111
Winter 2023

Dispatches

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

SITUATION REPORT

1. YEMEN

An MSF team use a resuscitation dummy in a mass casualty training drill in the emergency room of Haydan hospital, Yemen.


Photograph © Fionnuala Ryan

2. SOUTH SUDAN

MSF nurse Scovia Morris examines 13-month-old Chan Akok in Aweil hospital, South Sudan, where he is being treated for severe malnutrition alongside his twin brother Garang Akok. The boys were carried to the hospital by their grandmother and mother, Arek Yai Yai, who made the journey on foot from their home, which is around an hour's drive away.


Photograph © Olivia Beth/MSF

CORRECTION

In a caption about MSF's work in the Philippines in the last issue of Dispatches, we referred to TB as a 'virus'. It is, of course, a bacterial infection. We'd like to apologise for this error.

3. HONDURAS

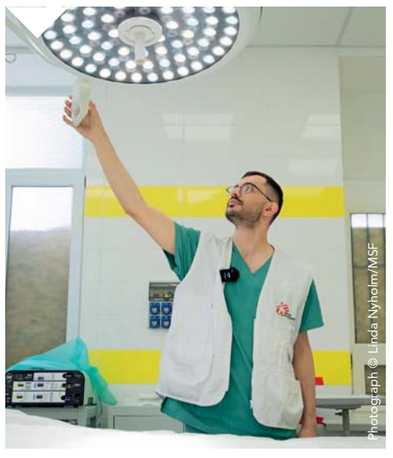
Nora López places a jar with Wolbachia mosquito eggs on the patio of her house as part of an MSF trial to reduce the transmission of dengue fever in Honduras, where more than 10,000 cases are reported each year.

MSF's new approach consists of releasing Aedes aegypti mosquitoes which carry the natural Wolbachia bacteria; this reduces their ability to transmit viruses such as dengue to human beings.


Photograph © Martin Cálix

4. UKRAINE

MSF's Dr Khassan El-Kafarna adjusts equipment in the operating theatre of Kostiantynivka hospital, in Ukraine's Donetsk region. After fighting moved closer to the city earlier this year, there was a sharp increase in the number of patients requiring urgent medical care and surgery. Between January and August 2023, MSF teams in Kostiantynivka hospital conducted 231 surgeries.


Photograph © Linda Nyholm/MSF


Photograph © Paul Odongo/MSF

AFGHANISTAN EARTHQUAKE

On 7 October, a 6.3-magnitude earthquake struck western Afghanistan, closely followed by three aftershocks, resulting in 2,445 reported deaths and 2,440 injuries. Many of the wounded were treated at Herat regional hospital, which is supported by MSF.

"When the first earthquake hit this morning, our teams rushed to evacuate all the children from the paediatric inpatient wards of the hospital," says MSF project coordinator Lisa Macheiner. "This was a precautionary measure in case aftershocks damaged the building. We dispatched mass casualty kits to the worst-affected areas to treat up to 400 wounded patients and stationed a medical team at the hospital's emergency room for further support if necessary."

800

Number of patients treated at Herat hospital in the aftermath of the earthquakes


Photograph © Paul Odongo/MSF

Additionally, the team set up five medical tents within the hospital compound with the capacity to accommodate 80 patients.

"As of 9 October, more than 540 patients have been treated at the hospital," says MSF programme coordinator Yahya Kalilah. "Most of the patients are women and children, as they were the ones at home when the earthquake struck mid-morning. A team made up of operational, medical and logistical staff left today to assess some of the most affected areas outside the city and to provide medical first aid."

On 11 and 15 October, two more powerful earthquakes struck the region. A further 117 people were treated in the emergency room at Herat hospital, while MSF teams set up a further five tents to accommodate an expected influx of wounded.

▲ Abdul Salaam digs through the rubble of his destroyed home, watched by his elderly mother.

Inset: MSF medics treat an injured patient in the emergency triage area of Herat hospital following the third earthquake on 15 October.

GAZA

PHOTOGRAPHY
MSF
DAWOOD NEMER/AFP

Conflict in Gaza

A HUMANITARIAN CRISIS IS UNDERWAY IN GAZA. MSF TEAMS HAVE WORKED TO TREAT THE WOUNDED AND SUPPLY OVERWHELMED HOSPITALS AS AIRSTRIKES AND A STATE OF SIEGE THREATEN THE LIVES OF MILLIONS OF MEN, WOMEN AND CHILDREN.

Guillemette Thomas is MSF's medical coordinator for Palestine, based in Jerusalem.

19 October 2023

"Since the evacuation order issued by the Israeli authorities instructing more than one million inhabitants to scramble to the south of the Gaza Strip, people have been forced to make extremely difficult choices between staying and leaving. For health workers, this has meant the choice between abandoning their patients to almost certain death or staying and risking their own lives.

▼ MSF nurse Mohammed Hawajari (centre) cleans the facial wounds of a boy who suffered severe burns following an airstrike, 19 October 2023.

◀ Ambulances carrying victims of airstrikes crowd the entrance of Al-Shifa hospital in Gaza City, 15 October 2023.

Some have stayed and continue to work despite the risks. We are in touch with some of our colleagues who are supporting Ministry of Health teams, particularly in Al-Shifa hospital in Gaza City, where MSF had provided care for burns patients for years.

Today, medical staff suffer the same fate as the rest of Gazans: they have been constantly bombed for the past 10 days. Our colleagues tell us that many doctors and other health workers have died since the start of the Israeli offensive.

They report that between 800 and 1,000 people are injured every day in the Gaza Strip, but this figure only includes those who manage to get to a hospital. Since access to health facilities is extremely dangerous, and made more complicated by the shortage of petrol, only the most severely injured patients seek hospital care.

Since the start of the conflict, more than 9,700 people have been injured. I believe that these people are in serious danger of dying in the next few hours because it is becoming impossible to get medical attention."

IS THE HEALTH SYSTEM STILL FUNCTIONAL IN GAZA?

"We are already witnessing the collapse of patient care. Medical staff can no longer treat people or admit new patients properly. Everything is being done in extremely poor conditions, with a shortage of staff, medicines and medical equipment. There is a constant flow of seriously injured people with complex trauma wounds, burns, fractures and crushed limbs.

Al-Shifa hospital now hosts thousands of people who went there seeking protection from the constant bombing. While Gaza is in darkness, Al-Shifa is one of the few places that still has electricity, although the fuel [to run its generators] will only last another 24 hours at most.

Without electricity, many patients will die – especially those in intensive care, neonatology and on respiratory support machines. Pregnant women and patients with chronic illnesses such as diabetes and cancer are also at risk due to a general shortage of medicines."

Dr Obeid is an MSF surgeon based at Al-Shifa hospital

23 October 2023

"Our operating theatre was full so we started operating on the floor, in the corridor. There was no other space. A mother had brought her injured 13-year-old daughter and nine-year-old son to us. His foot was severely injured and we needed to amputate.

I had to amputate his foot right there in the corridor. We lack medical supplies so we had to carry out the procedure with the boy only slightly sedated. The anaesthetist had to keep the boy's mouth open to prevent strangulation.

You cannot imagine this. We had to carry out this procedure right there, in front of his mother and 13-year-old sister – a sister who was waiting for an operation.

But this is the situation we are in. We are doing the best we can. We can't do any more."

MSF is horrified by the events that began on Saturday 7 October – both the brutal mass killing of civilians perpetrated by Hamas in Israel, and the attacks on Gaza now being pursued by the Israeli military.

Due to the high number of wounded people in Israel, MSF quickly offered to assist the Israeli Ministry of Health with treating them. Our offer was appreciated but, as of going to print, our assistance has not been required.

MSF has been running medical programmes in Gaza for more than 20 years, supporting a health system that is desperately short of both medical staff and supplies.

To date, MSF does not run medical programmes in Israel, which has strong emergency and health services. Since we currently only run medical programmes in the Palestinian Territories, our reporting can only reflect the direct witnessing of our patients and staff on the ground in both Gaza and the West Bank.

MSF is an independent, impartial and neutral medical humanitarian organisation. Our neutrality ensures that we can continue to provide emergency medical care in Gaza and in other areas experiencing conflict and war.

MSF calls on all parties to this conflict to ensure the safety of civilians and medical facilities.

FIND OUT MORE AND READ THE LATEST UPDATES AT MSF.ORG.UK/PALESTINE

SURGERY ON THE FRONTLINE

EVERY YEAR, MSF TEAMS CARRY OUT TENS OF THOUSANDS OF SURGERIES. FROM TREATING WAR WOUNDS TO EMERGENCY CAESAREANS AND RECONSTRUCTIVE SURGERY, OUR SURGEONS ARE AT THE FRONTLINE OF OUR LIFESAVING CARE. IN THE PLACES WHERE WE WORK, DEMAND FOR SURGICAL SERVICES IS INCREASING. HERE, TWO MSF SURGEONS SHARE THEIR EXPERIENCES OF PROVIDING LIFESAVING CARE.

MSF surgeon Anitha Muthusami carries out surgery in Agok hospital, Suth Sudan.

Photograph © Tomas Sebek/MSF

DANIELA GABAYET IS A MEXICAN SURGEON WHO HAS WORKED FOR MSF IN YEMEN, CENTRAL AFRICAN REPUBLIC, HAITI, SOUTH SUDAN AND DEMOCRATIC REPUBLIC OF CONGO.

HOW DID YOU COME TO JOIN MSF?

"I was working as a surgeon in Mexico and found myself not really liking my job. I was in the private sector and it made me realise that medicine had become a business – it wasn't really about the patient anymore. I'd been thinking about MSF for a while and I'd always felt it would be a good fit for me. So I applied and in 2017 I was offered Yemen as my first placement. I was sent to one of MSF's surgical projects, and it was basically war surgery: gunshot wounds, shrapnel injuries. We also had a fair number of traffic accident injuries – there are a lot of road accidents in Yemen – along with everyday surgeries such as appendectomies. Those types of medical conditions don't stop just because there is a war on."

WERE YOU PREPARED FOR THE CONFLICT INJURIES YOU SAW?

"I did my training in Mexico City, so I was used to treating gunshot wounds and stab wounds. I'd had some exposure to the sort of trauma surgery we were dealing with. But the other type of war-related injuries – explosions, mines, grenades – no. You have to be in a conflict zone to experience those injuries. I was on a learning curve, but you bring your experience to the new situation and you cope."

WHILE IN YEMEN, YOU EXPERIENCED A NUMBER OF MASS CASUALTY INCIDENTS, WHERE LARGE NUMBERS OF WOUNDED PEOPLE ARRIVE AT THE SAME TIME. AS A TEAM, HOW DO YOU DEAL WITH THOSE SITUATIONS?

"We knew that mass casualty incidents do happen, so our team had started training and we'd run a simulation in order to prepare for it. A week later, we had our first incident.

It was a Thursday or Friday at nine o'clock in the morning. There had been an explosion about 20 minutes away from us and, very quickly, we were inundated with patients. In those situations, it's all hands on deck and you do what needs to be done. There was a never-ending line of trucks and pick-ups and cars bringing wounded people in. Altogether, more than 50 injured people arrived: children, women, men, young and old, a complete mixture.

We immediately began to triage them. I was at the triage point with one of the nurses, to assess and identify which injuries were life-threatening and what should take priority for surgery. It's all about teamwork and helping out where you're most needed at that moment. Once that was done, I went to theatre and began to operate."

ON A PERSONAL LEVEL, HOW DID YOU COPE WITH THE SITUATION?

"It was my first mass casualty incident and, being at the entrance of the hospital and seeing so many patients arriving – it was shocking. You keep thinking: how are we going to manage? We only have two operating theatres. People are arriving with really traumatic injuries and there is a lot of blood everywhere.

We're used to seeing blood, but it's the screaming that's really tough. Because it's not only patients arriving at the hospital – it's their family and friends and everybody else: people searching for loved ones, people in complete distress, screaming their lungs out. It's chaos, and at that point you realise just how vital it is to have the logistics team there doing crowd control. Without them you'd never get close to the patient you need to treat, because they'd be surrounded by 15 distraught people.

We were doing surgeries for the next three weeks on the patients we admitted that day, doing dressings and debridement and follow-up surgery. We were living next to the hospital and we'd go in at two or three in the morning to work. But even after we'd discharged the last patient, there was still no real let-up.

But the long hours, the running around, the not sleeping, you get used to it. That's what you're trained for."

"In those situations it's all hands on deck..."

Photograph © Oliver Barth/MSF

▲ MSF team members in Diffa, Niger, treat four-year-old Halima, who was admitted to hospital with a head injury.

WHERE DID YOU GO AFTER YEMEN?

"I was six months in Yemen, and since then I've worked continuously for MSF: South Sudan twice, Central African Republic twice, Yemen again, Haiti and now Democratic Republic of Congo (DRC). All the projects were challenging in different ways, but Haiti was the most intense.

Working in Haiti was crazy. We were at MSF's hospital in Tabarre and were getting five to ten gunshot wounds a day along with regular stabbings. It was constant. I've never experienced anything like it.

In those sorts of situations, you basically have two types of surgery: damage control, or definitive surgery. If the patient is really unstable, then it's damage control. If there's major bleeding, then you must stop it or control it. If it's the bowel, you either remove the perforated part or you leave it and tie a knot on each side. The aim is to be in and out in 45 minutes so you can send the patient to the intensive care unit to recover. Any longer than that and there's a good chance the patient will die on the table.

After 48 or 72 hours in the intensive care unit, depending on how they're doing, you might then bring them back to theatre to take a second look and do the definitive surgery."

ARE THERE PARTICULAR PATIENTS WHO YOU STILL THINK ABOUT?

"Oh for sure, there are patients that never leave you. Sometimes the outcome was good, sometimes bad, but they stay with you. There was one child I treated in South Sudan who I think about quite a lot. He was two years old and he had a gunshot wound to the head. His mother had been shot in the arm and had a broken humerus, but she'd carried her boy for five days, walking all the way, to reach us.

The boy's injury was horrific. A large part of his brain was exposed through this bullet wound. It was completely infected and – there's no way to sugarcoat this – there were maggots in the brain tissue. But the boy was calm and seemed completely normal, apart from the fact that half his head had been blown away.

At that point, I really started questioning myself. I'd never seen somebody with a wound like that survive five days, let alone appear so normal. You look around and see how limited your equipment and options are and you wonder what are you supposed to do.

I called the medical team together and said: 'Guys, what do you think? I'm open to any and all suggestions here.' It was clear I couldn't touch the brain to remove the infection. We talked it through and decided that the only real option was palliative care."

Photograph © Guillaume Binet/MYOP

▼ The MSF team at Aden hospital, Yemen, treat the wounded during a mass casualty incident, 1 July 2015.

“If you’re in South Sudan or Central African Republic, you could be the only surgeon within a 200-km radius”

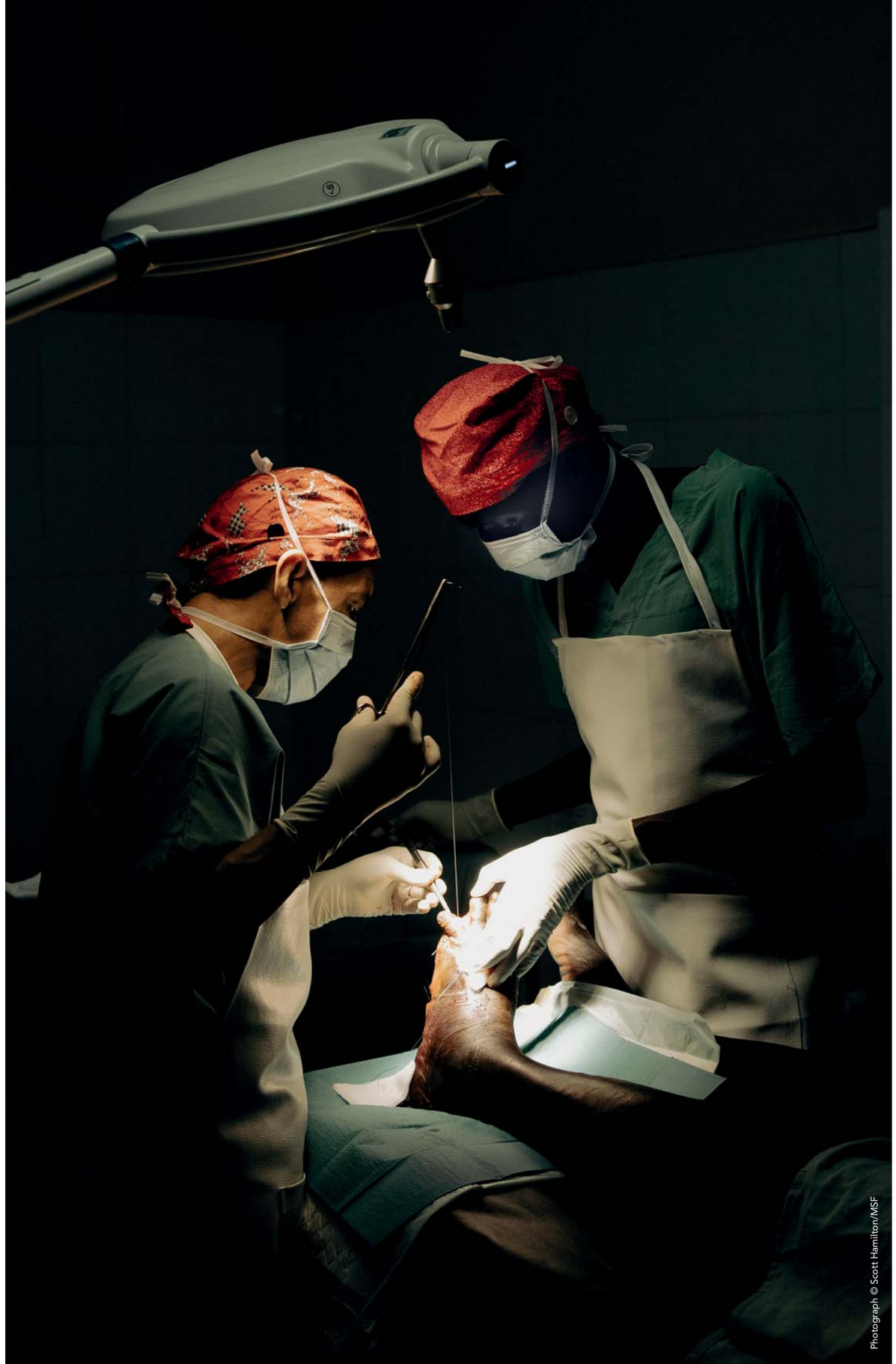
For five days, that’s what we did. But after five days, the boy had no fever, no convulsions, was eating perfectly well, was playing with others, but just wasn’t talking or walking. So we said: ‘We should probably revise this.’ So we completely changed course. We gave him full antibiotics, kept changing his dressings, sorted out his nutrition with Plumpy’Nut, and threw everything we had at him. On day 15, the swelling was reduced and there was no longer any infection. There was still brain exposure, but everything was improving. At three months, I was able to do a graft to cover the exposed brain. Then we were able to discharge him. By that stage he was walking, talking, eating, playing, running. Here was a boy who had survived a gunshot wound to the head with no neurological deficit. It still amazes me.

It just goes to show how resilient people can be and, even if you think there’s no hope, patients can still sometimes surprise you.

And people can inspire you too. In all the projects I’ve worked in, I’ve found people who will go beyond their limit to provide care, to be there for others and for their community.

We have staff who have been through war, have been chased from their villages, have seen entire villages massacred, have hidden in swamps. But they return to the MSF hospital or clinic and they just want to work and give of themselves. And they do it with a smile. You never want to complain after experiencing people like that.

It’s very motivating to know that the work we’re doing is really helping people. The last surgical assignment I did here in DRC, MSF was the only organisation that stayed on once the fighting started. There was nobody else. When I go back to Mexico, people sometimes say: ‘Why don’t you come back home and just get a job and do what normal surgeons do?’ But they don’t understand that if you’re in South Sudan or Central African Republic or DRC, you could be the only surgeon within a 200-km radius, and when a patient is right there in front of you, dying from some small wound that’s got infected and would be easily treated elsewhere, you’re probably all they’ve got.”



Photograph © Scott Hamilton/MSF

▶ At Ameth-Bek hospital, MSF’s Dr Carlos Ajuria (left) and Dr Meen Monytur clean and suture a gunshot wound to the foot of Deng Agok, who was shot while fleeing intercommunal violence in Abyei, a disputed region on the border between Sudan and South Sudan.

JOCELYN NOTHOMB IS A BELGIAN SURGEON WHO HAS WORKED WITH MSF IN CENTRAL AFRICAN REPUBLIC, HAITI AND SOUTH AFRICA. HE RECENTLY RETURNED FROM WORKING IN MSF’S INFLATABLE HOSPITAL IN ADRÉ, IN EASTERN CHAD, WHERE THOUSANDS OF PEOPLE FLEEING THE CONFLICT IN SUDAN HAVE RECEIVED SURGERY FOR THEIR WOUNDS.

“The inflatable hospital is really impressive. It’s this huge structure in the middle of the desert, yet the team managed to put it all together in around 10 days. There are 250 beds with two operating theatres. It’s amazing and very professional.

When I arrived, there were 250 patients in the hospital, most of them wounded during the fighting. There were a lot of open wounds, a lot of infections and fractures. We were conducting 30 to 40 surgeries a day, which is a lot. The team were amazingly good – I’ve never worked in a hospital as efficient as that one. A lot of that was down to the Chadian staff who were very, very motivated. The cleaners responsible for the operating theatres were super-quick and super-efficient. Some were university graduates who couldn’t find other jobs and they really bought into the MSF teamwork mentality. MSF is really good at creating that team spirit and that drive for efficiency. I’ve seen that in every place I’ve worked with MSF.

The conditions we were working in were extreme. It was hot, extremely hot. We’d carry out surgeries, then take off our gloves and pour water out of them. There were flies everywhere. They’d land on your eyes and fly into your mouth when you were talking or eating. It was tiring and very difficult and I don’t think I felt comfortable at any point during the month I was there. But, medically and surgically, it was a great experience and I felt we did good work.

CONTROL THE INFECTION

We were mainly dealing with trauma patients who had already survived 24 or 48 hours since being wounded, usually as a result of gunshots. It took that long for them to reach us, and by that time their wounds were already infected.

The first thing we did was try and control the infection. That means cleaning the wound using water, disinfectant and swabs. Bone really doesn’t

▼ An MSF team carry a war-wounded patient into a tented ward at Adré hospital, Chad, where more than 385,000 refugees have arrived after fleeing the violence in neighbouring Sudan.

like infection so, if there's a fracture, you need to clean and stabilise. Often you need to use external fixators to immobilise the fracture or else it's not going to heal.

For non-fracture patients, you are often faced with larger and deeper wounds. After the wound is cleaned, you need to be able to close it. If it's a big wound, say on the neck, you might have to do a skin graft and move some skin from the leg to cover the wound. You have to do so many things that you'd never normally do in your day-to-day working life back in Europe.

But that's the thing about working as a surgeon for MSF. I will never do a skin graft as a surgeon working in Europe. I will never clean a wound and it's unlikely I'll ever treat a gunshot injury. But working for MSF, you need to be able to do all these things and much more. That's why if it was a choice between asking a surgeon from Europe who had never done those things to clean a wound, and asking a nurse from Chad, I would go with the nurse every time. They've done it many times, they're experienced at it and they will do a better job.

WE DO THE BEST WE CAN

We treated a number of patients with gunshot wounds to the thorax. What happens is that the bullet first hits your clothes and then goes into your thorax and then travels out again. But by hitting your clothes, it's getting charged with all the bacteria that's on the fabric and on your skin, and all that goes inside with the bullet and stays inside. The bacteria spread from there.

For those surgeries, we'd open up the patients and go between two of the ribs to clean up the infection. The problem with this procedure will be clear to anyone who has ever broken a rib. It's very painful for the patient afterwards; every time they breathe, the pain comes back.

What makes it harder is that, to help recovery and try to ensure the infection doesn't come back, it's important for the patient to move and do breathing exercises. That's a hard sell. You have patients who have been shot, who have been traumatised, who have no energy and who are in constant pain, and you're asking them to move about.

We had one young man in that situation. He was 16 years old and he'd had enough. We'd given him a chest tube to drain the pus and we had operated on him once and we needed to operate again. But it was too much for him. He disappeared from the hospital before the surgery. Thankfully, he came back a day later and we were able to treat him, but not all of our patients had such a positive outcome. It's a terrible situation and there is a lot of suffering. But we could only do the best we could do.

A LITTLE LESS STUPID

It was a great honour to work in Chad and I felt grateful to be asked to be there, to assist in whatever way I could. We surgeons can be difficult people. But I think working for MSF helps to make you a little less stupid and a little less arrogant on that front. When you see how much people suffer and when you work with people who are so dedicated, it puts things in perspective. I always come home saying: 'There are things I won't think or say anymore; there are things I won't complain about anymore.'"

READ MORE AT **MSF.ORG.UK/SUDAN**

Photograph © Mohammad Ghannam/MSF

THE INFLATABLE FIELD HOSPITAL

All photographs © Mohammad Ghannam/MSF

The sandy ground is levelled and prepared.

The tents are erected manually, with some elements inflated by mechanical air pumps. Each tent is equipped with pressure gauges to adapt to changing temperatures.

MSF logisticians set up the specially adapted cooling and heating systems, while water and sanitation engineers establish a water supply.

In June, more than 15,000 people fled fighting in Sudan and crossed into Chad, making their way to the small border town of Adré. Many were war-wounded and in desperate need of emergency trauma surgery.

Adré's hospital, which is supported by MSF, was quickly overwhelmed, prompting MSF to deploy one of the most innovative pieces of lifesaving kit available to our teams: an inflatable field hospital.

Developed for use in the aftermath of natural disasters and during conflicts, this modular hospital kit enables an MSF team to create an entire field hospital inside inflatable tents. It includes two operating theatres and 170 beds, as well as various wards and specialist rooms.

"We worked day and night to set up the hospital so it would be ready as quickly as possible," says emergency logistician Olivier Brandtner.

To help us construct it, we employed around 50 people and worked around the clock.

"The main difficulties we faced were the extreme heat; the preparation of the ground, which was very sandy; getting in supplies, as we were in a very remote region; and the short timeframe we had to make the hospital operational."

Working non-stop, the team of 50 levelled the ground and inflated the multiple tents using large pumps that would go on to serve as air-conditioning units.

Next the hospital was stocked with medical equipment and supplies needed to treat both basic and complex medical conditions. It became operational on 27 June.

The inflatable hospital includes:

- 170 beds, including 108 for gunshot and trauma patients
- Two operating theatres
- A sterilisation room
- A maternity unit with 36 beds for deliveries and emergency caesareans
- An X-ray unit
- A laboratory

Women collect water from a hand-dug waterhole in a dry riverbed in Illeret.

Water in the desert

OPPRESSIVE HEAT, WHIPPING WINDS AND BROKEN WELLS. IN NORTHERN KENYA, WHERE THE NOMADIC DAASANACH PEOPLE LIVE, IT HASN'T RAINED IN THREE YEARS. IN THIS DROUGHT-AFFECTED LANDSCAPE, MSF WATER AND SANITATION ENGINEER **DANIEL SÄRNER** TALKS ABOUT A DIFFERENT TYPE OF LIFESAVING PROJECT: SECURING PEOPLE'S ACCESS TO WATER.

KENYA

WORDS
DANIEL SÄRNER

PHOTOGRAPHY
LUCY MAKORI

"In northern Kenya , sandwiched between Lake Turkana and the Chalbi Desert, lies the small village of Ileret. The people here are nomads who live on both the Ethiopian and Kenyan sides of the border. They call themselves Daasanach. The challenges for the Daasanach people are many. The temperature is between 36 and 40 degrees Celsius, humidity rarely rises above 40 percent, and hot winds with speeds of up to 60 mph never stop blowing.

THREE YEARS OF DROUGHT

Infrastructure such as roads, water and electricity is almost completely absent. The people who live in this area have been neglected for a long time. The lake and groundwater are salty. The small amount of potable water in the area collects in the sandbanks of seasonal rivers, where women and children dig waterholes by hand. Often they have to wait in line for six hours every day before they can fill their containers with water.

When I arrived in Ileret, it had been three years since the last rain had fallen. The Daasanach people rely on their livestock, and the drought that has ravaged East Africa in recent years has hit the Daasanach people hard. A year ago, the ecosystem collapsed and 90 per cent of all their livestock died of hunger and thirst. For these people, it's a disaster.

In Ileret, archaeologists have found the oldest human footprints in the world. That the cradle of humanity may become uninhabitable as a result of climate change and neglect is a cruel tragedy.

A COLD CAN BE A DEATH SENTENCE

There are aid organisations here that distribute food but, in the case of malnutrition, getting extra food does not always help. If you get sick, it can be difficult for the body to absorb nutrients, so a common cold can be a death sentence. At the small health centre in Ileret, three nurses provide medical care for around 26,000 people. The nearest hospital is four hours to the east, but getting there is fraught with danger due to conflicts between the various tribes in the area.

MSF arrived here in March 2022 with two goals: to provide care for malnourished children and to improve people's access to clean water. As a water and sanitation engineer, it was my job to meet the second goal. Working alongside me were my local staff colleagues: hospital cleaners Abdia and Naomi; Lore, the cook; Adan, the driver; health promoter Ambia; and technician Patrick. All of them possessed crucial knowledge of Ileret.

The only tap at the health centre was used by patients, staff and visitors alike, and the water ran out every week. I sat down with my colleagues to come up with solutions. Patrick mentioned that he had seen an old water tank nearby that was not being used.

We decided to try to install this tank. The goal was that it would hold enough water for a week's use and would be filled up at times of the day when water consumption in the village was low. A few days after installing it, we could see that our idea had worked: the health centre was receiving a constant supply of water and our patients could now collect water from their very own tap!

A LESSON IN BIOLOGY

Hygiene in the health centre had also been substandard for a long time, and there was no clear structure for how the cleaners should perform their jobs. So we started by developing a cleaning schedule, alongside the healthcare staff. I asked nurse Sylvester if he would mind teaching an introductory lesson in biology and infection.

After that we booked an appointment with John, who works in the small lab at the health centre. He let us look through the microscope to see what bacteria and viruses look like up close, to increase our understanding of different infectious agents and how they spread. The training session gave us all a better understanding of how best to carry out our work. It was hard to hide my pride when Abdia scolded me one morning for missing one of the weekly activities on the cleaning schedule.

Several wells and boreholes had been built around Ileret by various aid organisations, but only two were functional. Most had been drilled incorrectly and had become salty or filled with sand. It was clear that improving people's long-term access to fresh water was not as simple as drilling a couple of wells and hoping for the best.

My colleagues and I once again sat down and thought it out. Naomi said she would introduce us to Joseph, the local engineer who had built one of the working wells. We visited the well with him and he told us how he went about building it.

From the beginning we had intended to build a system of wells, but as we investigated how to get hold of materials and tools, how to construct the wells, and how much it would cost, we realised just how difficult it would be. We had to rethink.

GOING TO THE SOURCE

Something engineer Joseph had said stuck with me: 'I started by improving what people were already doing.' It made me realise that we should go to the source, rather than hoping for some magic product or technical solution that would be impossible to maintain in the long run. We started visiting the waterholes, talking to the women and children there, and helping them to dig the pits.

In the end, we came up with a plan together with the villagers. We started by donating shovels to each village. Health promoter Ambia gathered people into water committees that would be responsible for water collection. The next step was to train people in how to reinforce the waterholes with corrugated iron – a material available locally – and to distribute water purification tablets to improve water quality and therefore reduce disease.

By the time my assignment in Ileret had come to an end, the plan was well on its way to being implemented. I left it in the capable hands of Patrick, Abdia, Naomi, Lore, Ambia and Adan, who will be there, working for their home and their people long after all the aid organisations have left. It's the first step of many, but with that team working on it, I know it will get done."

▼ Fozia, a community health volunteer, feeds a sachet of highly nutritious peanut-based paste to two-year-old Murikow, who has moderate acute malnutrition.

MSF'S UK VOLUNTEERS

Afghanistan: Louis Dowse, *Project coordinator*; James Lee, *Doctor*; Sadhbh Lee, *Doctor*; Sarah Grantham-Hill, *Paediatrician*

Bangladesh: Patrick Sharkey, *Water and sanitation manager*; Sarah Mitchell, *Water and sanitation manager*

Brazil: Laura Guardiola, *Nurse*

Central African Republic: Mariana Goncalves, *Water and sanitation manager*; Caterina Quagliani, *Programme manager*; Grainne Larkin, *Doctor*; Alison Antunes, *Health promoter*

Chad: Aoife Nicholson, *Project coordinator*; Charles Hardstone, *Water and sanitation manager*

Democratic Republic of Congo: Mark Blackford, *Finance coordinator*; John Boase, *Logistician*

Ethiopia: Cara Brooks, *Head of mission*; Jasmine Sawyer, *Paediatrician*

Haiti: Eleanor Harvey, *Pharmacist*

India: Nicole Hart, *Deputy medical coordinator*; Mary Rimbi, *Doctor*

Indonesia: Roger Teck, *Head of mission*

Iraq: Julia Smith, *Health promoter*

Kenya: Paul Banks, *Procurement manager*; Marcus Shelley, *Logistician*

Lebanon: Caroline Jones, *Doctor*

Myanmar: Zoe Bennell, *Field communications manager*

Nigeria: John Canty, *Project coordinator*

Palestinian Territories: Elma Wong, *Doctor*; Chris Hook, *Doctor*; Jessica Comi, *Operating theatre nurse*; Gavin Wooldridge, *Doctor*

Serbia: Joan Hargan, *Medical team leader*

Sierra Leone: Molly Brammer, *Midwife*; Clare Templar, *Nurse*

Somalia: Dana Krause, *Head of mission*

South Sudan: Gillian Murphy, *Project manager*; Harriet Fielder, *Nurse*

Sudan: Edward Taylor, *Head of mission*; Matt Cowling, *Advocacy manager*; Fabian Erwig, *HR coordinator*

Syria: Elizabeth Harding, *Head of mission*

Tajikistan: Philippa Lowth, *Nurse*; Ruth Moore, *Finance & HR manager*

Ukraine: Thomas Marchese, *Logistician*

Venezuela: Tamsin Nicholas, *Nurse*

Zimbabwe: Michael Parker, *Project coordinator*

Cover image: An MSF nurse attends to an injured child in Al-Shifa hospital, Gaza, 19 October 2023. Photograph © Mohammad Masri

▼ MSF nurse Rejoice Albino takes the temperature of six-year-old Zanib Hababah, seated with her mother in front of a tented clinic in Wedweil refugee camp, South Sudan, after walking for 15 days from their home in Nyala, Sudan. Photograph © Peter Bräunig

Médecins Sans Frontières/Doctors Without Borders (MSF) is a leading independent humanitarian organisation for emergency medical aid. In more than 70 countries worldwide, MSF provides relief to the victims of war, natural disasters and epidemics, irrespective of race, religion, gender or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

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ABOUT
Dispatches 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 is printed on recycled paper and costs £0.76 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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