there to defend the zone from other armed groups which are pushing into the area.

The bottom line is that guns are an essential ingredient of cocaine production and, under their shadow, folk are reluctant to talk openly about the conflict. What seems clear is that people are scared to move around. Someone tells me his brother was recently killed at a checkpoint on the river.



The conflict in Colombia lasted decades, until a peace process which concluded in 2017. The local armed group is a remnant of the FARC guerrillas who rejected the peace process and continue squabbling over control of lands bordering Ecuador. But holding on to vast swathes of coca plantations and hidden cocaine labs is never easy. Other dissident groups are on the warpath and already fighting has broken out upriver.

Above: An MSF team discuss the medical and psychological care on offer to a patient in Tumaco. Photograph © Lena Mucha

Below: MSF psychologist Brillite Martinez conducts a session with an eight-year old girl who was the victim of violence. Photograph © Marta Soszynska/MSF

MASSACRES AND MASS DISPLACEMENTS

MSF teams were in this area soon after local farmers, known as *campesinos*, were forced at gunpoint to flee into the jungle, only to return to find their houses looted, their crops destroyed and the dismembered bodies of combat victims buried piecemeal around the village.

'It was a symbolic act of terror,' an MSF colleague, Samuel, tells me. 'They turned the village into a cemetery.'

MSF sent a medical team and psychologists to the village. Mental health is a major issue in the aftermath of violent events. And these events are increasing.

The 2016 peace process between the government and the FARC group has hardly touched here, and may even have made things worse, as fragmented groups in the Pacific coastal region squabble over the spoils left behind by the guerrillas.

Massacres and mass displacements are monthly events, and other less visible incidents, such as confinements, combat and individual killings, go on constantly behind the curtain of conflict.

SHOT TO SHREDS

Samuel is leading this particular MSF team visiting the area. He has a good grasp of local geography and context, though I quickly get lost in the alphabet soup of armed groups: GUP, FOS, ELN, AGC, E30FB, Frente 30, not to mention Los Cuyes and Los Contadores.

How does MSF navigate this maze of obstacles to reach vulnerable communities with healthcare? One advantage is MSF's 30 years of experience working in the Colombian conflict.

'The older fighters remember us from the days gone by, and that helps,' says Samuel, who is aware that new groups of young fighters could pose a higher risk to medical teams entering dangerous zones.

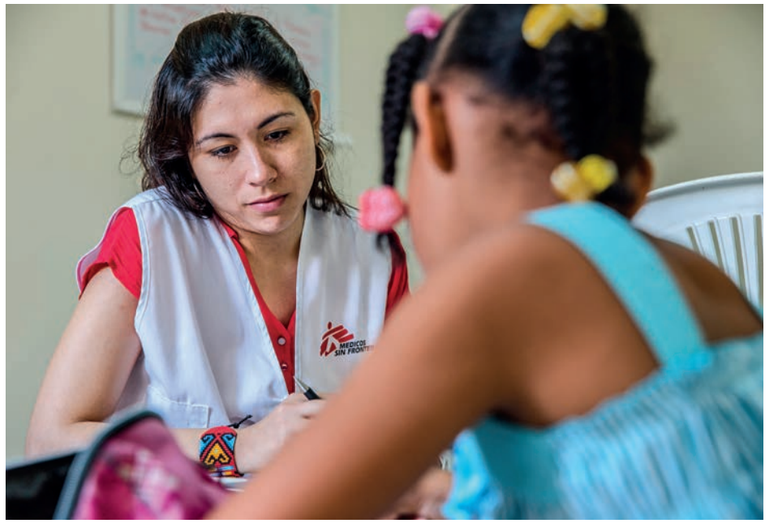
The repeating cycles of conflict become even more apparent when Samuel shows me photos of a nearby health post shot to shreds and filled with grenade shrapnel, a result of combat between opposing non-state groups earlier in the year. MSF health teams visited the community a month later.

The irony is that ten years ago MSF teams worked in the same place during an earlier spate of fighting. In fact, back then MSF rebuilt the same health post.

'Sometimes it seems like we're going round in circles,' says Samuel.

"200,000 PESOS FOR A BOY"

But this time around MSF has a new strategy. Rather than focus on health posts and infrastructure (which tend to fall down again), MSF has adopted a 'people-centred approach' which aims to increase their resilience to repeated cycles of conflict, explains Samuel.



That means putting MSF teams more permanently in communities – of course giving direct medical care, but also engaging with traditional self-help systems.

'Even before the conflict, these communities created their own coping mechanisms, often based on traditional health practices,' says Samuel.

This explains why I am now upriver talking to an elderly birth attendant about how much she charges to deliver a baby.

'It's 200,000 pesos for a boy and 100,000 for a girl,' she says, though why boys cost more is not exactly clear.

For the next few days, while the medical team are busy dodging hornets in the clinic, I wander through the community talking to spiritual healers who fix the evil eye, *yerbateros* (herbalists) who treat malaria with local plants, and a *cosero* – 'stitcher' – who sews up wounds for 20,000 pesos a stitch.

Most adults bear wounds, often from razor-sharp machetes, and not all are accidents. Alcoholism and domestic disputes are rife in these riverine communities.

KIDS ARE EVERYWHERE

With the lack of family planning and reproductive healthcare, many mothers have five children, even in their 20s, and are desperate for the contraceptive implants that can prevent pregnancy for five years.

The procedure takes time: mothers must first be tested and assessed to see if they fit the criteria, then given a local anaesthetic in the arm before the plastic strip implants are pushed under the skin through a brutally large steel needle.

Implants are the most requested medical service as many women try to escape the expectation of being a baby-mill. Large families are the norm here: one boat driver has 15 children, and he proudly tells us about his friend who has 35 offspring by three partners.

Kids are everywhere, engaged in a fascinating variety of active play using whatever comes to hand.

I watch a group of kids – none more than eight years old – commandeer a canoe and propel it up the river using bits of scrap wood for paddles.

I imagine this idyll is short-lived. Young teenagers are expected to pick coca on the farms, which can be several hours' boat ride from the village. Adolescent girls are expected to start families at 15. That's also the age when the armed groups come looking for volunteers.

"Keeping kids out of the conflict is an uphill struggle"

Above: An MSF mobile medical team push a canoe with an outboard motor through the shallows of a river in Chocó. Photograph © MSF

COEXISTENCE

At present the gangs are not forcibly recruiting children, explains the local schoolteacher. But joining a group is attractive to impressionable youngsters with few alternatives. Keeping kids out of the conflict is clearly an uphill struggle.

'Every week I intervene with families to try to keep their kids in school and studying,' he tells me.

The most successful strategy is football, so in his free time the teacher coaches four teams – two boys' and two girls' – and has organised a league with other villages, relying on donations to buy balls and nets.

Back at the clinic, patients are still queuing and the kids are still colouring in. But in my absence, a villager came to wage war with the hornets in the schoolhouse by spraying the nests with chemicals. The fumigated insects lie dead on the classroom floor.

Meanwhile, the men with guns are drinking rum by the billiard hall and checking their high-end mobile phones. I wonder how long they will coexist here before rival groups come to steal the coca crown.

THE HORNET'S NEST IS WAITING…

That day might come sooner rather than later, explains Samuel, pointing to his map. Already another group of dissident FARC fighters – the Frente 30 – is spreading from the Andes down into the jungle and the rivers. Their current trajectory could soon bring them to this village.

Of course, a truce could prevail. But the more probable outcome is yet more conflict, with communities terrorised and confined to their villages. And even less chance of a visit to the hospital.

This makes MSF's quest to place health teams in these villages even more urgent. That will be a challenge in the current conflict. The hornet's nest is waiting."

Behind the masks

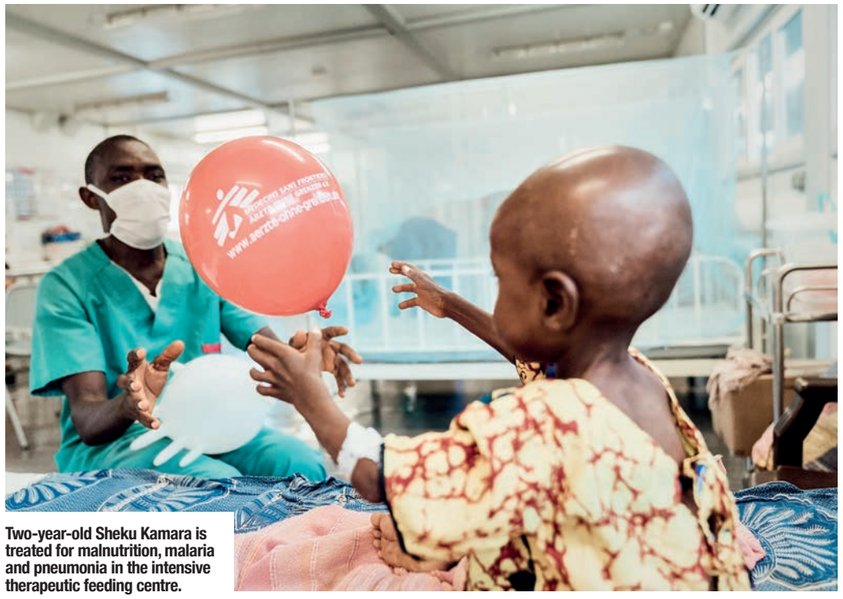
Sierra Leone's maternal and child mortality rates are among the highest in the world. An already fragile health system and a dire lack of health workers, caused in part by the 2014-16 Ebola outbreak, have also led to a drastic rise in the number of deaths among children under five.

MSF's Hangha hospital in eastern Sierra Leone opened in March 2019 and provides emergency medical care to children under five.

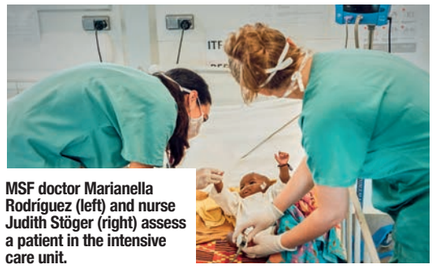
Since opening, over 16,000 children have been triaged in its emergency room and over 9,600 have been admitted to the emergency department.

All photographs © Peter Bräunig

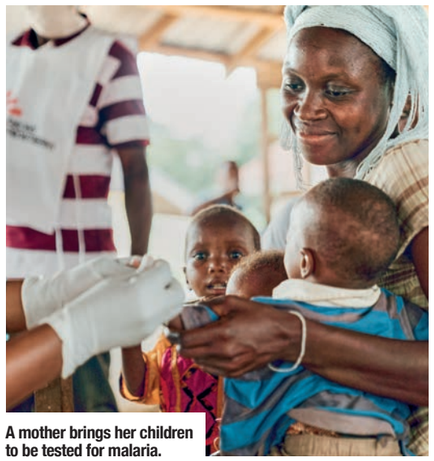
Watch videos of the project at **msf.ie/hangha**



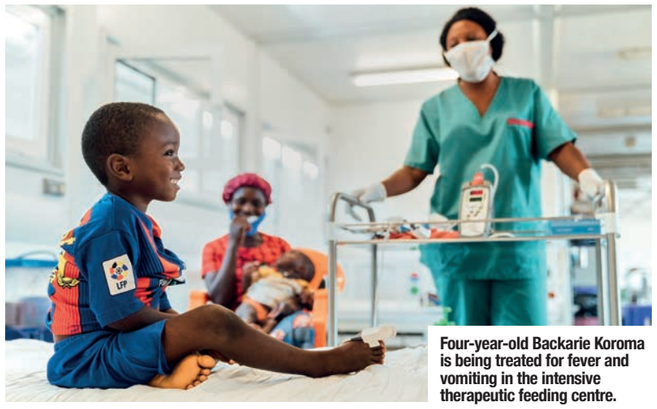
Two-year-old Sheku Kamara is treated for malnutrition, malaria and pneumonia in the intensive therapeutic feeding centre.



MSF doctor Marianella Rodríguez (left) and nurse Judith Stöger (right) assess a patient in the intensive care unit.



A mother brings her children to be tested for malaria.



Four-year-old Backarie Koroma is being treated for fever and vomiting in the intensive therapeutic feeding centre.

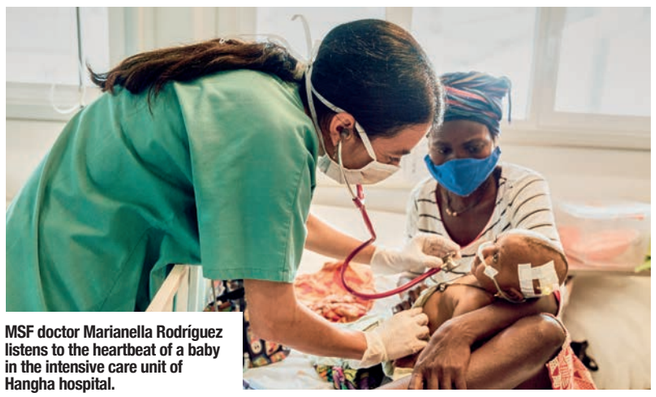
"I really enjoy my job because MSF is here to save lives. When you save a life, it's good."

MSF nurse Hannah Samba tests a boy for malaria, watched by his family, in Bumbeh village.

"You finish the day and you know you've done important work."

MSF health promoters raise awareness of health issues and assess children for common diseases in Bumbeh village.

More than
1,360
mothers die per 100,000 live births and around
109
children die per 1,000 live births

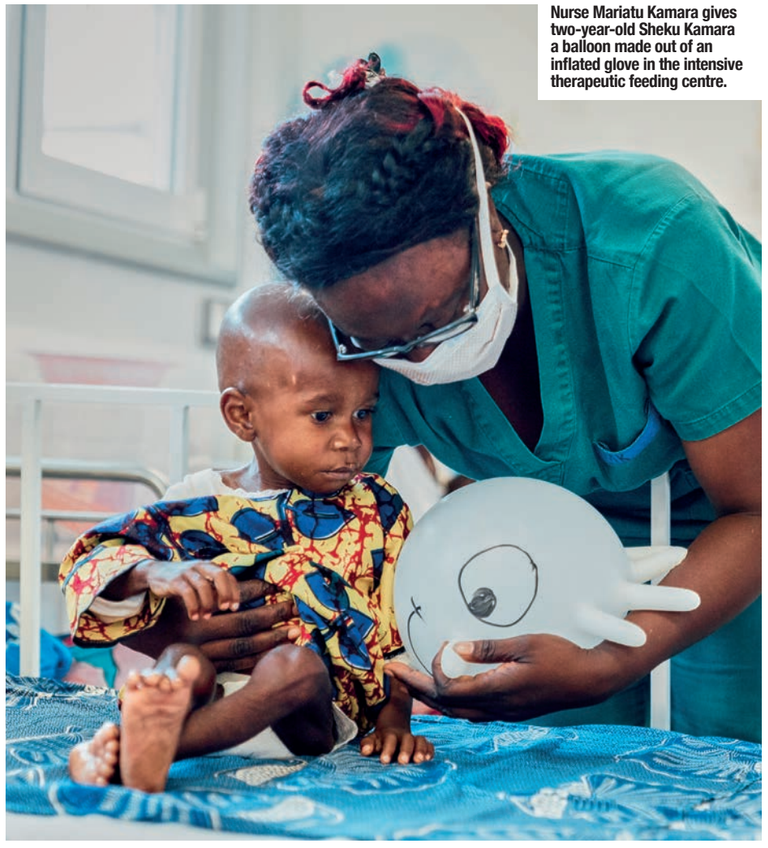


MSF doctor Marianella Rodríguez listens to the heartbeat of a baby in the intensive care unit of Hangha hospital.

Dr Marianella Rodriguez

"All the patients that arrive here are in a very bad situation. I'm in intensive care, so all the patients go to my ward. You have to be strong, because even after a patient dies, you have to continue working. Before I came here, I thought I would get used to the death. But you don't. It's difficult…

How do you maintain your energy? A lot of our patients don't die, and they give me the energy to continue. I know I can do it when I see them. You finish the day and you know you've done important work."



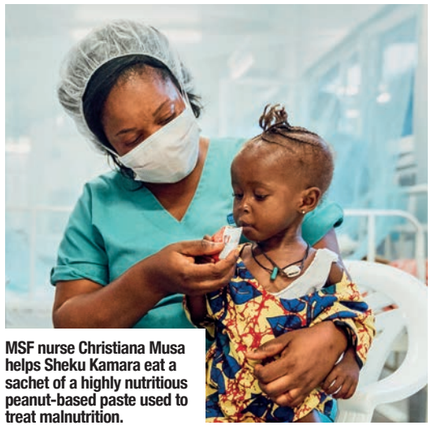
Nurse Mariatu Kamara gives two-year-old Sheku Kamara a balloon made out of an inflated glove in the intensive therapeutic feeding centre.

Hannah Samba, nurse

"Because of COVID-19, some patients don't want to come to the hospital because they are scared of the disease. So we go in search of these people and identify those who are at risk.

We go house to house to see if there are sick children there, and we look for pregnant women who have problems. When we find them, we encourage them to come to the clinic for treatment.

I like my job so much. It really pleases me being a nurse. I really enjoy my job because MSF is here to save lives. When you save a life, it's good."



MSF nurse Christiana Musa helps Sheku Kamara eat a sachet of a highly nutritious peanut-based paste used to treat malnutrition.

‘I wanted to help people’

Bern-Thomas Nyang’wa was the first Malawian doctor to work for MSF; soon he will be MSF’s medical director. He describes a life in which he has consistently pushed the boundaries.

“I was born in Lilongwe in Malawi, the sixth of seven children. My grandfather worked as a doctor and my older sister was a nurse, but growing up, what I most wanted was to play professional basketball.

Back in the 1980s, Malawi was under the dictatorship of Hastings Kamuzu Banda. My boarding school, Kamuzu Academy, was set up by him. His aim was to select two or three people from each district and mould them into the future leaders of Malawi. The school was very strict in lots of ways but it was positive in that it really pushed you to your limits.

I had one very inspiring teacher: a British man called Mr Harwood who taught biology. He kept me focused and his passion helped me understand certain complexities, not only of education but of life as well.

The biggest influence on my early life was my dad, who died when I was 18. He believed in me more than I did myself and never allowed me to settle for anything less than the best. He fully supported my plan to become a doctor. My route into medical training was expensive, but my dad said: ‘If you want to do medicine, we will find some money to pay for it and I’ll help you get there.’

Below: Bern (far right) with fellow students at the University of Malawi’s College of Medicine. Photograph © Bern-Thomas Nyang’wa

Right: MSF staff examine a patient with advanced HIV at Nsanje district hospital, Malawi. Photograph © Isabel Corthier/ MSF

‘I WANTED TO HELP PEOPLE’

At that time in Malawi, there were not many professions where you could make a difference and earn a decent living – which was why I chose medicine. In particular I wanted to help people with HIV.

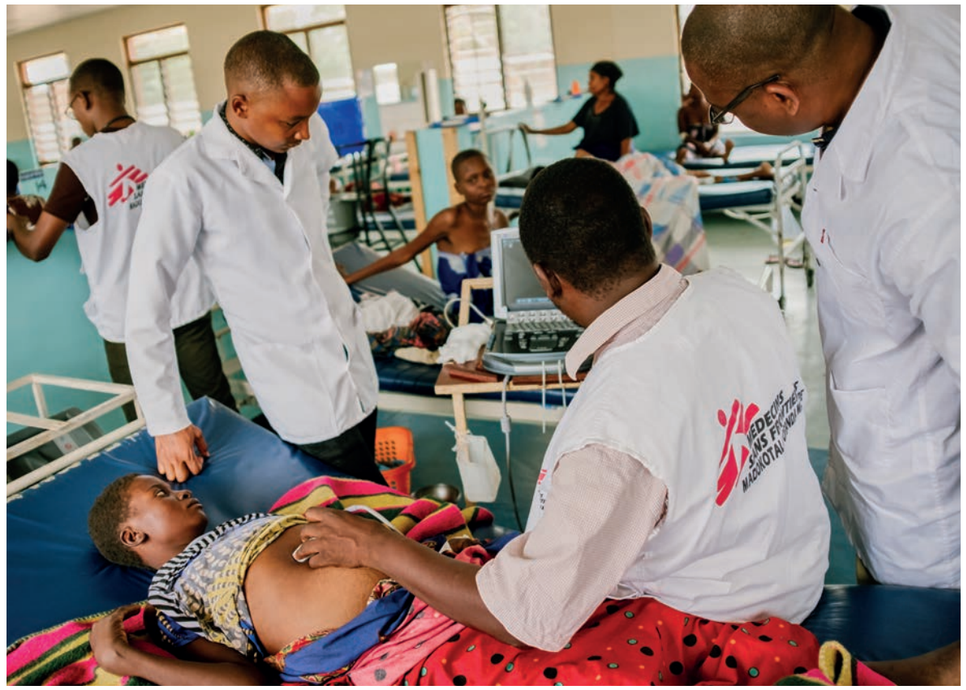
HIV had a very big impact in southern Africa in the late 1990s and early 2000s. There was still no treatment for the disease and life expectancy in Malawi was just 45 years. I knew so many people of my age whose parents had died of it.

In 1998 I started at the College of Medicine in Blantyre. There were just 14 of us in the year. Five years of hard work later, I graduated. I remember that feeling of combined relief, excitement and pride – it was really quite a moment.

We all had to do an 18-month-long internship in Malawi’s central hospital in Blantyre, taking turns in all the different departments. We worked around the clock, sometimes for 72 hours at a stretch, and were paid pretty much nothing. I didn’t have much of a life outside the hospital but, looking back, I can see that I learnt a lot in those months when I was really being pushed to the limit.

PARADISE FOR A DOCTOR

During the last months of my internship, I heard of MSF for the first time. MSF was running an HIV project nearby in Chiradzulu and needed someone to cover for one of their doctors. Knowing very little of MSF, I thought I’d go there for a couple of weeks and make some money. But when I got there, I found it was pretty much paradise for a medical doctor.



In the central hospital in Malawi, you knew that 90 per cent of your medical patients had HIV. You knew you were just treating whatever acute illness they had and that, after a few months, they would come back and would probably never go home.

With MSF in Chiradzulu, I had all the drugs I needed and I could prescribe antiretrovirals, which at that time were only available in the private sector and cost a lot of money. But here, in this rural health centre, all I had to do was prescribe them. I had everything I needed to actually manage patients.

I also had a really good team. Together we discussed what we saw and what could be improved. They were very interested in what I had to say. I realised I was the first Malawian doctor to work for MSF.

After finishing my internship, I got a job with MSF. Over the next two and a half years, I treated hundreds and hundreds of patients and did thousands of consultations in Chiradzulu. At the same time, I worked my way through the various roles within MSF: as a doctor, as a medical team leader and then as deputy medical coordinator.

I felt ready to be a medical coordinator but was told point-blank by MSF that I could not do this job in Malawi, because of its different rules for local and international staff. A lot of people in MSF still face these structural barriers to progress. My only option would be to do the job elsewhere. Even though this was not part of my plan, I was forced to leave Malawi.

ON THE ROAD

Nigeria, on the other side of the continent, was a big change. The culture in western Africa is very extroverted – a complete contrast to Malawi’s laidback culture.

I was hospital manager of a trauma centre in Port Harcourt. The pace was very fast-moving: you needed to make decisions quickly and know when to stand your ground.

Below: MSF clinical officer Christopher Banda helps Austin, a patient with HIV, to board an ambulance. Photograph © Isabel Corthier/ MSF

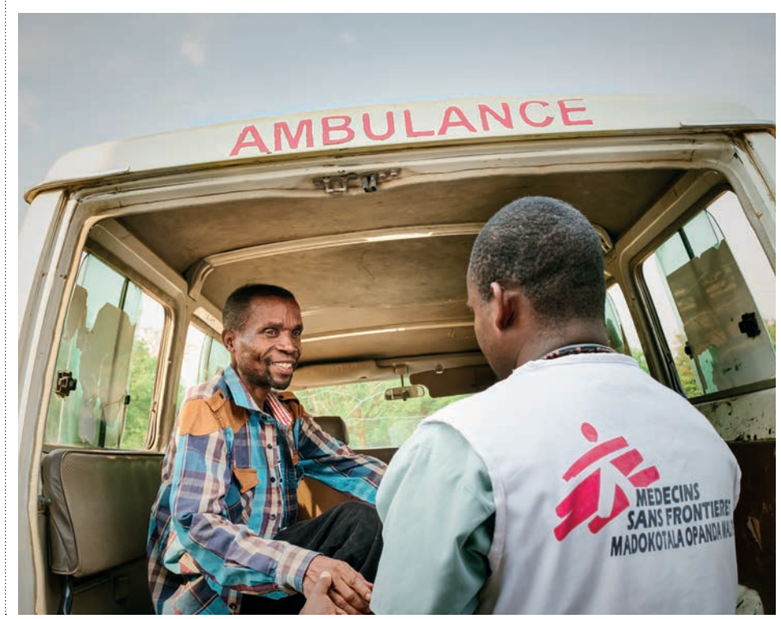
I had to learn to put my foot down and say: ‘This is how we are going to do it.’

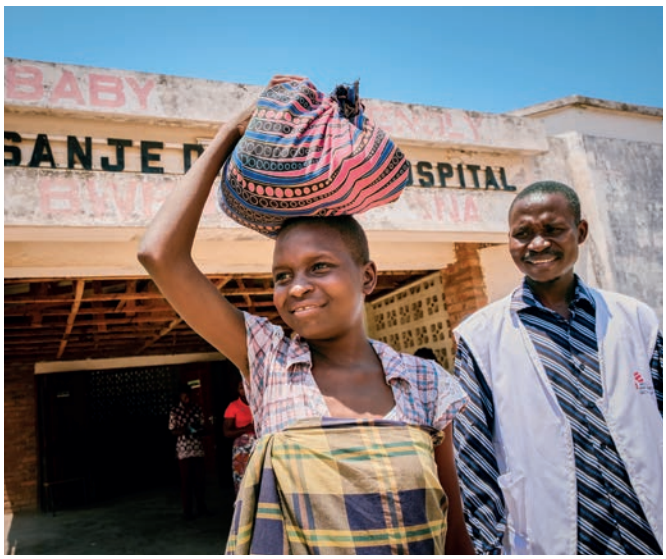
We had the opportunity to push the boundaries of internal fixation surgery within MSF. The hospital was getting too full of patients, so we needed to find a way of treating patients and sending them home safely. People felt that you could not do internal fixation surgery in this setting, but we said we didn’t have a choice and proved it was possible.

Next I went with MSF to Chad. There were major security issues. We had a mishap – we were attacked in one of the camps – and it was so traumatic that I decided to leave, going instead to Central African Republic to set up a tuberculosis (TB) and HIV programme.

TB BREAKTHROUGH

After Central African Republic I got married and considered that my chapter with MSF was closed. My wife, a year above me in medical school, was in the middle of doing her specialisation as a paediatrician in the UK, so that’s where I went. I was happy just to be with my wife. I thought I’d do some training too, then probably work as a doctor there.





HIV patient Esther is discharged from Nsanje district hospital with support from MSF staff. Photograph © Isabel Corthier/ MSF

But then I heard that MSF's Manson Unit had a vacancy for a Tuberculosis project implementer. It was an exciting job and a good transition for me: we'd spend four to six weeks at a time at MSF's projects in Central Asia or eastern Europe, where multidrug-resistant TB (MDR-TB) was a growing problem.

Through these visits, we saw the challenges of treating patients for MDR-TB, because the only drugs available were highly toxic and had severe side effects. This led to the TB-PRACTECAL project – a multi-country clinical trial into new, shorter and more effective treatment regimens for drug-resistant forms of TB.

I was project manager and later chief investigator for the trial. I'm very proud of the progress we've made and the care we are giving to patients in the trial: we've treated 500+ patients with MDR-TB with really good outcomes.

In the 12 years since I've moved, I've done a Masters' in Public Health, I'm completing a PhD at the London School of Hygiene and Tropical Medicine and I'm an honorary lecturer at UCL's Institute for Global Health. I really enjoy trying to mix the robust thinking and reflectiveness of academia with the pragmatism of MSF.

A SIGN OF PROGRESS

After all my years with MSF, I still feel its passion – the friendships and the respect, the focus, the ability to push for what is best for our patients – and I hope to take this passion into my new role as medical director of MSF. I'm excited and honoured that MSF has entrusted such an important role to me.

I can't pretend I'm unaware that I'll be the first black African who started as local staff to take on the role of MSF medical director. That in itself is a sign of progress, but at the same time it's a sign of how far we still have to go. MSF has a lot of local staff who are really invested in MSF – they could have done this long before me. But I'm optimistic about the current momentum within MSF to value and nurture the potential of our staff, regardless of their geographical origin, and I hope I will add to that momentum and the delivery of it.

Most of all, I'm looking forward to really being of help. Although a medical director is a couple of steps removed from the day-to-day activities in MSF's projects, I'm driven by the fact that whatever I do will have a positive impact on the patients that we serve, and I'm determined to do this with all my energy."

MSF IRELAND'S FIELD STAFF

Afghanistan
Aoife Ni Mhurchu, *specialised medical activity manager*, Co. Cork

Birgitta Gleeson, *labratory Manager*, Co. Roscommon

Jean Marie Majoro, *logistician*, Co. Kildare

Niamh Burke, *nursing team supervisor*, Co. Galway

Sarah Leahy, *project coordinator*, Co. Dublin

Bangladesh
Aine Lynch, *project coordinator*, Co. Wexford

Central African Republic
Eve Robinson, *epidemiologist*, Co. Dublin

Chad
Nicodeme Zirora, *finance manager*, Co. Dublin

Ethiopia
Kate Nolan, *project coordinator*, Co. Limerick

Iraq
Ahmed Barakat, *infection control manager*, Co. Dublin

Simon Gubbins, *medical doctor*, Co. Galway

Nijole Slapsinskaite, *nursing activity manager*, Co. Kildare

Kenya
Dana Krause, *head of mission*, Co. Dublin

THANKS TO YOU,

MSF will be ready to respond to the next emergency. Gifts left in Wills play a vital role in ensuring we have the funds to deliver medical care where and when it's needed. For more information on how you can support MSF's work this way, please contact Audrey Jones at **01-2815185** or **audrey.jones@dublin.msf.org**

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