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Spring 2022

Dispatches

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

SITUATION REPORT

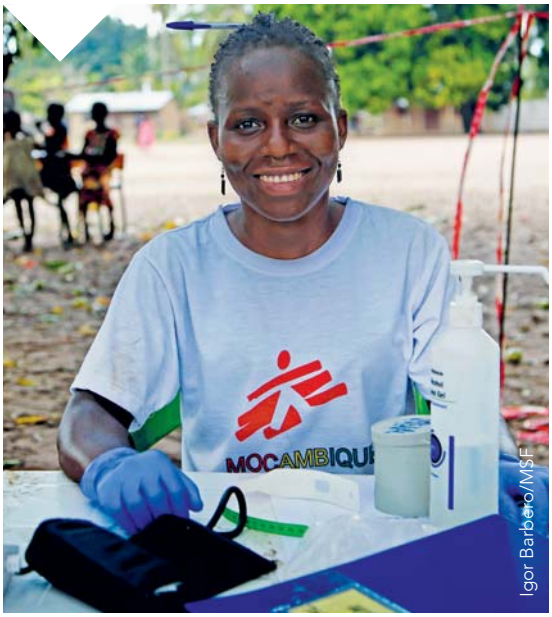

Ben Small/MSF

1. MYANMAR

Ma Sabai strokes the head of her sleeping baby, watched by her husband, at MSF's Moegaung clinic in Kachin state, where she is receiving antiretroviral treatment for HIV. Now aged 24, Ma Sabai was born with the virus. MSF has been at the forefront of Myanmar's HIV response for the past two decades, securing vital funding, pioneering antiretroviral treatment, providing high quality care, including for those coinfected with other diseases such as tuberculosis, and treating a total of nearly 42,000 patients. Over the past five years, MSF has worked to strengthen the government's capacity to care for people living with HIV, with the ultimate aim of transferring its patients to the National AIDS Programme.

2. MOZAMBIQUE

Following a recent surge of violence, MSF nurse Benvinda prepares to see patients at a mobile clinic near Mueda, in the northern province of Cabo Delgado, an area affected by five years of conflict. "Violent attacks and ongoing insecurity in several districts of central Cabo Delgado have driven thousands of people from their homes," says Raphael Veicht, head of MSF's emergency unit. "Our teams are responding by providing people with basic healthcare as well as much-needed household and shelter items. We are extremely concerned about the protection of civilians within this acute and escalating conflict."



Igor Barbero/MSF


Sophie Lecour/MSF

3. MADAGASCAR

Parents and children gather at an MSF mobile clinic set up in the shade of a tree in Taranake. After years of severe drought, southern Madgascar has been in the grip of a malnutrition crisis since March 2021, exacerbated by Cyclone Batsirai which struck on 5 February. MSF teams are treating people for malnutrition and providing them with food and clean drinking water.

800,000

people affected by flooding in South Sudan


Sean Sutton

4. SOUTH SUDAN

MSF water and sanitation engineers arrive by helicopter in Kaljack village, in Unity state, to repair a well. Severe flooding has hit eight out of 10 states in South Sudan since May 2021, forcing people from their homes and contaminating water sources. MSF emergency teams in Unity and Jonglei, the two worst affected states, are running mobile clinics and providing people with clean drinking water.

5. PHILIPPINES

An MSF emergency team walk through the streets of Surigao city in the aftermath of Typhoon Rai (also known as Odette) which struck parts of the Philippines in December 2021. "The typhoon has severely affected tens of thousands of people," says Chenery Ann Lim, MSF's emergency medical coordinator. "It is crucial to make basic services available again immediately to avoid the spread of waterborne diseases."


MSF

MSF'S UK VOLUNTEERS

Afghanistan: Rebecca Ferguson, *Nurse*; Thomas Casey, *Field communications manager*

Bangladesh: Saira Butt, *Epidemiologist*; Lucy Hart, *Paediatrician*; Sofie Karlsson, *Midwife*

Central African Republic: Prudence Jarrett, *Doctor*; Jean Willemyns, *HR manager*; Joanne Connell, *Doctor*

Chad: Javid Abdelmoneim, *Deputy medical coordinator*

Democratic Republic of Congo: Bryony Hopkinshaw, *Doctor*; John Boase, *Logistician*

Egypt: Elizabeth Wait, *Health promoter*

Ethiopia: Rebecca Kerr, *Advocacy manager*

Haiti: Ruth Zwizwai, *Epidemiologist*; Lucia Alvarez Marron, *Nurse*

Honduras: Roisin Bainbridge, *Mobile health activity manager*

India: Melissa Chowdhury, *Doctor*

Iraq: Milena Beauvallet, *Head of mission support*; Maria Zavala San Andres, *Nurse*

Kenya: Paul Banks, *Procurement manager*

Lebanon: Peter Garrett, *Doctor*

Liberia: Heidi Saweres, *Pharmacist*

Lithuania: Georgina Brown, *Medical team leader*

Mexico: Lindsay Solera-Deuchar, *Activity manager*

Myanmar: Ben Small, *Field communications manager*

Pakistan: Vincent Evans Gutiérrez, *Finance manager*; William de Glanville. *Epidemiologist*; Kate Thompson, *Finance coordinator*

Palestinian Territories: Helen Ottens-Patterson, *Head of mission*

Russia: Rebecca Welfare, *Deputy head of mission*

Sierra Leone: Rachel Crozier, *Nurse manager*; Nicos Vrahimis, *Doctor*; Suzanne Thorpe, *Nurse*

South Sudan: Melissa Perry, *Project coordinator*; Katherine Smeaton-Russell, *Nurse*; John Buckels, *Surgeon*; Cawo Yassin Ali, *Water and sanitation coordinator*; Mark McNicol, *Doctor*; Florentina Popa, *Midwife*; Iina Hiironen, *Epidemiologist*; Marc Woodman, *Doctor*; Sarah Cross, *Nurse*; Rowena Neville, *Doctor*; Daniel Acheson, *Logistician*; Rachel Fuller, *Nurse*

Sudan: Ibtehal Mohammed, *Paediatrician*

Syria: Rebecca Roby, *Advocacy manager*; Moses Soro, *Finance manager*

Ukraine: Andrew Burger-Seed, *Project coordinator*

Uzbekistan: Beatrice Blythe, *Anthropologist*; Gabriella Bidwell, *Doctor*; Mshauri Delem, *Project coordinator*

Venezuela: Wendell Junia, *Lab manager*

Yemen: Adeyemi Lawal, *Medical coordinator*; Olivia Butters, *Water and sanitation manager*; Mark Lee, *Paediatrician*

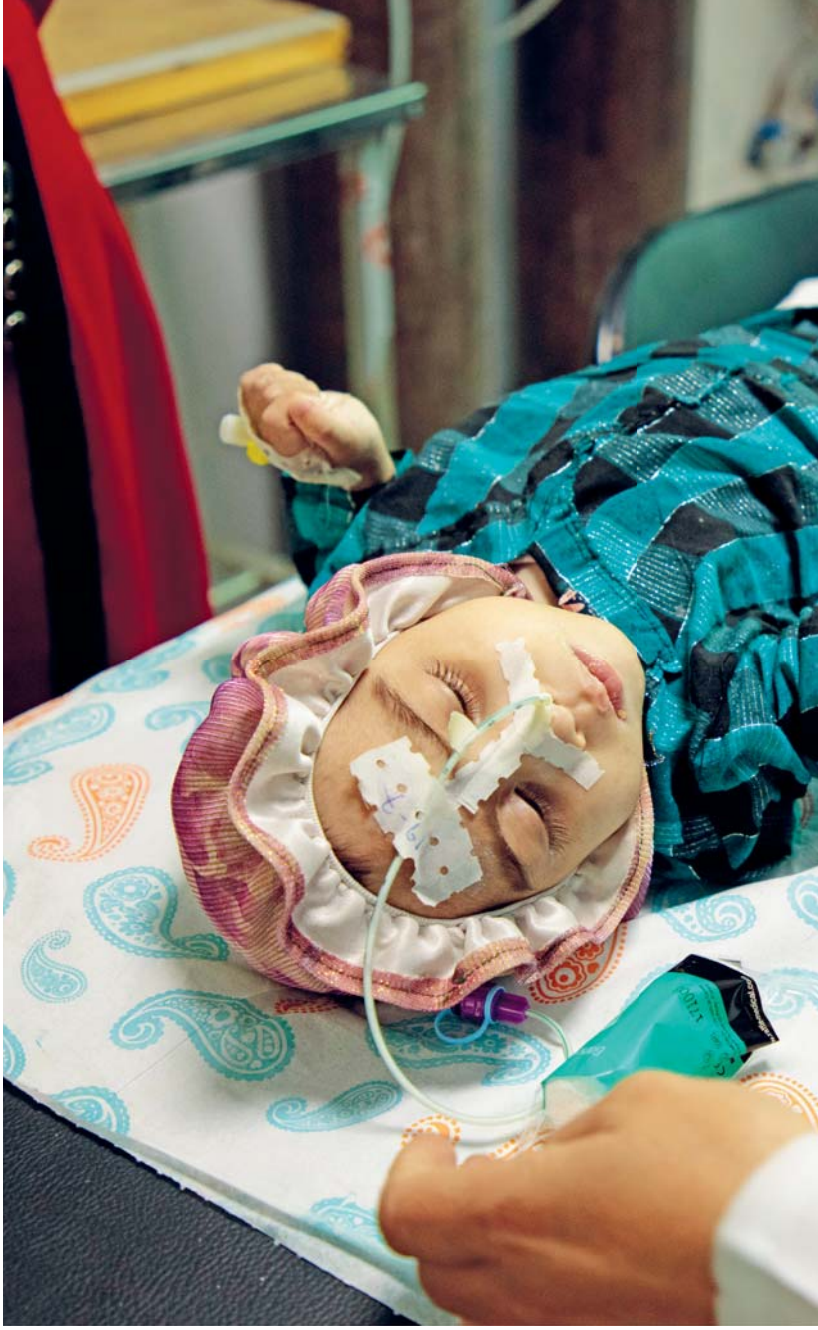
AFGHANISTAN

WORDS
DR MOHAMMED MAMMAN MUSTAPHA

PHOTOGRAPHY
SANDRA CALLIGARO

‘We’re facing a malnutrition crisis’

THE SITUATION IN AFGHANISTAN IS DESPERATE. HEALTH FACILITIES ARE OVERWHELMED AND LARGE NUMBERS OF MALNOURISHED CHILDREN ARE BEING TREATED AT MSF FEEDING CENTRES.



▲ A malnourished child is fed by nasogastric tube at MSF’s inpatient therapeutic feeding centre in Herat regional hospital, 13 October 2021.

▶ Women and children wait to see a doctor at MSF’s Kahdestan clinic in Herat, 12 October 2021.

DR MOHAMMED
LASHKAR GAH

“Right now, we are very busy. We’re treating 400 severely malnourished children in our therapeutic feeding centre at the hospital and every one of these patients is under five years old. Many are also suffering from complications such as pneumonia, diarrhoea or gastrointestinal problems.

Our team is working night and day to treat the direct medical complications of malnutrition, as well as constantly preparing therapeutic foods to feed every child three times a day.

Now that the security situation is more stable and people can travel again, we are seeing double the usual number of patients. In May, we admitted 250 children, but recently it’s been over 500 per month.

Our main concern now is that we’re running out of beds. At the moment it’s two families – one mother and one child – to every bed. We work hard to be flexible, but we can only admit the sickest. We make sure that those we can’t admit are seen elsewhere in the hospital.

The healthcare system has collapsed in Helmand province and people are travelling from distant districts to reach us. These journeys can take well over three hours, which is very far when a child is sick. Those who reach us are the lucky ones.

There was one family who came from Musa Qala, which has been under Taliban control since last year. The family were very poor and struggled to find food while the young mother was pregnant.

After the baby was born, the mother became very weak and couldn’t breastfeed her child. The little girl was malnourished from the very first day of her life.

Here in the feeding centre, we treat many patients for around three weeks, but this little girl has been with us for three months now. She is still weak, but we hope that she will improve with our care.

My work here for MSF gives me hope. I have worked here since 2010, when the hospital first opened, and I am still very proud of what we do every day. We are providing something that would otherwise be out of reach for people here: lifesaving medical care that is free.”

December 2021
Name has been changed to protect identity

MAMMAN MUSTAPHA
PROJECT COORDINATOR
HERAT

"I arrived in Herat on 31 December 2020. My assignment was meant to be short – just three months. I was responsible for coordinating our medical operations, negotiating with the authorities and managing the security of the team.

In those early months, the armed conflict was ongoing but Herat was relatively safe. I decided to extend my assignment: I wanted to better understand the environment and the health needs here.

However, from 1 May, almost everything changed. By July, the conflict had reached major cities. Negotiation was my daily job. We regularly explained to all parties to the conflict that we were here to provide emergency medical services, we were neutral to the conflict, we were independent, and we treated patients irrespective of their religion, gender or political affiliation, based on their medical needs alone.

Throughout the fighting, our staff were able to keep coming to work and our doors stayed open, providing lifesaving assistance to the sick and wounded even during the height of the conflict. It still makes me incredibly happy that we were able to do this.

By mid-August, the fighting was over and Afghanistan had a new government. The safety and security of my team and our patients remained my number one priority, and I had to rapidly establish new contacts with the government, starting every relationship from scratch.

I met the new health representative on the morning following the takeover. This was my first meeting with the new government and it gave my team the courage to continue our work without hindrance. But there were still huge challenges.

Airports and banks were closed and many other organisations were scaling down their work as funding was suspended by the EU, World Bank and others. As a result, the healthcare system almost collapsed.

As an organisation funded directly by private donations, we didn't face the same funding challenges. So we were able to keep working, though under increased pressure.

There is no armed conflict in Herat, but people are still dying because many of them can't afford to buy food. The number of malnourished children arriving at our feeding centre was significantly higher than in the same months the previous year. This is an indicator of a general malnutrition crisis.

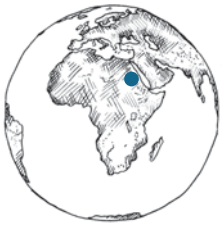
I finished my assignment in Afghanistan in October, saying goodbye to my Afghan colleagues whose dedication and zeal had given me so much encouragement.

The work was challenging and intense, but seeing the results kept me positive. And the work is continuing. The future of almost everything here is uncertain and our activities are still under pressure.

But it's clear we are needed there, that our team is motivated, and that we are doing the very best we can."

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

EMERGENCY ON THE MOUNTAINS



SUDAN

WORDS
DAN ROBERTS

PHOTOGRAPHY
LEAH COWAN AND
ANNA BYLUND

THE JEBEL MARRA REGION OF SUDAN'S DARFUR STATE IS A MOUNTAINOUS AND POLITICALLY VOLATILE REGION THAT HAS SEEN OVER A DECADE OF CONFLICT. MSF IS ONE OF THE ONLY INTERNATIONAL ORGANISATIONS ABLE TO OPERATE FULLY IN THIS AREA, WHERE MANY COMMUNITIES ARE CUT OFF FROM HEALTHCARE AND REACHABLE ONLY BY DONKEY OR CAMEL. **DR DAN ROBERTS** SHARES HIS ACCOUNT OF A MEDICAL EMERGENCY DURING A MOBILE CLINIC…

"As we load up the donkeys, squeezing the various medications and equipment into their side bags while they try to chomp as much grass as possible before we set off, one of our translators, Ahmed, finishes one of his constant phone calls.

After a month in the Jebel Marra mountains, I have just about mastered the art of mounting a donkey in a not completely undignified manner. I have also begun to understand the complex network of people that hold this geographically dispersed community together. To describe Ahmed as a translator does his work a massive disservice; he is the focal point for the various local community leaders and the traditional medical practitioners who were the only healthcare available before MSF started its activities.

'They are sending us a sick baby from Torran Tonga,' says Ahmed.

Leah Cowan/MSF

Leah Cowan/MSF

Overleaf: MSF staff travel to Dilli village by donkey to deliver medical supplies.

◀ Community leader Mohammed Abdallah Juma stands by his camel, an essential form of transport in a region without usable roads.

▼ MSF team members travel from Koya to Dilli village to conduct a measles vaccination campaign.

Anna Bylund/MSF

'What's the problem?'

'They don't know. He is three months old and he can't eat or drink.'

To my shame, my first instinct is to be a little dismissive. In a kid that young, not being able to breastfeed is a bad sign. If he survives the six-hour donkey ride from his village to our clinic (which itself is six hours from the nearest hospital), I'm not sure how much we'll be able to help, as our resources are basic.

'Not sure we can do,' I say neutrally.

'But doctor, up there they have nothing.'

The conversation is quickly forgotten as we trek up the mountain and then settle into the daily humdrum routine of the clinic.

I am very content in our consultation tent, which overlooks the mountains. The mist and clouds settling over the jagged valleys make it obvious why the region has zero usable roads.

The patients come on foot: the mothers diligently carrying their infants on their backs to collect supplementary therapeutic food; the young pregnant women coming for antenatal check-ups; and the myriad of other patients with a wide spectrum of conditions. We treat dysentery, skin infections, malaria, flu, dehydration and malnutrition as well as various other conditions that we have little hope of accurately diagnosing with our basic tools.

Ibrahim, our other translator, helps me work with Fatima, the sole clinician in the clinic. Ibrahim's young-looking face belies his experience and he educates me in the nuances of the region: about the area where all the teenagers have a bladder worm called schistosomiasis, and about how the locals describe malaria (confusingly the local language, Fur, uses the same word for malaria and fever). So we cure the curable, advise on the preventable and apologise for the untreatable. The clinic settles into its daily routine.

I notice the concern on her face first. She is cradling the baby in front of her – he's not tied to her back. This is another bad sign. Then I look at him: he looks terrible.

Pale, with skin pulled taut over his skull, his lungs are desperately gasping for air, pulling his chest rapidly back and forth, stretching the skin between his rib spaces. I know without touching him that his tiny arms and legs will be cool to the touch.

This child is sick.

I am an emergency doctor and this is what I am trained for. I mentally list the things we need to do and who I can get to do them as quickly as possible.

We move the family behind the curtain to our only bed. I ask Salah to get the scales and to bring Amna, the nurse, who fortunately is one of our most experienced team members.

I ask Fatima to get the equipment for intravenous paediatric cannulation and, most importantly, to ask Ibrahim to help me speak to the family. Having worked with Ibrahim for a month, I know that his English is more eloquent than mine, so I trust him completely to speak to this mother with the tact and sensitivity that is needed at this critical time.

'Your baby is very sick. We are going to treat him as best we can, but he might die very shortly.'

She nods simply as Fatima ties a band round her infant's hand to try and access a vein despite his severe dehydration.

I can tell by the mother's ashen face that she understands, but this conversation is too important for assumptions.

'Ibrahim, can you check she understands what is happening?'

There is a short back and forth in Fur.

'Yes, she understands.'

The baby has been weighed, an impossibly small figure of four kg is written down.

Two needles miss veins on the right hand as Fatima checks his sugar and checks for anaemia with drops of blood from his heel.

We need to get this drip running, I think. Really need to. This is something that doesn't need to be said out loud to the team – we all know this.

I whip my trusty tourniquet out of my pocket, get down on my knees and hold my breath as I see a hittable target on the back of his hand. One advantage when they are this sick is that they don't move much.

'Yep, I'm in.'

A fluid drip is started, Fatima preps the antibiotics and we breathe a little.

'I don't think it's malaria but should we test for it anyway?'

'Two needles miss veins… we need to get this drip running'


HEALTH CARD
CARTE DE SANTÉ

Leah Cowan/MSF

‘The medications we gave him probably cost less than £10. It is depressingly ridiculous how simple it was…’

◀ Mabola and her eight-month-old son Ahmad wait to see a doctor at MSF’s clinic in Dilli.

Fatima asks. I trust Fatima more than the vast majority of clinicians on this planet to sniff out a malaria case, and I agree – this doesn’t look like malaria. But this kid is what we what class as “proper sick” so it seems foolish not to use all the tests we have. Unfortunately it is negative; malaria is much easier to treat than the bacterial septicaemia I suspect he has.

The treatment goes in. We wait, we try and encourage breastfeeding. But then he starts to have a seizure.

I swear aloud and hope no one in earshot understands enough English to recognise my lapse in professionalism.

Right, we check blood sugar again: normal. One fit isn’t too bad.

Then he has another.

‘Amna, do we have any anti-seizure medications?’

‘I don’t think so, doctor.’

She knows our small pharmacy better than anyone, but we look through the second storeroom anyway to check that there’s no box of intravenous medication hiding in a forgotten corner. No such luck.

So that’s it. We are at the limit of out treatment capabilities. In the UK this kid would be in intensive care by now. But this is all we can offer: fluids and antibiotics.

After lunch, between seeing the regular clinic patients, we pop behind the curtain to check on him. He seems to be having less frequent fits now. If it is meningitis, the outlook is poor. Even if he survives today, he has a high chance of having some sort of permanent disability.

I hope he only has pneumonia with severe dehydration, causing electrolyte disturbance (which would cause his seizures). But speculation is academic at this stage. All we can do is watch and wait.

Later, Fatima, Ibrahim and I stand watching the kid on his mother’s lap, breathing a little less hard than earlier, supporting his head a little more. Then, as we look on, a gloriously clear stream of wee pours out of him all over the floor.

We laugh, fist-bump each other and his mother joins in, laughing through her tears. He has responded to the treatment to get enough blood to his kidneys. He might just live.

Two days later, after I have left the clinic and sent some oral liquid antibiotics up the mountain by camel, the baby is sent home. On a dodgy telephone connection, Fatima tells me he is feeding well and apparently back to his normal self. I laugh, congratulate the team and reflect on the madness of this job. The medications we gave him – two bags of intravenous fluids, three doses of intravenous antibiotics and a bottle of liquid antibiotics – probably cost less than £10 combined. It is depressingly ridiculous how simple it was.

But it took an organisation with the experience of MSF to make it happen: an organisation with the logistical knowhow to transport those antibiotics up a mountain by camel; with the political wherewithal to negotiate with the local armed groups to allow us access to the area; and with the clear sightedness to hire and support the fantastic team of Amna, Fatima, Salah and Ibrahim, without whom this sublime clinical encounter would not have happened.

But the relentless enthusiasm of the organisation does not stop there. One of my last acts before I left the Jebel Marra mountains to return home to the UK was to join some colleagues hiking the six hours to Torran Tonga, this family’s home village, to set up a new clinic. So, hopefully, my colleagues will be able to treat the next child before they get quite so sick.”

Dan Roberts
is an emergency doctor based in Brighton. Sudan was his first assignment with MSF

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

DEMOCRATIC REPUBLIC OF CONGO

PHOTOGRAPHY
MARTA SOSZYNSKA AND CAROLINE THIRION

ILLUSTRATION
MARKO PETRIK

A simple solution

AN INNOVATIVE PROJECT IS TRIALLING A SIMPLE SOLUTION FOR DISPLACED WOMEN MANAGING MENSTRUATION IN DEMOCRATIC REPUBLIC OF CONGO. DEPUTY MEDICAL COORDINATOR **ALAIN KIKWAYA-VANGI** SHARES AN UPDATE…

"I'm surprised," said the woman. "Surprised that MSF would want to help with something like this. It's so personal."

The woman was talking during a discussion group for a new project our team has been piloting in South Kivu, in eastern Democratic Republic of Congo.

The project aims to assess the feasibility of distributing menstrual underwear to women in the region who have been displaced from their homes. Menstrual underwear is made with special fabric so it's absorbent, washable and re-usable.

The idea came from a colleague who found it the best option for herself in the challenging contexts where MSF operates. If menstrual underwear worked for her, could it work for women living in these places full-time?

South Kivu has seen repeated cycles of armed violence between communities, forcing thousands to flee for their lives. In their search for safety, people in

Marta Soszynska/MSF

◀ An MSF motorbike team descend the High Plateau area on their way back from Numbi, in one of the most remote areas of South Kivu province.

200,000
number of displaced women in South Kivu province

£12
cost of a pair of menstrual underwear pants

this remote area often find themselves struggling to access essentials such as clean water, food and healthcare.

In December, I met a woman who told us that she'd woken in the middle of the night to find her house on fire around her: the village was being attacked. She managed to get out, but there was no time to grab anything. When we met her, she was living in a 10 m^2 schoolhouse with 40 other people; she had no bedding, no spare clothes, nothing.

All too often, menstrual hygiene is not considered in an emergency response. In the discussion groups we've been running with women who have been through this terrifying experience, they have told us how, in the aftermath of a crisis, they are completely dependent on materials they can find around them to help manage menstruation. Often these materials are not safe or hygienic, and this can impact both their physical health and their mental wellbeing.

The women we've talked to have shared their views and helped us understand their needs and the cultural perceptions around this sensitive topic. This has helped us feel confident to move to the next phase of the pilot. After several delays because of violence and insecurity in the area, we'll soon start distributing menstrual underwear to 200 women, who have agreed to test it out and share their feedback.

Whatever the final conclusions of the trial, I hope this project will show how vital it is that menstrual hygiene is a component in every emergency response, especially with displaced people. Consulting the community from the start has given us the opportunity to learn, to get closer to them and to optimise our approach, and this is something we'll be using in future initiatives too.

For now, our team is focused on the upcoming distribution and looking forward to hearing what the women have to say. They have already given us ideas for the next phase of the project!

Caroline Thirion/MSF

▲ A mother brings her two children to be vaccinated against measles in Botulu village.

'Consulting the community helped us to learn'

Alain Kikwaya-Vangi
is a Congolese deputy medical coordinator

HEAD TO **MSF.ORG.UK/SAPLING** TO MEET THE TEAM

WORDS
DR MOHANA AMIRTHARAJAH
DR JEAN-PIERRE LETOQUART
PHOTOGRAPHY
PIERRE FROMENTIN

'RESTORING PEOPLE'S DIGNITY'

Every year, MSF teams carry out tens of thousands of surgeries. From treating war wounds and bomb blast injuries to emergency caesareans and reconstructive surgery, our surgeons are at the frontline of our lifesaving care. In the places where we work, demand for surgical services is increasing. MSF surgical advisors **Dr Mohana Amirtharajah** and **Dr Jean-Pierre Letoquart** discuss some of the unique challenges MSF faces.

What are MSF's biggest challenges in regard to surgery?

Dr Mohana Amirtharajah: "One of the huge issues we always face is recruitment – and COVID has made it worse. MSF has traditionally been quite dependent on international staff for surgery and it's become very clear that that dependency is a weakness – not only because COVID has made it difficult to move surgeons to our various hospitals, but also because of issues around continuity of care. Of course, we still need international surgeons and we always will. But one of our big pushes is to identify key local staff and to train and upskill them in surgery so that we are not so dependent on international surgeons."

Dr Jean-Pierre Letoquart: "If you look at the international surgeons who work for MSF, most of them are older. It has become very difficult to recruit young surgeons for the sort of work we do. It's not because they are unwilling, but because their training now is so specialised that they don't have the general surgical skills we need. They are learning perhaps only 40 per cent of the type of surgeries we face in the field."

Mohana: "For example, I trained as an orthopaedic surgeon, but after residency in my second year, I never touched an abdomen. But at MSF we need our surgeons to do everything."

Jean-Pierre: "Also, so much surgery here in Europe is now technology-driven. But at MSF we don't do endoscopic surgeries, for example. It's not realistic for us to have this sort of equipment in our projects, because of expense and maintenance. We do open surgery, but open surgery has become rarer in high-income countries."

Mohana: "Younger, international surgeons are used to doing surgeries with high-tech equipment. To come and work for us, they have to learn to do things by hand. It's more traditional in some ways."

If you're a surgeon and you want to learn these skills, where do you go?

Jean-Pierre: "We have a new training programme in South Africa that's open to surgeons from countries where we work. It's very practical and we teach surgeons to do external fixations, caesareans, to treat burns, gunshot wounds etc..."

Mohana: "One of the reasons we picked South Africa was because we needed a place where our surgeons could get experience in treating penetrating trauma, by which I mean gunshot wounds. I trained in the US, where you see tons of gunshot wounds because there are a lot of shootings, so I was fairly comfortable with that before joining MSF. But if you're a surgeon who has trained and worked in, say, Japan, the most you might see is the occasional stab wound."

Jean-Pierre: "Of course, some surgeries you can only experience by working in a war zone. High-energy blast wounds, high-velocity bullets, explosions – you need to be working in a place like Yemen to face those injuries. Gunshot wounds in a war zone will be more severe than those you might experience in Haiti, for example, where there a lot of bullet injuries, but they are caused by handguns. A Kalashnikov creates a different and much larger injury than a handgun."

As an MSF surgical advisor, how important is it for you to be hands-on, visiting our hospitals and conducting surgeries?

Jean-Pierre: "It's vital. As a surgical advisor, I need to go to our projects to see that everything is working as it should be, and the best way to do that is by doing the job when you're there. It's important because good surgery is never just about surgery. For example, one of the first things I do when I arrive at a hospital is look at the pharmacy, because if the pharmacy is not working properly – if stock is out of date,

An MSF surgical team at the Hôpital Immaculée Conception, in the southern Haitian town of Les Cayes, operate on a boy injured in the August 2021 earthquake.

if items are missing, if there aren't good links between the surgical team and the pharmacy – then everything to do with surgery will be affected."

Mohana: "At MSF, we have to make choices. We can't do everything. But within those constraints, we want to ensure that standards are as high as they can be, whether that's war surgery in Syria or high-quality emergency surgery in a remote place with limited referral possibilities. Part of doing that is focusing on what we see most often in our operating theatres. Caesareans are the most common surgical procedure conducted by MSF by a long way. We also see a lot of surgery for infection, burns and complications due to typhoid. The goal is to focus on these so we can be consistent in the quality of surgical care we provide for these common conditions."

Does this approach have a positive knock-on effect on other areas of our work?

Mohana: "Yes, definitely. There's no getting away from the fact that many of the places where we work have very limited health systems, meaning that there are a lot of preventable deaths. Our job is to work as hard as possible to ensure that in the hospitals where we work, surgical standards, and infection prevention and control standards, are as high as they can be in order to ensure we're saving as many lives as possible."

What would you most like to see improved?

Jean-Pierre: "Our data collection. There is a real need for us to digitise our patient records. Nearly everything is paper-based at the moment and it's very difficult to keep on top of all the information. But without that information, it's hard to ensure right treatment and proper follow-up occurs. To do that in all the places where we work will be difficult and very expensive. But it needs to be done."

Mohana: "I agree. We collect so much information and there are so many documents that it's just overwhelming. It should be feasible to have electronic medical records, even in remote places. There are a lot of cheap tablets around and staff could type notes up and upload them via WiFi. It will take a lot of upfront investment but it's something we should be working towards."

Despite the challenges, do you feel positive about the surgical care we provide?

Mohana: "Absolutely. Surgery is about saving lives, about restoring people's dignity. When you join MSF, it becomes very clear, very quickly, that in many places where we work, if our teams weren't there providing emergency surgical services, then nobody would be. It's important work."

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

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

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Cover image: An MSF worker travels by donkey to deliver medical supplies to Dilli village in the Jebel Marra mountains in Sudan's Darfur region. See story page 6. Photograph © Leah Cowan/MSF

ABOUT
Dispatches is written by MSF staff and sent out quarterly to our supporters to keep you informed about our medical work around the world, all of which is funded by you. Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. It is edited by Marcus Dunk. It is printed on recycled paper and costs £0.61 to produce, package and send using the cheapest form of post. It is an important source of income for MSF and raises three times what it costs to produce. We always welcome your feedback. Please contact us using the methods listed, or email: **dispatches.uk@london.msf.org**

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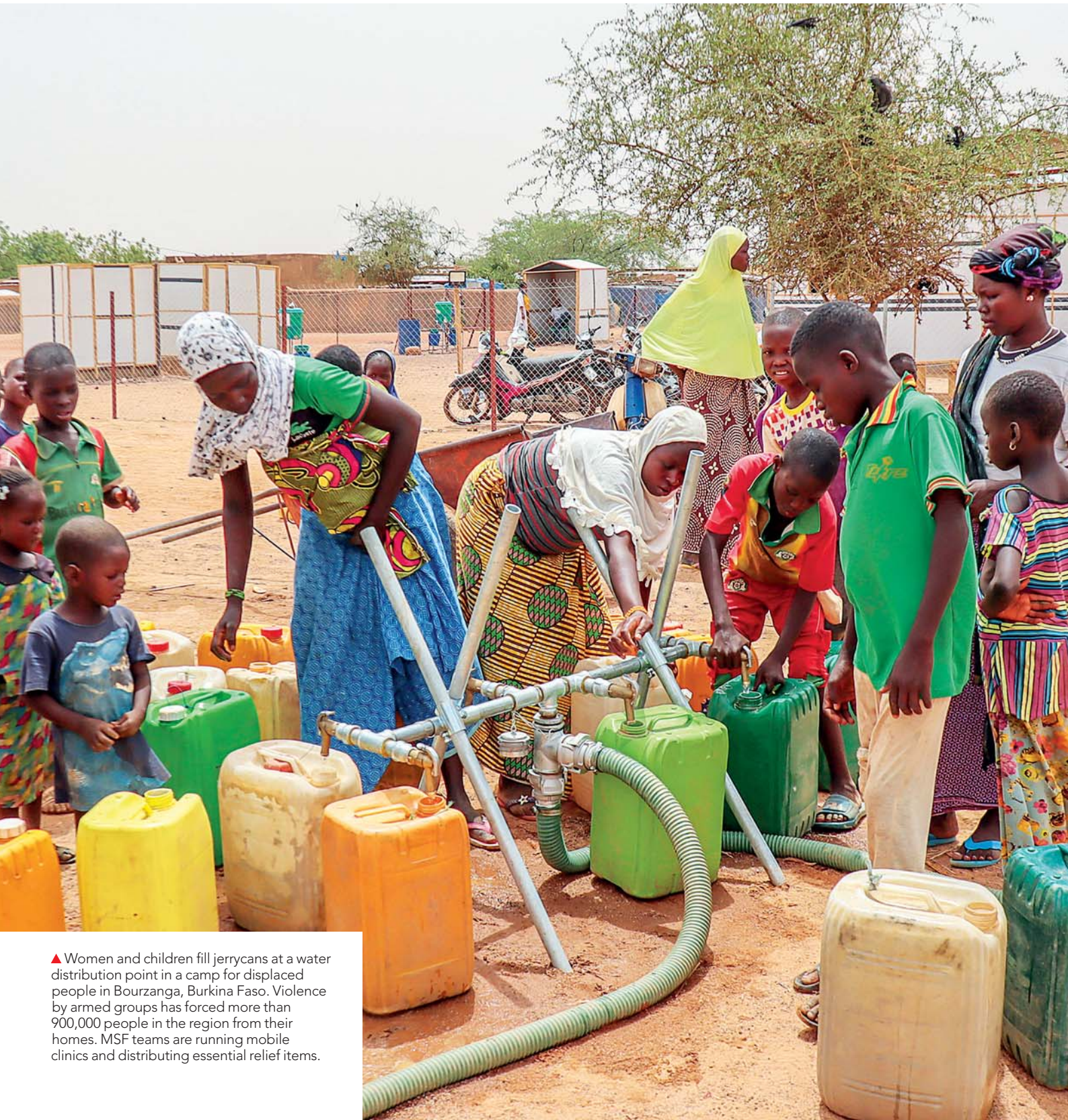

▲ Women and children fill jerrycans at a water distribution point in a camp for displaced people in Bourzanga, Burkina Faso. Violence by armed groups has forced more than 900,000 people in the region from their homes. MSF teams are running mobile clinics and distributing essential relief items.