SYRIA

THE NEEDS RIGHT NOW AND IN THE FUTURE

South Sudan
Displaced and in Danger

Libya
Assessing the medical needs

Iraq
The Frontline in Mosul

Global
How MSF treats Malnutrition
For those observing the month of Ramadan, there will be few occasions when we feel the needs of others more keenly. The act of fasting will for many serve as a reminder that there are those who have known hunger throughout their lives – lives that will change little without a broader shift in circumstances. That people suffer from malnutrition, in our world of plenty, is difficult to comprehend. That nine children die from it every minute, is difficult to express, because even one is unacceptable.

However, ‘unacceptable’ does not equate to unbeatable, because the means to fight malnutrition is within our grasp.

From assessment, to therapeutic food and education – right now, MSF teams in South Sudan, Nigeria and Yemen are working to ensure our patients receive the treatment they need.

This response, and our responses in almost 70 countries around the world, are based on a medical need – regardless of whether they are in the news. Our teams are able to respond to these needs because of people like you – people who continue to read about our work, who engage when it would be easier to look away.

Our work will continue for as long as there is a need, and for as long as people like you believe in it.

For your support and belief, I say thank you.

Yours sincerely,

Mohamed Bali
Executive Director
Médecins Sans Frontières UAE

Front cover photograph: Surgeons operate at the Amman reconstructive surgery hospital in Jordan, where MSF treats many patients from Syria in need of extensive treatment. © Alessio Mamo.

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

MSF is a member of International Humanitarian City, UAE.
MSF: SITUATION UPDATES

Every day our teams around the world are providing emergency medical care to people affected by conflict, epidemics, disasters or lack of access to health care. Our work is funded mainly by donations from the public. This gives us the independence to provide quality medical care to those who need it most, regardless of race, religion or political affiliation. Here we bring you updates from some of our projects around the world.

ETHIOPIA

THOUSANDS HIT BY OUTBREAK OF ACUTE WATERY DIARRHOEA DURING WORST DROUGHT FOR DECADES

A serious outbreak of acute watery diarrhoea is sweeping through Dools zone, in Ethiopia’s Somali region, exacerbated by one of the worst droughts in 30 years. In response, MSF teams are working alongside Ethiopian health authorities to bring the outbreak under control, while warning that more external funding and resources are urgently needed to stop the disease from spreading further.

Officially declared on 7 April, the outbreak has affected more than 16,000 people in the whole region since the start of the year, with about 3,500 new cases per month, according to local authorities. The government has so far deployed over 1,200 health professionals, including nurses and doctors, and set up 100 centres to treat people with the disease. Even if an overall decline in acute watery diarrhoea numbers is registered in the region, the risk of re-infection remains high.

NIGER

INNOVATIVE VACCINE COULD PREVENT THOUSANDS OF CHILD DEATHS

Rotavirus infection is the leading cause of severe diarrhoea and kills an estimated 1,300 children each day, primarily in sub-Saharan Africa. A new and innovative vaccine – known as BRV-PV – has been shown to be both safe and effective against rotavirus, according to the results of a recent trial in Niger, published in the New England Journal of Medicine on 23 March. The new vaccine is particularly adapted to the strains found in sub-Saharan Africa.

“This is a game-changer,” says MSF Medical Director Dr Nicole Schrauwen. “We believe that the new vaccine can bring protection against rotavirus to the children who need it most.”

YEMEN

URGENT SCALE-UP OF AID NEEDED IN YEMEN

Speaking at a donor conference in Geneva on 25 April, MSF made the case for an urgent scale up in the humanitarian response in Yemen. To avoid total collapse, the healthcare system in Yemen desperately needs support. In the 11 governorates where MSF works, the shortage of functioning health facilities, specialist care, equipment, medical staff and supplies are severely compromising people’s ability to access lifesaving medical care. Those suffering from chronic diseases are dying avoidable deaths, while the most vulnerable groups – children, pregnant women and the elderly – are at heightened risk of disease. Resuming the payment of salaries to civil servants, essential medical staff, is vital to stop the healthcare system collapsing.

DRC

MSF STAFF TREAT MEASLES CASES ACROSS FIVE PROVINCES

Since November 2016, MSF has vaccinated over 675,000 children against measles, and cared for more than 14,000 patients in health zones throughout five provinces in the Democratic Republic of the Congo (DRC): Maniema, South Kivu, Tanganyka, Ituri and Equateur (as of 28 April).

To guarantee effective immunisation coverage (the vaccination of 95% of children aged 6 months to 14 years) the teams must cover even the most remote areas. In a country as huge as DRC, which also lacks road infrastructure, this can mean travelling hundreds of kilometres on motorbike, crossing rivers in dugout canoes, or walking for days through inhospitable forests.

SYRIA

HOSPITAL BOMBING IN NORTHERN SYRIA

25 March 2017: At around 6pm Latamneh hospital in northern Hama governorate was targeted by a bomb dropped by a helicopter, which hit the entrance of the building. Information collected by the hospital medical staff suggests that chemical weapons were used.

Two people died as a result of the attack, including Dr Darwish, the hospital’s orthopaedic surgeon. Thirteen people were transferred for treatment to other facilities. “The loss of Dr Darwish leaves just two orthopaedic surgeons for a population of around 120,000,” says Massimiliano Rebaudengo, MSF’s head of mission in northern Syria. Following the attack, the hospital went out of service for three days, after which the emergency room reopened.

COLOMBIA

MSF REACHES SURVIVORS OF COLOMBIA MUDSLIDE

In the early hours of Saturday, 1 April, heavy rains caused three mudslides in Colombia, striking landslide-prone areas in several parts of the town of Mocoa. In the flooding of the Mocoa, Putumayo and Guaviare rivers, some 350 people were killed and a further 2,000 were reported missing, according to the government. The towns were destroyed, leaving around 30,000 people homeless.

Within hours of the disaster, MSF staff were sent to Mocoa from the city of Villavicencio, Colombia. Over the next two weeks, 11 MSF teams began to provide psychosocial support and medical care at one of the shelters in the area.
EMERGENCY UPDATE

MOBILE HEALTHCARE: SOUTH SUDAN

South Sudan is the world’s newest nation. It is rich in oil but, following years of war, it is also one of the least developed regions on earth. The fighting of the past three years has forced millions to flee their homes, split much of the population along ethnic lines and paralysed agriculture, resulting in a precarious supply and lack of access to food. Siegfried Modola, freelance photographer, spent a week with MSF teams in the county of Leer to report on the situation.

TOUCHING DOWN!

We take off early in the morning from the international airport of the capital, Juba, on an MSF flight.

The airport in Juba is a hub of humanitarian activity: numerous aid organisations are trying to supply the population of the country, who are in desperate need of even the most basic services.

I am on the eight-seater plane with MSF medic Dr Philippa Pett and MSF security focal point Georg Geyer, our team leader. It’s nearly a two-hour flight to Thaker in Leer county, to the north of South Sudan. The plane is full of medical supplies and other equipment needed for our stay in the bush for the next eight days. We land on a dusty and windy space of open bush. It’s a scene of desolation. At a distance are several tuñuls (mud huts), but few people can be seen.

Thaker was the scene of skirmishes between different armed groups just two weeks prior to our arrival. We are told that most young men left with the cattle, to a different location for security reasons.

Minutes after our arrival we meet with James, an MSF supervisor who tells Dr Philippa that there is a woman with serious pregnancy complications waiting for treatment close by, inside a hut. The plane takes off without us just as we approach the sick woman.

MSF has few planes operating within the country, so they run on a tight schedule. Every extra minute spent on the ground is a wasted minute in a different location.

Dr Philippa examines the woman, who is heavily pregnant. She has been in labour for two days, the baby is stuck and she hasn’t felt it move for over 24 hours. “She needs to be referred to our hospital in Bentiu,” she says.

The plane that took off minutes before is called back by radio after Dr Philippa gets a green light for the referral from the MSF team in Juba. The woman is flown with a caretaker to the MSF hospital inside the UN Mission in South Sudan (UNMISS) base in Bentiu, Rubkona county, for emergency treatment.

In the evening of that same day, the team receives the wonderful news that the mother is well and that the baby has been born and is weak but alive.

TREATING PATIENTS

This is a hot, inhospitable place. It feels incredibly dry. The wind burns the skin. I am constantly thirsty. It is not a place where one can afford to become sick. I wanted to know all these mothers and children cope in such a hostile environment.

A woman arrives with her daughter who shows signs of severe malnutrition. The baby looks much younger than her real age.

An old woman arrives escorted by a relative – she walks slowly, supported by the other woman. Some of the people I meet have come a long distance for the chance to receive medical treatment. Another woman lies on the ground in the queue to be seen; she is too weak to sit up straight.

A pregnant woman is stabilised after becoming unconscious. In the three days I’m in Thaker, the MSF team treats more than 600 patients.

Late in the afternoon a woman with suspected meningitis is escorted to the clinic by a group of relatives.

STAYING SECURE

The situation can change from one moment to the next, and the MSF team needs to be prepared to act accordingly. The priority is to minimise the risks of danger from armed groups. MSF staff are not usually a target in such conflict scenarios. However, the unpredictability of the situation means that things can go wrong.

On the afternoon of 22 March, five days into our assignment, we hear reports from local people of troop movements in the area, and rumours of a possible attack in the vicinity.

MSF’s project coordinator in Juba makes the decision to pull the international team out the following day to minimise their risk of being caught in the crossfire of the conflict.

On the morning of 23 March, after setting up our second clinic in Gier, a few kilometres from Thaker, we make our way back to the original drop-off point to wait for the same MSF plane to take us out of the area.

Speaking to James, the MSF Supervisor, I get an insight into some of the risks faced by staff and patients:

“It is a dangerous job that we do as health workers. We follow the population wherever they are or go. Once I spent eight hours with others in the swamps to hide from gunmen. Five people were shot and died around me during this time. I remember seeing a mother holding her child, trying to breastfeed him. She didn’t know the child had died. I love this job nevertheless. I love serving my community. People need medical care. They need us to be here to help them. Many are dying because they can’t reach a hospital in time. Many children are dying because of malnutrition and because they don’t have the appropriate vaccines.”

THOSE WHO STAY BEHIND

While there are a number of MSF expatriate workers in South Sudan, the vast majority come from the country itself. “This story should be about the local MSF staff on the ground. They are the ones who face most of the dangers in their profession. They are targeted by armed gangs who believe that they have money as they work for an international organisation. My job here is to train them, to make sure they know how to diagnose and treat patients. They are the ones who stay behind when we leave,” says Dr Philippa.

To read Siegfried’s full article, see more photographs and learn about MSF’s work in South Sudan, please visit: msf.exposure.co/medicine-on-the-go
**MEDICAL UPDATE**

Images: Dr Tankred Stoebe

**MEDICAL EVALUATION: LIBYA**

**FROM MISRATA TO TRIPOLI**

April 2017 - The fighting continues in Libya, a country fragmented by a multitude of power centres. Since mid-2014, the humanitarian situation has deteriorated due to the resumption of the civil war and political instability. Millions of people across Libya are feeling the impact, including refugees, asylum-seekers and migrants. Dr Tankred Stoebe spent the month of January in the country coordinating a medical assessment that took him from Misrata to Tripoli. This is his account.

**MISRATA**

Ismaïl and Maïdji were both 19-year old students when the revolt began in Libya in 2011. Like thousands of others, the two fervent idealists took up arms against Mu'ammar Gaddafi’s regime with no training or understanding of military strategy. The two young men, who both narrowly escaped death, met much later in Malta. During the fighting Maïdji sustained wounds to the face and was blinded, while Ismaïl was paralysed and can now only move his right hand. They became friends from the moment they met in the intensive care unit. Separated during their convalescence, they kept in touch and now meet up in Misrata whenever they get the opportunity. “We’re like brothers,” they told me in chorus. Maïdji pushes his friend’s wheelchair and Ismaïl reads to his blind friend. Misrata is steeped in history. Strategically located on the Mediterranean Sea, the city is known as much for its pride and independence as its traders, smugglers and pirates. Subjected to heavy fighting between February and May 2011, Misrata is a sandy and dusty but bustling desert city. Economically and militarily powerful, its hospitals are well equipped and its health system was better organised than in the east. Compared to Benghazi and Tripoli, Misrata is now relatively safe, so this was where we decided to set up base.

Every day we saw people from Sub-Saharan Africa, each with their own agricultural or construction tools, brushes and drills, stationed at the city’s crossroads looking for work as day labourers. Few are arrested, but some get caught at police checkpoints and interned in camps before being deported back to their home countries. There are around 10,000 migrants in Misrata, mostly from Niger, Chad and Sudan. Fearful of arrest and deportation, when they fall sick they usually go to pharmacies and buy the often high-priced drugs they are advised to take. For more serious problems, they prefer private medical facilities because, although expensive, these are not required to report undocumented patients. But when they have a chronic illness, their only choice is to go home. When I asked them if they didn’t want to get on a boat to Europe, they smiled and shook their heads: “It’s too dangerous. We thought they would try to get to Europe again, they replied, horrified, ‘Never again!’”

**MISRATA AND TRIPOLI**

Compared to Benghazi and Tripoli, Misrata has been left intact. Syrte was subjected to a heavy bombing. The Libyan coastguard intercepted an inflatable dinghy near the Mediterranean coast and they were sent to the detention centre. Rooms were small, dirty and jam-packed with mattresses. As we entered the hall, there was a putrid stench. We walked through puddles of urine. There were no showers, the toilets didn’t flush and the women had to relieve themselves in buckets. They used a little of their drinking water to wash. They were utterly desperate and begged me to help them get back to Nigeria. When I told them I was a doctor, they didn’t believe me to start with but then they accepted the treatment we offered them. Their average age was 22 and almost all of them (93%) had health issues. Many had scabies (38%), which we gave them prescriptions for, and some various aches and pains (48%). Other non-specific ailments were due to emotional trauma — or at least, that’s what we deduced from the stories they told us about their flight and from their almost palpable fear. When I asked them if they thought they would try to get to Europe again, they replied, horrified, “Never again!”

**SYRTE**

Our visit to Syrte was a real eye-opener. Close to the oil fields, the town is known for being the birthplace of Mu’ammar Gaddafi. In spring 2015, the so-called Islamic State, who controlled 300 kilometres of the country’s coastline made Syrte their stronghold in Libya. It was only in December that militias from Misrata succeeded in retaking the town with help from the US Air Force. The battle lasted seven months. Many fighters died and over 3,000 people were wounded. Ten ambulance crews were damaged and three rescue workers were killed. Armed with a special permit and a police escort we managed to enter the coastal town. Reduced to rubble, not one building has been left intact. Syrte was subjected to a brutal war that left a trail of total destruction.

A deathly silence hangs over the town that, from a historical perspective, was unique. We went to Ibn Sina hospital. Relatively unscathed by the bombs, it had been ransacked. Abandoned over a year ago, the hospital was once a modern, 350-bed facility equipped with several operating theatres, an intensive care unit, MRI scanner, a cardiac catheterisation laboratory and twenty practically new dialysis machines. It’s completely destroyed, with ripped up flooded floors, smashed windows and sagging ceiling tiles.

**TRIPOLI**

When we reached Tripoli I was stunned by the towering height of the ancient ruins. MSF staff were already in the capital providing assistance to people spread among seven detention centres. Most of those wanting to cross the Mediterranean to Italy are from Nigeria, which is mired in conflict; Eritrea, which is governed by an authoritarian regime; and Somalia, a country embroiled in civil war. People flee northwards to escape poverty and terror. To reach the Libyan coast, they have to pass through Chad and Niger, both particularly poor countries. According to the International Organization for Migrations (IOM), over 300,000 people crossed through them last year. However, there are no precise figures on how many have died of hunger or thirst or from falling off a truck along the way. According to most estimates, at least as many thebeth were killed crossing the desert as those who have drowned in the Mediterranean Sea — the statistics on people who drowned are more reliable. Be that as it may, the many survivors are insistant that the desert is by far the hardest part of the journey. The many dead migrants also pose a problem. We went to hospital mortuaries overflows with unidentified corpses washed up on beaches, and of people who simply died. Many have been there for months. As the authorities don’t have the resources for DNA testing, it’s impossible to identify the dead and ship them back home or bury them.
THE FRONTLINE: IRAQ

TREATING EMERGENCIES FROM MOSUL

On February 18th, the Iraqi army launched an offensive with the support of an international coalition to retake west Mosul, the part of the city still under so-called Islamic State control. The fighting has claimed many victims while large numbers of people living in neighborhoods gradually recaptured by the army continue to flee, some ending up in camps in Qayyarah. The MSF team is now caring for patients from west Mosul, displaced persons camps, the town and the region.

HOSPITAL FOR MEDICAL AND SURGICAL EMERGENCIES

The MSF team treats medical and surgical emergencies at the hospital in Qayyarah has an emergency room, operating theater and inpatient departments. The level of activity is intense — between January and March, more than 3,750 patients were admitted to the emergency room.

A 4-bed intensive care unit was recently opened to provide care for burn victims, patients in shock and other critical conditions. The team in the emergency room sees casualties wounded in airstrikes and explosions or by mortar fire.

Away from major roads there are still mines that occasionally injure children, farm workers and shepherds. But in west Mosul it’s sometimes whole families who fall victim to the fighting.

MEDICAL AND PSYCHOLOGICAL CARE

MSF has set up mental health consultations in Qayyarah for patients from the hospital and displaced persons’ camps. The team — a psychiatrist, two psychologists and a counsellor — treat adults and children alike.

The hospital MSF opened in Qayyarah last December is 60 km south of Mosul. Far away enough not to hear the sound of airstrikes and rocket fire but sufficiently close for the wounded to be brought in when medical facilities nearer the frontline are no longer able to cope.

AN INCREASING NUMBER OF CHILDREN AMONG THE PATIENTS

MSF’s hospital in Qayyarah is the only hospital structure that is properly set up that to receive children in the area of Nineva so far. As a result, around half of all patients receiving treatment in the emergency room are under the age of 15. And of the 192 patients who attended a mental health consultation from the beginning of February to mid-April, 30 were children under the age of 13.

8-year-old Duha (centre-top-right image) and her family lived in west Mosul. Last month their home was hit in an airstrike. Her mother and father and 16 other people in the house at the time were all killed in the bombing. Duha was the sole survivor. A neighbor dug her out of the rubble and her hands, hands and one leg were severely burned. She now lives in east Mosul with her uncle who brings her to the hospital regularly to have her dressings changed.

THE FRONTLINE: IRAQ

CHILDREN FROM WEST MOSUL MALNOURISHED

As the Iraqi army advanced into west Mosul, families were able to escape. And MSF teams have been seeing children with acute malnutrition. They have been affected by food shortages in besieged West Mosul. To treat malnourished children, MSF has set up a 12-bed therapeutic feeding centre in Qayyarah hospital. And most of the children are under six months, as explains Ana Leticia, MSF emergency doctor: “There is a food crisis, which affects the most vulnerable – mostly children under five. There is also an issue for children under six months old, who are traditionally fed with formula milk, which has been non-existent in west Mosul since the siege. So these children are fed with sugary tea and biscuits – a lot of them are arriving malnourished.”

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“TREATING EMERGENCIES FROM MOSUL

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WHAT ARE THE LONG-TERM IMPLICATIONS FOR HEALTHCARE IN SYRIA?

We save the lives we can, but the fact is that people need more than saving. They need physiotherapy to help them walk again, they need reconstructive surgery to help them regain mobility and perform everyday tasks. So many people will now suffer from disabilities. This new generation growing up will be particularly vulnerable to disease, because they simply didn’t receive the routine vaccinations they needed. In medical circles, people discuss the eradication of things like Polio – but that’s just not realistic. When so many young people will go without the protection they need. Aside from the physical issues, an enormous number of people will now have to live with post-traumatic stress disorder. They will have to learn to live, to work and to interact with others, after witnessing stunning brutality and widespread carnage. These things can’t be underestimated.

WHAT ARE THE PRIMARY MEDICAL CONCERNS IN SYRIA RIGHT NOW?

The victims of war are highlighted in the media – we are confronted with horrifying images of people killed and injured in bombings – but these are the direct victims. We hear very little about the indirect victims. Currently, there are huge numbers of people with chronic diseases without medication; there are people who are sick, but won’t seek help as they fear hospitals may be targeted by military attacks.

Most of the health facilities now functioning were created in a state of emergency. As large facilities are so frequently targeted, medical staff tend to work in converted shops, houses or farms. Often we have to work in poor conditions, with a lack of supplies. The most vulnerable demographic right now is women and children, and the lack of routine vaccination (against preventable diseases like measles, rubella, tetanus or pneumonia) is a serious concern. MSF seems to be the only organisation providing routine vaccinations right now.

HOW DOES THE SITUATION IN SYRIA COMPARE TO WORKING IN OTHER ARMED CONFLICTS?

That’s different here because we have been forced to stay away from such a catastrophe, with zero ability to negotiate humanitarian space, for such a long period of time. The last time I was there was in May 2013, visiting two of our medical facilities in Atma and Qabasin soon after they were opened. Our project in Qabasin closed in October 2014. We had already evacuated the expatriate team following staff kidnappings by the so-called Islamic State (IS) earlier in the year. The kidnappings actually occurred far from Qabasin, but there were so many armed groups operating at the time, that it became difficult to tell who was who, and who it was possible to negotiate with. Initially it was possible to negotiate with certain groups, and they gave us space to work, even IS. But this diminished rapidly, and we were never able to negotiate with the government in Daraa. Crossing the border with Turkey became very complicated in the summer of 2013. We withdrew expatriate staff from Atma on February 2014. Since the evacuation of expatriate staff, we have relied on working with our Syrian colleagues through remote management.

HOW EFFECTIVE IS THIS REMOTE MANAGEMENT OF MEDICAL FACILITIES?

Our Syrian colleagues are sustaining the projects remarkably well under the circumstances. To qualify that statement, it’s important to understand that the majority of medical staff now working inside Syria were not trained to work in a war zone, but they have had to learn as they work. This is not ideal, and medical staff at MSF are usually expected to have a good level of experience before they even begin their training for emergency situations. There is a big difference between medical work in a secure, well-staffed and well-equipped environment, and frontline medical work. So the fact that the staff inside Syria continue to save lives, with remote training, guidance and assessment, is amazing. However, this approach comes with problems. Without being there in person, it’s very difficult to assess the total situation and for experience. This is extremely frustrating.

DO YOU EVER WITNESS THE TRAUMA WE HEAR SO MUCH ABOUT IN THE MEDIA?

I remember when the hospital in Atma first opened – we could hear the shelling. At that time the frontline was about 13km away. When we heard the shelling, the teams would prepare for mass casualties. Sometimes military helicopters would fly over, and the fear in our patients was palpable. In fact, any time a plane or a helicopter flew over, people would become nervous. When the situation posed a more imminent threat, we would gather our staff and patients into a small, slightly more secure room.

The first patient I saw, and one that I won’t forget, was a 12-year-old boy, wounded by shrapnel. It’s always a shock to see civilian casualties in war, but some stay with you.

The further away the frontline moved from the hospital, the more internally displaced people would come to the hospital for assistance, and the more burns patients we received, as a result of living conditions in displacement camps. Apart from that, Syria used to have a good health system, so people used to receiving healthcare suddenly didn’t know where to turn. Earlier on in the conflict, we had plans to open more paediatric facilities, and centres for mothers and children. But the opportunity for this diminished.

HOW DO THE STAFF COPE WITH THE CONSTANT THREAT OF WARFARE, AREN’T THEY SCARED?

Unfortunately people become used to it – it becomes a normal part of life. There have even been medical staff who have lost family members, and they have event even been threatened. There have been events like the recent chemical attacks (04.04.2017) and understandably, staff become worried. We try to keep the team as healthy as possible, and staff at MSF are usually expected to have a good level of experience before they even begin their training for emergency situations. There is a big difference between medical work in a secure, well-staffed and well-equipped environment, and frontline medical work. So the fact that the staff inside Syria continue to save lives, with remote training, guidance and assessment, is amazing. However, this approach comes with problems. Without being there in person, it’s very difficult to assess the total situation and for experience. This is extremely frustrating.

WHAT DO YOU THINK HASN’T BEEN SAID, THAT IS WORTH SAYING?

We see a lot of images and reports on military action, a lot of discussions on the war itself, but very few reports on the mass displacement and human costs that go beyond numbers. There isn’t a human face to this war.

“We save the lives we can, but the fact is that people need more than saving.”
IN PICTURES
Images: Bruno Fert

DOMESTIC ROUTES

Domestic Routes is a collection of photographs and testimonials, gathered by photographer Bruno Fert. He chose to give an insight into the lives of migrants by showing their dwellings. These shelters, although temporary, reflect the hopes of the people residing there. They tell stories of vulnerability and fortune, of lives at a difficult and important moment.

“I want to meet the migrants who crossed the Mediterranean to find refuge in Europe. I chose to photograph the interiors of shelters people build, for a stage in their journey, in camps or ‘jungles’ in France and Greece.”

“"The interior of any dwelling is a place of life, a home. It is a place of intimacy. It reflects what everyone has and who they are, their identity and aspirations. What interests me is the way in which these men and women reconstitute a home with a few objects: objects kept during the journey in memory of their past life, objects made or purchased to improve their daily life, transforming their refuge and their distress.

To the images of interiors are added the portraits of their occupants. Conceived on a neutral background, these images show the faces of these men and women by disassociating them from the context. It is no longer the image of a migrant, stranded in a muddy camp, but the face of someone similar to you or me.”

Abdelraouf, 40 years old, born in Blue Nile state, Sudan
His parents lived in a round house, made of branches and thatch. He remembers swimming in the Nile, he remembers fields of wheat and family crops.
Abdelraouf misses the times when there were no boundaries between homes, or between people. In 2013, he left Sudan because of the war, and travelled to Libya. However, war broke out in Libya too, pushing him to flee for Europe. Arriving in Calais, he thought he would simply buy a train ticket to London. The other refugees explained that he would need to hide in a truck. At first he refused, finding it too humiliating. But since then, he has found a reason to try, and has attempted it almost every day for more than a year. Today he is tired of hiding, tired of failing, tired of the violence committed by some police.
Calais, France
Leal 7 years old, Yasmine 26 years old, Raïs, 18 months, Maya, 9 years old, et Hamza, 5 years old, from Syria

Maya protests. She says that she isn’t happy here. She wants to find her father, she preferred living in Homs, at least there she had a house and didn’t sleep in a tent.

Yasmine is 26 and has four children. Her husband had already been in Germany for eight months when the fighting approached their district in Homs. Yasmine sold their house and left for Europe with the four children. She seems happy to have arrived in Greece, even if she doesn’t know when or how her children will see their father again.

Ionnina, Greece

Hamdan, Sudan

Hamdan is deaf and mute. Communication is difficult, even with his own countrymen. Normally he uses translation software on his mobile phone, but he has run out of credit. He still has a big French-Arabic dictionary.

Calais, France
Barham, 31 years old, hairdresser, Iraqi Kurdistan.

The only chair in Barham’s room is never empty. He cuts an average of 25 people’s hair each day, but only five or six have the means to pay him the five euros that the cut costs. He also practices the traditional wire-waxing of people’s cheeks, and some Frenchmen come to see him specially for that, he said proudly. In town, the hairdressing salons are beautiful but, according to him, the hairdressers don’t know how to cut hair. Barham arrived four months ago. He opened his salon at the entrance of the camp of Linière. But he would like to cut hair in Britain.

Grande-Synthe, France

El Hatib, 68 years old, Shepherd from a village near Mosul, Iraq.

The region where El Hatib lived is now controlled by the so-called Islamic State. In 1974 he participated in an international shepherd’s competition organised in Iraq – he took second place. The winner was an English Shepherd. He thinks that Britain is a good place for sheep farming. El Hatib has already sent the seven members of his family to the other side of the Channel. His wife even went ‘as collateral’, a tariff where the ferryman assures the arrival at destination. Now El Hatib would like to cross too, for his daughter is waiting for him on the other side to celebrate her marriage.

Grande-Synthe, France
HOW MSF TREATS SEVERE CHILD MALNUTRITION

It’s the single greatest global threat to public health, according to the World Health Organisation. More than 175 million children around the world last year suffered from malnourishment. It is also the underlying contributing factor in about 45% of all child deaths, making children more vulnerable to severe diseases. Below are examples of different tools our medical teams use to assess and treat malnutrition:

MUAC BRACELET

The mid-upper arm circumference (MUAC) band is a simple, yet effective diagnostic tool for assessing malnutrition.

WEIGH SCALE

A child’s weight is vital to diagnosing malnutrition. Portable and easy-to-use, these scales can help save lives.

THERAPEUTIC FOOD

Ready-to-Use Therapeutic Food is packed with all the essential vitamins, minerals, fat and protein to regain a healthy body weight.

FEEDING CENTRES

Malnourished children who have no appetite or suffer from medical complications—such as measles, malaria, pneumonia, or anorexia—continue to require hospitalisation and are admitted to MSF inpatient feeding centres for intensive care.

ASSOCIATED CARE

Malnourished children are more susceptible to illness and infections, their weak bodies unable to mount a proper defense. This means diseases which are otherwise treatable can be deadly. Diagnosing and treating other diseases in conjunction with malnutrition is vital.

COMMUNITY OUTREACH

In every population we treat for malnutrition, we carry out an outreach survey to gauge the extent of the problem and understand the resources needed. Where malnutrition is likely to become severe, we take a preventative approach by distributing RUTF to at-risk children.

EDUCATIONAL PULL-OUT

WEIGH SCALE

THERAPEUTIC FOOD

FEEDING CENTRES

ASSOCIATED CARE

COMMUNITY OUTREACH

MSF currently runs more than 100 nutritional programmes in 25 countries.

The number of malnourished children admitted to inpatient or outpatient feeding programmes in 2015.

The number of children who suffer from severe acute malnutrition every year.

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سواء التغذية الحاد لدى الأطفال

تشعيلة أطفال بحالات سوء التغذية

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