DISPATCHES

An MSF Land Cruiser crosses a river on the way to the town of Ndinguiri, Central African Republic. Photograph © Caterina Schneider-King/MSF

Countdown to conflict

pages 10-11

Spring 2018
No 88

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

INSIDE

HAITI

A nurse checks on a patient with a broken leg in MSF's trauma hospital in Tabarre, Haiti. *Photograph © Jeanty Junior Augustin/MSF*

YEMEN

MSF battles new threat from diphtheria

MSF teams in Yemen are tackling an outbreak of diphtheria that is threatening to cause a new public health emergency. By the end of December, MSF teams had treated more than 300 patients with diphtheria.

"After two and a half years of violence and a blockade on supplies, including medicines and vaccines, the healthcare infrastructure is in tatters," says Marc Poncin, MSF's emergency coordinator in Ibb. "The blockade on fuel means that patients cannot afford to travel to the few health centres still operating across the country. If infected people are unable to get regular treatment, diphtheria will spread through their body and be fatal in up to 40 percent of cases."

Diphtheria is a contagious bacterial infection, which starts in the respiratory system but can spread through the blood to affect the nerves and heart. Even with treatment, recovering from diphtheria can take a long time.

To tackle the outbreak, MSF has opened an intensive care unit in Sadaqa hospital in Aden and a diphtheria treatment unit in Nasser hospital in Ibb city. MSF is bringing in supplies of antibiotics and the antitoxin needed to treat the illness.

"Isolating and treating patients, offering preventative care for affected communities and raising public awareness are crucial to halt the spread of diphtheria," says Poncin. "Yemen's healthcare system cannot afford another outbreak."

msf.ie/yemen

SIERRA LEONE

Children play with tyres outside Kabala district hospital, Sierra Leone, where MSF is supporting the paediatric and maternity wards. The hospital provides lifesaving services to more than 400,000 people living in the district. *Photograph © Xaume Olleros*

UGANDA

MSF responds to Marburg fever outbreak

MSF teams responded to an outbreak of Marburg haemorrhagic fever in eastern Uganda, late 2017, after an outbreak which killed three people, all from the same family.

Like Ebola, Marburg fever is caused by a filovirus. Transmitted to humans by fruit bats, the disease can spread rapidly from human to human through blood and bodily fluids. Also like Ebola, outbreaks of the disease are rare, but can cause dramatic numbers of deaths, with fatality rates of up to 88 percent.

MSF set up and ran a 10-bed treatment unit in Kween, and managed a nine-bed treatment unit in Kapchorwa hospital alongside the Ministry of Health. An MSF epidemiologist assisted local health authorities in tracing and monitoring everyone who had been in contact with an infected person.

"This is the first time that Marburg fever had been diagnosed in these districts of Uganda," says Dr Natalie Roberts, head of MSF's emergency operations. "But strong national surveillance meant that the epidemic was noticed and confirmed early enough to allow for a rapid and effective collaborative response."

On 25 August, the Myanmar military launched a series of operations in Rakhine State against people from the Rohingya ethnic minority group. Since then, more than 647,000 have fled Myanmar to Bangladesh. MSF surveys conducted in refugee camps in Bangladesh estimate that at least 6,700 Rohingya were killed during those attacks, including 730 children. MSF teams have been on the ground since the beginning of the crisis.

Rohingya crisis

KATE WHITE

"When the refugees finally cross the river which divides Myanmar and Bangladesh, our teams do initial medical assessments. Most medical issues we're seeing are to do with the fact that people have walked for more than 10 days before arriving in Bangladesh. We're seeing cases of severe dehydration; injuries sustained during the crossing; and vulnerable children and pregnant women. Our team is offering real human support: reassuring new arrivals that we understand, we know what they've been through to get here, and we're prepared to listen. That contact alone makes a massive difference."

RUBY SIDDIQUI

"Emergency response is what MSF does, and does well. We opened new health posts across the settlements, built new inpatient facilities, expanded our hospital intake and constructed new water points and latrines. We trained teams of community volunteers to identify the sick and refer them to our services."

DR IAN CROSS

"Our facility was the only hospital in the area that could provide a more advanced degree of care. So when they had some patients who were too difficult to manage, the obvious place to send them was to our hospital, not realising how basic the care we could offer was. But we never turned anyone away. We accepted everyone. If it meant putting down mattresses in the ward, we'd do it. Our bed occupancy was running at 120, 130 percent. Someone would come in in the morning, deliver a baby, then move out by lunchtime. Someone else would come in the afternoon, deliver a baby, then move out by evening."

DR KONSTANTIN HANKE

"People arrived in a horrific state. Some said they had been trapped in houses that were set on fire. We treated unaccompanied children who had lost their families."

DR EVAN O'NEILL

"Among the refugees are orphans. I saw one today who was just seven months old, adopted and breastfed by this kind mother – already with four of her own. The baby girl was found alone in Myanmar by someone else. Where? How? Why? It's all unknown, but it doesn't matter. She is here now."

15 Number of health posts run by MSF in Bangladesh

2,258 Number of MSF staff working in Bangladesh since the end of August

204,938 Number of patients treated by MSF between end of August and end of December

4,371 Cases of diphtheria treated by MSF since 22 January

1,522 Number of latrines built by MSF

218 Number of water wells dug by MSF

16 Number of deep boreholes drilled by MSF

DR KONSTANTIN HANKE

"We treated a young girl with a head wound; an hour later her mother was admitted with severe burns. They said they were the only survivors from their family. The girl was always bringing her mother food and helping her eat. We're providing play sessions for the child, counselling sessions, a caretaker to help with daily needs, and treating the mother's burns. We're also giving them supplementary feeding so they are in a better overall state to heal, and they are steadily improving."

DR IAN CROSS

"One young man escaped with some friends. He was travelling at night to avoid any contact with the military. It was four o'clock in the

continued on page 4

continued from page 3

morning. He was walking past a mosque – the last place you'd think of being ambushed. And he was shot in the side, the bullet going through his abdominal wall and out the other side. And he just ran. And he ran and ran and ran, and got to the banks of the river. He didn't wait for low tide; he wanted to get across with his mates, so he swam across with a bullet wound in his abdomen. He got to the other side and collapsed, not surprisingly. His friends managed to get a vehicle for him and he was in our clinic within an hour. We did some basic tidying up – first aid, stopped the bleeding – and we were able to send him on for formal surgery to clear him up. He made a great recovery."

RUBY SIDDIQUI

"My role is to measure the size of the health problem in the settlements. There are some key health indicators we need to know. The most important is the crude mortality rate, which tells us the scale and severity of the emergency. By understanding the rate at which people are dying and why, we can try and prevent further similar deaths."

KATE WHITE

"Our teams are bringing everything into the camps on foot, including technical equipment to build latrines and install safe water supply systems. Bricks, sacks of sand and cement and all the typical building supplies are carried into the camps. Supplies going to the health posts are carried in as far as one hour from the main road. It's difficult to get patients out in an emergency when they're sick – some are being stretchered by our outreach workers, who navigate through difficult terrain for hours at time to get to the closest hospital."

RUBY SIDDIQUI

"We are training an additional team of 20 community volunteers to perform a health survey, collecting data on smartphones. This will give us an idea of the main health conditions and diseases currently affecting people. In addition, we will measure vaccination coverage rates, malnutrition rates, and health-seeking behaviour practices which will help us to understand the main disease risks so we can target our operations."

DR IAN CROSS

"I flit from one urgent problem to another. The hospital sees about 100 emergency cases and over 400 more routine cases every day. The main problems are respiratory infections, acute watery diarrhoea, skin problems and musculoskeletal problems.

I also see the patients who have had unsuccessful treatment for violent injuries – joints smashed to smithereens by bullets, paralysed by spinal cord injuries or with infected bones."

A small child looks out across Tasnimarkhola refugee camp in Bangladesh. Conditions here are grim and many refugees are living without adequate shelter, food, clean water or latrines.
Photograph © Mohammad Ghannam/MSF

Konstantin Hanke, doctor

Kate White, emergency medical coordinator

Ruby Siddiqui, epidemiologist

Ian Cross, doctor

Evan O'Neill, doctor

Arunn Jegan, emergency coordinator

One-year-old Ayob receives treatment at MSF's health facility in Tasnimarkhola camp after suffering a high fever and breathlessness.
Photograph © Mohammad Ghannam/MSF

KATE WHITE

"When we first started, we were treating blast injuries and gunshot wounds, but now it's flipped to accidents due to living conditions. The fact that people have to build shelters out of bamboo is risky. I think we see a bamboo injury at least five times a day – who knew bamboo could result in so many injuries?"

DR IAN CROSS

"Most of the children in the ward suffer from severe acute malnutrition. They have very little strength to resist serious infections and, despite us pulling out all the stops with antibiotics, nutritional support and oxygen, they often succumb."

DR EVAN O'NEILL

"Children do a lot of smiling here and, in my mind, each smile is an act of defiance in the face of the statistical peril facing paediatric patients. Children don't know the numbers, but they know hunger. We are seeing more children suffering from severe acute malnutrition. It is said that if you are a child with malnutrition, you are 10 times more likely to die from common camp afflictions, like diarrhoea or respiratory infections."

ARUNN JEGAN

"Before I left Cox's Bazar, I was

walking through the camps with one of the medical coordinators and we spotted two young kids walking in front of us. To me, it looked like a scene straight out of a movie: a pair of hopelessly innocent kids laughing and holding hands, walking through a refugee camp. We wondered what life would look like for these two kids when we were no longer here. What will it be like in 10 years' time?"

Halima Khatu cries at the bedside of her eight-month-old son, Mohammed, as he receives treatment for acute pneumonia inside MSF's medical facility in Kutupalong camp. *Photograph © Paula Bronstein/Getty Images*

DR IAN CROSS

"These people are not terrorists. These people are not overthrowing the government or anything like that. They're just normal, simple villagers. It makes me very angry. I have to separate these feelings from how I deal with my patients. Emotion is there, of course, but I try to stay calm and cool and not worry about how they got here, but focus on making them better. Without MSF, there would be a gaping hole in health provision. If we were not here, I think it would be much worse for the refugees."

"It makes me very angry… but I try to stay calm and cool and focus on making them better."

Medics treat a young women with a head injury inside the emergency room at MSF's hospital in Kutupalong. *Photograph © Paula Bronstein/Getty Images*

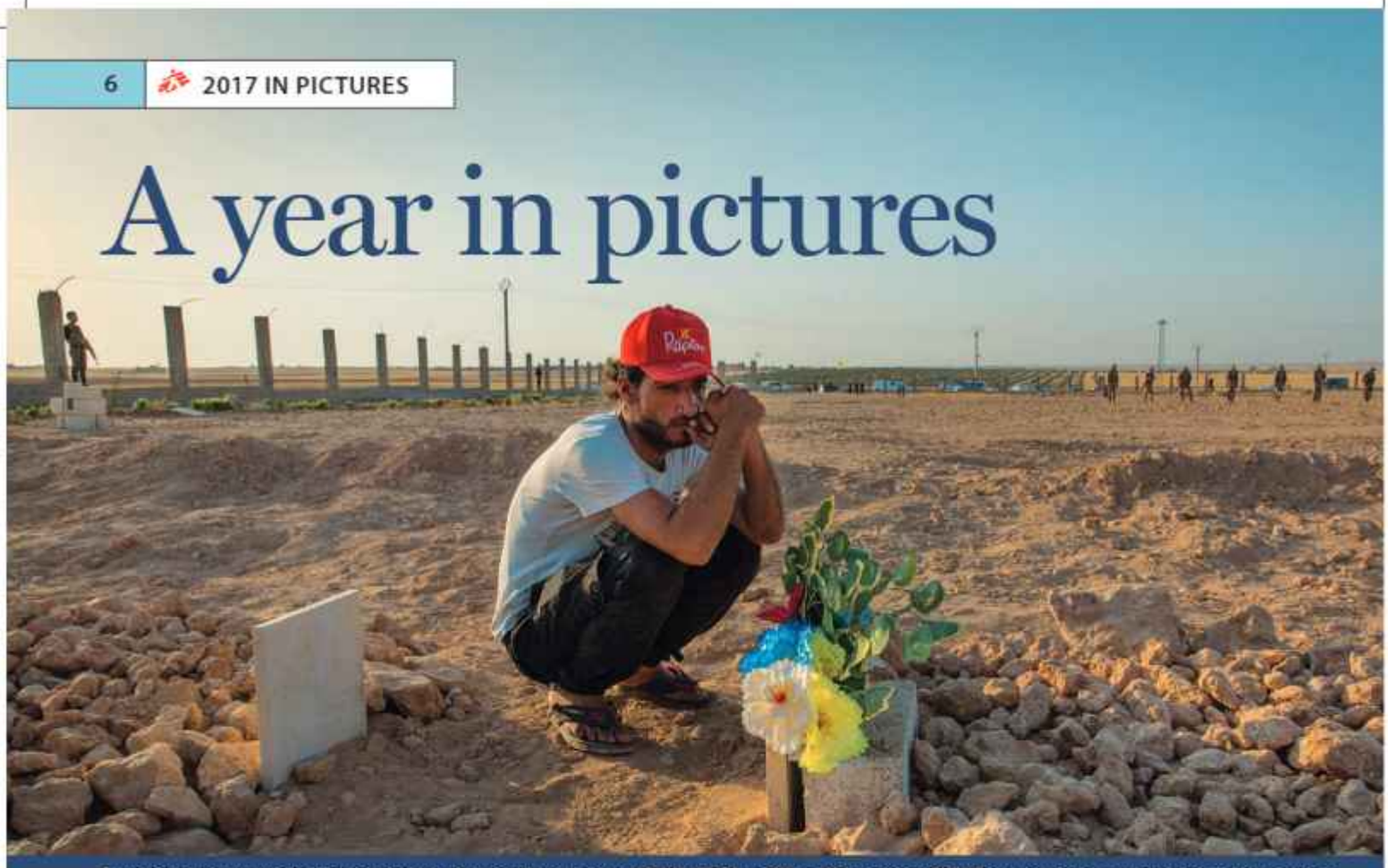
ARUNN JEGAN

"It's important to feel angry. It's important to feel sad. I don't think I can walk away from this thinking, 'That was that'. It's going to be difficult to disconnect from what I've seen in Bangladesh. However, the resilience that the Rohingya have shown is remarkable. And the compassion of the Bangladeshi population is inspiring. With the combination of these two things, there can be a positive outlook."

KATE WHITE

"The situation is still precarious and the possibility of a public health emergency is still very real. But MSF is taking proactive measures to improve the conditions. Our water and sanitation teams are significantly increasing the number of latrines, tube wells and hand pumps. Our boreholes are at least 100 metres deep to prevent contamination in the drinking water. It's two steps forward and one step back. But in saying that, I remain optimistic. This is a resilient people. The services are available and people are defying the odds and finding ways to get things up and running."

A year in pictures



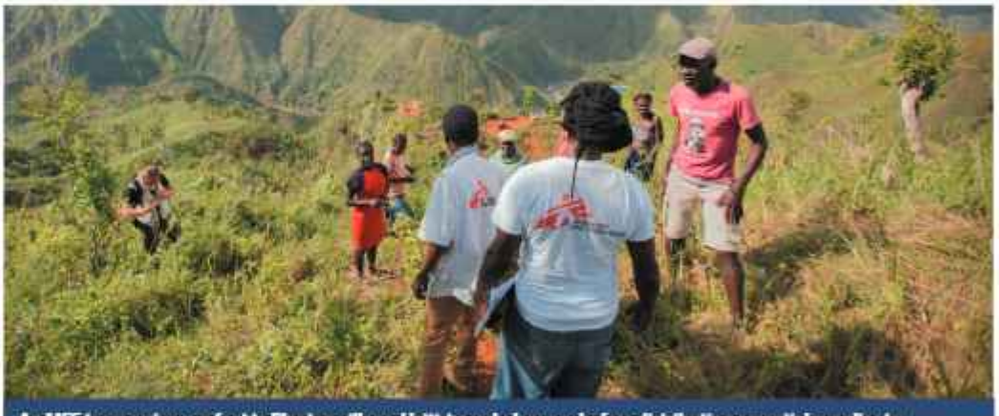
Ismael sits by the graveside of his friend, Hout, who was killed two days earlier by an Islamic State sniper in the battle for Raqqa, Syria. In a camp in Ain Issa, 55 km north of Raqqa, MSF teams are providing general healthcare and stabilising the wounded before referring the most severe cases to Kobane hospital.
Photograph © Chris Huby/Agence le Pictorium

In 2017, MSF teams around the globe provided medical care in some of the world's worst crises. From wars in Yemen and Iraq, civil strife in South Sudan and Nigeria, to epidemics and natural disasters in Madagascar and Mexico, our staff have been on the frontline of saving lives throughout a turbulent year.

In all these emergencies, photographers have been there to capture moments and bear witness to the suffering and strength of people and communities caught up in these crises.

Here, we remember and pay tribute to those who have struggled, those who have persevered and those who have perished.

Thank you for your support.



An MSF team arrives on foot in Planton village, Haiti, in early January before distributing essential supplies to the residents of the remote, mountainous area, which was hard-hit by Hurricane Matthew the previous October.
Photograph © Jeanty Junior Augustin

Gatbel, an MSF community health promoter, tests a child for malaria at an outdoor clinic in Thaker, Leer county, South Sudan.
Photograph © Siegfried Modola

An MSF surgical team changes the d
injuries in Khamir, Yemen. *Photogra*

Saom Koem (right) lives with his family in Pni Ro Luk, Cambodia. Two years ago, he contracted malaria but was treated and recovered. This year, his family took part in an MSF project for proactive voluntary screening for malaria. By testing healthy people who are at risk of catching malaria, the project aims to eliminate the malaria parasite from the district.
Photograph © Tim Dirven/Panos Pictures

Dr Mohammed and Dr Kyi examine a small baby during ward rounds inside MSF's therapeutic feeding centre in Maiduguri, northern Nigeria. The centre currently treats 70-80 severely malnourished children each week.
Photograph © Ivan Muñoz/MSF

A midwife uses an ear trumpet to check the heartbeat of a child in its mother's womb. *Photograph ©Frederic NOY/COSMOS*

A woman attending an MSF antenatal clinic in Diffa, Niger, stares back at her reflection in a handheld mirror. *Photograph © Juan Carlos Tomasi/MSF*

In torrential rain, a boy watches Rohingya refugees arrive in Bangladesh after crossing the Naf River from Myanmar.
Photograph © Antonio Faccilongo

ressings on a young child with burn
oh © Florian Seriex/MSF

Small solutions

In 2017, surgeon Shannon Chan travelled to Bor in South Sudan, where she discovered that you can achieve a lot with local materials and a little ingenuity...

"When I was in South Sudan, my small stature created some interesting situations. I'm only 160 cm (5'2"), and when I arrived in Juba, the capital of South Sudan, no one behind the immigration counter would believe my age. They thought I was 15 years old. The immigration officer refused to let me in. It took me two hours to prove that my passport was not a counterfeit.

Perhaps the mistake was unsurprising when you consider that the average height of the Dinka people (one of the tribes of South Sudan) is around 1.8 m (5'10"). Both men and women. I felt tiny when I was next to them, so it was little wonder nobody thought I was an adult.

The hospital where I was based was in Bor, northeast of the capital, Juba. Bor was one of the cities caught up in the intense fighting that broke out in 2013 and the hospital had been badly affected by the conflict. My job was to help provide technical support to the hospital as well as train the local medical staff.

As a surgeon, my main responsibility was, of course, performing operations. And, as usual, the height of the operating table was adjusted to the chief surgeon (in this case, me). There was a very hard-working local doctor named Haroun who made ward rounds with me every day and scrubbed up for every operation so as to learn as much as he could. However, he was from the Dinka tribe and was 2 m tall (about 6'7"). After two weeks working with me, he had severe neck and back pain. No one I met in South Sudan complained much, yet I started to hear him mumbling about his sore neck.

This was a problem that had to be solved. Our logistician, Scott, tried to find a platform for me, but in vain. There was no ready-to-use metal platform, and a wooden platform wouldn't meet our infection control standards. Eventually he found a giant cooking pot which he turned into a platform for me. This giant pot was with me until I completed the three-month mission. We christened it the 'pot stool'.

Standing on the 'pot stool', Shannon is almost as tall as her colleague, Dr Haroun. *Photograph © MSF*

Using what's available

Using local materials in an innovative way was a vital lesson for all of us. In a resource-strapped environment, using advanced equipment and materials is great, but the problem arises when the humanitarian organisation leaves and the supply is cut. Enabling local staff to rely on themselves and what they've got to hand is the most ideal and sustainable way to ensure that the work can carry on.

One simple example: during surgery to irrigate the abdomen, we always needed warm saline that was heated to body temperature. But with a sporadic electricity

A patient receives treatment for cholera at MSF's medical facility in Lankien, South Sudan. *Photograph © Albert Gonzalez Farran*

supply, incubators were unreliable. Our solution? With an average outdoor temperature of 35-38 degrees Celsius, we put the saline bags out in the sun for a few hours to get them ready for use.

Coffee-lid colostomy bag

Another instance was during resuscitation, when we needed pump sets to increase the rate of IV fluids delivered to the patient. We didn't have the luxury of a pump set, but what we did have was tall and strong Dinka staff. We took advantage of their height and asked them to hold up the saline packs, acting as a 'human pump' to exert pressure onto the pack. It worked perfectly!

Sometimes you really need to twist your brain to find the right local materials for different situations. DIY colostomy bags to collect patients' excreta was one of our best innovations. Previously we had used adhesive tape to stick the surgical gloves used as colostomy bags onto the patients' stoma (the opening in the abdomen from where excreta is removed). But the problem was that they leaked.

After a brainstorming session, Rodel, our ward nurse from the Philippines, came up with a brilliant idea: connecting the surgical glove to the sterilised lid of a jar of coffee powder. We could tie it onto our patients and make sure that the glove was changed every day.

Our coffee-lid colostomy bag worked perfectly, until we received a four-day-old baby whose stoma was the size of a coin. The lid of the coffee jar was way too big for him. We wracked our brains and eventually hit upon a lid from a glue stick, which we connected with a condom and then a surgical glove.

Do not look down on these little tricks. The local medical staff now know how to make their own colostomy bags and can cope with all manner of urgent needs, even when they don't have the latest equipment."

The improvised colostomy bag made with the sterilised lid of a coffee jar. *Photograph © Shannon Chan/MSF*

MSF IRELAND'S FIELD STAFF MARCH 2018

Afghanistan
Shannon Price, *Paediatrician, Co. Dublin*

Nigeria
Daniel Crowell, *Technical referent -Water Sanitation, Co. Dublin*

Swaziland
Laura Cooke, *Medical Doctor, Co. Clare*

Chad
Jean-Marie Majoro, *Project Supply Chain Manager, Co. Kildare;* Zuzanna Kurcharski, *Humanitarian Affairs Officer, Co. Dublin*

Central African Republic
Sarah Leahy, *Project HR/Finance Manager, Co. Dublin*

Iraq
Samuel Almeida, *Humanitarian Affairs Officer, Dublin*

Syria
Padraic McCluskey, *Humanitarian Affairs Officer, Co. Galway;* Deirdre Foley, *Paediatrician, Co. Meath*

Bangladesh
Thomas Fitzgerald, *Project Supply Chain Manager, Co. Dublin;* John Canty, *Human Resources/Finance, Co. Cork*

Greece
Declan Barry, *Medical Co-Ordinator, Co. Galway;* Myriam Abdel-Basit, *Cultural Mediator, Co. Dublin*

South Sudan
Mark Sherlock, *Medical Activity Manager, Co. Monaghan*

Thanks to you, MSF will be ready to respond to the next emergency. Gifts left in Wills play a vital role in ensuring we have the funds to deliver medical care where and when it's needed. For more information on how you can support MSF's work this way, please contact **Colm Dolan at 01-2815184 or colm.dolan@dublin.msf.org.**

Countdown to conflict

MSF team members walk across a damaged bridge to reach Bangassou, Central African Republic. During recent fighting in the town, all the surrounding bridges were destroyed. *Photograph © MSF*

When anaesthetist Michael Berry arrived in Bangassou, Central African Republic, last February, the town was a haven of relative peace in a very volatile country. By the time he left in May, the city was days away from being attacked.

"Central African Republic (CAR) is just six hours away by plane from mainland Europe, yet most people have never even heard of it.

Arriving on the red dirt airstrip in Bangassou, I saw the town was made up of small brick houses and huts surrounding some colonial-era buildings which were severely damaged.

But its dilapidated looks were deceptive, because actually it was in the centre of all kinds of activities, with all sorts of people passing through: traders on boats going up and down the Mbomou River, cattle herders from neighbouring Chad and South Sudan, miners from Democratic Republic of Congo, dealers in diamonds and ivory, weapons smugglers, poachers, armed groups...

Hand-to-hand combat

MSF's 100-bed hospital provides care for adults and children, with a maternity unit, a paediatric ward and a surgical department.

As an anaesthetist, I spent a lot of my time in the operating theatre. At the start, most of the surgery was either 'civilian trauma', for example people falling out of mango trees, or the usual things you see in any society such as hernias, abscesses and appendicitis.

But we increasingly carried out surgery for war trauma – for young men wounded with knives, machetes, clubs and improvised guns. The violence involves hand-to-hand combat – it's close and personal. Imagine you go up to someone, you stab them, they slash you, and then you find yourself lying in adjoining beds in the same hospital ward.

Barely a year ago, CAR was touted by the international community as a good-news story of stabilisation following conflict. But since the beginning of 2017, the country has slid back into open warfare, starting in the cities of Bambari and Bria, 350 km to the north.

War-related injuries

As the fighting began to move south towards Bangassou, we saw many more people with war-related injuries. There was a natural form of triage – if you're severely injured, you simply don't survive. We saw the ones who had made it to the hospital after a journey of up to seven days.

One man had been shot in the chest and spent six days in the forest looking after himself. When he arrived at our hospital, half of his chest was infected. He survived for a couple of weeks, but we didn't have the facilities to open up his chest and he died.

Others made surprising recoveries. One young child fell off a truck while fleeing the fighting and ruptured his spleen. He was brought to us, received treatment and survived.

There is high mortality – people die a lot. Unlike at home, it is young people dying. They are fit and healthy, they can work eight or 10 hours in a field in the sun – they shouldn't be dying. They die because of the fighting, because they have no access to healthcare or because the care they do get is sub-standard.

Most health staff in CAR have almost no medical training: there is only one nursing school in the country and its few graduates mostly choose to work in the capital, leaving rural areas with close to no health professionals. The quality of care is very rudimentary. Drug doses become difficult if you can't do the maths. In any case, basic health posts have few drugs to dispense.

Walking 300 km to the hospital

We try to provide people with safe surgery and post-operative care. We do the best we can with what we have. Back home, operating theatres are full of high-tech equipment. In CAR, it was just me, some basic kit and my clinical judgement.

People will walk for a week to come and have surgery. There are no cars and almost no public transport so there's no other way to get here. People are generally in incredibly good physical shape. You see 50-year-olds with six-packs that would be the envy of any gymgoer at home. As well as walking everywhere, they all grow all their own food, so everyone does a lot of physical work.

After being cut off for three days without food, water or medical care, people are finally able to flee Bangassou to a nearby Catholic church, where other displaced people are already sheltering. *Photograph © MSF*

Two women walked 300 km to our hospital. One had a prolapsed womb, the other had a huge hernia which distended her stomach. On the way they slept in convents or out in the open. They got bitten by mosquitoes and suffered bouts of malaria, which set them back on their journey. But finally they arrived. We treated them and they walked back home.

When I first arrived, I could walk to the hospital too – 2 km in the morning and then 2 km back to the MSF compound at the end of the day. The compound is in the remains of a 1960s hunting lodge, from the days when this area was a secret destination for big game hunters. In the evenings we had wifi and there were lots of people to talk to.

But then the security situation deteriorated, and the big team of 30 international staff started leaving and we could no longer walk anywhere. Eventually there were just six or seven of us left.

The emergency grab bag

We all had an emergency grab bag in case we had to flee. Mine contained a radio, a head torch, money, toothbrush, deodorant and a medical book in case I had to do any field anaesthesia. Our safe plan was to cross the river to Democratic Republic of Congo.

Despite the active fighting around us, I felt safe for the most part. Any fear I had was from the very young fighters who had the reputation for being aggressive and ruthless. They roamed around with guns and you never quite knew what was going through their heads.

As the weeks went by, you could sense that something major was about to happen: people were stockpiling food, fleeing into the bush, you could hear fighting in the distance, and more and more injured were arriving at the hospital.

My time came to leave and I flew back home. Five or six days later, violence broke out in Bangassou. Soon after the town was invaded, armed men pulled two Muslim patients out of the hospital and murdered them outside the compound."

After Michael left Bangassou, MSF continued to provide immediate lifesaving medical care to people in the area. But in November 2017, after a violent robbery, MSF was forced to evacuate its last team members from the town. They will return to Bangassou as soon as it is safe to do so. Meanwhile, MSF teams are working in 10 other locations across the country.

A patient is examined during an MSF mobile clinic outside Bangassou. *Photograph © Natacha Buhler/MSF*

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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

Diary of a Flying WatSan

Daniel Crowell is a Water and Sanitation (WatSan) specialist engineer from Co Dublin, currently travelling across multiple MSF projects in Nigeria ensuring each hospital and clinic has running water.

Saturday morning in Zamfara in north western Nigeria. I've been trying to write this all day but it's been delayed by 16 calls from a contractor, a visit to the hospital and 30 minutes standing still on top of a septic tank – trying to trick a gang of rats spotted hiding underneath. It's a far cry from the engineering offices I'm used to but at least I'm not medical; they never get a break!

I'm a Flying WatSan, which means I look after the water and sanitation over all our projects in Nigeria. It sounds very 'Indiana Jones' but in reality I should be called a Driving WatSan. Lots of long, bumpy rides between the four projects. I'm mostly based in Sokoto, which is a city in Northern Nigeria but feels like a large West African town. First thing I did after being matched to this project was to Wikipedia Sokoto where it said it's one of the hottest cities in the world. Not ideal!

There is a good mix of work that keeps things interesting. I'm with the Emergency Response Unit for the mission which responds to epidemics and situations where people are internally displaced due to flooding or violence. Things can be slow and then suddenly you have to travel into the communities to reach patients with only a couple of hours' notice. We did an assessment for a suspected cholera outbreak last week and the conditions in the local hospital needed some improvement. We brought in some hygiene materials to set up handwashing and oral rehydration salts (ORS) points and it's amazing how big an impact some advice and a tiny investment can have.

Next is the Noma Hospital in Sokoto, which is the only hospital dedicated to this disease in the world. Noma is a terrible disease in which bacteria literally eat away facial tissue; like a jaw, cheek or nose. In collaboration with the Ministry of Health, MSF surgical teams provide reconstructive surgery four times a year to these children with severe facial deformities who are often hidden away from their own communities. I've seen some of the surgeries and it's amazing to see how quickly they can fashion a nose or an eye lid from folding some skin. After the surgeons are gone, the team will be quietly helping the patients through the next stage of their recovery; things like helping kids adjust to being visible in community life or intensive physiotherapy.

At the moment I'm digging a new borehole in one of our outreach towns, Bagega. This town is known for artisanal mining in the region and, as such, lead poisoning cases. After engagement with the community and mining cooperative, we agreed to provide wash areas for them, as this helps to reduce the causes of lead poisoning. Miners not having access to wash facilities at work can accidently contaminate their homes. This inevitably affects kids the worst as they have weaker immune systems and play on contaminated soil throughout the day.

People fill jerry cans at a camp for displaced people in Bama, Nigeria.
Photograph © Benoit Finck/MSF

My most exciting project, is supervising construction of an underground water reservoir I designed which will finally bring sustainable running water to the hospital; it should have a huge impact and will be finished early 2018. We will be able to provide more hand washing points to stop the spread of disease, make life more comfortable for the mothers during their stay, save resources spent trucking in water and overall promote good hygiene in the hospital. It was nice when I arrived in the town that the locals knew why I had come and were so appreciative that the hospital would finally have a reliable water source after so many years.

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Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. We welcome your feedback.

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