DISPATCHES

Medical detectives

The riddle of Ebola, one of the world's deadliest viruses

MSF nurse Lucie Perardel checks her goggles at a clinic in Guinea, where staff are working to combat an outbreak of Ebola *Photograph: © Sam Taylor/MSF, 2014*

Summer 2014
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Komotini Detention Centre, Greece 2014

GREECE

End the prolonged detention of migrants, says MSF

A new report from MSF reveals the devastating impact of prolonged detention on the physical and mental health of migrants and asylum seekers held in Greece.

"Over a period of six years, we have carried out more than 9,900 medical consultations inside detention centres and police stations where migrants and asylum seekers are held," says Dr Apostolos Veizis, MSF's head of mission in Greece. "But despite our repeated calls for improvements to detention conditions and migrants' access to healthcare, we have seen little change, while the overall situation continues to deteriorate."

Even vulnerable groups – such as minors, victims of torture and people with chronic diseases or disabilities – are subjected to prolonged detention, while overcrowding, inadequate heating, insufficient hot water, poor ventilation, a lack of access to the outdoors and a poor diet contribute to the emergence and spread of respiratory, gastrointestinal, dermatological and musculoskeletal diseases among detainees. Detention is also detrimental to their mental health: symptoms of anxiety, depression and psychosomatic manifestations are observed in many, while it is not uncommon for desperate migrants to go on hunger strike, to self-harm and even to attempt suicide.

Since the Greek police launched 'Operation Xenios Zeus' in 2012, the number of irregular migrants and asylum seekers held in administrative detention has skyrocketed. At the same time, the capacity of detention facilities has grown by 4,500 places with the addition of five pre-removal centres, while detention is being applied systematically for the maximum period of 18 months. Meanwhile, sanitary conditions and the provision of basic services remain largely unacceptable.

MSF calls on Greece and the EU to put an end to the indiscriminate, systematic and prolonged detention of migrants and asylum seekers; stop detention in inappropriate facilities; cease to detain vulnerable people such as minors, victims of torture and chronically ill patients; and to invest in a reception system adapted to the physical, medical and humanitarian needs of migrants and asylum seekers. Read the report at **msf.org.uk/invisible_suffering**

UKRAINE

MSF surgeons and psychologists give aid in Kiev

Widespread protests in central Kiev in February culminated in violence that left 77 people dead and hundreds injured. Following the violence, an MSF surgeon helped treat 20 wounded at a health facility in Kiev, providing minor surgery for bullet and blast wounds and treatment for fractures. Shortly after, two MSF psychologists joined the emergency response team in Kiev, providing mental health support to those affected by the violence.

MSF also donated medical equipment, including operating tables, infusion stands, operating lamps and stretchers to hospitals and clinics around the capital.

MSF continues to monitor events closely, and has an emergency plan in place should further violence occur. MSF's regular drug-resistant tuberculosis project in Donetsk is continuing to operate as normal.

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Syria, 2013 © Robin Meldrum/MSF

SYRIA

Five MSF staff held in Syria released

Five MSF staff held captive by an armed group in northern Syria since 2 January have been safely released. The abduction forced the closure of one hospital and two health centres in the Jabal Akkrad region of north-western Syria.

"The relief of seeing our colleagues return safely is mixed with anger in the face of this cynical act that has cut off an already war ravaged population from desperately needed assistance," says Joanne Liu, MSF International President.

"The direct consequence of taking humanitarian staff is a reduction in lifesaving aid. The long-term victims of this abduction are the Syrian population. Some 150,000 people in the Jabal Akkrad region are now deprived of MSF's medical care, while living in a war zone."

On 2nd January, 2014, five MSF staff were taken by an armed group in northern Syria, where they were working in an MSF-run hospital providing essential healthcare to people affected by the conflict. Three of our colleagues were released on 4 April, and two returned on 14 May are on their way to be reunited with their friends and families.

In 2013, MSF medical staff in these three facilities performed 521 surgical operations, 36,294 medical consultations, and safe hospital deliveries for more than 400 mothers.

Across northern Syria, where MSF continues to operate other medical facilities, security constraints have made it extremely challenging to provide assistance. Medical facilities have been attacked and bombed, and health workers killed or threatened by armed groups.

Elsewhere in Syria, denial of official access and insecurity have blocked MSF from setting up medical activities.

"This incident is representative of the complete disregard shown toward civilians throughout Syria today," says Liu. "While millions of Syrians need assistance for their survival, among some of the armed parties to the war, the very idea of independent humanitarian presence is rejected.

"We should be running some of the largest medical programmes in MSF's 40-year history, in line with the massive needs of the Syrian people; but in the current environment our capacity to respond is painfully limited."

Out of respect for the privacy of the five, MSF is not disclosing their identities, nor will the organisation comment further on the circumstances of the captivity or the release.

© Marcus Bleasdale/VII, Bangui, CAR, 2014

BREAKING NEWS

Three MSF workers killed in Central African Republic

Sixteen civilians, including three of MSF's Central African staff, were killed during an armed robbery on MSF hospital grounds in the northern town of Boguila, in Central African Republic (CAR) on 26 April.

"We are extremely shocked and saddened by the brutal violence used against our medical staff and the community," said Stefano Argenziano, MSF head of mission in CAR. "Our first priority is to treat the wounded, notify family members and to secure the safety of our staff, patients and the hospital."

"This appalling incident has forced us to withdraw key staff and suspend activities in Boguila. While we remain committed to providing humanitarian assistance to the community, we also have to take into account the safety of our staff."

CAMBODIA

Searching for TB infections one village at a time

MSF is trialling a project that targets high-risk groups for tuberculosis (TB).

"Cambodia has the second biggest prevalence of TB in the world, with 800 people in every 100,000 infected with active TB," says Jean Luc Lambert, MSF head of mission in Cambodia. "60,000 people are infected with the disease every year, but the existing health system will only identify 25,000 to 30,000 of those infected."

To help plug this gap, MSF is trialling a new project that actively seeks out high-risk groups. "In Cambodia, we know that the prevalence of TB in the elderly is three times higher than in the general population," says Lambert. "So we are implementing systematic screening for people over 55 in order to detect and treat the disease early."

Matthew Smeal/MSF, Angkor Chea, 2014

Kim Federici is in charge of the project in Tboung Khmum, a town 30 minutes outside MSF's main operations in Kampong Cham.

"We have two outreach workers who go into the community, explain what the test is and that it's free," she says. "We organise for people to be transported to the hospital and answer any questions they have."

Once at the hospital, the villagers have a chest X-ray. If the doctor suspects TB, a sputum sample is requested. "It's a very simple process," says Kim. "We can screen 100 people in four to five hours."

MSF will now analyse the data to confirm the pilot programme's success and cost-effectiveness.

"I'd like to see the programme continue and expand, especially in rural areas of Cambodia," says Kim. "Expanding it would go some way to minimise the spread of this disease."

‘Tracking Ebola is like detective work’

Clockwise from far left: All equipment and clothing used in the isolation zone must be either disinfected or destroyed; the mobile team wear protective suits to investigate cases of Ebola in the community. Above: Michel Van Herp explains to villagers how to protect themselves from infection. Right: After 10 days in the isolation ward, Ebola survivor Rose is hugged by a nurse as she leaves MSF’s centre in Conakry.

Photographs © Kjell Gunnar Beraas; Joffrey Monnier; Amandine Collin, MSF, 2014

MSF has launched an emergency response to combat an Ebola outbreak in west Africa, which has so far claimed 83 lives. MSF epidemiologist Michel Van Herp reports on efforts to combat this terrifying disease

I received a message at home in Brussels about this strange disease which had broken out in southern Guinea. They thought that perhaps it was Lassa fever, but when I received a description of the patients’ symptoms, it was clear to me we were talking about Ebola. A couple of days later I was in Guinea.

‘It’s like detective work’

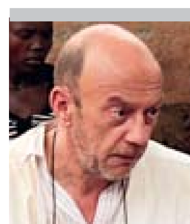
I’ve worked in every major outbreak of Ebola since 2000. What makes this one different is its geographical spread, which is unprecedented. There are cases in at least six towns in Guinea, as well as across the border in Liberia.

The problem is that everybody moves around – infected people move from one village to another while they’re still well enough to walk; even the dead bodies are moved from place to place. So, as an epidemiologist tracking the disease, it’s like doing detective work.

The other problem is that Ebola has never been confirmed before in Guinea, so you can be blamed for being the messenger – you’re the guy bringing the bad news that the village has been touched by Ebola. To them it means death, so people often refuse to believe the reality.

No confidence in the health system

We were tracing a patient who we finally found staying with family members in a very small village. He was an educated man – a professor. He’d become infected while caring for a colleague, who had caught the disease by caring for his sick uncle.



> ‘For health staff it is normal to feel fear when you enter the isolation area’
>
> **Michel Van Herp**

The professor realised it was probably better for him to come with us to the MSF centre, but his nephew and an elderly female relative suddenly appeared and took the sick patient off into the forest.

They had no confidence in the health system, and believed that people were killed in our centres, so they decided to keep their relative in the forest and cure him with leaves and herbs.

I followed them into the forest. They were very aggressive – the nephew took a big stick and was hitting the ground – but behind the aggression you could hear the pain in his voice.

Eventually, we got a sample from the sick man to make a proper diagnosis. The next day he asked us to come and collect him.

‘Fear is normal’

For health staff, it is normal to feel some kind of fear when you enter the isolation area for the first time, even if you are well protected. But you follow a kind of ritual – for dressing and undressing, and for all the activities you perform inside – little by little, you gain confidence.

You never enter the isolation area alone – you always enter in pairs. And you only go in for short periods, because it is very hot in Guinea and even hotter inside the yellow protective suits. It is tiring, especially if you are doing physical work. We always write our names on the front of our aprons so that the patients know who is in front of them.

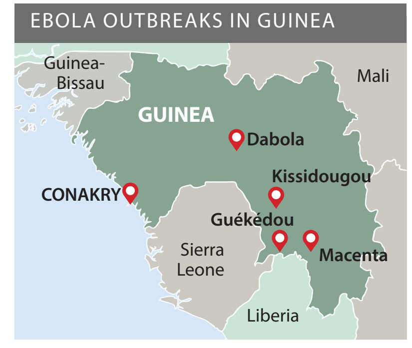
Inside the centre, we try and make the patients as comfortable as possible. Sometimes we bring the parent of a sick person in to visit them. They have to wear a protective suit with a mask and goggles and gloves. The relatives are supervised, so there is no possibility of any contact with a patient’s bodily fluids.

Patients who are deeply affected by the disease do not have a lot of energy to communicate. The mood can be very sombre with those in a terminal stage, who have only a few hours left before they die.

When a patient dies, we put them in a special body bag so that the burial can be done according to family traditions. If the patient comes from a village, we take the body back and advise relatives about what they can do – and what they should not be afraid to do – during the funeral.

Once the body bag has been sprayed, it can be handled with gloves, so the mourners can wear their normal clothes to the funeral. We do not steal the body from the family; we try to treat it with dignity, and respect their traditions as much as possible.

EBOLA OUTBREAKS IN GUINEA



> ‘As patients left our teams were cheering. To know that they survived helps you forget all the bad things’

‘People can survive’

The mortality rate for Ebola is high, but there are survivors. Just before I left Guinea, our first two patients left the MSF centre cured of the disease: Thérèse, 35, and Rose, 18. Both are from the same extended family, which had already seen seven or 10 deaths from the disease.

Their relatives were overjoyed. There was a huge celebration in the village when they returned.

They come from a family of local healers, so the news that they were cured will spread to other villages, and I hope this will create further trust.

People can survive; as the patients left, our teams were cheering. To know that they survived helps you forget all the bad things.

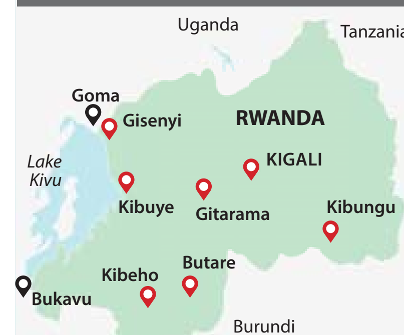
Only justice could heal the deep wounds in Rwanda

In April 1994, close to one million people were massacred during the Rwandan genocide. Dr Rony Zachariah was a member of MSF's team in Butare.

WARNING: This article contains first-person testimony that some readers may find upsetting.

When I think of Rwanda, I think of 20 April 1994, when MSF houses in two refugee camps were raided. They were set on fire. All our staff were taken outside in a violent manner. Their identity cards were closely examined for their ethnic groups. Tutsi staff were placed on one side; Hutu staff were placed on the other. The militia then gave the Hutu staff guns and machetes and told them to kill their Tutsi colleagues. Those who refused were hacked to death in the most ruthless manner possible.

RWANDA



Map of Rwanda by FreeVectorMaps.com

We lost 50 MSF staff that day.

So for me, the Rwandan genocide is about Gerard, it's about Everest, it's about Jean-Marie: friends and colleagues who died or were killed simply because of who they were.

When the genocide started, MSF operations were a mixture of providing protection to civilians through safe havens and care for surgical wounded. I think the greatest difficulty we had was protecting MSF staff and civilians, because every time people gathered in schools or in churches, in tents or in NGO compounds, these sites became sites for massacres. So we were never really sure, even when we thought people were within safe havens, that they were actually being protected. And clearly the evidence, with hindsight, showed us that there was no protection.

Sabine

When I think of the Rwandan genocide, I also think of 23 April 1994, when 150 civilians under our protection in Butare hospital — women, children — were massacred in front of our own eyes. Among them were several MSF staff.

Sabine was one of them. Sabine was a Hutu, she was seven months pregnant, she was a good friend. When they came to take Sabine, I intervened physically. I got between the soldier, and I screamed, "Sabine is Hutu, Sabine is Hutu, leave her alone."

The soldier opened his back pocket and took out a piece of paper; it was a list. He looked at me, straight into my eyes, and he said, "Doctor, you are right. Sabine is Hutu, but this baby is going to be Tutsi." For the first time I realised that, in Rwanda, the child follows the paternal line. So Sabine was killed and so was her baby.

For me, the Rwandan genocide is about Sabine, it's about her baby, it's about all the other staff that we lost — staff who worked courageously even when they saw death in front of their own eyes.

Left, one of Rwanda's many orphans rests by the road in Rilima. Above, refugees are crammed into a camp at Kibeho in October 1994. Six months later, Kibeho – one of the largest camps in Rwanda – was the scene of a mass killing. Far left, young soldiers of the Rwandan Patriotic Front pose with their weapons.

> 'For me, the genocide is about Gerard, it's about Everest, it's about Jean-Marie; friends and colleagues who were killed simply because of who they were'

Quest for justice

I think the Rwandan genocide was a historic moment for MSF, both as individuals and as an organisation, because it was the first time in our history that we actually witnessed the massacre of over one million human beings. And, in particular, it involved the massacre of close to 250 MSF colleagues. Such losses are unprecedented in our history.

Did we fail?

The undeniable truth, when we look back at the Rwandan genocide, is that it occurred. And today, none of us has the moral authority to deny our own share of responsibility and guilt for the loss of one million lives. So yes, indeed, we failed.

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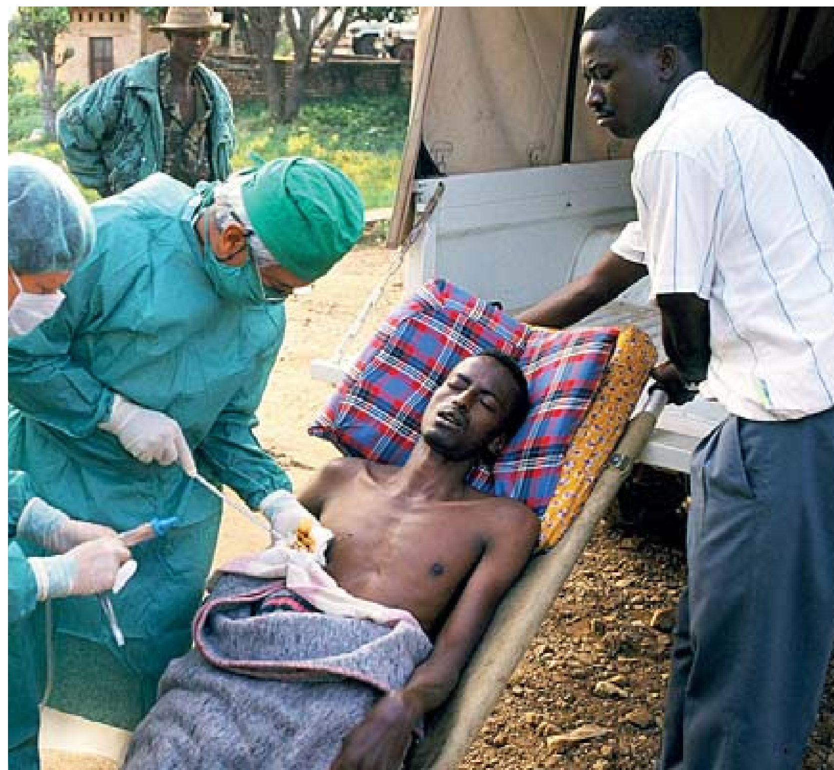

The international community failed, we as an organisation failed, I as an individual failed, because, in Rwanda, it was humanity itself that failed. And when humanity fails, we all fail.

How does one cope with the memories?

I remember those incidents like they were yesterday. At the time, despite the many odds against us, we tried to do all we could. And I think I got a lot of consolation from that, and the fact that, even now, I still feel that maybe historical truth is something you can contribute to.

How does one cope with it, having gone through a genocide? It's very difficult. For me personally, when I left Rwanda, I swore to myself that I would do all I could to find justice for the victims. And that has given me great determination. It's given me great power. It's given me great strength.

I was in the International Criminal Court for Rwanda in Arusha, Tanzania, thinking of all my MSF colleagues who died. And seeing the perpetrators there, meeting them eye to eye, gave me an incredible sense of liberty of conscience. Somehow, all these years down the line, historical truth is there. I haven't let my colleagues down.

I think that has given me the possibility to cope. It also brought me to a level of proximity with the few survivors. This is so important from a human perspective. It has kept me going, because it's very difficult to cope with the emotional trauma linked to a genocide.

And perhaps, put in the simplest terms and in the simplest manner, impunity serves as the best fuel for more violence, more hatred, more misery, and eventually more injustice. As individuals, we have a role, under certain circumstances, to bear witness to crimes, particularly when they are crimes against humanity and genocide.

Extracted from **The Inside Story: Personal Testimonies from MSF**

Top left: a man with gunshot wounds is treated in Nianza; above, a man who escaped the killing in Gitarama in July 1994. *Photographs © Roger Job/MSF, 1994*

Please note: MSF does not officially collaborate with the International Criminal Court or other ad hoc tribunals. If we were suspected of collecting evidence, we would not be able to work in many of the places where we are needed most. Nevertheless, we fully support individuals like Rony in giving testimony about what they witnessed during their time working with MSF.

Below left, Tutsi militia in July 1994; below, Rwandan Tutsis in a clinic in Kigali in April 1994 *Photographs © Roger Job; Xavier Lassalle/MSF*

'When I left Rwanda I swore to myself that I would do all I could to find justice for the victims. And that has given me great determination'

NAME Javid Abdelmoneim
MISSION Mobile clinic, South Sudan
ROLE Doctor, flying team

What does running a mobile clinic entail?

Mobile clinics are just that – you pack your meds in a box and go. You set up your triage area and treat whatever comes your way. The big three are respiratory infections, diarrhoeal diseases and malaria. So you prepare yourself for just that, but you also get cuts and scratches, other infectious diseases, anything. You spend four or five days in the bush and then come back, or go on to the next place.

You travel by helicopter or plane, depending on the weather. You get there around noon and open at 8 am the next day, so in the space of an afternoon you have to hire and train local staff, while the logisticians are building the clinic and the place where you're going to sleep.

In other places, our flying team is supporting South Sudanese staff at MSF projects. We fly in with supplies, payroll and mosquito nets and then head to the next place. Alongside treatment, we also do surveillance – we always screen for malnutrition.

What has been your favourite mission with MSF?

I loved Iraq because it was my first mission and I got to use my Arabic. I also really enjoyed the training aspect of the work – I love that. Haiti troubled me because I found it so, so hard, professionally and personally, but then in hindsight I loved it because I did it, my French was good and I made so many good friends. And then this mission has been exciting and challenging. I had a great mix of responsibilities, from training the South Sudanese staff to hands-on medical care – it had everything. This last mission has refreshed me and it's made me decide that I'm going to make myself available for MSF for two months every year.

Above: Javid with 'everything you need to run a mobile clinic' *© Javid Abdelmoneim*

Are there any patients who stick in your mind?

The first patient I met was a nine-year-old boy called Kherro. He had been shot through the chest and airlifted by the flying team to our hospital in Juba for medical care ten days previously. I met him when he was nearly ready to be discharged after a blood transfusion, antibiotics, tetanus immunisation, wound care, therapeutic nutrition, malaria treatment and chest X-rays – no mean feat of medical care in the middle of a camp.

When the flight day came I woke at 6 am and went to collect him and his mother – they were hitching a lift home on the plane with the team. It was the first time I'd see him smile. On arrival in Gumuruk, we were greeted by many people on the airstrip. Kherro and his mother walked off into the distance after a really heartwarming 'thank you'.

I made sure she understood that she ought to bring him to the clinic in two days for changes to his dressings, and so it wasn't quite a final goodbye. I sneaked a cheeky photo of him walking into the bush with his mum (*bottom left*). Note to self: he's one for the feel-good bank.

EXPAT ESSENTIAL KIT

1. A mental personal space - no matter how hard the work is, if I can get even just half an hour away from it all, I can recharge and carry on.
2. I always take a book, although I didn't read a single page during my last mission. It's a mental crutch.
3. My iPhone so I can take pictures, photos and videos for memories.

MSF'S UK VOLUNTEERS ABROAD

Afghanistan Dewi Hughes *Anaesthetist;* Joseph Mclean *Logistician;* Friedl Schlunz *Doctor*
Bangladesh Richard Kinder *Project Coordinator*
Central African Republic Zoe Allen *Logistician;* Emma Pedley *Nurse;* Angelica Orjuela *Logistician;* Anna Carole Vareil *HR Coordinator*
Chad Liam Reilly *Doctor;* Caroline King *Financial Coordinator;* Robert Malies *Logistics Team Leader*
Dem Rep Congo Louise Roland-Gosselin *Humanitarian Affairs Officer*; Catherine Kirby *Doctor*; Miriam Peters *Nurse*; Jacob Goldberg *Nurse*
Ethiopia Sean King *Logistician*; Natalie Roberts *Project Coordinator;* Aidan Reilly *Water & Sanitation Expert;* Robert Allen *Logistician;* Joan Hargan *Nurse;* Elizaberth Harding *Deputy Head of Mission*
Haiti Dominique Howard *Logistician*
India Christopher Peskett *Nurse*; Melanie Botting *Nurse*; Shobha Singh *Mental Health Specialist*; Luke Arend *Head of Mission*
Jordan Alma Wong *Anaesthetist;* Daniela Stein *Nurse;* Eimhin Ansbro *Doctor;* Paul Foreman *Head of Mission;* Tharwat Al-Attas *Medical Coordinator*
Kenya Virginia Ponsford *Doctor*
Lebanon Judith Nicholas *Midwife*
Myanmar Alvin Sornum *Doctor*; Simon Tyler *Deputy Head of Mission*; Jose Hulsenbek *Head of Mission;* Laura Smith *HR Coordinator*
Nigeria Danielle Wellington *Project Coordinator*
Pakistan Aoibhinn Walsh *Doctor*; Maryann Noronha *Doctor*; Nicole Hart *Nurse*
Papua New Guinea Jonathan Henry *Head of Mission*; Jerry Lim *Anaesthetist*
South Africa Andrew Mews *Head of Mission*; Amir Shroufi *Deputy Medical Coordinator*
South Sudan Sarah Maynard *Project Coordinator*; Timothy Tranter *Project Coordinator*; Shama Khan *Doctor*; Anna Halford *Project Coordinator;* Julian Barber *Water & Sanitation Expert*; Angela Clare O'Brien *Nurse*; Vicky Herkelian *Nurse*; Iain Bisset *Logistician;* Andrew Burger-Seed *Logistician;* Emma Rugless *Nurse*; Nicholas Tunstill *Logistician*; Roberta Masotti *Midwife*; Stuart Garman *Logistician;* Joanna Kuper Bruegel *Humanitarian Affairs Officer*; Sophie Sabatier *Project Coordinator*
Sudan Alison Lievesley *Doctor*; Shaun Lummis *Project Coordinator;* Alvaro Dominguez *Deputy Head of Mission*
Syria Helen Ottens-Patterson *Medical Coordinator*; Jens Pagotto *Project Coordinator*
Tajikistan Fadumo Omar Mohamed *Mental Health Specialist;* Sarah Quinnell *Medical Coordinator*
Turkey Forbes Sharp *Project Coordinator*; Terri Anne Morris *Intersectional HR*
Uganda Christopher Hall *Logistical Coordinator*
Uzbekistan Emily Goodwin *Project Coordinator;* Marielle Connan *Nurse*; Nina Kumari *Mental Health Specialist*
Yemen Luke Chapman *Doctor*
Zimbabwe Rebecca Harrison *Epidemiologist*

Getting used to gunfire amid the birdsong

The violence affecting Central African Republic continues unabated, with civilians bearing the brunt of the clashes between militias and armed groups. MSF nurse Alison Criado-Perez describes what it is like to work in this conflict zone.

2 April, 2014

I've just come back from a bike ride. The sky is blue and cloudless, the green verges are splashed with the bright yellow of the first daffodils. Birds are singing, ponies graze happily in the fields. Spring is arriving, and all is tranquil in the peaceful countryside of Rutland, where I'm lucky enough to live.

My mind turns to where I will be in just four days. Bangui, capital of Central African Republic, and scene for the last few months of the most horrendous acts of violence.

When I came back from DR Congo just before Christmas, I said I'd done my last mission with MSF. It was incredibly tough physically, and I thought that at my age — which is a secret, but I'll admit to having my bus pass — I didn't think I wanted to put myself through that again. But I always say going on mission is rather like having a baby: you forget what an ordeal it was and just go for it again!

Getting a request to help in such an extreme situation is a challenge I can't refuse. Tough it will be, probably tougher than anything I've done before, but we'll be providing healthcare to a terrified and distraught population where otherwise there would be none.

Which is why I'll be on the plane to Bangui in a few days, far from this green and pleasant land, where, in the lottery of life, I had the good fortune to be born.

9 April, 2014

My natural alarm clock woke me this morning, as usual, at 5.15: a bird warbling in a mango tree outside my room. That sounds idyllic, a far cry from the horrors that are occuring just a kilometre or so from our house here. As I sit writing on my day off (in spite of the emergency, we try to have a day off each week, to recoup our strength for the week ahead) – the birds are still singing, but their sweet sound is interspersed by the rattle of gunfire.

It's surprising how quickly you get used to an abnormal situation. As well as the background of gunshots and shelling, I'm getting used to the strong military presence, with heavily armoured cars rolling down the main streets heading to the flashpoints. Although I was fairly alarmed on leaving the hospital one afternoon to find the perimeter wall surrounded by crouching soldiers, machine-guns at the ready. For a brief second I thought we were being attacked, but quickly realised they were protecting a journalist who was interviewing someone.

I'm also getting used to different classifications for the MSF statistics. Normally I'm filling in details of how many cases of malaria, respiratory tract infections, diarrhoeal diseases or malnourished children we're treating; now I'm classifying the admissions to the emergency department by wounds from gun shot, grenade or "arme blanche" – the latter being any other type of weapon, mostly machetes.

I've been here two weeks now, as the nurse/medical focal point for the hospital MSF started running on behalf of the Ministry of Health. Previously a maternity hospital, we have provided a team to deal with the emergency trauma cases as well as keeping the maternity department going.

Joy amidst the tragedy

On my first day, our departure to the hospital was delayed because of an "incident" in a largely Muslim neighbourhood bordering the hospital. When we arrived, several people were in the emergency room being treated for shrapnel wounds. It seems a young boy had thrown a grenade.

And so it has continued most days, although this last week the number of admissions for conflict trauma has diminished. There are joys among the tragedies. Belen, one of our doctors, came into the pharmacy where I was doing the boring but necessary task of counting stock. "Do you want to see a miracle?" she asked. Of course I did. I looked down at the tiny bundle, the 800-gram baby, who had arrived prematurely. Tiny but alive. This conflict brings hardship to so many, but delivering a baby safely can be especially difficult. This little mite could now be referred to a specialist paediatric centre run by MSF.

It's good to have the miracles in the midst of the ongoing tragedy.

READ MORE

Find out more about Alison's work at **blogs.msf.org/car/author/alisoncp**

Marmite, English Breakfast tea, my down pillow, a silk sleeping bag – they're on the essentials list and are already packed. Everything will be on full view on the washing-line, so no scanty lace Elle MacPherson numbers, nor do I want to own up to the sagging, greying cotton pants on the line. So that means a special trip to M&S.

MSF IN CENTRAL AFRICAN REPUBLIC

MSF is running 20 projects across Central African Republic, providing life-saving medical care and humanitarian assistance. Since January, we have treated more than 3,250 people for violence-related injuries, conducted more than 300,000 outpatient consultations and treated over 3,000 people for malaria. **msf.org.uk/car**

Map of CAR by FreeVectorMaps.com

Clockwise from top left: A child is weighed at a mobile clinic in the village of Zere; Dr Tahir Wissanji treats a 10-year-old boy in MSF's clinic in M'poko camp at Bangui airport; a woman is rushed from a camp at the church in Bossangoa to the MSF-supported hospital *Photographs © Ton Koene; Christian Nestler; Marcus Bleasdale /VII; 2013-14*

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 60 countries worldwide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

MAURITANIA

Quadruplets thriving in the desert

Above and bottom right: Masaya Agidiasi and Taghry Walet Tokeye with their quadruplets. *Photographs © Damien Follet/MSF; René Colgo/MSF*

Last issue we brought you the story of the refugee camp quadruplets: four babies delivered by MSF in a refugee camp in Mauritania. Their parents, Taghry and Massaya, had fled fighting in Mali in early 2013 with their six children, walking for five days and nights until reaching Mbera camp in Mauritania.

It was while in the camp that Taghry discovered she was pregnant, although she had no idea she was carrying quadruplets until an ultrasound revealed the news.

"It was a very good surprise to hear that," says Taghry. "I was feeling quite heavy so I knew there had to be more to it."

After a rushed journey across the desert in an MSF ambulance, Taghry gave birth to three healthy boys and a healthy girl.

Four months on

Four months on, and the babies are doing well. The smallest — who was a mere 1.8kg at birth — is now 3.5kg, thanks to their mother's care, MSF's support and a little help from their brothers and sisters. "My other children are too young to help with the babies," says Massaya. "But they can help their mum by getting water from the well and preparing the food."

Frederic Manantsoa Lai, MSF's head of mission in Mauritania, says the story of these four children is an inspiration: "It is one more proof that wonderful things can happen in even the most extreme of conditions. These new lives are a sign of hope for the refugees.

'The quadruplets represent hope for us — and a challenge'

Incredible courage

"At the same time, Taghry's story highlights how vulnerable these people are. Imagine if medical care was not available: had she not reached our facilities, this incredibly courageous mother might have lost her four babies, or even her own life, leaving behind six other children and a husband with no income."

For Massaya, Taghry and their family, the focus is on the future: "Without MSF's help we don't know how we could handle this," says Massaya. "The arrival of the quadruplets represents hope for us but it's also a big challenge."

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About Dispatches

Dispatches is written by people working for MSF and sent out every three months to our supporters and to staff in the field. It is edited in London by Marcus Dunk.

It costs 8p to produce, 17p to package and 27p to send, using Mailsort Three, the cheapest form of post. We send it to keep you informed about our activities and about how your money is spent.

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. Please contact us by the methods listed, or email: **marcus.dunk@london.msf.org**

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