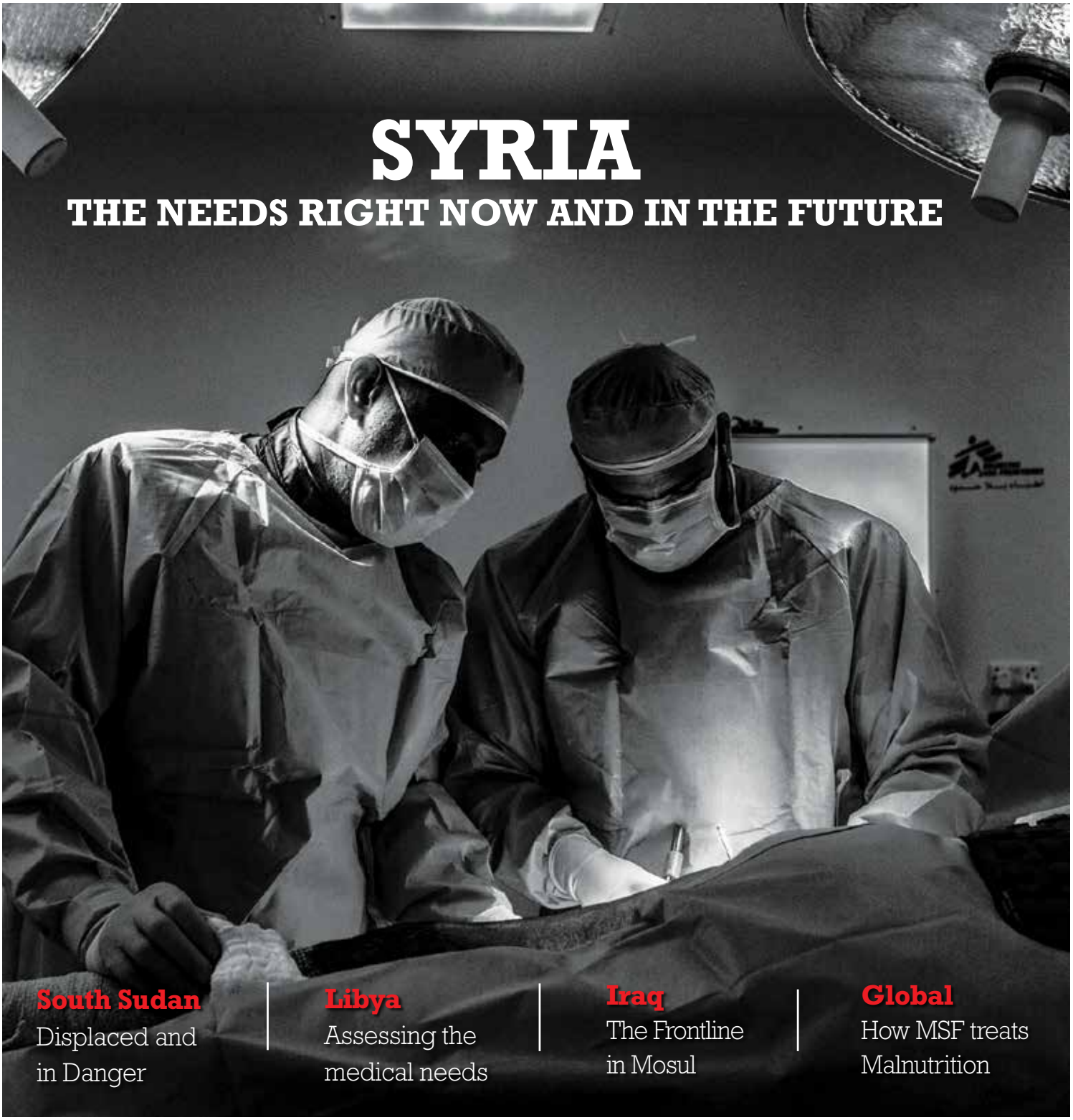
WITHOUT BORDERS

Issue 36 | May – July 2017

MEDECINS SANS FRONTIERES
أطبّاء بلا حدود

MEDICAL AID WHERE IT IS NEEDED MOST. INDEPENDENT. NEUTRAL. IMPARTIAL.



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WELCOME

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

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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.

Images: Awad Abdulsebur, Florian Seriex, Séverine Bonnet, Angel Cabello, Candida Lobes

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.

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.

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 shortages 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, specifically 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.

ETHIOPIA

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

A serious outbreak of acute watery diarrhoea is sweeping through Doolo 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.

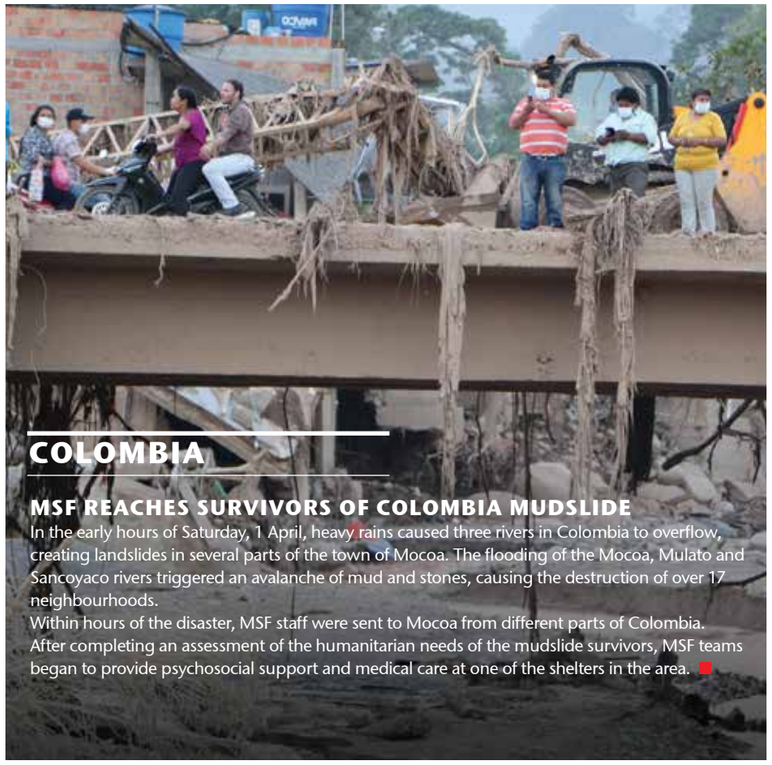
Officially declared on 7 April, the outbreak has affected more than 16,000 people in the whole region since the start of the year, with about 3,500 new cases per month, according to local authorities. The government has so far deployed over 1,200 health professionals, including nurses and doctors, and 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 Micaela Serafini. "We believe that the new vaccine can bring protection against rotavirus to the children who need it most."



COLOMBIA

MSF REACHES SURVIVORS OF COLOMBIA MUDSLIDE

In the early hours of Saturday, 1 April, heavy rains caused three rivers in Colombia to overflow, creating landslides in several parts of the town of Mocoa. The flooding of the Mocoa, Mulato and Sancoyaco rivers triggered an avalanche of mud and stones, causing the destruction of over 17 neighbourhoods.

Within hours of the disaster, MSF staff were sent to Mocoa from different parts of Colombia. After completing an assessment of the humanitarian needs of the mudslide survivors, MSF teams began to provide psychosocial support and medical care at one of the shelters in the area.

Image: Siegfried Modola

MOBILE HEALTHCARE: SOUTH SUDAN

DISPLACED AND IN DANGER

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.

Patients queue to receive medicines at an MSF outdoor support clinic in Thaker

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 tukuls [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 her 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.

SETTING UP

Just a few hours after our arrival in Thaker, the team sets up the outdoor mobile clinic.

There is a queuing area, where patients are given a medical card and children are weighed and checked for fever and signs of malnutrition. Then patients proceed to the consultation area, where they are sent for urine tests, malaria tests or directly to the dispensary to receive medicines.

It is just past midday and there are several dozen people waiting to be seen under the shade of some acacia trees. Most are women and children who have come to receive medical care. There are a few old men but, in all the days that I was there, I saw almost no young men. I was told that most of them had left for the cattle camps.

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 wonder how 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.

Nyareat , 24, brings along her four-month-old baby girl, Nyakueka, who has a fever. She walked for an hour to reach the clinic. There is dignity in the people I have met who face a daily struggle for survival.

"There is dignity in the people I have met who face a daily struggle for survival."

An aerial view shows homes in Leer County, South Sudan Sudan

MSF Community Health Worker Tang poses at an outdoor clinic in Thaker

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 ■

Images: Dr Tankred Stoebe

Dr Tankred Stoebe begins checkups for the female inmates of a detention centre.

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

Ismaël and Masjdi 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 Masjdi sustained wounds to the face and was blinded, while Ismaël 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. Masjdi pushes his friend's wheelchair and Ismaël 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 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 don't want to die in the sea."

MISRATA AND TRIPOLI

Living conditions and hygiene are truly appalling in the detention centre halfway between Misrata and the Libyan capital. Intended for 400 refugees, there were only 43 detainees, 39 of them women from Egypt, Guinea, Niger or Nigeria who'd been there for a month with no contact with the outside world or their families. Most come from Nigeria and told me their homes had been bombed. The Libyan coastguard intercepted their inflatable dinghy near the Mediterranean coast and they were sent to the detention centre.

"When I asked them if they thought they would try to get to Europe again, they replied, horrified, 'Never again!'"

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 (58%), 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 its 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 ambulances 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 a 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 people have died 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, survivors are insistent 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 overflowing 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. ■

Image: Javier Rius Trigueros, Suhaib Salem

THE FRONTLINE: IRAQ

TREATING EMERGENCIES FROM MOSUL

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.

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 as 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.

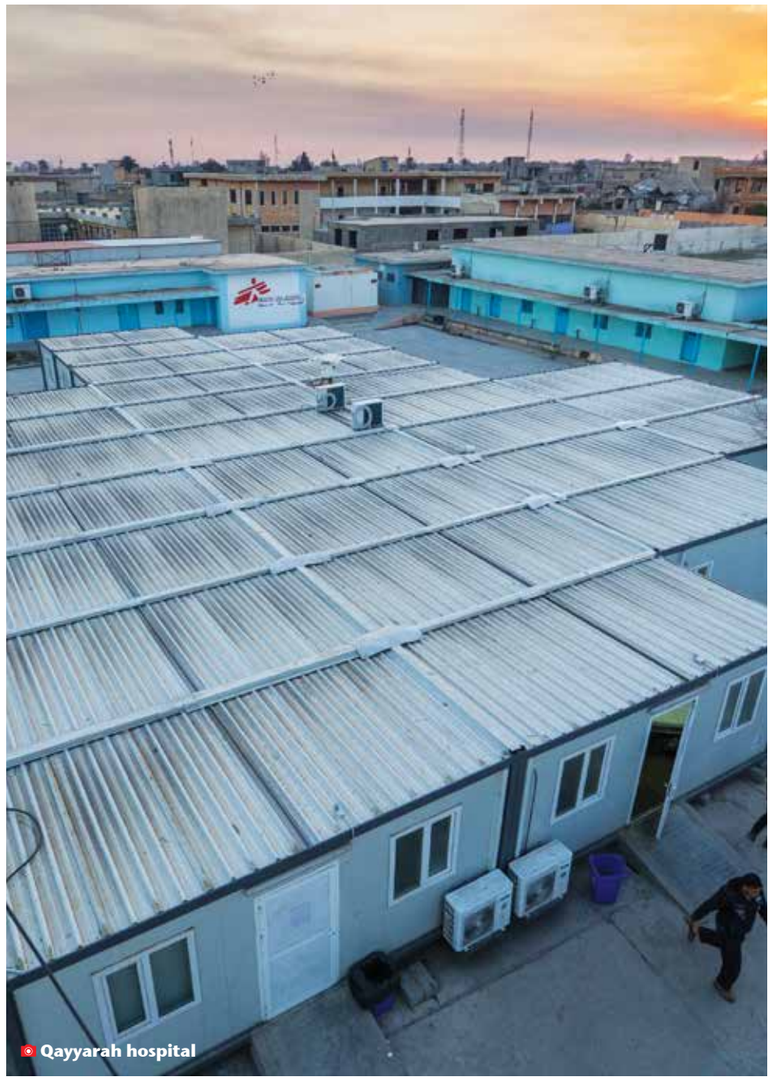
A 4-bed intensive care unit was recently opened to provide care for burn victims, patients in shock and other critical conditions.

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.



Qayyarah hospital

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 Ninewa 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 head, 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.

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."■

"There is a food crisis, which affects the most vulnerable - mostly children under five."

MSF'S WORK IN MOSUL

• An average of 1150 patients are received each month in MSF›s emergency hospital in Qayarrah, 60 km south of Mosul.

• In two months, 919 patients were treated in a hospital set up in the eastern suburbs of Mosul, 57 per cent of these patients had conflict-related injuries.

• MSF is also working in a hospital in East Mosul, where more than 2,900 patients have received treatment. An average of 34–40 babies are delivered here each week.

• In March MSF also opened a 16-bed maternity ward in East Mosul and a centre for medical and surgical emergencies.

• Since 19 February, MSF has been treating the wounded in a centre equipped for surgery, 25 km south of Mosul. In a little more than three months, 1,296 wounded were treated, 21 per cent of whom were emergency cases.

• Further from the frontline, MSF mobile clinics are providing care for displaced people. In December 2016, they provided more than 2,500 medical consultations and more than 1,800 psychological consultations at 14 sites.

A young child comes from an IDP camp to receive treatment for a non-consolidated fracture in Qayyarah hospital

A teenager wounded by a stray bullet receives surgical care at Qayyarah hospital

Images: Eddy McCall, Scott Hamilton, Karam Almasri

Q&A: SYRIA

SIX YEARS OF WAR

Dr Khalid Elsheikh, Deputy Programme Manager for Iraq, Syria, Jordan and Turkey, and Dounia Dekhili, Programme Manager for Iraq, Syria, Jordan and Turkey, are both members of MSF's operational cell based in Dubai, and it's from there that they manage some of MSF's activities in Syria. In early April, they agreed to discuss the way MSF works in Syria after six years of war, the challenges faced, the changes and the constants.

Dr Khalid Elsheikh

WHEN WERE YOU LAST IN SYRIA AND WHAT WAS YOUR OBJECTIVE THERE?

I was last there in 2014. I was conducting an explo (exploratory trip to evaluate the medical needs) along with two colleagues – a surgeon and a nurse. The needs were vast, particularly among internally displaced people, but it was impossible to act on them. Every day and every night we were shelled, it seemed to be targeted. The area where we stayed, along with the hospital where we conducted evaluations, had never come under attack before, and suddenly there was a period of intense bombardment in a localised area. We even moved our accommodation to a new area, and once again we came under fire from missiles. It became clear that our presence put the local population in danger, and we made the decision to withdraw.

I felt lucky after that – it really was just a matter of luck that we weren't hit.

YOU'VE BEEN TO DIFFERENT PROJECTS IN SYRIA A NUMBER OF TIMES, INCLUDING PROJECTS IN ALEPPO AND IDLIB. HAVE YOU EVER WITNESSED ONE OF THE MASS CASUALTY EVENTS WE SEE SO OFTEN IN THE MEDIA?

I'm a General Practitioner by training and my role in Syria was as an Emergency Coordinator rather than as a medical responder. However, I did witness some mass casualty events, and during these I took responsibility for triage. During these events, there were huge influxes of people, and it was incredibly crowded. People are desperate in these times – being responsible for triage can mean telling people that their loved ones can't be treated – desperate families would bring someone who had already died and insist on their receiving treatment. When there are so many others who need urgent attention, we have to continue. But it's very difficult trying to explain why someone can't be taken to the operating theatre when their loved ones insist.

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.

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 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.

Dounia Dekhili

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

What's different here is that 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 Damascus. 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 level of danger our staff experience. This is extremely frustrating.

DID 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 15km 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 normal for them. But then you have events like the recent chemical attacks (04.04.2017) and understandably, staff become worried. We put staff psychologists in place so that our colleagues have someone to turn to, but obviously working remotely means we can only offer a phone line. It's not ideal, but people do use it. When more parties became involved in the war, notably when the Russian intervention began, the bombing intensified. People were certainly scared after that.

A lot has changed in this war, but the one constant has been the total disregard for civilian protection. Not just from the warring countries, but those who refuse to give refuge.

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."

Images: Bruno Fert

THE INTERIOR

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 fortitude, of lives at a difficult and important moment.

''I went 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, Soudan

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

Images: Bruno Fert

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

Leal 7 years old, Yasmine 26 years old, Raïs, 18 months, Maya, 9 years old, et Hamza, 5 years old, from Syria

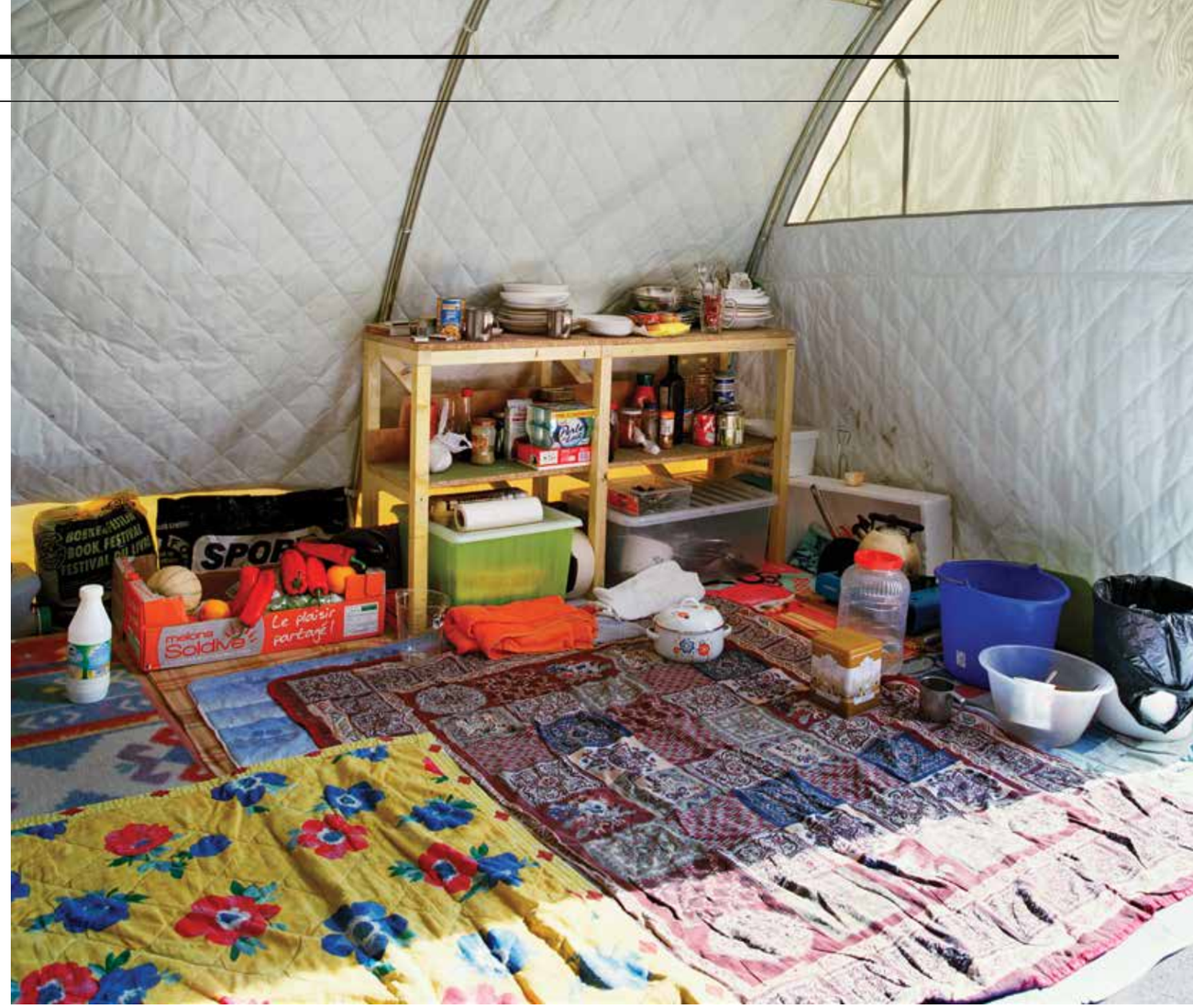
Maya protests. She says that she isn't happy here, she wants to find her father, she preferred living in Homs, at least there she had a house and didn't sleep in a tent.
Yasmine is 26 and has four children. Her husband had already been in Germany for eight months when the fighting approached their district 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.

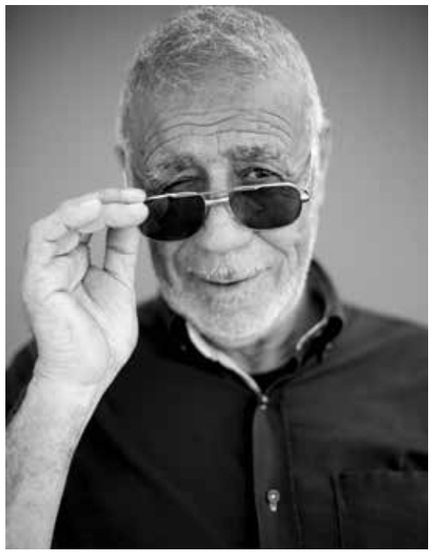
Ionnina, Grèce

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 himthe five euros that the cut costs. He also practices the traditional wire-waxing of people's cheeks, and some Frenchmen came 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

Images: Trygve Thorson, Mohammed Sanabani, Tiziana Cauli, Louise Annaud, Corinne Baker, Sara Creta

الصور: تريجف ثورسون، محمد السنباني، تيزيانا كاولي، لويس أنود، كورين باكر، سارة كريتا

MALNUTRITION

سوء التغذية

HOW MSF TREATS SEVERE CHILD MALNUTRITION

كيف تعالج أطباء بلا حدود سوء التغذية الحاد لدى الأطفال

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:

يعتبر سوء التغذية الخطر المفرد الأكبر على الصحة العامة بحسب منظمة الصحة العالمية. فقد عانى أكثر من 175 مليون طفل حول العالم من سوء التغذية في العام الماضي. كما أنه يشكل العامل الأساسي المسهم في نحو 45 في المئة من إجمالي وفيات الأطفال، ويجعل الأطفال أكثر عرضة للأمراض الحادة. فيما يلي أمثلة عن عدة أدوات تستخدمها فرقنا الميدانية لتقييم وعلاج سوء التغذية:

COMMUNITY OUTREACH
التوعية المجتمعية

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

في كل مجتمع نعالج فيه سوء التغذية نقوم بإجراء استطلاع مجتمعي للوقوف على مدى المشكلة بهدف فهم الموارد اللازمة.وعندما يتبين لنا احتمال أن يصبح مستوى سوء التغذية حاداً نقوم باتباع النهج الوقائي بتوزيع الغذاء العلاجي الجاهز للاستخدام على الأطفال المعرضين للخطر.

ASSOCIATED CARE
الرعاية المرتبطة بسوء التغذية

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 manlnutrition is vital.

الأطفال المصابون بسوء التغذية أكثر عرضة للمرض والتقاط العدوى، فأجسادهم الضعيفة لا تقوى على القيام بالدفاع الملائم. ومعنى هذا أن الأمراض القابلة للعلاج والشفاء قد تكون قاتلة لهم.
لذلك لا بد من تشخيص وعلاج الأمراض الأخرى المترافقة مع سوء التغذية

FEEDING CENTRES
مراكز التغذية

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.

الأطفال المصابون بسوء التغذية ممن ليس لديهم شهية للطعام أو يعانون من مضاعفات طبية - كالحصبة أو الملاريا أو فقر الدم أو فقدان الشهية، يتم إدخالهم مركز التغذية الداخلية في المستشفى ليحصلوا على رعاية مركزة.

THERAPEUTIC FOOD
الغذاء العلاجي

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

الغذاء العلاجي الجاهز للأكل جميع الفيتامينات الأساسية والمعادن والدسم والبروتين اللازمة لاستعادة وزن الجسم الصحيح.

WEIGH SCALE
ميزان الوزن

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

يعتبر وزن الطفل مؤشراً أساسياً لتشخيص سوء التغذية. هذه الموازين سهلة الحمل والاستخدام يمكنها أن تساعد في إنقاذ حياة الأطفال.

MUAC BRACELET
سوار قياس محيط منتصف العضد

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

سوار قياس محيط منتصف العضد هو أداة تشخيصية بسيطة وفعالة لتقييم سوء التغذية.

NINE CHILDREN DIE EVERY MINUTE FROM MALNUTRITION

تسعة أطفال يموتون كل دقيقة

181,600

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

عدد الأطفال المصابين بسوء التغذية الذين يتم إدخالهم في برامج التغذية داخل المستشفيات وخارجها في عام 2015:

25  **100**

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

تدير أطباء بلا حدود حالياً أكثر من 100 برنامج غذائي في 25 بلداً:

20,000,000

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

عدد الأطفال الذين يعانون من سوء التغذية الحاد الشديد كل عام

Malnourishment is the underlying contributing factor in about 45% of all child deaths.

سوء التغذية هو العامل الأساسي المسهم في نحو 45 في المئة من إجمالي وفيات الأطفال: