DISPATCHES

Under cover

How one man and a tarpaulin saved thousands of lives, pages 8-9

Photograph: Robin Meldrum/MSF

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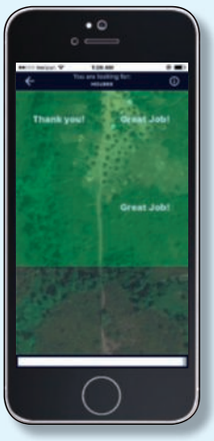
MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

INSIDE

Mapswipe

MSF has unveiled a first-of-its-kind mobile phone app with which people can help map communities in remote parts of the world affected by natural disasters, disease outbreaks or conflict.

Shockingly, the homes of hundreds of millions of people from the world's most vulnerable communities are not mapped. This makes it impossible for aid workers to know exactly where and how many people live there, making it hard to plan mass vaccination campaigns or understand how diseases are spreading.



'MapSwipe', developed in collaboration with the Missing Maps project, allows users to choose a crisis-prone part of the world they want to help, such as villages at risk from a cholera outbreak in Democratic Republic of Congo. They then swipe through satellite images of the region, tapping the screen when they see recognisable features including villages, roads and rivers. This information is fed back to mappers who use it to build up detailed maps.

"We don't think anyone has done anything like this before," says MSF's Pete Masters of Missing Maps. "The app empowers anyone with a phone or tablet to help medical professionals across the world get vital care to those in need, whilst being just as fun to use and addictive as a dating app."

Some of the crisis areas that urgently need to be mapped are Jonglei state in South Sudan and the border regions of Sierra Leone, Guinea and Liberia.

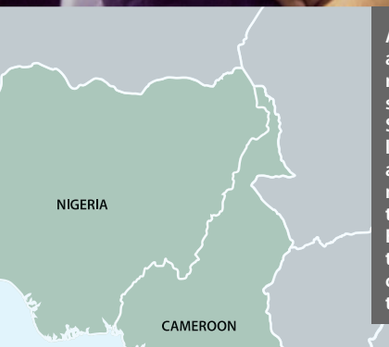
The maps created will be available for use by everyone, everywhere, benefiting humanitarian organisations like MSF, but also local people, giving them something fundamental that much of the world takes for granted.

"It only takes five minutes to identify around 40 images, so whether you're waiting for a bus to arrive or your tea to cool, we urge you to spare some of your time," says Masters. "It even works offline, so is perfect for the morning commute. Swap a few minutes of playing a game on your phone for a few minutes identifying settlements in South Sudan. These minutes can help save lives."

Download the app at the Apple app store or at Google Play

Find out more at msf.ie/mapswipe

GREECE



NIGERIA

Malnutrition crisis

A massive health emergency is underway in northeastern Nigeria's Borno state, where more than half a million people are in urgent need of food, water, shelter and medical care after being forced from their homes or cut off by fighting between the Nigerian army and Boko Haram militants. Efforts to reach people with aid are being complicated by ongoing insecurity in the region.

"Aid agencies must deploy a massive relief operation to respond to this health disaster," says Dr Isabelle Defourny, MSF director of operations. "It is vital to provide assistance to people who are cut off or in remote areas."

Bama lies on the front line of the conflict and is now a ghost town, only reachable under army escort. An MSF medical team in June found mortality rates among Bama's remaining 10,000 residents were well above the emergency threshold, while 15 percent of children were so severely malnourished they were at risk of death.

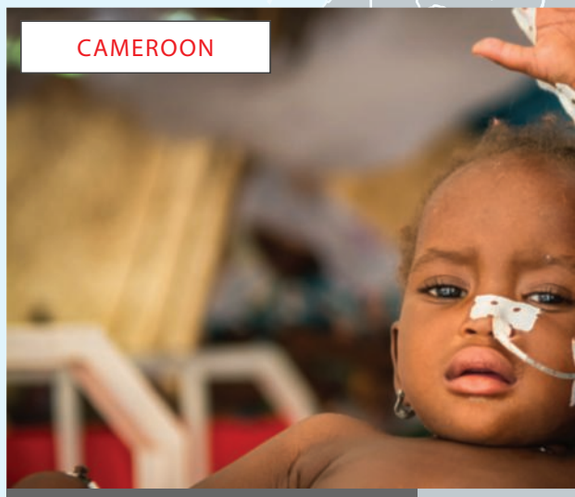
Some 1,500 of the most sick and vulnerable have been evacuated by authorities, while the MSF team is providing medical and nutritional treatment to reduce the number of deaths. "Everything suggests that the situation of people in other towns is just as critical and that they also need food and medical care," says Dr Defourny.

An MSF team has managed to reach the town of Dikwa, where some 70,000 displaced people are sheltering, many of whom recently fled areas controlled by Boko Haram. The team found that 13 percent of under-fives were severely malnourished, and evacuated the most urgent cases to an MSF therapeutic feeding centre.

"The crisis has stopped people from cultivating crops; they haven't been going to their farms for quite some time and this has resulted in a shortage of food," says Bright Mukhana, head nurse at MSF's therapeutic feeding centre. "Malnutrition kicked in as a result of food scarcity."

See the latest updates at msf.ie/nigeria

CAMEROON



A girl is treated for malnutrition in Mora hospital, near the border between Cameroon and Nigeria. MSF is increasing the number of beds in its therapeutic feeding centre in anticipation of a rise in the number of children with severe acute malnutrition as the annual 'lean season' gets underway. Since 2013, the food situation has got much worse, with fighting in the Lake Chad region forcing 2.5 million people to leave their homes and fields, leaving many to go hungry. *Photograph ©Louise Annaud/MSF*

A boy is vaccinated by MSF health workers against six common childhood diseases in a refugee camp inside the derelict Elliniko sports stadium, built for the 2004 Olympic Games. Some 3,500 refugees and migrants have been living in two sports stadiums and a disused airport terminal on the edge of Athens for some months. They became trapped in Greece after the route through the Balkans to northern Europe was closed. Some 50,000 people are thought to be stranded in Greece, living in dire conditions and with no idea of what will happen to them. *Photograph © Pierre-Yves Bernard/MSF*

PAKISTAN

'She is very strong'

Aisling Semple is an Irish paediatrician working in Quetta, Pakistan. Here, she writes about the fight to save a baby's life, in an emergency that could have been prevented with a routine vitamin injection.

"My phone rings one evening – the familiar old Nokia tune. It's the doctor on call – she tells me a newborn baby has just come into the nursery. There is profuse bleeding, can I come now?

I rush to the nursery and find our patient lying on the examination table, on blankets stained with bright red blood. I see her parents scared and helpless nearby. She's three days old, the nurse tells me. She was doing fine until the bleeding started suddenly this morning. My chest tightens. I've seen this once before.

A few months ago the night doctors called me early one morning, asking me to come to the nursery immediately. There I found the staff resuscitating one of our previously stable babies. She had started bleeding suddenly from her mouth and nose. The blood pooled in her throat and she couldn't breathe. We tried our very best to save her, but we didn't succeed. Breaking this news to her heartbroken mother is something I'll never forget. It was a horrible morning.

This condition, which causes sudden and dramatic bleeding, is called 'haemorrhagic disease of the newborn'. It's caused by a lack of vitamin K, which is essential for blood clotting. At home, all babies get a vitamin K injection shortly after birth. Most women here in Pakistan deliver at home, so their babies don't receive this protection.

The baby is losing a lot of blood. It's bright red, which means that it's fresh. She hasn't gone into shock and her colour is still good – she doesn't look anaemic.

We give her vitamin K, but the bleeding continues overnight, and the next day she is pale and weak. We arrange a blood transfusion and she perks up. There's still a lot of old, clotted blood in her tummy so we can't let her feed yet. She makes it clear that she is not happy about this.

On the third day I see her parents looking relaxed and smiling. I peek into her cot. She is pink and active, kicking her legs and trying to suck on anything nearby. She looks great. I've grown accustomed to sign language here, and gesture to her parents that she is good, she is strong. To my surprise, her father answers in English. "Yes, she very strong," he says proudly. "Thank you," he says. His wife nods, grinning in agreement.

So, on behalf of this one family, I thank you all. Thank you for supporting us and thank you for helping us save this baby's life."

Read Aisling's blog at blogs.msf.org

ZIMBABWE

Ngonidzashe lives near the town of Gutu, where she is being treated by MSF for HIV. After MSF set up a screening programme in Gutu for cervical cancer – which is known to be more common among HIV-infected women – she learned she had early signs of the disease, and successfully underwent treatment to remove the abnormal cells from her cervix. Cervical screening is not widely available in Zimbabwe, and travelling to Harare would have been prohibitively expensive for Ngonidzashe. *Photograph © Melanie Wenger/COSMOS*

Warzone classroo

Doctors examine an X-ray at the bedside of a wounded patient in MSF's Khamer hospital in Amran, Yemen. *Photograph © Rawan Shaif*

For the past two decades, MSF surgeon David Nott has spent several weeks of each year in warzones and other crises, from Sarajevo and Iraq to Syria, Chad and Afghanistan. Just back from Yemen, he talks about the pressures of working in conflict zones, and why teaching war surgery is his new passion.

'Getting to Yemen is not easy. Because of the conflict, the easiest and most secure way is by boat from Djibouti to Aden. MSF has hired a small fishing boat which does the 14-hour trip once a week, and although that sounds quite pleasant, it was pure hell. The sea was very choppy, the boat was all over the place, it was 40 degrees and the smell of diesel was very strong. I was seasick the whole journey.

I remember lying on my side on the deck with one eye open, trying not to move and thinking 'oh this is so awful', when I saw a colleague who was sleeping on the other side of the deck, suddenly thrown up into the air by a wave and land in the middle of the deck, soaking wet. It really was dreadful. To top it all off, it was also my 60th birthday.

We arrived in Aden early in the morning. At the MSF-supported hospital we did lots of operating on gunshot wounds and blast injuries for three or four days, working alongside Yemeni surgeons, showing them various techniques. The day we arrived, there was a suicide bomb outside a military base which killed five people and injured 14, which then became a mass casualty incident to deal with.

Aden is actually a lot calmer than other parts of Yemen at the moment, but we could still hear the sound of gunfire and AK47s all day long and we had four or five gunshot wounds a day coming to us. And they weren't just small gunshot wounds – they were major abdominal, leg and arm wounds. A lot of people had been transferred from other hospitals around Yemen, so they might already have travelled five or six hours in the back of a truck, meaning they needed intensive treatment. Learning how to treat these sort of injuries is a large part of the course we run.

The course is called HEST, which stands for 'hostile environment surgical training'. For three days, I and my colleague and friend Ammar Darwish (who I first met when we worked together in Syria) taught 43 Yemeni surgeons all the operations that any surgeon working in conflict needs to know. We started with cardiovascular and dealt with keeping the airway open; then we covered how gunshot wounds affect the chest, when to open the chest, how to open the chest, how to deal with lung injuries and heart injuries, and how to deal with gunshot wounds to the neck, upper neck, and lower neck; then we covered all the injuries they'd see in the field from conflict and from gunshot wounds and fragmentation wounds; and then we went through how to deal with blast wounds. We gave a whole lecture on ballistics and how to manage high energy and low energy impact wounds. We also did a lot on plastic surgery.

A surgeon going to the field needs to be able to do about 100 different types of operations. If you can do those, then you'll probably be able to get through most of the war surgery or the conflict and catastrophe surgery that you'll see. The courses we run equip you to do this. You know, the best way of teaching this stuff is to go into the operating theatre and talk through the operation as you're doing it. But the second best way is to have intensive lectures and videos of the operations. It's the sort of stuff I wish I'd been exposed to 20 years ago when I first started doing war surgery.

The Yemeni surgeons were great. They sat through 22 hours of solid lecturing

and there were a lot of questions and a lot of back and forth, talking about difficult cases and discussing how best to manage them. They didn't move from the classroom. The course is certified with the Royal College of Surgeons so everybody got a formal qualification at the end.

'A surgeon going to the field needs to be able to do about 100 different operations'

It can be difficult adapting back to normal life after being in a warzone. One moment you are being shot at and bombed in an environment that is very stressful where you're seeing things that hardly anybody on this planet ever really sees – people being really mangled and badly damaged – and then the next thing you know you're standing in a queue at Starbucks getting a coffee, and somebody's arguing about how much coffee they've got in their cup. It just doesn't bear contrast.

Have I got better at adapting? Yes and no. I've done about 25 missions for MSF, the International Committee of the Red Cross (ICRC) and other organisations, and I haven't yet got to the stage of burn-out, where you can't actually do it anymore. But you do get some post-traumatic stress disorder. I don't think the trauma of seeing awful things gets any easier the more you're exposed to it – I think it actually gets worse. It adds to the bucket of things that you've seen and sometimes that bucket overflows.

I've worked in Syria three times. What's happening in Aleppo at the moment is absolutely dreadful. I'm still in contact with a lot of the doctors there; your heart just bleeds for them and for the people there and of course you want to be there to help. But to go back to a place where you've got a high chance of being killed – it's just not worth it. One of the wonderful things about MSF is that they don't take risks with security, and if you are in a place that suddenly gets very hot, they pull you out rapidly.

I've been in plenty of dicey situations where I've been afraid. In 2006 I was in Democratic Republic of Congo in an MSF vehicle driving a patient to Goma when we came across a roadblock. It was a dangerous area and there had been a lot of fighting. We stopped and a man came out of the bushes with an AK47, and that's when I made the stupid mistake of looking him in the eye. Instantly the dynamic changed. I couldn't stop staring at him as he came towards the vehicle. I tried to close the window but, before I could, the barrel of the gun came through and stuck on my neck.

You could smell the alcohol coming off him. I just froze and thought, 'this is the end'. You always think that in those situations you'll swing into action and do something, but I was just paralysed by fear and couldn't move. One of my colleagues in the back started shouting and eventually the guy took our money and left. But that was a moment when I felt sure that I was going to die. I did learn, however, never to look anybody in the eye at a checkpoint.

An armed man passes a boy in the street in Al Asha, northwestern Yemen.
Photograph © Guillaume Binet/MYOP

'Being a war surgeon is like going back to the old days of surgery"

You try your best to keep your emotions out of the work. When you're dealing with injured patients, you're thinking 'this is terrible', but you just try to deal with the human machine in front of you and try to fix it. But it has become harder for me since I've had a child. I was working on the Syrian-Turkish border in March this year and a child of the same age as my daughter was brought in. She was so badly burned that it was really, really, emotionally very difficult. It was the first time I started blubbing. You're just thinking how terrible it must be for those parents and how awful they must feel about their lovely child who they'd do anything to protect.

Surgeons are so super-specialised now that they don't have the skills to do all the operations you need in the field. That's why I developed these courses, which we started running with the Royal College of Surgeons in 2013. Being a war surgeon is like going back to the old days of surgery before laproscopic equipment, robotics and scans. You've got a knife, a pair of scissors and forceps – how do you cope? It's making the best use of the kit you have and thinking on your feet - like using a knitting needle instead of a pin and nail for a fracture of the femur, as I had to do in Chad once. It's fascinating to work like that.

Giving to MSF is great value for money – I've always known that. Even if you're giving €10, that's €10 that's going to help people and save lives. What could be better than that?'

DAVID NOTT

1. For surgery, I take my headtorch, magnifying glasses and a small Doppler machine to measure blood flows.

2. Listening to music on my phone is vital – it's such a stress-reliever. In Aden we had a nurse who played the accordion. On the last night we had a BBQ, he played and we all sang – it was wonderful.

3. An Arabic textbook. I'm trying to teach myself Arabic, but it's not going well. Plus I prefer to spend any spare time chatting to people and finding out about their lives, rather than reading.

There are more than 4,400 patients with renal failure in Yemen who are struggling to get weekly dialysis sessions to stay alive. *Photograph © Malak Shaher*

Conor Prendeville from Castleknock in Dublin worked in Yemen as MSF's project coordinator.

Over the past six years, Conor also spent time with MSF in Chad, Haiti , the Democratic Republic of Congo, Colombia , Ethiopia, Turkey and Syria. Here Conor describes his time in Yemen.

'When you go on a new mission with MSF, there's always a sense of curiosity about what your project station is going to be like. You're going to live and work somewhere new, at least for a few months, and you're eager to visualise it, to meet the people, to experience it. Are you going to like it...? Are you going to do a good job...? Are your colleagues going to appreciate you...? Are you going to be able to help...? Your arrival is always loaded with question marks. If nothing more, then what will the food be like?

Upon my arrival into the city of Sadah, the heartland of the Houthi rebellion in northern Yemen, this curiosity could be described as apprehension. What did I know about the project before my arrival? During my briefings in the HQ, a few phrases cropped up more than others: "difficult", "frequent airstrikes", "high workload", "busy hospital", "constant mass casualties", "forgotten population", "no other actors present"...

These were the phrases ringing in my ears when the Landcruiser first started to weave its way through the rubble of Sadah's outskirts. The physical destruction of the city is the first clue to the dynamic of your new home, and it is arresting.

As a field coordinator, you're also going to be the new boss of the project, so the curiosity is mirrored by those who are welcoming you: the project staff. Are you going to treat them well...? Are you going to support them in their work...? Are you going to improve the project....? Are you going to be a tyrannical overlord...? These are the questions you can see on their faces as they present themselves, and you try to do your best to put their concerns at rest.

What first struck me about the project was the flow of war wounded into the ER. I have worked in a few war-torn countries, but I have never seen such a constant influx. In hospital projects all over the world we have a contingency plan called the 'mass casualty plan'. It dictates how the Emergency Room and Triage should be adapted to the influx of a mass casualty, i.e. over 8 – 10 patients from a single event. Normally, a mass casualty plan is something remarkable, something that happens

occasionally... exceptionally. Here, the mass casualty is the rule rather than the exception! At any time of day or night, the call comes in from the ER and everyone goes to their pre-appointed stations. It's my responsibility as coordinator to find out where the mass casualty is coming from and what kind of

'Here, the mass casualty is the rule rather than the exception!"

patient flows we can expect. So you call around, try to find out what happened, where did the airstrike hit and whether there are more injured than have already been received.

I suppose when you look at the destruction of the city and when you listen to constant airstrikes that fall on and around it, it's to be expected that there should be such an influx of dead and wounded.

18-month-old Zeinab recovers in the intensive care ward of the MSF – supported hospital in Amran, Yemen. Zeinab has been hospitalised at least three times during the past year, once for malnutrition and twice for schistosomiasis, a disease contracted from unclear water.
Photograph © Rawan Shaif

The support that MSF provides here is the only real support available to the people in this region. The UN and NGO systems don't really penetrate this difficult part of the world. And it is a difficult part of the world. With the traditional "janbiya", or ceremonial curved dagger sticking out of their belts, the war-hardened Houthi are used to conflict, it's been a constant for them for decades if not centuries now.

The first time I toured the wards with the medical team, they pointed out a young Ethiopian man, a migrant, on his way to the Promised Land of Saudi Arabia. He had crossed the Red Sea and was seeking to cross the Yemeni border into Saudi Arabia. He got caught up in fighting, wrong time/wrong place I guess, got badly injured, had both legs amputated and

12-year- old Hussein Ahmad at the intensive care ward of the MSF – supported hospital in Amran, Yemen. Hussein, was severely injured when he received gun shot wounds to the abdomen after being caught in the middle of a land dispute.
Photograph © Rawan Shaif

'He got caught-up in fighting, wrong time/wrong place I guess, had both legs amputated.'

had now been lying in our ward for over a month. What future did this man have? He was young, probably about the same age as me. He had been seeking a better life, perhaps seeking to send money back to his family in Ethiopia. Now, what lay ahead of him? Lying on an ambulance bed in the middle of one of the world's most active warzones, in one of the worlds poorest countries, no legs, without a word of Arabic or English, we couldn't even communicate the status of his wounds to him.

And then there was the bombing of MSF supported hospitals. The discussions with the families of killed staff are something I will never forget. I spoke to one lady two weeks after losing her husband (one of our guards) during an attack on a hospital near the Saudi border. Her timid dignity from behind her hijab, as required by cultural norms for discussions between sexes, belied the loss her family had incurred and her fear of a future as a widow with children.

Now my mission is over. I'm back at home and looking back on it I compare my initial expectations and curiosity with the reality I found upon arrival. There's always a discord, but rarely have I felt so empty after a mission. All I can hope for is that for the time I was there, I supported the team in their Sisyphus-esque task and maybe helped make a small difference for someone, somewhere'.

On Friday 19 August, MSF withdrew staff from six hospitals it supports in northern Yemen, following the airstrike on Abs hospital that killed 19 people (including one MSF staff member) and injured 24 others. It was the fourth attack on an MSF-supported hospital in Yemen.

MSF continues to respond to the humanitarian crisis by providing essential medical care in eight regions across the country.

Find out more at msf.ie/yemen

The humanitar

For MSF's logisticians, the humble plastic tarpaulin is an indispensable piece of kit, used to make everything from fencing to guy ropes. Former MSF-er Patrick Oger describes how he came to be tasked with designing the perfect humanitarian tarp.

'I was a working as a mechanic in France, when a friend who worked for MSF asked me to help convert a city bus into a mobile clinic so they could bring healthcare to homeless people in Marseille. It was an exciting job, the people were friendly and the ambience was great. I met logisticians coming back from the field and heard their stories. I felt I'd found a second family in MSF somehow, so I went with MSF to Sudan, as a mechanic, and then to Malawi and Kenya. I had never travelled before. It was an immense experience and I discovered the world.

When I returned to France, I got a job at MSF Logistique in Bordeaux, and was given the task of procuring millions of square metres of plastic sheeting.

'Indispensable'

When people's homes have been destroyed, plastic sheeting is a fast and easy way to create an emergency shelter – to shield them from the rain, the sun, the cold, to protect them from major disease and offer them some privacy.

A plastic tarp can become an emergency tent, like this one sheltering a family forced to flee their home in Carnot, Central African Republic, in 2014. *Photograph © Yann Libessart/MSF*

As a logistician, plastic tarpaulin is indispensable – and not just for shelters. You can use it to make fencing or walls for latrines; you can spread it on the ground when you are sorting out emergency food rations; you can use it to cover the food when you're fumigating against insects. I've even seen it made into guy ropes for a large tent, as it's extremely strong, with very high tensile strength.

But it wasn't always so dependable. When aid organisations first started using plastic sheeting in the 1970s, they used agricultural film, which wasn't reinforced and was very fragile. They went on to use the kind of cheap plastic tarps you can buy in a supermarket. They cost just 20 cents per square metre – but they tear easily and the polyethylene is very sensitive to the ultraviolet rays in sunlight, so they degrade very fast. After just a couple of weeks in South Sudan, you find the plastic has turned into powder.

"I discovered that the white fibres were weak, but the black ones kept their strength." *Photograph © Patrick Oger*

However, there was one Danish company making very high quality tarpaulins out of thick plastic with braided reinforcement inside, with plastic eyelets every metre. But the problem was the price – they cost US$1.5 per square metre – which is a lot when you need one million square metres.

We started from scratch

We couldn't find competitors for their tarpaulins, because the product was under patent so we couldn't copy their design. So, along with the UN refugee agency, the UNHCR, we decided to start from scratch and write our own specification, which we would take to the international market so companies could bid to manufacture it. As I was in charge of plastic sheeting, and had studied technology as a mechanic designer, I was given the job to write a spec for the perfect plastic tarp.

I did plenty of testing with different plastics. I asked our logisticians in the field

a rian tarpaulin

MSF teams suspend rectangles of tarpaulin from ropes strung across a field to make thousands of emergency shelters in Endebess, Kenya, for people whose houses burned down in electoral violence in December 2007. *Photograph © Brendan Bannon*

to send me back pieces of plastic, along with information about what they had been used for, for how long, and how much sunlight they had been exposed to. With support from laboratories, I was able to extract the technical information.

Black is the colour

The colour was significant. I noticed that one of the tarps I tested tore easily in one direction, but not in the other. It was woven out of a mixture of black and white fibres, and I discovered that while the white fibres were weak, the black ones kept their strength. The reason for this was that the black fibres had absorbed the UV rays in sunlight, and prevented them from degrading the fabric. Black fibres also increased the opacity of the fabric, keeping shelters cooler.

So black it had to be. Making black plastic is easy and cheap – you mix it with carbon black, which is similar to soot. But psychologically a black shelter is not nice to use, so we decided to coat the plastic with another colour.

We tried blue, green, grey, red, transparent, aluminium. When I tested them, I discovered that white offered most protection against the sunlight to reduce the temperature inside the shelter.

So I designed a tarp made of black fibres, for high opacity and UV resistance, but coated on both sides with white.

The size was important too. To build a basic shelter – a simple ridge tent with two poles that is 2 metres high at the ridge and has a footprint 4 metres wide – the minimum size of tarp you need is 4 x 6 metres.

After three years, the research ended, and I finalised the specification. We found companies to manufacture the tarps in China and Korea, and the cost came in at just 40 cents per square metre for a high quality product. It is now also produced in India, Pakistan and Kenya.

And this is the tarp that MSF uses now – all the large organisations use it. I use one myself – to cover my woodpile.

Hats, raincoats and bags

I've seen them made into hats and raincoats. In Haiti I've seen them made into big sacks to collect recycled plastic, as they are easy to stitch and very strong. The most amazing use I've seen was in Congo, where people pulled apart the durable black fibres and wove them into money bags.

In the local markets, these tarps have a high value compared to other tarpaulins – which is always a good sign.

Now I'm working on designing a new type of family tent for use in emergencies. What material are we using? Why, the best material in the world – the plastic tarpaulin we developed!'

Patrick tests the quality of a tarp manufactured to his specifications in Kenya. *Photograph © Patrick Oger*

The book of life

Jeremiah holds up the precious book, one of the only remnants of MSF's destroyed hospital in Leer. *Photograph © MSF; Bottom photograph:* When violence spread across southern Unity state, thousands of people fled their homes, with some 2,000 people hiding amidst the swamps on Kok island. *Photograph © Dominic Nahr*

There is a book kept under lock and key in the tented HIV and tuberculosis ward of MSF's hospital in Bentiu, South Sudan. It doesn't look like much: its blue ink has started to fade and its pages emit a strong smell of mould and swamp water.

But it is precious, not only because it contains the confidential medical information of 120 patients, but because it's one of the sole remnants of MSF's hospital in Leer, completely looted during a wave of violence in May 2015.

This slim, A4 school book is the only link with the past for many patients on lifelong HIV treatment.

Running for his life

When MSF counsellor Jeremiah ran for his life after the hospital in Leer was attacked, he thought of two things: his family and his patients. Collecting his wife and two children, they sprinted towards the swamps and the bush. As his patients were already gone, he took what could help them: a bag full of antiretroviral (ARV) pills, and the book holding his patients' records.

In South Sudan, an estimated 2.7 percent of adults live with HIV, but barely six percent of those in need receive lifesaving ARVs, due to the scarcity of available care. Jeremiah knew that this book could be a lifeline for those patients under MSF's care. He just needed to keep it safe.

He stashed the backpack and hid in the water

He waded through chest-deep swamps to an island, where he buried the backpack so it couldn't be looted, before returning to hide in the reedy wetlands. He and his family stayed there all day, listening to the sound of gunfire and concealing themselves as best they could. "We were very afraid. I had no idea how long we were going to have to run for," says Jeremiah.

When the shooting finally subsided, Jeremiah returned to the place he'd

buried the bag and they continued on their journey. He sent his family ahead to Bentiu, where they eventually found refuge in the protection of a civilian's camp, but he chose to stay behind and help people using the medicines he'd stashed in his backpack.

The only other time he let the bag out of his sight was when he was forced to do so to save his own life.

On that day, armed men were rapidly gaining on him as he ran through the swamps. The water-soaked backpack kept getting caught in the tall grass and slowing him down. He stashed the backpack in the reeds and hid in the water, with only his mouth and nostrils above the water so that he could breathe.

Through the water, he heard the thudding of gunshots. He stayed in the water for hours. When the shooting finally subsided, he crept from the water and returned to the place he'd hidden the bag, but had trouble finding it. He began a frantic search.

"I came out from my hiding place and I was struggling to get the bag," he says. "It was lost in the dark, there was a lot of grass and there were mosquitoes biting me everywhere." After more than an hour of searching, he found the bag and laid out the book to dry so that the patients' records would be preserved. "That day was very difficult," he says.

'You are safe!'

His efforts paid off shortly afterwards. While sheltering on a small island in the Sudd (a vast swamp formed by the White Nile), Jeremiah encountered a group of his former HIV patients.

Dr Pippa Pett examines a child in Thonyor. The destruction of their homes, animals and crops left people vulnerable to malnutrition and other diseases. *Photograph © Jacob Kuehn/MSF*

They had lost the 'runaway packs' containing three-months' worth of ARVs that Jeremiah had given them when the fighting got dangerously close to the hospital.

Using the records he'd saved in his backpack and the drugs he had available, he was able to replenish the medicines the patients desperately needed. "When they saw me and received their medicines, they were so happy," he says. "They said 'Jeremiah you are safe!'"

'I'll buy you a goat'

Eventually, Jeremiah was able to reconnect with the MSF medical team in Bentiu camp, where his family was waiting for him. With the help of the book, some of his former patients who had fled were re-enrolled in their treatment regimens.

But there were still many other patients in the camp who had not yet come to the hospital to resume their treatment, due to the fear of stigma around HIV.

For some of them, Jeremiah's arrival was a turning point. He made a radio announcement for MSF, and many people heard Jeremiah's familiar voice urging them to come for treatment. "Within a week, 10 patients had come to the hospital to go back onto their treatment," he says. "One man was so happy he even offered to buy me a goat. But I said to him, 'you keep that goat for now, just get better first'.

"The patients think they are the happiest people. But I'm even happier than they are, because now I can see them and I can see that they are okay. They are getting healthy and their lives can continue. I am very happy for them, very happy."

IRISH VOLUNTEERS CURRENTLY IN THE FIELD

Dem Rep Congo Aidan Magee, *Anaesthetist*, Co. Dublin
Ethiopia Aoife Nicholson, *Laboratory Manager*, Co. Galway
Donal Doyle, *Laboratory Manager*, Co. Sligo
Haiti Dominique Howard, *Human Resources Co-Ordinator*, Co. Dublin
Katerina Chaintarli, *Epidemiologist*, Co. Dublin
India John Canty, *Logistician*, Co. Dublin
Kenya Sharon Mealy, *Logistician*, Co. Kilkenny
Myanmar Federica Crickmar, *Human Resources Analyst*, Co. Dublin
Sierra Leone Niamh Burke, *Nurse*, Co. Galway
Niamh Allen, *Doctor*, Co. Dublin
South Sudan Oonagh Carlin, *Human Resources Manager*, Co. Dublin
Anne Marie Crosse, *Heath Promoter*, Co. Donegal
Uzbekistan Joan Hargan, *Tropical Medicine Nurse*, Co. Antrim

i 60 SECOND INTERVIEW

Aidan Magee, an anaesthesiologist from Co. Dublin, has recently departed on his first mission with Médecins Sans Frontières (MSF) to the Democratic Republic of Congo.

Why did you choose to work with MSF?

I have followed the work of MSF closely for years after being introduced to them by a few friends. I really admire their work in the field and their independent stance.

What work will you be doing on the ground?

A large part of my role will be a combination of providing safe anaesthesia for obstetric surgery (primarily C-sections) and training local staff in anaesthetic techniques. I will also be involved in other emergencies in the local hospital including major trauma and neonatal resuscitation.

What essentials are you bringing in your rucksack?

A kindle and the Game of Thrones boxset for some down-time (hopefully!). Also, insect repellant and a French dictionary!

What are you looking forward to most?

I'm really looking forward to starting work in a totally new and challenging environment. I'm also excited to meet the rest of my team who I imagine I'm going to get to know very well over the next few months!

What will you miss most from home?

Friends and family, especially my two little nieces, Anna & Laura. I'm also going to be away for a few weddings of some very good friends.

CHRISTMAS CARDS

Médecins Sans Frontières Christmas cards will be available to order online from October.

Each pack has selection of incredible images from our projects around the world and contains 10 cards.

Keep an eye on **msf.ie** for more details.

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Médecins Sans Frontières (MSF) is the only medical humanitarian organisation in Ireland where your money goes directly to saving lives on the front line. We provide emergency medical care to people caught up in war, disasters and epidemics. We are funded primarily by donations from the public which gives us the independence to provide quality medical care wherever it's needed most, free from any political, military or religious agendas. With independent donations, we can quickly deploy skilled teams to the front lines of wars and disasters while also retaining capacity to respond to forgotten emergencies.

'Gunshots are a part of daily life'

Jackie Boyd is an MSF doctor who spent three months at Boost provincial hospital in Lashkar Gah, Afghanistan.

'It's strange to be in a place where gunshots are a part of daily life but rain is something special. When there was gunfire outside, the Afghan staff in Lashkar Gah hospital wouldn't blink an eye, but when it began to rain, they were all pressed up against the windows.

I was working in Lashkar Gah, in Afghanistan's Helmand province, as a doctor. The conflict was close. When we flew out of the city, the plane did a tactical take-off to avoid rockets.

We looked after the general population's medical needs – nobody else was doing that because it was a conflict zone. Because of the instability, we weren't allowed to go out, other than to and from the hospital and the compound where we slept.

War has been going on around Lashkar Gah for quite some time, so it's not as developed as other cities – it's very flat, with lots of square buildings, and with the desert close by. When we turned into the hospital every morning, across the lake you could see this huge Ferris wheel. It seemed very out of place, this remnant of how life used to be, until I heard that it was still in use at weekends. I was surprised to find that, even in a warzone, people still try to get on with their normal lives. And that's what MSF is there to do: to help people get on with their normal lives.

I was one of seven in the internal medicine team, most of whom were Afghan doctors employed by the Ministry of Public Health.


© Jackie Boyd/MSF

In the ward, we had up to 60 inpatients to look after. Many were older patients who had suffered heart attacks, pneumonia or had smokers' lungs, but I also cared for a number of children.

One little girl of two-and-a-half had stepped on a landmine and lost part of her foot. She had had a skin graft, but after it became infected she had to have months of treatment. I used to take balloons on my ward round – and "balloon" soon became her only English word. With her brilliant smile, she managed to get hold of all of our balloons.

There was also a 16-year-old girl who had been born with a heart defect and needed a constant supply of medication to stay well. Often, the only way to get hold of medicines in Afghanistan is to pay a visit to a private doctor. Her family didn't have much money, but they all pooled what they had so that she could see a doctor. Once on medication, she got better, but then they ran out of money and she became sick again. This whole cycle repeated itself a number of times. Eventually she heard that MSF provided free treatment, so she came to us.

When the girl arrived, she was very short of breath and her oxygen saturation was so low that she had to have oxygen the whole time while sitting in bed. Eventually we assisted with referrals so she could travel to Kabul for further treatment.

The Afghan staff were lovely and always welcoming – they are the absolute backbone of what we do – and the work in the hospital was of a very high standard. As a woman, there were challenges, such as dressing in the heat. When I first arrived, it was minus two degrees centigrade, but when I left three months later, it was around 40 degrees. Being female, you have to be completely covered, right down to your ankles and wrists.

For the Afghan staff, rain may have caused excitement, but thunder brought out other emotions. One night there was a big thunderstorm, and the next day one Afghan doctor told me he hadn't slept all night. He thought the thunder was bombs and shelling, and that the city was being taken over. People suffer chronic anxiety that they rarely talk about because, even though they are living in a warzone, they just have to try and get on with their lives.

People are glad that MSF is there. Not everybody back home is in a position where they can go and work for MSF, but everybody can be part of it through their support. We would definitely not be able to do the work that we do in Lashkar Gah if it wasn't for that support.'

Find out more about our work in Afghanistan at msf.ie/afghanistan

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

YOUR SUPPORT | www.msf.ie/support-us

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.

Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. We welcome your feedback.

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