DISPATCHES

‘When the fighting started, we hid in the house...’

Portrait of a conflict, pages 10-11

Karim has had surgery to remove six pieces of his skull that became lodged in his brain after his house in Syria was hit by an airstrike. *Photograph © Tom Barnes*

Autumn 2017
No 86

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

INSIDE

NIGERIA

Malnutrition crisis

Julia Hill recently returned from Maiduguri, northern Nigeria, where more than one million people are sheltering after fleeing the conflict involving militant group Boko Haram and the army.

"There's still a steady flow of people coming into Maiduguri from outlying areas. Although the city is one of the most stable areas in the region, the security situation remains volatile. The number of attacks in the city increased while I was there, with regular explosions and suicide bombings.

Big increase in numbers

I was project coordinator for MSF's therapeutic feeding centre in the southeast of the city. When I arrived, we were seeing about 40 children a day in the outpatient programme, and had about 30 children in the inpatient ward. Over the next seven weeks as we began to distribute food to families, the outpatient numbers grew to where we were often seeing more than 200 children daily. This was partly due to the 'hunger gap' [the season between harvests when food runs short] hitting earlier than expected, but it was also due to the fact that we were one of the few organisations treating five-to-10-year-olds and not just under-fives.

We had discovered that rates of malnutrition were higher in the older children than the younger ones. And yet this age-group was struggling to get treatment because few organisations were providing that care.

We immediately began to scale up. I spent a lot of time making sure we had enough staff and enough therapeutic food.

Supplies became the biggest challenge, as older children need more therapeutic food because they are bigger. The planned shipment was taking longer to reach us than expected. Every day we could see our supplies dwindling as the number of patients increased.

'The hardest thing I've had to do'

The days went on and the shipment still hadn't arrived. It came to the point where the medical team and I decided that we had to temporarily stop new admissions to the centre for the older children. That was the hardest thing I've ever had to do working for MSF.

We made the tough call and rapidly cut our consumption by about 70 percent. Those two weeks were very long, but then the shipment arrived and we scaled back up again.

A transformation

We found that a lot of kids started to improve fairly quickly – the programme was working! It was such a boost to walk through the inpatient ward every day. You'd see the kids as they progressed from the intensive care unit to the stabilisation area until they were ready to be discharged. It's wonderful seeing the transformation they undergo. The impact of the medical care they receive is so immediate."

msf.org.uk/nigeria

GREETINGS CARDS

Sending seasonal greetings cards to family and friends is a great way to support our emergency medical work and spread the word about MSF. We have a selection of designs, including photos of MSF teams at work in Zimbabwe and Democratic Republic of Congo, as well as two images donated by Delia Cardnell of the Royal Institute of Painters in Watercolours.

Cards come with envelopes in packs of 10 and cost £6.00 each; MSF receives 66% of the pack price. To place your order, visit **msf.org.uk/cards** or call Anne Farragher on **020 7067 4214**.

CAMEROON

A child looks out from her mother's arms after arriving in Minawao refugee camp. The family fled Nigeria when their village was attacked by militant group Boko Haram. *Photograph © Pierre-Yves Bernard/MSF*

CENTRAL AFRICAN REPUBLIC

During a vaccination campaign in Maloum, an MSF team member uses a megaphone to call on displaced people in the area to bring their children to be vaccinated against a range of common childhood diseases, which can be fatal if left untreated. *Photograph © Colin Delfosse/Out of Focus*

YEMEN

Cholera outbreak

Yemen is in the midst of a cholera outbreak, with an estimated 463,000 cases and 1,940 deaths reported by early August.

Poor levels of sanitation and a lack of safe drinking water have increased the spread of the disease, while the ongoing conflict has made it difficult for people to get to medical facilities for treatment.

"Our teams are seeing an extremely poor sanitation situation and insufficient access to clean drinking water," says Gabriel Sánchez, MSF programme manager for Yemen. "This is clearly a main factor in the spread of the current outbreak. Water and sanitation was an issue even before the cholera outbreak, but it is especially concerning now. Either we act now or we will face an even bigger humanitarian crisis in the weeks and months ahead."

MSF is operating 18 cholera treatment centres and units throughout the country, and treated 82,000 cases of cholera and acute watery diarrhoea between 30 March and 8 August.

msf.org.uk/yemen

Kariantti Kallios is a Finnish anaesthetist who was working in Yemen in April this year.

Day 6

"There is a little bit of tension in the streets today. We've been asked by our project coordinator, Claire, to move only by MSF car between the base and the hospital. Normally it's safe to walk. You can see there are fewer people in the streets.

Most of the patients in the hospital are doing better. We only have one patient in the intensive care unit (ICU) – a 10-year old boy, who was operated on elsewhere a month ago due to an abdominal gunshot wound.

His bowel was no longer working and he had been vomiting everything he ate. We operated on him last night and found

MSF logisticians set up a cholera treatment centre in Khamer when the disease broke out in March 2017. *Photograph © Malak Shaher/MSF*

that his stomach was full of adhesions [bands of fibrous tissue], possibly because of a previous post-operative peritonitis [inflammation of the stomach lining]. We had to leave him with a stoma [an opening on the surface of the abdomen], which the surgeons will close at a later stage.

Today he is already doing better and recovering from the big operation. So we have another bed free in the ICU – which is good, because of the rising tensions in the town.

Day 9

Things have started to speed up in the past couple of days, with the flow of patients into the hospital steadily increasing.

Yesterday, as we were performing a C-section on a mother with severe pre-eclampsia, the surgeon told us about a 40-year-old woman with a gunshot wound to the abdomen, who needed an immediate operation.

We took her quickly to the other operating theatre. Thankfully, the bullet had missed her more vital organs and she was hemodynamically stable.

Two-year-old gunshot patient

Suddenly, we seem to be drowning in trauma patients. In the evening, we received two more patients with gunshot wounds. One – a five-year-old girl – had superficial injuries. The other – her two-year-old sister, who had been shot in the abdomen – was critical.

There were multiple perforations in her bowel, so Dr Ali, the surgeon, could only perform damage-control surgery. She needed observation and treatment in the ICU, which was once again full.

Luckily the new mother with pre-eclampsia and her baby were both doing well, so we could move her to the maternity ward to get a much-needed bed. Two days after stabilising her, the surgeons made her a stoma.

Cholera outbreak

We are not the only ones with logistical problems. It seems we have an emerging cholera outbreak on our hands.

Two days ago, one patient with cholera was admitted to the isolation ward. Yesterday there were six and today 16.

The outbreak is quickly turning into an epidemic, and the isolation ward is already full. The hospital administrator, along with our project coordinator, Claire, our medical activity manager, Dr Yanu, and our head nurse, Dorothy, are planning strategies. They have already set up a cholera treatment centre in the hospital yard.

However, this still only gives us 15 more beds for cholera patients, so we have had to refer some of the patients to other cholera treatment centres.

We will just have to wait and see how things develop..."

CAMBODIA

Din Savorn is given a shot of a new and improved hepatitis C medicine, known as direct-acting antivirals, at MSF's clinic in the capital, Phnom Penh. *Photograph © Todd Brown/MSF*

UGANDA

South Sudanese children play in northern Uganda's Bibibidi refugee camp. Uganda is hosting almost one million refugees who have fled fighting in neighbouring South Sudan. MSF teams have launched an emergency response to provide the refugees with medical care and clean water. *Photograph © Frederic Noy/COSMOS*

Frontline medicine

Dr Ken and his team examine a patient who was brought into MSF's surgical unit near Mosul after being injured . *Photograph © Alice Martins/MSF*

The city of Mosul has recently been retaken by Iraqi forces after a battle lasting nine months. At the height of the fighting, Dr Ken Lo worked in MSF's emergency surgical unit a few kilometres from the frontline

"There is only one road south of west Mosul. It is the only route out of this part of the city, where the battle between Islamic State (IS) and Iraqi coalition forces raged from October 2016 to the end of June. Every day, hundreds of people used this road to escape the daily airstrikes, sniper attacks and mortar blasts that plagued the city. The road was a lifeline for people fleeing the frontlines of Iraq's terrible conflict.

MSF is running an emergency surgical unit about 10 km down this road, halfway between Mosul and the next town. During the fighting, it was so close to the frontline that we could hear the ongoing battle – the daily booms of mortar blasts, gunships circling overhead and the crackle of gunfire. We provided the first medical care that patients received after they escaped the city. When I arrived in February, MSF was the only organisation working in the area.

Mass casualty situations

I was running the emergency room. Every day I treated the victims of this violent war. Nearly all of them were civilians, and far too many were young children. Mass casualty situations – when 10 or more injured people arrive at once – were commonplace. In one month we had a total of 30. That's one every day.

On one occasion, a shell hit a queue of civilians waiting for food distributions. Most of the injured were children. As people tried to run away, they were shot by snipers. Our hospital was filled with patients with blast wounds and people with single gunshots to the back.

The toughest day

We treated 1,500 patients in my first month. On one occasion, I opened the back of an ambulance to find 16 people crammed inside. Some were incredibly

A father kisses his 10-year-old daughter, wounded in the le
Photograph © Alice Martins/MSF

A patient is kept warm with a reflective blanket before having surgery.
Photograph © Alice Martins

sick; others had already died. In the middle of the chaos you have no choice but to focus on and treat those most in need.

Everything was a blur. I was running from patient to patient, trying desperately to stabilise them. Four people were dying in front of me. There were only two surgeons and two operating theatres. And we were running out of blood. The nearest other facility – another MSF hospital – was several hours' drive away.

Who do you save?

So, who do you choose to save? The 10-year-old boy with multiple gunshot wounds who probably won't make it, or the old man with a single gunshot wound who might survive?

That was a tough, tough day. I remember pacing around those patients, trying to decide how much blood to use, who might survive a transfer to the nearest hospital, and who could wait until a space become available in the operating theatre.

So many people ask me what it's like to work for MSF, and part of it means making these tough choices. As a doctor, these split-second decisions can be the difference between life and death. Luckily, on this occasion, all four of my patients survived.

'I know these people'

The Iraqi staff are awe-inspiring. It's not uncommon for them to be caring for their neighbours, their friends or their family. Often patients will be brought in, and they'll say, 'I know these people'.

You cope because you have colleagues around you and you talk about it. Your humour becomes darker and darker until, by the time you leave, it's quite shocking.

You work so closely together and you live almost on top of each other. We were sleeping in the MSF office – there were six of us to a room, on bunkbeds and on the floor. We were eating on the landing and cooking in a bathroom.

Just a little bomb

Your sense of normality gets warped. I remember one evening our field coordinator asked me, 'Is it a busy night tonight?' and I said, 'No – just a little bomb; no one died tonight; only a few people with chest drains and gunshot wounds…' Obviously if that happened in London, the whole city would get shut down. Working in west Mosul, normal is not normal.

It was unnerving to hear the battle going on so close by. But at no point did I ever think, 'What am I doing here?' Every day in west Mosul the need was painfully obvious. We were meant to be there and people wanted us there, they needed us there."

eg and abdomen by an improvised explosive device, as Dr Ken prepares to wheel her into the operating theatre.

MSF'S UK VOLUNTEERS

Afghanistan Jane Ann McKenna, *Head of mission;* Federica Kumasaka Crickmar, *HR manager*

Bangladesh Madeleine Kingston, *Project coordinator*

Burundi Benilde Perez Amez, *Nurse*

Central African Republic Robin Scanlon, *Logistician;* Athanasios Koukoutsakis, *Logistician;* Conor Grant, *Doctor;* Jake Leyland, *Logistician;* Joshua Rosenstein, *Project coordinator*

Chad Clarisse Douaud, *Communications officer*

Dem Rep Congo Anna Halford, *Head of mission;* Claire Simpson, *Pharmacist;* Ghita Benjelloun, *HR manager;* Sarah Walpole, *Doctor;* Rebecca Harrison, *Epidemiologist;* Thomas Crellen, *Epidemiologist;* Stuart Garman, *Project coordinator*

Ethiopia Isla Gow, *Midwife;* William Pooley, *Nurse;* Kate Nolan, *Head of mission;* Jennifer Benson, *HR manager*

European migrant and refugee mission Jane Grimes, *Psychologist* (Greece); Declan Barry, *Medical coordinator (Greece);* Lauren Cape-Davenhill, *Project coordinator (Greece);* Anthony John Trethowan, *Logistician (Italy)*

Guinea Bissau Ana Teresa, *Nurse;* Danila Luraschi, *Doctor;* James Kelly, *Logistician;* Miriam Dos Santos França, *Nurse*

India Sakib Burza, *Medical coordinator*

Iraq Ciaran Laughlin, *Doctor;* Cristina Ceroli, *Midwife;* Roger Morton, *Logistician;* Patrick Durrant, *Project coordinator;* Mary Cheung, *Doctor;* Christopher Yates, *HR manager;* Miriam Willis, *Logistician*

Ivory Coast Stephen Bober, *Gynaecologist*

Jordan Peter Garrett, *Doctor;* Sunmi Kim, *Logistician*

Kenya Eamonn Faller, *Doctor;* Thomas Leyland, *Construction manager*

Kyrgyzstan Rebecca Welfare, *Project coordinator*

Lebanon Michiel Hofman, *Head of mission*

Malaysia Martina Caplis, *Midwife;* Cressida Arkwright, *Humanitarian affairs officer*

Mozambique Andrew Connery, *Doctor*

Myanmar Alison Fogg, *Mental health manager*

Nigeria Gabriella Gray, *Logistician;* Andrew Mews, *Head of mission;* Elisabeth Ganter Restrepo, *Pharmacist;* Daniel Acheson, *Logistician;* Sarah Hoare, *Nurse*

Pakistan Jacklyne Scarbolo, *Midwife*

Papua New Guinea Wendell Junia, *Lab scientist*

Serbia Andrea Contenta, *Humanitarian affairs officer*

Sierra Leone Melanie Villarreal, *Pharmacist;* Laura Doriguzzi Bozzo, *Training officer*

South Africa Amir Shroufi, *Medical coordinator;* Rebecca O'Connell, *Doctor*

South Sudan Philip Andrew, *Nurse;* Melissa Perry, *Finance officer;* Elizabeth Harding, *Head of mission;* Federico Luca Ilio, *Construction manager;* Karl Flynn, *Logistician;* Clare Coleman, *HR manager;* Mark McNicol, *Doctor;* Bob Jones, *Deputy head of mission*

Swaziland Maria Verdecchia, *Epidemiologist;* Laura Cooke, *Doctor*

Syria Edward Taylor, *Project coordinator*

Turkey Simon Burroughs, *Deputy head of mission;* Terri Anne Morris, *Head of mission*

Uganda Samuel Turner, *Head of mission;* Haydn Williams, *Head of mission;* Jacob Goldberg, *Deputy medical coordinator*

Ukraine Eleanor Davis, *Communications manager;* Vita Sanderson, *Logistician*

Uzbekistan Mansa Mbenga, *Medical coordinator;* Amada Sanchez Gonzalez, *Doctor*

Yemen Aimen Sattar, *Logistician*

Zimbabwe Fadumo Omar Mohamed, *Mental health officer;* Daniela Stein, *Project coordinator;* Simon Blankley, *Research coordinator;* Dominique Kehat, *Project coordinator*

Tents are set up in MSF's acute watery diarrhoea treatment centre, where patients are rehydrated by drinking oral rehydration fluids or through a drip. *Photograph © Awad Abdulsebur*

My watsan life

Alexandra Chen is a water and sanitation specialist, or watsan, working to stop an outbreak of acute watery diarrhoea in Wardher, Ethiopia

"The region where I'm working has missed out on the last three rainy seasons, and the drought has caused high rates of malnutrition among children.

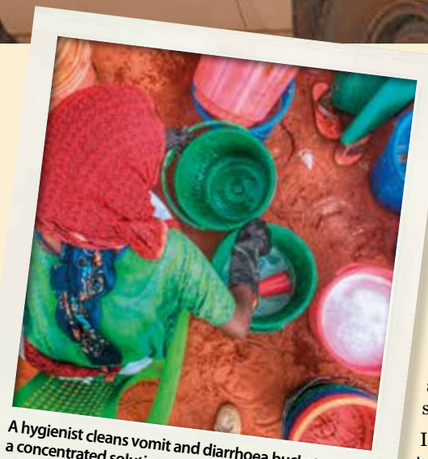
Traditional water reservoirs have dried up with the lack of rain. More than 400,000 people in the region depend on 18 submersible pump wells, three of which provide water for the Wardher region. Trucks have become the main method of distributing water to various camps and villages, but the roads are often impassable.

People's herds of livestock – including camels and goats – have died as a result of the drought.

Most people are now living on less than two litres of water per day – the World Health Organization and MSF recommend 15-20 litres of water per person per day in emergency situations. This water is used not only for drinking, but also for basic hygiene and cooking. Bathing and laundry require even more water.

In March, acute watery diarrhoea broke out in Wardher. It is caused by bacteria transmitted via the faecal-oral route, usually through contaminated hands.

Symptoms can begin after a few hours and last for up to five days. Although symptoms are usually mild, one in 20 infected people develops severe vomiting and diarrhoea, which can lead to extreme dehydration, shock and death. The most vulnerable people are children under five and the elderly.



A hygienist cleans vomit and diarrhoea buckets with a concentrated solution of chlorine. Hygienists wear gloves and aprons to protect themselves and to reduce the risk of spreading the bacteria.

Week 1

I just flew for 48 hours to get from western Canada to eastern Ethiopia, so I feel great! (It's 3 am and I'm ready to start my day.)

I've been assigned to work in the acute watery diarrhoea treatment centre in Wardher. During the peak of the outbreak, the centre saw more than 50 new admissions per day, with a daily average of 150 patients being treated.

This week I helped make improvements to the treatment centre in case the outbreak peaks again. Currently there are 25-35 patients in the centre.

These improvements included upgrading the toilet structures and expanding the laundry area where hygienists wash contaminated blankets and clothes. We also built an area for the kitchen hygienists to wash dirty plates and store them in a clean environment to reduce the risk of contamination.

We dug trenches around the toilets and showers to collect and contain any waste run-off. And then we expanded the chlorine solution preparation station.

Week 2

For this emergency project, MSF constructed smaller versions of treatment centres, known as treatment units, in some of the surrounding towns and camps for displaced people. This week, I visited the treatment unit in the town of Wal Wal, 30 minutes northeast of Wardher.

On entering the unit, I was greeted by a large tree in the shape of an umbrella. Beside the tree was a large, clean tent. The tent itself was empty, but surrounding it were a dozen blue mosquito nets strung up between the central tree's branches and nearby bushes. The patients, all elderly people or children under five, rested on mats with their IV bags hung from the branches of the tree.

A hygienist sprays a bed to disinfect it after a patient has been discharged. The beds have holes in them with buckets underneath for patients who are too weak to reach the latrines.

Despite having fewer resources than the main treatment centre in Wardher, the unit in Wal Wal was running efficiently. There was a vomit pit for fluids and a pit for burnable waste, a latrine, and handwashing and oral rehydration points.

Aprons – worn by all the watsan staff for protection – are hung up to dry in the sunshine.

While we were inspecting the water, hygiene and sanitation needs of the unit, we noticed four children who looked extremely sick and malnourished. We called an ambulance to take them to the main treatment centre in Wardher, where teams also provide nutritional support.

I've been adjusting well to Wardher life and my role managing the watsan staff at the treatment centre. The team is composed of local people who work various positions such as disinfection sprayers, chlorine solution technicians, guards and hygienists.

Three different concentrations of chlorine solution are made every day by the chlorine solution technicians. The weakest solution (0.05%) is for handwashing at the entrance and exit of all the tented wards, latrines and waste area, as well as for disinfecting plates used by patients.

Next is a slightly higher concentration of chlorine solution (0.2%), which is used to disinfect floors, beds, latrines, laundry and the soles of shoes when entering and leaving areas of contamination.

A chlorine solution technician prepares a 2% chlorine solution to disinfect vomit and diarrhoea buckets.

The highest concentration of chlorine solution (2%) is used for disinfecting vomit and diarrhoea buckets, as well as the bodies of the deceased.

The inevitable has happened: I have diarrhoea. Even though I'm dancing between bed and toilet, I'm thankful that it isn't acute watery diarrhoea. I'll be back on my feet soon."

All photos © Alexandra Chen. Follow her photo blog at: blogs.msf.org/alexandra

Clean rubber boots are lined up ready for watsan staff to put on as soon as they arrive for work.

Managing a crisis

South Sudanese refugees refill their water containers after a water truck gets stuck in the mud in Uganda's Palorinya refugee camp following heavy rain.
Photograph © Fabio Basone/MSF

Tara Newell is head of MSF's emergency team – known as the E-desk – in Amsterdam. When a conflict breaks out or a medical emergency or natural disaster occurs, the E-desk is in charge of MSF's initial response.

"I was backpacking around the world when I first saw MSF in action. It was 2005 and I was travelling through Pakistan when a huge earthquake struck. I saw how quickly MSF deployed its teams and how many competent, experienced people they had working for them. Their proficiency was amazing. When I got back home, I said, 'That's the organisation I want to work for'. I've been with MSF for 11 years now.

I work on the E-desk. It exists to make sure that MSF can respond fast to new emergencies and adapt as the emergency changes. Crises evolve moment by moment, so you need to have somebody constantly changing strategy, adapting the response and moving things along quickly to make sure we keep on top of everything.

Can-do attitude

The team I manage is made up of about 20 doctors, nurses, midwives, logisticians and epidemiologists. They have the right, can-do attitude: they're flexible and are people who really want to get in there and solve problems quickly. You send them out to an emergency and they know what to do.

Sometimes a new emergency will occur in an area where MSF is already working – like a disease outbreak in South Sudan. The team there might not have the capacity or the staff to respond, so they ask us to come and take over.

Poni (left), Muja and their friend live in neighbouring tents in Palorinya refugee camp, northern Uganda, after leaving their hometown of Kajo Keji, in South Sudan, with their families after fighting broke out.
Photograph © Fabio Basone/MSF

Boys cross Busia bridge between South Sudan and Uganda on one of the routes used by South Sudanese refugees fleeing civil war for the safety of camps in northern Uganda. *Photograph © Frederic Noy/Cosmos*

Or the emergency could be in an entirely new country where we have no presence on the ground, in which case we run in and launch a new response. The E-desk is generally not on the ground long-term: we coordinate the emergency response until the situation stabilises and then we scale back or hand over to another MSF team.

Places like Syria and Yemen fall outside that rule. We've been in charge of MSF's response in Syria now for almost five years, because it's been in a constant state of evolution, conflict and instability, and there's always a new state of emergency around the corner. It needs a lot of focused attention. The same with Yemen. But they're not in the normal run of things.

Our biggest medical emergency

I'm also managing our response in northern Uganda, where almost one million South Sudanese refugees have fled. It's a classic camp-based humanitarian emergency. We went in from scratch and built from the ground up. I'm also managing our response to a malnutrition crisis in the Somali region of Ethiopia, which I would say is the biggest medical emergency we have at the moment.

Every day I'm in touch with our staff on the ground. They update me on mortality rates, how the situation compares to yesterday, whether we need to adjust what we're doing in any way. Do they need more resources, more people? Is there advocacy work that needs to be done?

Seeing for myself

I flew into Ethiopia in the initial stages of the crisis to get my head around the situation. It's so much easier to manage from headquarters if I've been on the ground to see the emergency myself.

Once I arrived, there was an outbreak of acute watery diarrhoea, so we went from scaling up for a nutritional emergency to suddenly having to change our strategy to respond to both crises. Then the acute watery diarrhoea started spreading faster than we could stay ahead of it.

IV lines under trees

Many of the acute watery diarrhoea patients were in rural areas, so we had to set up impromptu treatment centres under trees, with IV lines hanging from branches.

Then on top of this we had a measles outbreak. We had to work out how to stop measles spreading amongst very vulnerable malnourished children who had potentially had acute watery diarrhoea recently.

You're doing all this at the same time as putting in place basic systems and trying to get hold of vehicles. You're trying to set up a mission while responding to a massive medical emergency, and that's all in a six-week time period and is just one emergency of many. Never mind the day-to-day craziness of managing Syria or Yemen, or bombings, kidnappings and working on the frontlines of conflict.

Not for the faint-hearted

We're all adrenaline junkies to some extent, I guess. Working on the E-desk is certainly not for the faint-hearted and it does require a lot of stamina. And it's certainly not nine to five, because emergencies don't stop, bombings don't stop. You have phonecalls in the evenings, phonecalls on the weekends – there's no end to it.

The work takes a lot out of you, but we do a good job of pacing ourselves and supporting each other. We have our down days. I've shed tears when I was in Libya watching how people are tortured and treated in those detention centres, and that will never leave me. I've seen people executed in Ivory Coast, and that will never leave me. I've had local staff killed in the line of duty while running mobile clinics in South Sudan, and that never leaves you.

Really horrible things happen, but you have to just keep moving forward, because you know that, for all those horrible things, we can also do a lot of amazing things.

I've seen MSF from the outside and from the inside, and I know that we really are one of the best organisations in terms of mounting fast and effective responses to emergencies and saving lives.

You know, for as much as the job takes from you, it gives so much more. Being able to treat so many people, to save as many lives as we do – it's a privilege to have the opportunity to do that. It's enormously humbling."

An MSF team unloads tent materials and other equipment for constructing a new acute watery diarrhoea treatment unit near Kebridehar in Ethiopia's Somali region. *Photograph © Awad Abdulsebur/MSF*

‘Every day we hear the bombs on the Syrian side of the border’

Photographer Tom Barnes went to meet and photograph patients and staff at MSF’s emergency trauma project in the Jordanian town of Ramtha

“When I visited MSF’s emergency trauma project in Ramtha, just a few miles from the Syrian border, I hardly knew what to expect. It’s a specialist facility treating Syrians with life-threatening injuries from the war – many of whom have been living under siege and bombardment, who have been medically evacuated across the closed border, and whose family members are still trapped in Syria.

When I walked into the ward that first morning, I saw rows of beds filled with people with parts of their bodies missing or external scaffolding coming out of their legs.

But despite the horrific nature of their injuries, and the horrendous experiences they had survived, the atmosphere wasn’t sombre in the least. The wards were full of people and chatter. Almost everyone I met was friendly and positive, keen to share their stories and quick to praise MSF for having saved their lives.

As for the staff, they gave off an air of being extremely capable and flexible – as if no matter what came through the door, they’d be able to deal with it.

Of all the patients I met and photographed, six-year-old Faiza was one of the most amazing. A month before, she’d lost one of her legs, and yet now she was skipping around on crutches and racing people down the corridors in her wheelchair, a whirlwind of energy. She had a strength of character that left me full of admiration.

I came back from Ramtha feeling as if something within me had changed after meeting all of these people whose lives have been altered forever by Syria's long, cruel war.”

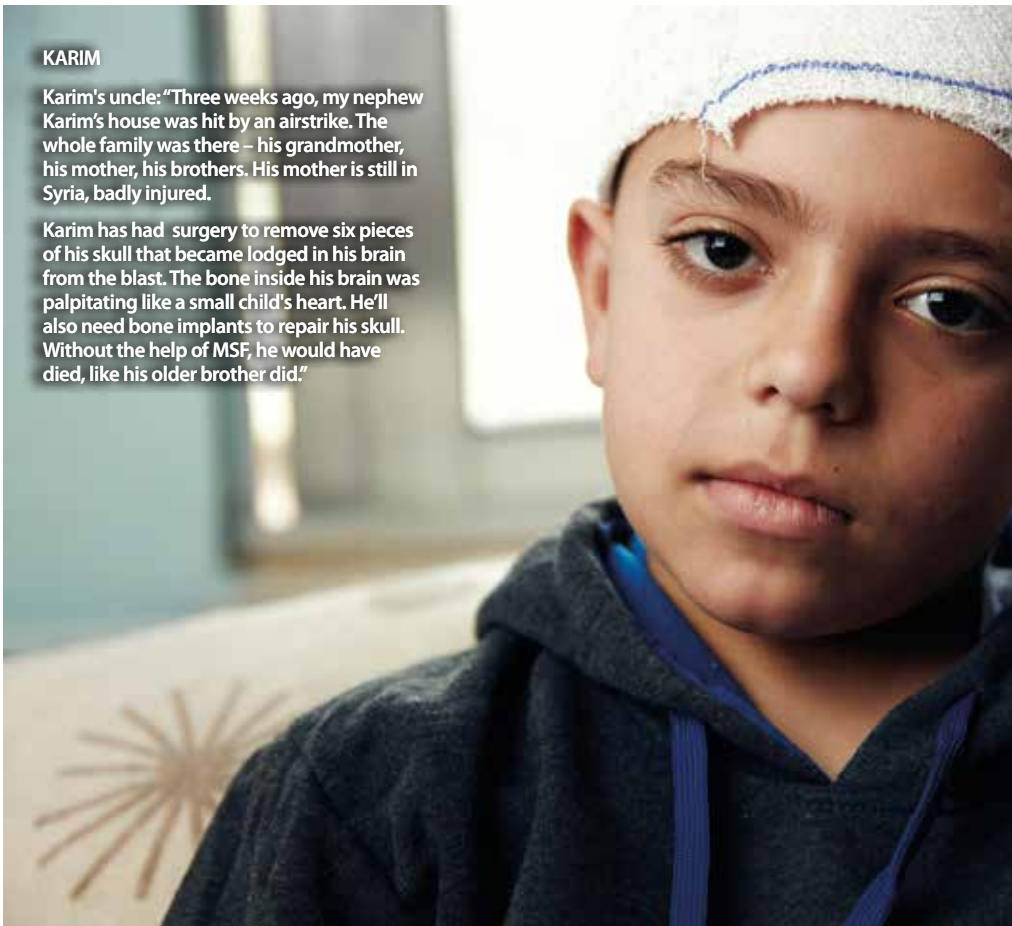
Patients’ names have been changed

DR MOHAMMED

“I used to be a pharmacist, but then I switched to medicine, because that’s my passion. This hospital is so important because it’s one of only a few facilities treating people hit by rockets or otherwise wounded in the war. What I find so shocking is that this war doesn’t distinguish between a baby of eight months, a pregnant lady or a man – all of them are targets.”

GIULIA

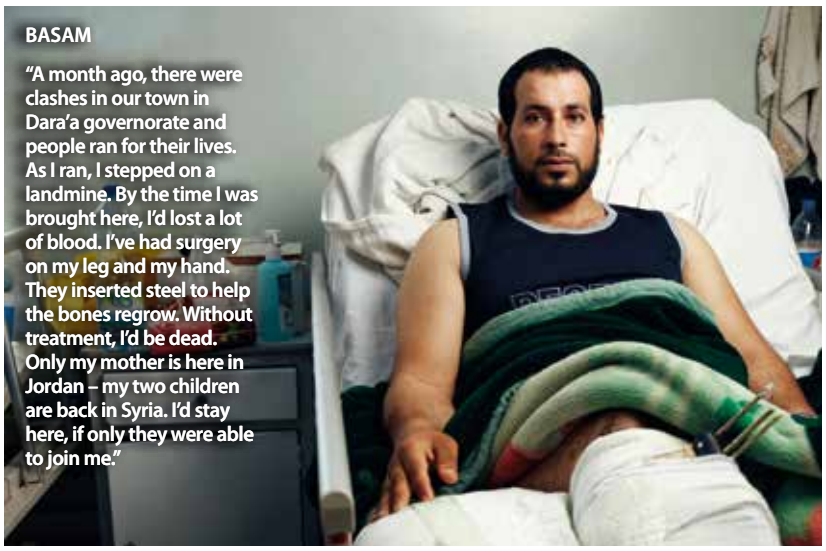
“I’m a nurse specialising in surgery and trauma. MSF’s work here is so important. Almost ever day we hear the bombs on the Syrian side of th border. I left my job in Italy to work here with MSF, helping people wh really need it. When you think about how much we have, and how muc we can offer, then this i the least we can do.”



KARIM

Karim's uncle: “Three weeks ago, my nephew Karim’s house was hit by an airstrike. The whole family was there – his grandmother, his mother, his brothers. His mother is still in Syria, badly injured.

Karim has had surgery to remove six pieces of his skull that became lodged in his brain from the blast. The bone inside his brain was palpitating like a small child's heart. He’ll also need bone implants to repair his skull. Without the help of MSF, he would have died, like his older brother did.”



BASAM

"A month ago, there were clashes in our town in Dara'a governorate and people ran for their lives. As I ran, I stepped on a landmine. By the time I was brought here, I'd lost a lot of blood. I've had surgery on my leg and my hand. They inserted steel to help the bones regrow. Without treatment, I'd be dead. Only my mother is here in Jordan – my two children are back in Syria. I'd stay here, if only they were able to join me."

FAIZA

Faiza's mother: "When the fighting started up, we hid in the house, but then the house was hit by a shell. My daughter Faiza, who is six, lost her leg, and one of her brothers was wounded in the head by shrapnel. Faiza was evacuated from the besieged area but I couldn't bring my boy because his injuries were so severe. We've been at MSF's hospital for a month. Sometimes, at night, she can't sleep because of the pain, but during the day she's whizzing around, she's happy, she's back to herself."

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Médecins Sans Frontières/Doctors Without Borders (MSF) is a leading independent humanitarian organisation for emergency medical aid. In more than 60 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.

Night shift in Chad

UK doctor Sarah Wookey describes a long, hot night in MSF's hospital in Am Timan, Chad.

"It's hot. Very hot. So hot that I have to wait for the water (stored on the roof) to cool down before I can step into the shower. Chocolate reaches melting point in about 30 seconds. I keep having to put my iPad in the freezer in order to turn off that annoying message telling me it feels too hot to work today. 'How do you think I bloody feel?' I want to shout at it.

I've just arrived at the hospital to start the overnight shift. We have 70 children in the acute malnutrition centre (entry criteria: significantly underweight plus another complication such as gastroenteritis or pneumonia). 'Evil white woman!' I hear in Arabic as I pass the kitchen. Hapsita, one of the milk ladies, knows that one glance at my strange, pale face triggers howls of fear from many of the small patients. 'Evil black woman,' I reply instantly in Arabic, to gales of laughter from the assembled mums. We repeat this show most days. One day the wrong person is going to hear us and it's going to get me into huge trouble.

'He needs blood urgently'

I take a little wander around the wards to see what's going on. Infections that healthy children would shake off at home can rapidly progress to life-threatening here. If a child coughs and breathes faster than usual at home, we suggest paracetamol and plenty of drinks. Here? Seven days of heavy-duty antibiotics.

A child comes in very ill with anaemia. He needs blood urgently. The only available donor is his father. Quick check on dad – HIV negative, hepatitis B negative, but the malaria test comes back positive, indicating that he's had malaria in the past three weeks. If we give his blood to the child, we might well give him his dad's malaria too, but if we do nothing, he'll die. I give him the blood with a slug of antimalarial medication and hope for the best.

A ban on needles

Twins are born, very prematurely. Each weighs less than 1 kg. We know that, with the facilities we have here, the chances that they will survive are minimal. We offer their mum the choice between taking them home or caring for them here. She understands that her babies are not going to survive and says she'd prefer to stay with them in the hospital. We agree to prescribe expressed breast milk, close physical contact with mum, and a total ban on anything sharp or painful – like needles.

A severely malnourished child with pneumonia arrives. His blood sugar levels are dangerously low. The nurse who sees him initially has given him a sugar drink, sited an intravenous catheter (into a vein I can barely see), checked him for malaria, measured not only his height and weight but his oxygen levels, heart rate, breathing rate and temperature. For good measure, the nurse has also got out the appropriate antibiotic and is ready to give the first shot as soon as I arrive.

Morning. I hand over a list of the night's events to my colleagues and crawl back to breakfast, shower and bed.

We've run out of Marmite, but that's another story…"

Read more of Sarah's blog at http://blogs.msf.org/SarahW

Dr Sarah checks a baby's pulse, watched over by the child's mother, in MSF's hospital in Am Timan.
Photograph © Sara Chare/MSF

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