

WITHOUT BORDERS

BILA HUDOOD Issue 17 | July-September 2012

**Bringing hope to
victims of violence in
the Middle East**



Lead story:
Malnutrition
in West Africa

page 2

In the region:
Reconstructive
surgery in Jordan

page 3

Around the world:
Syria, Afghanistan
Yemen , Guinea, Haiti

page 5

Special report:
Maternal health
in Somalia

page 7

Interview:
Experiences of an
MSF 'flying doctor'

page 9

Photo essay:
Niger: Saving
Aicha and Mariama

page 11

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Front cover photograph:

A boy at the MSF surgical programme in Amman, Jordan. The programme provides surgical treatment as well as physiotherapy and psychological support to adults and children wounded in war and violence in countries across the Middle East. © Jiro Ose

MSF has been in the UAE since 1992 under the patronage of His Excellency Sheikh Nahyan Bin Mubarak Al Nahyan.

Editorial

Wake up to the crisis of malnutrition

Malnutrition is the underlying cause of death for between three and five million children under five every year. Images of starving children in emergency settings are part of the public conscious, but the reality is that the vast majority of children suffering from malnutrition do so in silence, far away from the public eye.

Insufficient diets are a fact of every day life for hundreds of millions of children. The signs of malnutrition are so common – a short child or a child who has lost some weight - that we don't see these children as sick or suffering. But they are. When a child's diet fails to give her/him all the nutrients the body needs to maintain normal functioning, not only does growth falter, but susceptibility to common diseases increases. This is why a common cold or bout of diarrhea can kill a malnourished child.

Malnutrition is a medical emergency. It weakens resistance and increases the risk of dying from pneumonia, diarrhoea, malaria, measles or AIDS - five diseases that are responsible for half of the nearly ten million deaths in children under five every year. Persistent high rates of child mortality in sub-Saharan Africa and South Asia will not be reduced if malnutrition is not addressed more effectively.

Current approaches that focus on advice about how to feed children are not enough to address the problem of malnutrition. In



places where highly-nutritious foods are not available, or where people don't have the money to buy such foods, what is needed is access to energy-dense, nutrient-rich foods, including animal-source foods to provide the 40 essential nutrients a young child needs to grow.

Simple, highly-nutritious ready-to-use foods (RUFs), specifically designed to address the nutritional needs of young children, have greatly expanded the potential for effective nutritional interventions. MSF and others have documented the successes that can be achieved through use of RUFs - high cure rates with high coverage, as well as low mortality.

Malnutrition is a treatable condition, yet MSF estimates that only 3% of the 20 million children suffering from severe acute malnutrition each year receive the treatment they need.

New strategies of delivering essential nutrients must be developed, and scaled up. RUFs should be placed in the larger context of innovating strategies that can help families give the youngest children the nutrient-rich diets they need.

Lead story



Five-month-old Sani is recovering well from a severe acute respiratory infection. Niger. © Julie Remy
Due to the immunodeficiency caused by malnutrition, severely malnourished children suffer from additional illnesses, such as respiratory tract infections, diarrhea, or even tuberculosis. They may also be too weak to eat and must be fed through a gastric tube.

Malnutrition in West Africa

This year the annual 'hunger season' in the Sahel region of West Africa threatens to be particularly serious, with some areas likely to face acute nutritional crises in the coming months. MSF is stepping up activities to address the seasonal peak in malnutrition rates, while also developing longer-term approaches that can be integrated into its regular health programmes.

According to Unicef, up to 15 million people in six countries in the Sahel are at risk of food insecurity this year. In a region where malnutrition rates amongst children regularly hit the 'warning threshold' of 10 percent, any reduction in people's access to food can see a worrying situation tip into a full-blown nutritional crisis.

This is an area of the world where MSF has long-running, large programmes reducing the high mortality rates among under fives. In 2011, more than 100,000 severely malnourished children received treatment in MSF's programmes in Niger alone.

MSF teams are currently ramping up our emergency response in the areas most

affected in Niger, Mali, Mauritania, Senegal, Chad and Burkina Faso.

Recurring crisis

This is a recurrent problem in the region, which is constantly afflicted with high malnutrition rates. Even in 'good years' hundreds of thousands of children are severely malnourished. In Niger alone, 330,000 children received treatment for severe acute malnutrition in 2010, making it a 'crisis' year. In 2011, which was deemed a 'good' year for farming, the number still reached 307,000, suggesting this is a recurring crisis.

"An emergency humanitarian response is necessary to save lives, but it cannot be the only option."

"We have to rethink what constitutes a 'crisis' and what is 'normal' in this region," says Stéphane Doyon, manager of MSF's malnutrition campaign. "More than 300,000 severely malnourished children is an enormous number – and that's just in Niger. An emergency humanitarian response is necessary to save lives, but it cannot be the only option."

This time around, early warnings issued in late 2011 by the governments of six countries in the region have made it possible to develop an ambitious response – at

least on paper. The financing has still to be obtained, while accessing the region's more remote areas will be a challenge. On top of this, insecurity and violence in some areas, including Mali and Niger, are already complicating the deployment of aid.

Dual response to malnutrition

Many of the aid organisations working in the region have agreed to move from an emergency response towards more structural measures that will help combat malnutrition in the long term. MSF is already implementing these long-term preventive measures, while also responding to the current needs.

"We now know that treating children by giving mothers responsibility for their care, and encouraging prevention by using specialised milk-based products, offer extremely encouraging results," says Doyon.

"Our objective is to help identify the most simple, economical approaches possible so that all children have access to them – just like regular vaccinations or healthcare – which have already been recognised as being effective in reducing child mortality," continues Doyon.

To find out more about MSF's response in Burkina Faso, Chad, Mali, Mauritania, Niger and Senegal, visit: www.msf-me.org

MSF in numbers



Income

- Private 89%
- Public institutional 9%
- Other 2%

How was the money spent?

- Operations 82%¹
- Fundraising 12%
- Management, general and administration 6%



Event triggering intervention

- Armed conflict 39%
- Epidemic 37%
- Health exclusion 19%
- Natural disaster 5%

Project locations

- Africa 62%
- Asia 26%²
- Americas 11%
- Europe 1%

¹ programmes, HQ programme support cost, awareness raising and other humanitarian activities

² Asia includes the Middle East and the Caucasus

What is MSF?

Founded in 1971 by doctors and journalists, Médecins Sans Frontières (MSF) / Doctors Without Borders is an international medical humanitarian organization.

MSF is neutral and impartial, delivering emergency medical care to people caught in crisis regardless of race, religion, or political affiliation.

MSF is independent from any political, economic or religious power. Ninety one percent of MSF's overall funding comes from private sources, not governments.

MSF is transparent and accountable. Every year, MSF provides detailed activity and financial reports including audited and certified accounts

MSF controls the entire chain of its medical services, from the independent assessment of needs to the delivery of medical care, and does not subcontract to other organizations.

In 1999, MSF received the Nobel Peace Prize

In 2002, MSF received the Emirates Health Foundation Prize

In 2004, MSF received the King Hussein Humanitarian Leadership Prize



Medical staff with a patient at the MSF surgical facility in Amman. © Vara Szajkowski/BBC

Giving hope to victims of violence in the Middle East

In a special project at a hospital in Jordan, MSF is treating people from across the Middle East who have been wounded and maimed in war and unrest. The patients are victims of violence who have been unable to get the treatment they need in their own country. At the MSF facility in Amman, doctors are reconstructing their broken bodies and helping them rebuild their lives.

When MSF set up the programme in 2006 it was meant to be a temporary project offering treatment to patients wounded in Iraq. But with recent violence in several countries in the region, the hospital has had to expand, increasing its capacity by 45%. In the last year, the MSF project has taken in patients from Egypt, the Palestinian Territories, Syria, Libya, Yemen and Iraq. There is a long waiting list, and the facility will need to expand again to cope with demand.

Advanced procedures for devastating injuries

In 2011, MSF specialists performed a total of 830 operations at the medical facility in Amman. By the time patients come to the

facility, they are all extremely complicated medical cases. They need advanced reconstructive surgery, often over many months and even years. They stay in a nearby hotel rented by MSF, where they rest in between operations.

“All the patients have something in common, they have been terrorised - by explosions, by bullets, by catastrophe.”

At the hospital the surgeons and medical teams work long hours, under intense pressure, treating complex war-related injuries not usually seen in such concentrations. The complexity of injuries often requires a multi-staged reconstruction of both hard and soft tissues.

The patients show extraordinary bravery and resilience in the face of terrible suffering caused by war and violence. “All the patients have something in common,” says orthopaedic surgeon, Dr Majd el-Rass. They have been terrorized – by explosions, by bullets, by catastrophe. I admire my patients, they are great. They are strong.”

Physiotherapy to bring back mobility and function

As well as reconstructive surgery, patients being treated at the MSF facility receive long-term physical therapy. They generally have never had physiotherapy after their injury, so they come to Amman with severe physical incapacities.

Patients with burn injuries arrive at the MSF facility with severe deformities and limited capacity to use their affected limbs. They need physiotherapy before and after surgery. Similarly, orthopedic patients require physiotherapy to help restore the functionality of the injured limb and improve the quality of the soft tissues and joints.

Patients with maxillo-facial injuries have usually lost the ability to eat solid food, open their mouth, talk, or smile. Physiotherapy after the surgery helps improve the condition of the patient by reducing pain, and restoring the function of the jaw including chewing and swallowing.

Healing the emotional scars

As well as the very visible physical injuries, patients have to deal with the hidden mental pain and deep emotional scars. Disability and disfigurement often mean that men have been rejected for work because of their disfigurement; women have been divorced by their husbands; and children have been ostracized at school.

An MSF team of psychologists and counselors works alongside the surgical and physical therapy teams to care for the psychological and social welfare of patients.

“Many of the young men with severe burns will never look at themselves in the mirror.”

Through counseling, group activities and interaction, the MSF project provides a uniquely supportive environment where doctors and psychologists see their patients emerge from the shells into which they retreated after their injuries.

“Some of them at first refuse to go out,” says psycho-social counselor, Muntaha Mashayekh, who works with children and women. “We need to coax them to do normal things.”

The group activities enable patients to interact with other people with similar problems who are very supportive of each other. This helps them gain back some confidence.

“Many of the young men with severe burns will never look at themselves in the mirror,” says Dr Peter Wigg, psychiatrist supervisor. “But by talking to other people in a similar situation, they start to forget the disfigurement. It’s a big relief to them to look at other people and get used to the idea that you can look at people like this. They can then look at themselves in the mirror and see they are still who they are.”

Children, who make up 10% of the patients, are especially affected by their disabling injuries. Many of them have missed months of education because of their injuries, so a makeshift school has been set up for them in one of the hotel rooms. The children eagerly rush into class the moment the teacher arrives.

“Almost all the children arrive in Amman frightened, timid and not mixing,” says Dr Wigg. “They haven’t played with other children for a long time. Their parents haven’t sent them to school in case they are shunned or made fun of by other children. In Amman, they quickly become lively and interactive when they find themselves surrounded by other children like them, and none of them care. They just play together and they blossom.”



A teenager takes his first steps supported by a physiotherapist. He enjoys his first moments of satisfaction after surgery and weeks of physical therapy. Walking again after months in a wheelchair is a new challenge for the wounded. © Valerie Babize

Dr Nancy Foote, medical coordinator, says, “While the Amman project is different from the usual MSF model of life-saving interventions, it is awe-inspiring to see how the surgeries and therapy here change the lives of people who were once too disabled to work or participate in society. They are given new lives here.”

MSF project in Jordan

From 2006 to 2011:

- 1,666 admitted patients
- 4,087 surgical interventions
- 10,965 physiotherapy sessions

The project has 90 national staff and 16 international staff.

MSF does not accept any government funding for its project in Amman. All its funding comes from private donations.



After plastic reconstructive surgery and physiotherapy, 13-year-old Khetam is now able to hold a crayon and colour – something she had not been able to do since she was badly burned in an explosion in Iraq in 2010. © Enass Abu Khalaf



Iraqi patients in their room at the hotel where they live while receiving medical treatment. © J.B. Russell



A team of surgeons prepares to operate on a 7-year-old child. © Valerie Babize



Young Iraqi men during a psycho-social group session. © J.B. Russell

Syria
Safety of wounded and medical workers must be prioritized

In recent visits to parts of Syria, after reaching the governorates of Homs and later Idlib, MSF teams found wounded people and medical workers remain targeted and threatened, preventing people from receiving life-saving emergency medical care.

“Being caught with patients is like being caught with a weapon,” said an orthopedic surgeon whom MSF met in a village in Idlib governorate. “The atmosphere in most medical facilities is extremely tense; health care workers send wounded patients home and provide only first aid so that facilities can be evacuated quickly in the event of a military operation.”

MSF calls on all parties to the conflict to fully respect the safety and integrity of wounded people, doctors, and healthcare facilities. MSF also calls for increased political and diplomatic efforts to ensure the safety of patients and medical workers, without the use of force.

MSF has been seeking official authorization for several months to work with medical personnel in the Syrian governorates most affected by violence. To date, none of the organization’s efforts, either directly with Syrian authorities or via various intermediaries, have succeeded.

While MSF has only a partial view of the medical situation inside Syria due to the lack of authorization to work in the country, the information obtained by MSF in Idlib is consistent with what it witnessed in Homs.

“Health facilities are being targeted, thus endangering patients and preventing healthcare workers from doing their jobs.”

We saw militarized healthcare facilities, meaning that access to medical care depends on which side you belong,” said Brice de le Vingne, MSF’s director of operations in Brussels. “Health facilities are being targeted, thus endangering patients and preventing healthcare workers from doing their jobs.”

During its short time in the Idlib area, the MSF team was able to perform some medical work.

“In one public hospital we worked as hard as we could for three days straight,” recounted an MSF surgeon. “We operated on 15 wounded people and then had to pack everything up in 10 minutes after being notified of an imminent attack. Elsewhere in the Idlib region, an operating room was closed because it was simply too dangerous to perform surgery on wounded patients,” he said. “Doctors were threatened, and they discouraged us from setting up a medical facility because the situation was so risky,” he said, adding that he was told the hospital had been severely damaged.

Absent official authorization to operate inside Syria, MSF continues to support networks of Syrian doctors in Homs, Derah, Hama, Damascus and Idlib, delivering supplies and medicines from neighboring countries. MSF also treats those who were wounded or tortured in Syria at a surgical hospital in Amman, Jordan. Additionally, MSF is providing primary health care and psychological support to Syrian refugees in Lebanon.

MSF reiterates its call for authorization to work inside Syria.

Afghanistan
Maternity unit closed after attack

MSF suspended medical activities in its recently opened maternity hospital in Khost Province in eastern Afghanistan, after an explosion inside the hospital compound on 17 April. Seven people were injured in the blast, including one child.

“Nothing is more important to us than safety in our hospitals,” said Benoit De Gryse, MSF’s country representative in Afghanistan. “As a medical organization and as guests in Khost, we have to rely on others to ensure we can treat patients without the threat of violence. We call on all relevant actors in Khost to do what they can to make sure that the environment is safe enough for us to return.”

MSF will continue to monitor the situation in Khost and carry out consultations with the community there. The organization is also awaiting results of investigations into the explosion by all relevant authorities.

“It was a difficult decision to suspend our work in Khost, where we have invested so many resources and where more than 100 staff members are working, but unfortunately the circumstances make it impossible to continue our work,” said De Gryse. “It is unacceptable that the lives of our patients should be put at risk when they are seeking health care.”

There is an enormous need for free quality maternal health care in eastern Afghanistan, and MSF deeply regrets that the current environment makes it impossible to continue its work at the maternity unit.



An MSF patient takes a dose of the new oral cholera vaccine in Guinea. © David Di Lorenzo



MSF staff members and a patient at Nap Kenbe Center in Haiti. © Yann Libessart

Yemen
MSF treats bomb-blast victims

MSF treated increasing numbers of people amidst increased violence and fighting in southern Yemen in April and May.

In May, MSF teams received over 50 patients admitted to health facilities in Jaar, Lawdar, and Aden, following a new wave of violence and fighting around Zinjibar, capital of Abyan Governorate, and Lawdar, 100 miles northeast of Zinjibar.

Eight severely injured people were transferred to Aden from an emergency health post in Jaar, while 43 people were treated at Lawdar Hospital. All patients were civilians suffering from bomb-blast injuries. MSF staff at Lawdar were unable to refer patients to other health facilities as road blockages made travel impossible.

At an emergency health post set up in a post office in Jaar, MSF and staff from the Ministry of Health provided basic emergency care to the injured. The conditions were extremely challenging, which have made it impossible to obtain essential medical supplies, to transfer emergency patients to the hospital, or to communicate with teams in Aden.

During 15 days of heavy clashes in April, more than 200 heavily injured people were received in the emergency room of Lawdar Hospital, where MSF has been working since January 2012.

MSF has been working in Yemen since 1994 and continuously since 2007. MSF does not accept any government funding and relies solely on private donations to fund its activities in Yemen.

Guinea
Vaccinating against cholera

In a vaccination campaign led by MSF, more than 170,000 people in the Boffa region of Guinea recently became the first in Africa to receive a new two-dose oral vaccine for cholera. The initiative could spur an improved response to cholera epidemics worldwide.

In collaboration with the Guinean Ministry of Health, MSF focused its response on Boffa, a coastal region in Conakry, which was considered a hotspot of the epidemic.

“We were faced with an outbreak and we wanted first to protect people by vaccinating them, and to limit the spread of cholera,” said Dr. Dominique Legros, MSF’s innovation initiative manager in Geneva. “MSF is regularly involved in responding to cholera outbreaks and it is always difficult to control the disease. Because cholera evolves quickly, oral vaccination provides us with a new tool to try to contain [it]. If we can control the most active spots, we can reduce the spread of cholera.”

The cholera vaccine is approved by the World Health Organization (WHO). Efficacy is over 60 percent for at least two years. MSF has used the vaccine as a preventive measure in endemic countries, but this is the first time the vaccine was used in response to an outbreak in Africa.

Oral cholera vaccination represents a promising new tool in the response to outbreaks, but it cannot be used alone. Awareness-raising activities, improved hygiene practices, and treatment are still important components of the cholera response. The provision of safe water and sanitation remain essential during all outbreaks.

Haiti
MSF Opens Surgical Center

MSF opened a new emergency surgical center in the Haitian capital, Port-au-Prince, in April. The 107-bed center, named ‘Nap Kenbe’— Creole for “staying well”— is located in the Tabarre neighbourhood.

It is the third facility providing emergency treatment to be opened by MSF in Port-au-Prince since the 2010 earthquake, and its fourth in the Ouest department.

“By bringing together Haitian health professionals and high tech equipment, the Nap Kenbe center makes it possible to deliver high quality care in a city where many Haitians have had no access to emergency trauma treatment,” said Gaëtan Drossart, MSF’s head of mission in Haiti.

The center treats victims of accidental trauma, such as falls and road accidents, and victims of violence who have suffered beatings, assaults, and gunshot wounds.

“MSF is now supporting the Ministry of Public Health and Population with 600 hospital beds in Haiti for emergency care,” said Drossart. “This is still far from adequate, but is nevertheless an advance.”

In a country where 75 percent of the population lives below the poverty line, and where referral facilities are vastly inadequate, MSF’s new center will improve access to surgical care for the population of Port-au-Prince’s metropolitan area.

MSF has been working in Haiti since 1991, responding to crises and natural disasters. After the earthquake of 2010, MSF launched the largest emergency operation in its history.



Makeshift hospital in Idlib governorate destroyed by armed forces end of March. © MSF



Inside MSF’s maternity hospital in Khost. © Hilde Cortier/MSF

Maternal Health: Another major challenge for Somalia



Woman in MSF’s Guri El hospital in southwestern Somalia. © Otavio Omati

Dr Hamida Shakib Mohamed just helped deliver a healthy 3.6 kg boy. It’s a good thing the mother made it to this health centre; it was a difficult labour and she needed the assistance of a skilled birth attendant to complete the delivery.

She lives in a village about 110 kilometers north of here, but her father insisted she make the trip. He appreciates the MSF supported services here after his wife was treated for post partum hemorrhaging just a few months ago. We give the “right care,” as Dr Hamida puts it, “so people come to us.”

Maternal and obstetric care

MSF expanded its medical services in Galcayo North in December 2011 by adding maternal and obstetric care. The number of deliveries has since boomed to about 200 per month, many coming from increasingly far away.

Dr Hamida is happy about this. She is Somali, educated in Mogadishu in the 1980s, but holds a foreign passport. She has lived abroad for most of the past two decades. “I’m free and I want to give my energy to the Somali community,” she says, now that her children are grown. She could not be needed more.

Insecurity in Somalia

Insecurity in Somalia prevents MSF and others from keeping international staff on the ground for very long and some places are completely inaccessible. Therefore, MSF relies on its Somali staff for the bulk of its work.

It’s a challenge to keep standards up, but through intensive training courses, on-the-job coaching during “flash” visits and advice from experts based outside Somalia, dedicated staff, like Dr Hamida, keep up a high quality of care.

The war in Somalia is now going into its 21st year. After the drought and the enormous crisis of last year, people survive and live from hand to mouth, and are still highly vulnerable to infections, disease and malnourishment.

Maternal mortality

Most of the patients are happy to be here. Almost all of them echo Shamso, who gave birth to her third child last night. “I know I can get good health care here,” says Shamso. It’s also free of charge, a factor that weighs heavily in most of the women’s choices.

Shamso is lucky; she didn’t have any complications before or during labour. Somalia has amongst the highest maternal mortality rates in the world rates – 1,200 in every 100,000 live births, according to various sources. In other words, more than one mother dies for every hundred children born, and the trials faced by so many other women are immense.

Down the hall, a very young and sad looking woman recovers after losing her child. She arrived two days ago while suffering eclamptic fits – convulsions that can occur during labour. A caesarian section was needed but in Somali culture such a procedure cannot occur without the consent of the husband.

He could not be found in the displaced persons camp on the outskirts of town where they live, and although mobile phones are common in Somalia, no one had his number – not even his wife who now sits quietly next to her daughter. After twelve hours, an uncle from the father’s side consented, but the baby had died by then.

Fistulas

In another room lies a woman who came from Ethiopia after a four day labour. It was too much for the baby, who died shortly after birth. It may have been too much for the mother, too. She lies in a delirious state, chest heaving unevenly, not sure where her baby is. She’s passing urine unchecked and the midwife thinks she may also have a fistula.

Obstetric fistulas, the tearing that occurs from obstructed labour, are common in Somalia. They leave women in pain and incontinent. It is a devastating and permanent condition unless surgery corrects it.

MSF staff in Somalia

Having children can be risky in Somalia, but delivering them can be, too. “Security is shaky,” says Dr Hamida. Last Friday, she was called in at night to assist with a retained placenta. On the way to the hospital, a drunken policeman stopped them waving his AK-47.

He told everyone to get out but, luckily, after pleading that the doctor was needed for an emergency at the hospital, the policeman waved them on. After a blood transfusion, she

was able to stabilise the patient. Despite the danger, Dr Hamida is happy to be here and she likes that it’s so busy “because you are achieving something.”

Without the dedicated work of employees like Dr Hamida, MSF could not continue to run programmes in Somalia. Maternal care is only one of MSF’s numerous medical activities throughout the country, but Somalia has extremely high maternal mortality, so maternal care is an essential part of MSF’s health care package. Having children in Somalia is a dangerous activity, made slightly less so by the huge effort of MSF’s Somali staff.

MSF in Somalia

MSF has been working in Somalia continuously since 1991. MSF relies solely on private charitable donations for its work in Somalia and does not accept any government funding.

In the period from May to December 2011, MSF was running 22 projects in many different parts of Somalia and in refugee camps for Somalis in Ethiopia and Kenya.

In this period, covering the height of the crisis, MSF treated over 78,500 patients for severe malnutrition and over 30,000 for moderate malnutrition, more than 7,200 patients for measles and vaccinated over 255,000 persons against disease in the Horn of Africa. MSF assisted in over 6,000 deliveries and provided over 537,500 out-patient consultations.

Inside Somalia, MSF will not step up its activities or open up new projects until its two colleagues - Montserrat Serra and Blanca Thiebaut, abducted in Dadaab and held in Somalia since October 2011 - are reunited with their families.

Maternal death: a preventable tragedy

Worldwide, around 1,000 women die every day of complications during pregnancy and childbirth.*

99% of all maternal deaths occur in developing countries.

MSF provides obstetric care in around 30 countries.

To explore our interactive maternal health centre and find out how we prevent and treat complications during childbirth and pregnancy, visit: www.msf.org.au/obstetrics

* World Health Organisation (WHO)



Mothers with young children waiting to be seen by the medical doctor at the MSF hospital in Guri El. © Peter Casaer/MSF



MSF hospital in Guri El. © Otavio Omati



Educational mural on breastfeeding in the out patient waiting area at the hospital MSF runs in Galcayo South. © Sven Torfinn

Reaching people in ‘the middle of nowhere’

One of MSF’s ‘Flying Doctors’ talks about his experiences



Dr Erwin Guillergan on an assignment in India.

Dr Erwin Guillergan is a pediatrician and one of MSF’s ‘Flying Doctors’. Originally from the Philippines, he has worked in Afghanistan, Pakistan, India, Myanmar, Ethiopia, Malawi, Swaziland and Papua New Guinea. He has spent seven years with MSF and recently started his role as a flying medical coordinator. His job is to coordinate MSF’s medical assessments and interventions in emergency situations, and to fill in any gaps in medical coordination.

We took the opportunity to catch up with Dr Guillergan while he was in Dubai briefly between assignments. An obviously caring and resourceful humanitarian worker, he answered our questions frankly and gave us a fascinating glimpse of the life of an MSF doctor.

Can you tell us about your most memorable assignment with MSF?

It was in Ethiopia - my best mission so far. The project was catering mainly for Ethiopian and Sudanese migrant workers coming into the northern-most part of Ethiopia to work in the fields. So at any given time just before the rainy season, we had three to four hundred thousand migrant workers in that area. We were running a mini-hospital in the middle of nowhere.

Three months after I arrived, there was a large cholera outbreak. So we set up and ran

a cholera treatment centre. I think it was the most memorable assignment I had because there was one outbreak after another. There was a cholera outbreak, there was a malaria outbreak, there was a Kala Azar outbreak, there was the hunger gap, on top of the usual things that we were doing. I was exhausted at the end: I was at the point of crying, and saying I’m going to leave now, but at the end of the day, it’s quite heart-warming to see how your patients are doing and to manage such a project.

We had quite a lot of patients coming, and the sad part was that when they come from other parts of Ethiopia, they succumb to a lot of diseases like malaria, Kala Azar and HIV, and some come very late to the clinic. When you have something like Kala Azar, it’s very difficult to reverse or kill the parasite, so a lot of them die nameless, in an unknown place. It’s quite sad, and I think MSF just being there, answering to people’s needs on a day-to-day basis is creating quite a big difference.

Do doctors working in remote areas and in difficult circumstances ever feel frustrated because they want to be able to do more?

I think most of the frustration comes when doctors feel they want to do more, if only they could have used a certain drug or technology. But in some contexts it’s totally different. If you are out in the bush, you can’t do the things that you would have done back in

New York or in London. You don’t even have a Doppler or an x-ray in some places. So you have to rely on your skills as a doctor to manage your patients the best that you can. It always has to go back to your skills.

“If you are in the middle of nowhere, as soon as you’ve identified your limitations, you have to work from that basis.”

The thing is, if you are in the middle of nowhere, as soon as you’ve identified your limitations, you have to work from that basis. You have to be very resourceful to find the means to provide maximum quality care for your patients. For me it’s a matter of accepting that I’m here, I’m here now, this is what I can do, this is what I have, how can I make the most of what I have to improve this situation. And then it’s a matter of doing it.

MSF has a lot of experience in providing medical care in less-than-ideal circumstances. Can you tell us more about that?

Yes. We don’t often get the latest drugs or equipment that we want into the country because of licensing or import restrictions. So MSF has developed protocols to deal with such situations by providing alternative options. The protocols guide you, if you don’t have a particular drug, what is the other alternative and how do you manage this case? If we stick to the MSF protocols that we have, we manage patients without compromising



Travelling by boat to reach families stranded after the floods in Bihar, India.

quality. So if we have the basic drugs, we have our skills as doctors, we can have more impact, rather than waiting for something that may never come.

Part of your role now is to respond to natural disasters when they happen. How quickly does MSF mobilize assistance after a natural disaster?

To have a larger impact, things need to be done soon after the disaster happens. If you really want to save lives, that’s the time you should be there – the first two weeks. MSF is experienced in mobilizing assistance quickly, but often there are diplomatic and visa issues, with the government denying that there is a need for assistance. It’s a matter of the government saying, ‘Yes it’s a big thing. We need help.’ I think it’s basically that. In Turkey for example, when there was an earthquake, the assessment team was sent immediately because we were given access. Or in the Philippines for example, a flood covered almost half of Metro Manila in 2005. The floods happened on a Monday, by Wednesday the whole team was there.

How do you reach the people needing assistance after a natural disaster?

It depends on the country and context. But one thing I love about working in emergencies is that we can make things happen very quickly. In India for example, when the dam between Nepal and India broke, there was a flood in Bihar. There was a massive amount of water everywhere. It was a huge vast place so we had thousands and thousands of people who were stranded or had set up makeshift tents in dry areas.

“We knew we needed a boat. One week later, we had two boats sent to us from Amsterdam.”

Some of the displaced people were four to six hours away from the capital of Bihar by boat. Nobody could reach them, so we knew we needed a boat. One week later, we had two boats sent to us from Amsterdam. We had three mobile clinics, one big vaccination team, and we provided non-food items to vulnerable people. With the boats, we were able to visit places that the government couldn’t get to. The biggest success we had was we were able to rescue 30 to 40 families who were stranded and nobody had known about.

Of the MSF projects you’ve worked on, which would you say is having the most impact on the ground?

Last year we set up an MSF trauma hospital in Kunduz in Afghanistan. I believe we are creating a lot of impact there because we are treating patients who are victims of bomb



Dr Guillergan oversees an emergency delivery at an MSF clinic in Manipur, India. © Sami Siva

blasts or have war injuries. The number of patients we are seeing and the amount of work being done is just tremendous. The acceptance by the community has been good, and other NGOs are saying it’s amazing what MSF is doing in this place in this context. For me it’s the closest project to my heart so far.

It’s a very insecure and difficult context, but I’ve never seen such dedicated staff, and the team is quite amazing. I think the realization and acceptance that this is going to be a difficult mission was there right from the very beginning. In the first multiple casualty situation we had, 14 victims of a bomb blast were brought to the hospital. It was challenging for the whole team, but we were able to manage well.

Do you ever get used to the human suffering that you encounter in your work?

The first time that I actually cried was in Ethiopia. I had a patient who was 17 years old. He had travelled several miles and arrived at two in the morning with a seizure. We found he had money (800 birr) clenched in his hand. The man was almost naked, he didn’t have slippers, he didn’t have clothes. When he was lucid, I suggested he buy a few things for himself with his money. He said ‘I’m going to send this money home’. He died from Kala Azar the next day, and I really cried. It was quite traumatic for me. I realize people leave their families so they can earn some money and send it back home, but for this nameless person to die this way – it was senseless. 800 birr is a lot of money there, he could have bought one or two cows, six or seven goats.

And now he couldn’t send the money, and we don’t even know his name. So it was heavy for me.

I promised myself I would never cry again. I try my best to be rational with quite a lot of things, and over the years I’ve learned, but there are some incidents that you realize are senseless, and it saddens me. I tell my friends ‘I’m a softy after all.’

How do you cope with the emotional toll of your job?

I do quite a lot of things. Recently I discovered the stress-relieving benefits of cooking. So I cook for other staff, we gather, we have some comfort food and talk. If I don’t cook I always have my sketch book with me so I draw or paint. I have a friend who knows that when I am a bit stressed or depressed, I draw faces. If I’m drawing trees or landscapes, she says, ‘Ah, you’re happy’.

What do you like most about your job as a flying doctor?

The job is very challenging. It’s not the same every time. It keeps you on your feet, it keeps you resourceful, flexible, and the best thing is that you are able to make decisions right there and then. For example in emergencies you are able to reach more people in the shortest possible time and you’re able to maximize your experience and skills, bringing all your experience from the past into the specific situation. This is what I love most about the job.

Niger: “What will I do to feed Aicha if her mother dies?”

This photo essay tells the story of a family caught in crisis during the ‘hunger gap’ in Niger. Aboubacar is torn between caring for his two-year old daughter Aicha, who is severely malnourished, and his wife Mariama, who has just lost their second baby and whose life is now in danger. We follow Aboubacar as he races to save his wife and daughter.

All photos © Julie Remy

1 Aboubacar was at the MSF therapeutic feeding centre in Dakoro, Niger, with his daughter Aicha, who is suffering from severe malnutrition, when someone came to tell him that his 20-year-old wife, Mariama, has just lost their second baby. She was six months pregnant. Someone from the village called him to say that it was time to buy a shroud for his wife. He started crying in despair, thinking there was nothing to do to save his wife. “What will I do to feed Aicha if she dies?” he asks.



2 Aboubacar wants to go and see if his wife is still alive, but refuses to leave without Aicha. He decides to take her with him.



3 On the way home in the MSF ambulance, Aboubacar weeps when he thinks about his wife. He is afraid of what he will find when he arrives.



4 On the road home, Aboubacar sees his father and asks for his permission to bring his wife to the hospital



5 Aboubacar and Aicha arrive home. Aboubacar stops for a split second wondering what state he will find Mariama in.



6 An MSF midwife and an MSF health promoter approach Aboubacar's house.



7 The midwife finds Mariama on the ground fully covered, but breathing in a corner. Aboubacar's mother helps and prepares Mariama to leave for the hospital.



8 Aboubacar carries his wife Mariama in his arms to the MSF ambulance.



9 Mariama, Aicha, Aboubacar and his mother are ready to leave for the hospital.



10 When they arrive at the maternity unit at Dakoro hospital, Aboubacar gently lays his wife on the examination table.



11 The gynaecologist examines Mariama and diagnoses an infection of the uterus. She has lost a lot of blood. However, the infection is easily treatable with the right medicines, and her life should not be in danger.



12 After making sure his wife was in good hands at the Dakoro Hospital, Aboubacar and Aicha return to the MSF feeding centre to pursue Aicha's treatment. With good treatment and care, Aicha will make a full recovery.

MSF in Dakoro, southern Niger:

- In 2011:
- 40,000 women had antenatal consultations
 - 11,110 children were hospitalized
 - 3,400 babies were delivered, including 300 caesarean births
 - 12,500 malnourished children received outpatient treatment
 - 1,451 children with severe malnutrition and medical complications were treated in the inpatient feeding centre.

MSF AROUND THE WORLD

أطباء بلا حدود في العالم

MSF carried out medical activities in 68 countries in 2011

أجرت منظمة أطباء بلا حدود برامج طبية في ٦٨ بلداً خلال عام ٢٠١١

Total expenditure: 899 million euros

مجموع النفقات: ٨٩٩ مليون يورو

8,407,596 outpatient consultations

446,197 admitted patients

73,135 major surgical procedures

عدد الاستشارات للمرضى الخارجيين: ٨,٤٠٧,٥٩٦

عدد المرضى الداخليين: ٤٤٦,١٩٧

عدد العمليات الجراحية الكبرى: ٧٣,١٣٥

31,882 field staff, of which:

92 per cent national staff

8 per cent international staff

٣١,٨٨٠ موظفاً ميدانياً

٩٢٪ من الموظفين المحليين

٨٪ من الموظفين الدوليين

348,017 severely malnourished children

provided with treatment

191,960 babies delivered

821,812 antenatal consultations

تم علاج ٣٤٨,٠١٧ طفلاً مصاباً

بسوء التغذية الحاد

تمت المساعدة في ١٩١,٩٦٠ ولادة

تم تقديم ٨٢١,٨١٢ استشارة سابقة للولادة

All the above figures are for the year 2011. For a full report on MSF activities globally and in every country where we work, see the MSF Activity Report 2011 (available online from August 2012 at www.msf-me.org)

جميع الأرقام هي لعام ٢٠١١. للحصول على التقرير الكامل لأنشطة منظمة أطباء بلا حدود السنوي وللبلدان حيث نعمل، يرجى قراءة التقرير عن أنشطة منظمة أطباء بلا حدود لعام ٢٠١١ (النسخة العربية ستكون متوفرة ابتداءً من أغسطس/آب ٢٠١٢ على الموقع: www.msf-me.org)