Dispatches

Spring 2020
No. 96

The circle of care

HIV in Malawi

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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Front cover: MSF nurse Maria Goretti Uwamahoro assesses the condition of Austin, a patient with advanced HIV at Nsanje District Hospital, Malawi. Photograph © Isabel Corthier/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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Dispatches is written by MSF staff and sent out quarterly to our supporters to keep you informed about our medical work around the world, all of which is funded by you. Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. It is edited by Marcus Dunk. It costs £0.71 to produce, package and send using the cheapest form of post. It is an important source of income for MSF and raises three times what it costs to produce. We always welcome your feedback. Please contact us using the methods listed, or email: **dispatches.uk@london.msf.org**

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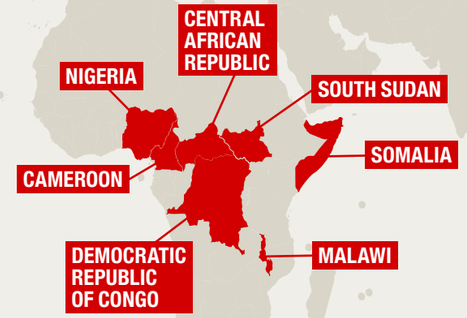
SITUATION REPORT



Five ideas to improve medical care in 2020

Toward the end of each year, MSF's medical and operational teams assess the year's work and establish priorities for the new year. The driving motivation is to expand and improve our work so that MSF teams can more successfully deliver lifesaving medical care across all our projects. Here are five examples of things we want to do better in 2020.

1. TRAUMA CARE: SAVING MORE LIVES BY TRAINING FIRST RESPONDERS

Dr Lynette Dominguez, surgeon

"MSF treats a lot of trauma patients – people who have been severely injured, usually by violence or in road accidents. But there are many people we are not able to save: the most critically wounded, who die before they arrive at our gates. By training the people who transport the wounded to our health facilities on how to keep these people alive, we hope to save more lives."

2. HIV: DEVELOPING NEW WAYS OF TREATING PEOPLE CRITICALLY ILL WITH HIV

Dr Marc Biot, director of operations

"In the 1990s, we saw a lot of patients dying of AIDS in hospitals. MSF developed new models of care that enabled the treatment of patients in low-resource settings and brought down the mortality of HIV. But today, nearly a million people still die every year of HIV-related diseases. We need to continue developing new models and we need to implement these in more places in order to save more people's lives."

3. PAEDIATRICS: PAYING MORE ATTENTION TO CHRONIC DISEASES

Dr Kemi Ogundipe, paediatrician

"Most of MSF's patients are children with acute illnesses. But many of these children also have chronic conditions and we often overlook these, as they're not the reason why the children are in our health facilities. We want to pay more attention to these conditions – such as asthma, sickle cell disease and epilepsy – because we know that doing so can prevent suffering and deaths."

4. DISEASE OUTBREAKS: IMPROVING COMMUNITY ENGAGEMENT

Gabrielle Schittecatte, medical sociologist

"Time is of the essence when containing outbreaks of infectious diseases. MSF is very good at being very fast in responding to outbreaks, but sometimes we're a bit too fast and we forget to listen to the people we're helping. Being better at engaging with the communities affected by epidemics will make our responses more impactful."

5. MATERNAL HEALTHCARE: FAMILY PLANNING TO SAVE MOTHERS AND CHILDREN

Dr Severine Caluwaerts, gynaecologist

"Medical assistance during childbirth saves a lot of lives, of both mothers and children. But there's another important way to save lives: family planning. By avoiding unplanned pregnancies, we can avoid a lot of death and suffering – not only for women, but also for their children. MSF wants to expand family planning services to more of our projects."

NIGERIA

Medical assistance urgently needed in areas outside government control

A man chops firewood in camp for displaced people in Bama. Photograph © Scott Hamilton/ MSF

We ask Guillaume Baret, head of MSF's operations in Nigeria and Niger, how MSF is managing to provide medical care in troubled northeast Nigeria.

Northeast Nigeria has been in a state of conflict for more than a decade. How are local people coping?

"Armed groups have strengthened their hold over many rural areas, but people continue to live in these places – the UN estimates that 1.2 million people live in non-government-controlled areas where essential services are lacking and healthcare is non-existent.

Malaria and malnutrition are among the main causes of death among young children, while epidemics are regular occurrences.

Since 2017, MSF has provided medical care in northeast Nigeria during outbreaks of meningitis, hepatitis E, cholera and measles. The number of patients we treat in government-controlled areas make us fear for the health of people in rural areas not controlled by the army."

Why is it so difficult to reach areas not controlled by the government?

"The main obstacle is the insecurity resulting from the presence of militants. In 2018, the Islamic State in West Africa Province (ISWAP) group started attacking humanitarian organisations. It murdered two midwives working for the International Committee of the Red Cross (ICRC), and in July 2019 it kidnapped six members of Action contre La Faim (ACF); one was executed in September and four others in December.

During an attack in early 2019, armed groups stole MSF's supplies of drugs and medical equipment intended for displaced people.

This means we have to be extremely prudent."

Despite the challenges, can solutions be found to provide aid in 'inaccessible' areas?

"For almost two years, we've provided medical care in northeast Yobe state, using mobile teams and an extensive network of community health workers trained to treat malaria, malnutrition and diarrhoea.

In that time, our teams have provided over 140,000 consultations and admitted 3,400 people for inpatient care at Maïné Soroa hospital, over the border in Niger. Our community health workers have treated 24,800 people with malaria and 2,700 children with severe malnutrition.

These experiences give us reason to believe that alternative ways of operating can be found and that it's possible to provide medical care to people living in these areas."

Photograph © MSF

SOMALIA
MSF medical team members carry supplies in Beledweyen town, central Somalia, where 270,000 people have been displaced by flooding.
msf.org.uk/somalia

Photograph © Nicola Flamigni

SOUTH SUDAN
MSF staff travel by boat to run a mobile clinic in Wechnyaath, South Sudan, an area badly affected by floods.
msf.org.uk/south-sudan

Photograph © MSF/Pierre-Yves Bernard

CAMEROON
A young burns patient plays with a balloon made out of a surgical glove while waiting to go into the operating theatre at Maroua regional hospital, where MSF provides 24-hour emergency care.
msf.org.uk/cameroon

Photograph © MSF

CENTRAL AFRICAN REPUBLIC
A child stands next to an MSF vehicle in Kaboro, Ouham province. Malaria is the main killer in this region, with 85 per cent of patients treated by MSF in 2019 suffering from the disease. Seeing a doctor can be a huge challenge in this remote region, with patients often walking long distances to reach medical care.
msf.org.uk/car

Photograph © Alexis Huguet

DEMOCRATIC REPUBLIC OF CONGO
Scholastique Odjako Bhayo leaves MSF's measles unit at Biringi hospital with her baby Avaga Roma, who has recovered from the disease. The current measles epidemic in DRC is the world's largest and has caused 5,600 deaths. From January 2018 to October 2019, MSF teams treated 46,870 measles patients and vaccinated 1,461,550 children against the disease.
msf.org.uk/drc

New pneumonia vaccine offers affordable protection against number one childhood killer

MSF welcomes the news that the World Health Organization (WHO) has just quality-assured a third pneumococcal conjugate vaccine (PCV), manufactured by the Serum Institute of India. This vaccine will protect children against certain types of pneumonia and will be more affordable than existing vaccines.

"This is a monumental day for kids around the world and the governments that are trying to protect them from life-threatening pneumonia," says Kate Elder, MSF vaccines policy advisor. "A more affordable pneumonia vaccine is a gamechanger in protecting more children against the world's number one childhood killer."

PROFITS OVER PEOPLE

For nearly 20 years, pharmaceutical corporations Pfizer and GlaxoSmithKline (GSK) have maintained a duopoly on the vaccine that has allowed them to keep prices high.

There is little transparency on the prices charged by Pfizer and GSK, as the corporations take great lengths to keep prices secret. The result of high prices is that governments cannot afford the vaccine, and children are left unprotected against pneumonia.

Today, 55 million children around the world have no access to the pneumonia vaccine, largely due to high prices.

BREAKING THE STRANGLEHOLD

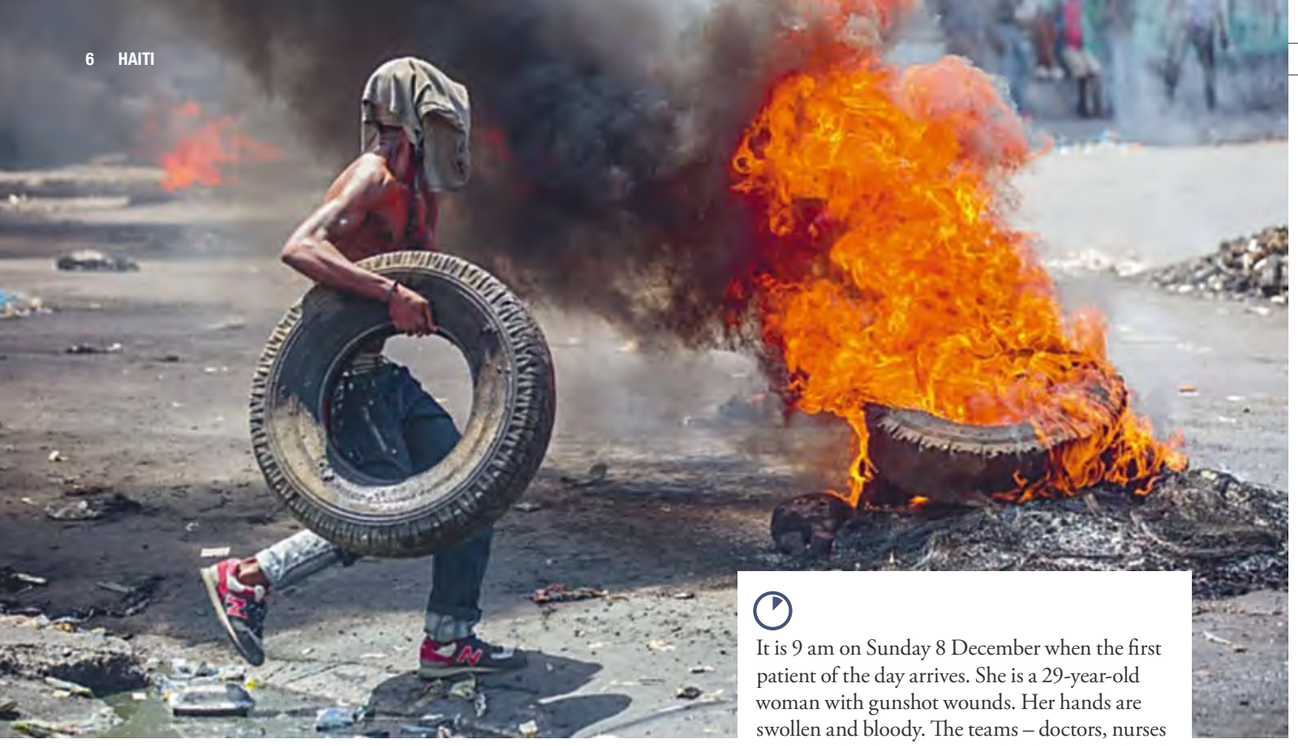
The Serum Institute of India says it plans to sell the vaccine for about £4.50 per child to the poorest countries, and for no more than £8.50 to middle-income countries, significantly less than Pfizer and GSK's products.

"We expect the Serum Institute of India to extend the lowest global price for its new pneumonia vaccine to all humanitarian organisations," says Elder.

Find out more msf.org.uk/access-medicines

MALAWI
Moses Luhanga, MSF's information manager in Nsanje district hospital, gives patient Manfred a high five. In Nsanje district, MSF and the Ministry of Health have set up a new community-based model, the 'circle of care', to improve care for people with advanced HIV. Malawi has long struggled with a high prevalence of HIV, with an estimated 13,000 AIDS-related deaths a year.
msf.org.uk/malawi

Photograph © Isabel Corthier/MSF



Haiti ten years on

Ten years ago, a catastrophic earthquake devastated Haiti, killing thousands, displacing millions and destroying 60 per cent of the country's dysfunctional health system. In response, MSF mounted its largest-ever emergency operation, treating more than 350,000 people in ten months.

A decade on, the country's medical system is once again on the brink of collapse. An escalating political and economic crisis, sparked by fuel price rises, has resulted in months of demonstrations, closures and unprecedented levels of violence.

In response, MSF has opened new clinics, including a 50-bed trauma centre in the Tabarre neighbourhood of Port-au-Prince. In its first five weeks, the trauma centre received 574 patients. This is the account of one day in the life of this vital facility.

574
wounded people were brought to MSF's trauma centre in its first five weeks

It is 9 am on Sunday 8 December when the first patient of the day arrives. She is a 29-year-old woman with gunshot wounds. Her hands are swollen and bloody. The teams – doctors, nurses and stretcher-bearers – attend to her immediately. "Bandits ordered her to put her hands together before shooting her twice," a nurse says. The X-ray reveals a double fracture to each hand.

"We knew we would be meeting a need here," says Jean-Fabrice Pietri, MSF project coordinator, "but obviously the situation is even worse than we imagined, so we we're having to adapt faster than anticipated." In its first three weeks, more than 250 people were triaged at the trauma centre and more than 100 were admitted for inpatient care. The staff added beds quickly to cope with the high number of admissions.

Jean-Baptiste, the second patient of the day, was injured in a motorcycle accident. He was struck by the moving vehicle and dragged along the road for several metres. He has a severe open fracture to the right tibia, burns on his hands and has lost a lot of blood.

Above: A protester blocks a street with burning tyres during a demonstration in Port-au-Prince on 13 June 2019. Photograph © Jeanty Junior Augustin/MSF

Right: MSF's surgical team operate on Jean-Baptiste's leg in the operating theatre at Tabarre. Photograph © Leonora Baumann

Once stabilised and his leg X-rayed, Jean-Baptiste is taken to the operating theatre. "He had an extensive wound on the anterior side of the lower leg," says orthopaedic surgeon Thomas Schaefer. "There's an underlying open tibia fracture, and so you have skin, fascia, muscle and bone altogether on view, which makes this a very extensive case of an open fracture."

An external fixator is fitted to hold the broken bone in place. This will be followed in the coming weeks by skin grafts and a long period of inpatient care. As Jean-Baptiste's nerves and arteries are largely intact, the team are hopeful that his leg will heal.

Clotilde, 52, was hit in the right leg by a stray bullet during a clash between rival gangs. She went first to MSF's emergency and stabilisation centre in Martissant before being transferred to the trauma centre in Tabarre. Unfortunately, the bullet hit major blood vessels and the team could not save her leg, which had to be amputated. Gunshot wounds account for more than half of admissions to the trauma centre.

Jameson, 28, arrives at 11 am, in shock and with a large wound to his left shoulder. He was attacked while playing dominoes with friends and suffered multiple stab wounds.

"The path that the weapon took in his body needs to be explored," says Thierry Binda, the medical activity manager. "We don't know the weapon and we don't know the trajectory or the depth of the wounds."

Jameson's X-ray reveals there is no lung damage; after treatment and two days of inpatient care, he is able to return home.

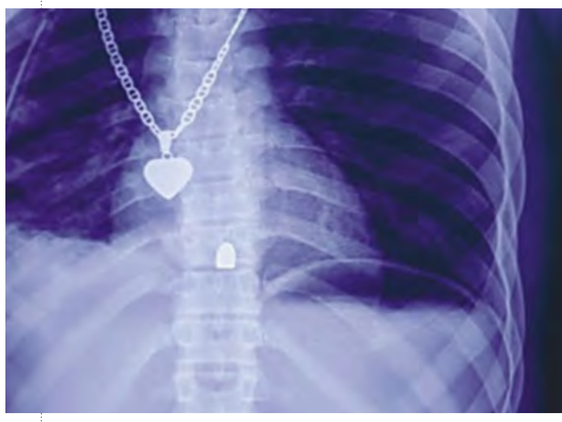
60%
of the country's dysfunctional health system was destroyed by the earthquake ten years ago

Other patients require extensive surgery. A 26-year-old man arrives at the hospital at 1 pm. He has been shot. During the clinical examination, the doctor notes an entry wound to the abdomen without an exit wound.

The patient is conscious but cannot move his legs. The MSF team insert a chest tube to avoid complications related to ongoing bleeding, then perform an X-ray and a laparotomy to determine how much damage the bullet has caused.

The operation shows no damage to the vital organs – the bullet narrowly missed his liver. However, radiography confirms that the bullet is lodged in the patient's spine.

"There is potential damage to the abdominal muscles," says anaesthetist Elsa Carise. "He will require constant monitoring and medical attention."



"We receive many cases of gunshot wounds to the chest and abdomen," says Katherine Holte, MSF surgeon. "But the team have been able to save the lives of many patients."

Above: Clotilde, 52, recovers from surgery to amputate her leg after she was hit by a stray bullet. Photograph © Leonora Baumann

Top: Surgical staff treat a gunshot victim in the emergency room of MSF's trauma centre in Tabarre. Photograph © Nicolas Guyonnet/MSF

Inset right: An X-ray of the 26-year-old man shows a bullet lodged in his spine. Photograph © Nicolas Guyonnet/MSF

Find out more

Find out more msf.org.uk/haiti

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‘Luckily, our care is free’

MSF often hits the headlines when an emergency breaks in the news, such as a natural disaster or a war. But a lot of our day-to-day work entails providing emergency healthcare in little-known places such as Bujumbura, Burundi. Here, anaesthetist **Kariantti Kallio** takes us inside MSF’s L’Arche de Kigobe trauma hospital.

“There is a true gem in Africa that not too many people know about – Burundi. Hidden between the greenest misty hills and the great Lake Tanganyika, it’s a stunning sight as you fly over it.

The air is fresh and there’s often a nice breeze coming from the lake. It’s full of kind people, interesting cultures and very cool drum music.

And last year, Burundi’s national football team qualified for the Africa Cup of Nations for the first time in nearly 50 years!

But the gem isn’t without problems – which is also something not many people are aware of.

In 2015, Burundi witnessed an increase in tensions and violence, especially in the country’s biggest city, Bujumbura. And although things have calmed down a lot since then, the political tensions are far from over.

TREATING VICTIMS OF TRAUMA

In the summer of 2015, MSF opened a trauma hospital, L’Arche de Kigobe, in Bujumbura in response to the rising violence.

Almost five years later, there is still a great need here for a trauma hospital that provides free emergency care.

Most of our patients are victims of traffic and domestic accidents, as well as burns, gunshots and other violent wounds.

DAY ONE

On arrival, I am taken to the MSF office, only to find a good friend of mine from my previous mission in Central African Republic – a Congolese man called Jacques – sitting behind the desk of the HR coordinator.

What a lucky coincidence! We’re off to a good start already.

FIRST IMPRESSIONS

Next day I head to the hospital.

I find a well-functioning trauma hospital (although squeezed into somewhat small surroundings) run by a very competent and nice group of Burundian and international staff, including nurses, surgeons, doctors, orthopaedic surgeons, anaesthetists, psychologists and physiotherapists.

The first week is rather slow, which is good as the other anaesthetist, Jerome, is on a training course in Brussels. However, as soon as my predecessor, Morten has left, things start to speed up…

EMERGENCY SURGERY

On Saturday morning, we receive a nine-year-old boy who has been hit by a car. He has bleeding in his abdomen and is in a state of shock, with tachycardia (a very high heart rate) and low blood pressure.

Top: Newborn twins born by emergency caesarean are held by their mother Josepha Habonimama (right) and grandmother Valerie at MSF’s hospital in Kabezi. Photograph © Sarah Elliott

Above: A pregnant woman with complications is taken to hospital by ambulance, cared for by MSF nurse Jeannie Marie Nzeyimama. Photograph © Sarah Elliott

Left: MSF nurse Mbalo Saddock visits a patient at home in Kabezi town. Photograph © Sarah Elliott

We find over half a litre of blood inside his abdomen and he has a ruptured spleen, which the surgeon removes.

EFFICIENCY IN ACTION

Luckily, we have blood for the boy in our blood bank, which we transfuse to him during the operation.

As his condition starts to stabilise, I am reminded of how much I like whole blood (compared to the various blood ‘components’ that we use back home) and I am impressed at how fast the surgeons here work. In fact the level of competence displayed by everyone in the team is really impressive.

After the surgery, we transfer the boy to the intensive care unit for further surveillance.

PARLEZ-VOUS FRANÇAIS?

Now I just have to manage all the patients until tomorrow when Jerome, the other anaesthetist, returns.

Did I mention this project is French-speaking, too? And no, I still don’t really speak it well.

Great! Luckily, everybody’s very understanding.

BACK IN BUSINESS

Jerome returns and we are back in business. With two new admissions to the intensive care unit and a full operating theatre list, we’ve got our hands full.

The previous night, the emergency doctor admitted a 35-year-old man to the intensive care unit with multiple trauma injuries, including a fractured femur and severe brain trauma. During the day we monitor his condition in the intensive care unit. He is sleepy but conscious from time to time, though very confused.

We’re having a hard time finding and contacting his relatives. The search goes on and for the time being we continue to monitor him.

THE LITTLE BOY WITH NO SPLEEN

The nine-year-old boy with the ruptured spleen is recovering well from his big operation.

After two days, we are able to transfer him to a normal ward for further recovery.

He will need some vaccinations in the future as he’s now without a spleen, but he’s alive and that’s something – actually, that’s a lot.

Something to remember for the bad days.

BUSINESS AS USUAL

In the operating theatre, it’s business as usual. Our days are filled with trauma patients, both minor and major.

We do a lot of external fixations to different fractures and we clean wounds on a daily basis.

When needed, we also do visceral surgery, which involves the internal organs. And skin grafts, of course, for the numerous burns victims we receive.

The team works very hard and we all take the work very seriously. It feels easy to join such a well-functioning team.

Above: Kariantti at work in L’Arche de Kigobe trauma hospital. Photograph © MSF

A NEW PERSPECTIVE

During the week, things slow down a bit, but we still have a lot of patients in the hospital. Looking at the number of patients in the wards and emergency and outpatient departments, I keep wondering whether we haven’t already treated half of the city! And more people keep coming every day.

It’s nice to see that MSF projects can treat more than just gunshot victims, as in some of my previous placements with MSF.

It’s also encouraging to witness how evolved orthopaedics and traumatology is here, and how hard the staff work to ensure that the quality of care is of the highest standard.

I guess that’s a story you don’t always hear from this part of the world.

The biggest problem is that people in Burundi seldom have the money to get the best possible care. Luckily, our care is free.”

Find out more

Find out more **blogs.msf.org/bloggers/kariantti-kallio**

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After the genocide

Emergency doctor **Kate Goulding** managed the emergency room and paediatric ward of Sinuni general hospital in Sinjar district, Iraq. She was quickly confronted with a large-scale mental health emergency among the Yazidi survivors of Islamic State rule.

"People rarely talk about what happened to them or the things they saw on 3 August 2014 – the day that the Islamic State group took control of many towns and villages around Mount Sinjar in Iraq. Five years later, everyone here carries around with them a deep-seated grief about what the Yazidis often refer to as their '74th genocide'.

The first mental health assessment I did in Sinuni, a town on the north side of Mount Sinjar, was for a 24-year-old man I will call Wisam. Brought to us by his brother, he showed symptoms of severe depression. During our first meeting, he told me about his stress, his headaches, his stomach pains, his loss of appetite, his difficulty sleeping and his nightmares, and he detailed the constellation of depressive symptoms that made his daily life so dreadfully difficult.

Wisam had seen people killed and been forced to kill. He was having thoughts of killing himself, and often others too. Recently he had pulled out a knife during a family argument. This would be alarming coming from any patient, anywhere in the world, but the part of Wisam's story that disturbed my sleep for days was that he was a soldier and had access to guns every day at work – guns he imagined using to kill himself and others.

THE UNCOMFORTABLE GREY

Mental health patients can be divided into three categories: those who can go home and have their mental health managed as outpatients; those who clearly need to stay in hospital to avoid harm to themselves and others; and those in the uncomfortable grey area in between. Wisam was grey. He needed to be started on antidepressants, but these can sometimes make the symptoms of depression worse and heighten the risk of suicide in the first days and weeks before they start helping the patient improve.

Usually a patient like Wisam, so clearly in the grey, would be handled by a team of psychiatric experts. If the situation was serious enough, he might even be kept in hospital against his will in order to keep him safe. In Iraq, however, there are no legal grounds for medical staff to keep severely ill patients in hospital against their will in an attempt to protect them from harm.

With no psychiatrists in the district, the uncomfortable decision about what to do rested with me.

I asked Wisam if he would agree to be admitted to the emergency room for a couple of days while he started his medication. He refused. The best I could do was to start him on medication while asking his employers to let him take a week off work. My letter read like a note from a parent to a schoolteacher, begging to keep Wisam and his angry, impulsive thoughts away from all the guns in Sinjar.

Unfortunately, Wisam's story is not uncommon; there are many of my politely worded schoolteacher letters floating around Sinjar – in many cases, to keep suicidal people away from weapons.

FEW WILL SPEAK

When we talk about the things that cause people stress, very few will speak about the genocide. However, a common theme in mental health consultations is the friends and family a patient has lost.

Universally, the sudden loss or disappearance of a loved one is a clear trigger for mental health struggles, with or without the associated trauma of conflict. What struck me in Sinuni was that in many ways they struggle with the same problems as any of us. It is universal to be sad when your husband dies, when your child is sick, when you break up with your partner, when you are separated from your family. Often these are the events that trigger exacerbations in their mental illnesses and bring them to us.

'This community has been the warmest and most welcoming group of people I have ever had the pleasure of knowing.'

The few things I have heard about the genocide have come from the staff I work with. Stories of panic when Islamic State militants came to their doors at night and took their money, phones and other belongings; the relief they felt as they managed to escape with their mothers and sisters; the drive out of town with so many people crushed into the car that the doors wouldn't close; how they felt in the following days as they hid in the valleys around Mount Sinjar.

THEIR DEDICATION IS INSPIRING

This community – especially the doctors, nurses and other MSF staff I work with here in Sinuni – has been the warmest and most welcoming group of people I have ever had the pleasure of knowing. Most days, happiness and hope radiate from their faces. And yet, occasionally, clouds pass over their faces from the storms in their minds.

My colleagues return to their families in Kurdistan whenever they are not working. Most of their families live in camps, for now and for the foreseeable future, and have no plans to return. As the main breadwinners my colleagues are under huge financial pressure.

They speak often of the sadness of being separated from family members who fled to Germany, and of the friends and relatives whom they suspect they will never see again. They wonder whether things in Sinjar will ever return to how they were before and whether people will ever come back. But always, they speak of their professional responsibility to care for their community and those who were previously a threat to them. Their dedication is inspiring. They are the driving force behind MSF's work here."

Above: An Iraqi girl looks at a health pamphlet while her mother queues to see an MSF doctor in Bir Jary, near the Iraqi-Syrian border. Photograph © Emilienne Malfatto

Below: Dr Kate Goulding and team assist a patient at Sinuni general hospital. Photograph © Gregory Kenzo Saito/ MSF

Top: A young woman has her blood pressure checked by an MSF nurse in Bir Jary, near the Iraqi-Syrian border. Photograph © Emilienne Malfatto

Left: A mother cares for her newborn baby in the maternity ward at Sinuni general hospital. Photograph © Emilienne Malfatto

Find out more

Find out more **msf.org.uk/iraq**

A year in pictures

In 2019, MSF teams around the globe provided medical care in some of the world's worst crises. From war in Yemen and flooding in South Sudan to the Ebola epidemic and the devastation of Cyclone Idai, our staff have been on the frontline of saving lives throughout a turbulent year. In all these emergencies, photographers have been there to capture moments and bear witness to the suffering and strength of people caught up in these crises. Here, we remember and pay tribute to those who have struggled, those who have persevered and those who have perished. Thank you for your support.

SOUTH SUDAN

MSF nurse Bárbara García and Nyamach play with a balloon made from a surgical glove in MSF's hospital in Ulang. April 2019.
Photograph © Igor Barbero/MSF

YEMEN

A girl carries her younger brother through a camp for displaced people in Abs district, after renewed fighting along a frontline. April 2019.
Photograph © Al Hareth Al Maqaleh/MSF

INDIA

Dr Vishwas Reddy treats Karam Laccha, who walked 10 km from his home in Telangana state to find medical care. October 2019.
Photograph © Tadeu Andre/MSF

TANZANIA

An MSF health worker hands a mother her newborn baby after taking them from hospital to Nduta refugee camp. November 2019.
Photograph © Pierre-Yves Bernard/MSF

MEXICO

Ana, a woman from Guerrero, one of Mexico's most violent states, chooses to hide her face as she describes the devastation wrought on her village by fighting between rival armed groups. February 2019.
Photograph © Juan Carlos Tomasi

HONDURAS

MSF health promoters go door-to-door in Nueva Capital, a neighbourhood on the outskirts of Tegucigalpa, to spread the word about MSF's medical services which include care for victims of violence. February 2019.
Photograph © Christina Simons/MSF

NIGERIA

A water and sanitation team visits the village of Ndiovu to disinfect the house of a local resident after they were diagnosed with Lassa fever. May 2019.
Photograph © Christina Simons/MSF

MOZAMBIQUE

A boat loaded with MSF supplies sets off for Chibuabuabua in the aftermath of Cyclone Idai. April 2019.
Photograph © Giuseppe La Rosa/MSF

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From watchman to engineer

Samuel Abuvu Paul, 24, started working as a watchman for MSF in Mundri, South Sudan, in May 2017. As in many places across South Sudan, young, bright, dedicated students in Mundri had their schooling interrupted when armed conflict forced them to flee for their lives.

To give these former students a chance to make up for missed educational opportunities and to further their professional development, MSF is awarding study grants to its South Sudanese staff. Known as STONE grants – or Support for Training Of National Expertise – they are funded by former international MSF staff members.

Samuel is one of eight South Sudanese recipients of the grant this year. The scholarship will allow him to study engineering at the International University of East Africa, in Uganda.

Growing up, Samuel Abuvu Paul loved riding his brother's bicycle. He'd weave between the shelters in the camp for displaced people outside Mundri until, inevitably, the gears would freeze up or something else on the bike would break.

"If I told my brother, he would beat me up," says Samuel. "So I stayed very, very quiet."

Instead, Samuel taught himself how to fix the bike.

Samuel asked his father: "When something breaks and you want to repair it, what do you study?" His father replied: "That's engineering."

Thanks to Samuel's clever repair work, his brother would return to find his bicycle just as he'd left it, and so began Samuel's quest to become an engineer.

"My father is a pastor – he has nothing to give to me because he doesn't have money," says Samuel. "But I love my father because he's always advising me to study."

Above: Two MSF Land Cruisers carry teams to a remote area of Mundri to run a clinic. Photograph © Tom Casey/MSF

Right: MSF midwife Anna monitors two-day-old baby Jacob, watched over by his mother, in the emergency room in Mundri. Photograph © Lauren King/MSF

HIDING IN THE BUSH

Pursuing his dream to study was no simple task. Because of the conflict, Samuel had to flee his home multiple times, moving from the town to the camp and back again, and hiding in the bush when fighting drew near. "There is a proverb in our language that goes: 'When elephants are fighting, grass is the one suffering'," says Samuel. "I suffered a lot in the bush."

Whenever Samuel was able to attend school, he always came top of the class. Even after joining MSF as a watchman in 2017, his dream of further study never faltered.

"When you speak to Samuel you can clearly see his passion for learning," says MSF project coordinator Jacob Kuehn.

Last year, Samuel applied for a STONE grant to study engineering, and in August learnt he had been successful. The grant will cover 90 percent of his university tuition in neighbouring Uganda.

'MSF IS NOTHING WITHOUT LOCAL STAFF'

Albertien van der Veen and Riejkje Elema set up the STONE scholarship after seeing a gap in educational opportunities for non-medical staff. Both Albertien and Riejkje had years of experience with MSF and firmly believed that developing the capacity of locally hired staff was crucial to MSF's operations and complementary to our work. "Everybody at MSF knows we are nowhere without our local staff," says Albertien.

'There is a proverb in our language that goes: "When elephants are fighting, grass is the one suffering". I suffered a lot in the bush.'

The scholarship fund seeks out people like Samuel whose intellectual passions may not fit squarely within MSF operations, yet who are committed to bettering their skills and capacities, which will in turn benefit their communities. The grant comes with no obligation to continue working for MSF.

"What is most striking about Samuel's focus," says Kuehn, "is the fact that he wishes to pursue engineering not for the money or the prestige from a career in that field, but rather for the skills that will enable him to give back to his community. His long-term goal is to start his own business in South Sudan and provide jobs so that local families can have a decent, healthy standard of living – truly the type of altruism that is aligned with MSF's core values."

Samuel has now begun his studies in Uganda. "I feel so much joy and happiness in my heart because I'm studying," he says. "In the future, I think I will do something great for my community."

Find out more

msf.org.uk/south-sudan

MSF's UK volunteers

Afghanistan Marielle Connan, *Project coordinator*; Jacklyne Scarbolo, *Midwife*

Bangladesh Mansur Abdulahi, *Water and sanitation expert*; Owen Bicknell, *Water and sanitation expert*; Oswald Tebit, *Logistician*; Mylene Appere, *Midwife*; Jennifer Benson, *Pharmacist*; Daniella Ritzau-Reid, *Communications manager*; Hanadi Katerji, *Nurse*; Rachel Folwell, *Doctor*

Central African Republic Jillienne Powis, *HR administrator*; Eve Robinson, *Epidemiologist*; Benjamin Hargreaves, *Logistician*

Chad Jean Marie Vianney Majoro, *Logistician*; Nicodeme Zirora, *Finance coordinator*

Democratic Republic of Congo Conor Moran, *Doctor*; Mark Blackford, *Finance coordinator*; Kate Nolan, *Emergency coordinator*; Liana Kemp, *Midwife*; Emi Alicia Takahashi Bensusan, *Epidemiologist*; Marc Wilkinson, *Pharmacist*; Harriet Zych, *Nurse*; Hannah Thompson, *Midwife*

Ethiopia Pranathi Ramachandra, *Psychiatrist*

Guinea Arnaud Badinier, *Head of mission*

India Lakshmi Jain, *Doctor*; Sarah Elizabeth Leahy, *Project coordinator*

Iraq Laura Williams, *Nurse*; Alex Dunne, *Humanitarian affairs officer*

Jordan Vittorio Oppizzi, *Head of mission*; Rowena Neville, *Doctor*

Kenya Dana Krause, *Head of mission*

Lebanon Laura Gregoire Rinchey, *Doctor*; Declan Barry, *Doctor*; Elizabeth Ashford, *Doctor*

Libya Hannah Wallace Bowman, *Communications manager*; Ghita Benjelloun, *Project coordinator*; Miriam Willis, *Logistician*

Mozambique Olga Ascurra Tarrillo, *Doctor*

Nigeria Andrew Mews, *Head of mission*; Mohammad Sesay, *Humanitarian affairs officer*; Christopher Hook, *Doctor*; Gabriella Gray, *Logistician*; Nijole Kymelyte Slapsinskaite, *Nurse*

Pakistan Aine Lynch, *Project coordinator*

Palestinian Territories Helen Ottens-Patterson, *Head of mission*

Sierra Leone Elena Rossi, *Midwife*; Laura Holland, *Water and sanitation expert*; Geraldine Munn-Mace, *Nurse*; Sarah Cross, *Nurse*; Thomas Casey, *Communications manager*; Claire Kilbride, *Learning manager*

South Sudan Anna Zolkiewska, *Deputy head of mission*; Christopher Curry, *Doctor*; John Boase, *Logistician*; Jennifer Hulse, *Doctor*; Angela Cave, *Nurse*; Joshua Rosenstein, *Deputy head of mission*; Andrew Burger-Seed, *Project coordinator*; Sara Mary Cronin, *HR manager*; Olivia Butters, *Water and sanitation manager*

Syria Vivienne Monaghan, *Nurse*; Georgina Brown, *Medical coordinator*; Agnes Van Der Velde, *Logistician*

Ukraine Timothy Hammond, *Doctor*

Uzbekistan Oshani Dissanayake, *Doctor*

Venezuela Ana Teresa Saraiva Afonso, *Medical team leader*; James Kelly, *Logistician*; Carl Rendora, *Water and sanitation manager*; Dominic Naish, *Advocacy manager*

Yemen Amy Garrett, *Midwife*; Alison Criado-Perez, *Medical team leader*; Rebecca Marcussen-Lewis, *Midwife*

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‘I was the only midwife at our field hospital in Syria’

A woman expecting twins goes into early labour. In any situation this would cause concern, but in a conflict zone with limited equipment and resources, it’s a stark matter of life and death. **Amanda Godballe** is a Danish midwife who found herself fighting to save the lives of premature twins at a field hospital in Syria.

“I was the only midwife on duty on the day Fawzia came to the MSF field hospital in Syria. She was only six months pregnant but her labour had already begun. She was expecting her first babies – twin girls.

There was no way to stop labour as it was already too far advanced. Our field hospital was very basic. We had no paediatricians, no incubators and no medicine to treat babies this premature.

I was the only midwife at the hospital that day, so some creative thinking was required.

FIRST THINGS FIRST

First, I knew that the babies were likely to need resuscitation. It was vital to stabilise them so they could be transferred to a fully equipped hospital over the border where specialised treatment was available.

Norwegian midwife Mali Ebrahimi – Amanda’s colleague at the field hospital in Syria – holds up a beaming Sedra. Photograph © Mario Travaini

I called the nurse to help me in the delivery room. She had never assisted with a delivery before, but inexperienced hands are better than no hands! At the same time, I called another Syrian colleague over to help me and act as interpreter.

MAKING DO WITH AN ELECTRIC RADIATOR

Both children were born quickly. First Sedra – bottom first – and then her sister – also bottom first. They each weighed about 1,200 grams. Sedra stabilised quickly with the help of an oxygen mask and an electric radiator we had set up to help keep her warm.

Unfortunately, her sister did not do as well. Just 30 minutes after being born, she died.

If we wanted to save Sedra we had no time to waste. We quickly organised an MSF ambulance to take her and her mother to the border. When it arrived, we all climbed in to make the nerve-wrecking journey.

There I was, sat in the backseat next to this teeny-tiny, vulnerable human being, all the odds stacked against her. Would she make it?

HANDOVER ACROSS BARBED WIRE

We made it to the border, but then had to wait for what seemed like an eternity. Finally, the medics arrived and I was able to hand this small bundle across the barbed wire fence. We said our goodbyes quickly, crossed our fingers, then drove back to our makeshift hospital, hoping for the best.

Weeks went by with no news, and then it was time for me to leave Syria. I doubted I would ever find out what had happened to little Sedra.

Six months later, I was back home in Denmark. One night, the phone rang. It was one of my colleagues from the hospital in Syria. She was calling to tell me that not only had Sedra survived, but she was now a healthy and happy baby with beautiful big cheeks. The team sent me this picture.”

Names have been changed.

Find out more

Around the world, 7,000 newborn babies die every day. In this Year of the Midwife, MSF is more determined than ever to reduce the number of newborn deaths and increase women’s access to maternal healthcare.

msf.org.uk/maternal-health

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