

MAMMELA

Médecins Sans Frontières / Doctors Without Borders South Africa

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

DRC © Franco Pagetti/VII

THANK YOU!

Pakistan Floods Relief

When the worst flooding in 80 years hit Pakistan during monsoon season, Médecins Sans Frontières / Doctors Without Borders (MSF) was able to respond immediately to the needs of those among the 14 million displaced by the devastating floodwaters.

MSF teams set up diarrhoea treatment centres, getting doctors to the field where they were needed most, while distributing much-needed relief items to people who lost everything during the deluge. All of this thanks to the generosity of MSF's private donors both internationally and here in South Africa.

Your donations not only enable a rapid response during emergencies but mean that people in need can trust our teams to deliver medical care free of charge and in an independent and neutral manner – steering clear of political agendas.

MSF South Africa would like to thank all our donors who contributed to making our emergency operations in Pakistan and elsewhere possible. In South Africa, MSF donors raised R380,000 for the floods emergency and the MSF Emergency Relief Fund.

Your continued support helps us save lives and bring medical care to those most in need. Thank you!



Pakistan © Ton Koene

Since the onset of the floods in late July, MSF teams have:

- Conducted **56,991 consultations** through **5 hospitals, 7 mobile clinics and 6 diarrhoea treatment centres**
- Treated more than **3,634 malnourished children**
- Distributed **1,250,400 litres** of clean water per day and built **714 latrines**
- Distributed **58,270 relief item kits** and **14,538 tents**
- 125 international staff, including three South Africans, are working alongside nearly 1,200 Pakistani staff in MSF's existing and flood response programmes in Pakistan.
- MSF's current **expenditure for the emergency response to the floods** has reached approximately **€7 million**.

MAMELA

Get in touch with us:

Write to the MAMELA readers' page and, if your letter is selected, you get an MSF supporters t-shirt.

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LOOKING BACK TO MOVE FORWARD

Currently, the MSF South Africa office is in the midst of the “ARO” – one of MSF’s many abbreviations, which stands for Annual Review of Operations. More than 60 people, mainly from Southern Africa but also from far and wide in the MSF movement, have gathered in Johannesburg to review our work in HIV and TB, as well as our projects assisting migrant populations.

Soon our plans for the office in 2011 will be signed off and ready for implementation after which, barring the occurrence of another natural disaster in a year filled with natural disasters, most staff will be heading off on well deserved leave.

2010 will go down in MSF’s history as “the year of Haiti”. Work that started on that fateful night in January, after the devastating earthquake struck, has continued throughout the year. Many MSF records were overtaken, such as the amount of money raised, the number of staff sent into the field, the number of surgeries performed. The ongoing work has continued throughout the year and our teams are currently dealing with a cholera outbreak. And yet, when another disaster in the form of the Pakistan floods occurred, MSF was able to meet the challenge. In particular our donors, who had been so generous with regard to the massive needs in Haiti, gave generously once again. Our funding target was met in less than three weeks with very little need to resort to special appeals.

Pakistan is very close to the heart of the MSF South Africa office. Two of our office staff and four of our field staff have spent time in Pakistan this year, so as the floodwaters rose we were familiar with the names of the places being submerged. We also knew that the people being affected by the floods had been living fragile lives even before the floods. Many were already displaced from their homes by the conflict swirling through the region. The floods took away what little they had left.

To express our solidarity with those affected by the floods we produced a photographic exhibition to help bring the reality of the floods to people’s attention in South Africa. There was a well-supported opening in the grounds of the Constitutional Court. In this edition of MAMELA we share some of these poignant photographs with you.

Particularly important to me in this edition is the article on the mental health programmes of MSF. Even in stable settings mental health is given the lowest priority and the smallest proportion of the budget, with the mentally ill often hidden away in dingy wards at the back of the hospital. So it is significant that MSF does recognise these needs and sets out to meet them in disaster and conflict zones where they could easily be forgotten among other pressing needs.

An MSF staff member tells the story of coming across a nine-year-old boy in one of our migrant health projects. He had walked all the way from Zimbabwe to South Africa to escape his unbearable life at home. When she put her arm around this tough little chap he burst into tears.

So it is with this boy in mind that I encourage you to continue your support for MSF and its staff in the field so that we can continue to meet the physical and psychological needs of those in need, whether in a conflict zone, a disaster area or a migrant’s shack on the edge of an insecure informal settlement.

Yours sincerely,
Dr Liz Thomson



General Director, MSF South Africa

Letter from the field

“PAL CAN GO HOME TODAY”

Stefan Schöne, MSF Nurse, southern Sudan



© Stefan Schöne

Like his mother and elder sister, two-year-old Pal William suffered from leishmaniasis, a very serious disease, before receiving treatment from us in Pagil, southern Sudan. “Pal can go home today,” I tell his mother, who is beaming with joy. Sadly, this type of treatment didn’t become available overnight.

I’ve been working as a nurse for MSF in southern Sudan since the beginning of 2010. The security situation in the region remains precarious and the people suffer from malnutrition, which has grown worse due to a late harvest. Leishmaniasis, a tropical disease transmitted by sand flies, is common here. The main symptoms include fever, an enlarged spleen, loss of appetite, weight loss and anaemia. Without treatment, the majority of patients die. Because leishmaniasis mainly occurs in poorer countries where patients can’t afford medicine, there are very few therapies available. The pharmaceutical industry doesn’t invest in treatments as there’s no profit to be had. We treat almost all our patients with a combination of drugs through intramuscular injections over 17 days, which causes them a great deal of pain. We also administer these drugs intravenously to pregnant women and those in the advanced stages of the disease.

In mid August I left Lankien for Pagil, a small village in northern Jonglei where leishmaniasis is a particularly serious problem. The nearest health clinics are about three days’ walk away. The rainy season has made the region inaccessible to vehicles, but at least there is a makeshift runway here. We

chose to set up camp in Pagil, due to the alarmingly high number of new leishmaniasis infections reported here.

During the last eight months I’ve been able to gain a great deal of experience around treating leishmaniasis and managing projects, but getting a project up and running – which is what I’m here to do – is new to me.

To start with, we have to move into the small, local health clinic in which medical staff, employed by the Ministry of Health, treat the most common diseases. It is the only permanent structure in the area so we really hope the next aeroplane will deliver some large tents so that we will be able to deal with the high number of patients we are expecting. We hire two translators, as there are no medical personnel and we have to provide the treatment ourselves.

Before clinically examining the patients, we speak with them and record their medical history. If we suspect leishmaniasis, we carry out a quick leishmaniasis test and also test for malaria. If the test is positive, we begin treatment immediately. These quick tests are great as they enable reliable, on-site diagnosis without the need for a laboratory or technicians.

The rains make life difficult, as we sleep in dome tents and live out in the open. Our plan to dig latrines and build showers and fences is delayed, as the ground is too wet. The tents aren’t really waterproof and we have to put our mattresses out to dry, once a week.

After running the clinic for 17 days we already have 104 patients, three of which we release with a clean bill of health. And thanks to the talented pilots who manage to land and take off on a muddy runway, the first tent finally arrives. Now that we’ve successfully treated 80 patients in the first five weeks, I’ll be returning to Lankien. But first I’m going to send little Pal home. Today he’s going to receive his last set of painful shots. We were able to release his sister a week ago and now it’s just their mother who has to finish her treatment.



HAITI HIT HARD, AGAIN

Cholera outbreak outstrips treatment capacity in Port-au-Prince

Since October, when a cholera epidemic was first confirmed in Haiti's Artibonite region, MSF teams have treated more than 20,000 suspected cases nationwide. In addition to MSF's 3,000 staff members in Haiti, more than 100 international staff and more than 400 national staff are working on cholera intervention activities. MSF is supporting two Haitian Ministry of Health hospitals in the Artibonite region. The epidemic has taken grip in Port-au-Prince and, while MSF teams are scaling up capacity to 1,000 beds, the number of cases being reported is already overwhelming MSF and public medical facilities.

Stefano Zannini, Head of Mission for MSF in Haiti, gives a first-person account of the situation in Port-au-Prince:

All the hospitals in Port-au-Prince are overflowing with patients. Yesterday we recorded 216 separate cases of cholera in the slum of Cite Soleil, located in the north of the city, while the total number five days before was 30. Patients are coming from throughout the city, both slums and wealthier areas. At the moment we have 400 beds set aside for the stabilisation and rehabilitation of patients and we're hoping to get that up to 1,000 by the end of the week.

If the number of cases continues to increase at the same rate, we're going to have to adopt drastic measures to be able to treat people, like using public spaces or streets. I can easily see this situation deteriorating to the point where patients are lying in the street, waiting for treatment.

We're looking for alternative spaces but, since the earthquake, every available space that wasn't damaged has been filled by camps where people are living in extremely precarious conditions. So for us to find room to treat people, is very complicated.

Currently we have more than 100 international and more than 400 Haitian staff working in cholera treatment centres throughout the country. More medical staff are arriving, but there's a chronic lack of personnel here in Haiti and we are close to being overwhelmed. Our teams are working 24 hours and fatigue is becoming an issue. Working inside a



Haiti © Spencer Platt /Getty Images

cholera treatment centre with the smell, the noise and the pressure of so many patients is not easy.

I am extremely proud of the passion and commitment of the teams in Port-au-Prince and Haiti, but we're at critical point. There is no cholera in living memory in Haiti and thus little knowledge of the disease. This means there are a lot of misconceptions which causes panic. Some people are staying away from the centres, or are afraid to have them in their neighborhoods because they think they spread the disease. We've been trying to explain that the opposite is true and that cholera can kill but it's also a disease that can be treated quite easily. It's extremely important that patients come as soon as possible to be treated.

Cholera treatment centres, where patients can be isolated, are critical for effective treatment. But when people finish their treatment and leave the centres, they go back to potentially cholera-infected areas. Here in Port-au-Prince, 1.4 million people are still living in camps where hygiene, sanitation and clean water are scarce so they depend entirely on humanitarian aid groups for clean water. Unfortunately, infrastructure is weak which makes it very difficult to get medical aid and water to all these people.



MALNUTRITION STALKS PAKISTAN'S MOST VULNERABLE

“Displacement has only exacerbated existing health problems as children become malnourished due to the lack of food, clean water and a place to stay.”

Suha is one year old, frail and suffering from severe malnutrition. She is running a high fever, vomiting and is fighting a severe bout of diarrhoea.

Her mother, Nabila, waits anxiously by her bedside while she is being treated at MSF's Intensive Therapeutic Feeding Centre (ITFC) in the paediatric ward of Railway Hospital. The centre operates in Sukkur, the heart of Pakistan's flood-devastated province of Sindh.

The floods have left people without access to basic necessities – food, water, shelter and basic healthcare. Hundreds of thousands of displaced people have recently fled to Sukkur, and children like Suha are among its most vulnerable. Like hundreds of others in their village of Lori, Nabila and Suha were forced to leave everything behind and live out in the open at a relief camp in Sukkur.

To provide essential nutritional support, MSF's medical teams have set up nine outpatient therapeutic feeding programmes across Pakistan and one ITFC in Sukkur to treat severely malnourished children. Outreach teams move between these, providing systematic medical check-ups and a week's supply of ready-to-use therapeutic food (RUTF) to those in need.

MSF staff have treated more than 3,634 malnourished children, despite the growing challenges facing the ambulatory feeding (ATF) teams who must ensure that the children complete their treatment, even as the flood-displaced start moving back home, which makes follow-up care more difficult.

Most patients are referred through MSF's mobile clinics, where a tool for rapid screening, called MUAC



Pakistan © SEB GEO



(middle-upper arm circumference) helps determine the nutritional status of children under the age of five.

“Displacement has only exacerbated existing health problems as children become malnourished or even severely malnourished due to the lack of food, clean water and a place to stay,” says MSF nurse Abdul Wasay.

The ITFC is run by four doctors, eight nurses and four health educators, and is open around the clock. The therapeutic feeding programme provides high-calorie, nutritious foods including fortified milk and RUTF supplements, which are rich in micronutrients and protein.

“It is important that the ITFC stays open all day and night,” says Wasay. “Each child has to be fed every two hours, and we need to monitor their appetite, digestion and weaning diet closely.”

In an isolated room, eight-year-old Kubra’s head rests in her mother’s lap. “We need water, food and accommodation,” says Kubra’s mother, Noor. “We need everything.” Kubra is isolated from the other patients because, in addition to being malnourished, she also has tuberculosis, which is highly contagious.

“Most patients have been admitted with another associated disease such as acute watery diarrhoea,

pneumonia or tuberculosis. It is important that they are correctly diagnosed and treated. Our health workers help the mothers understand the treatment process and raise awareness about nutrition, hygiene and disease prevention measures,” says Wasay.

MSF does not accept funding from any government for its work in Pakistan and chooses to rely solely on private donation.



Malnutrition is not about too little food

Malnutrition—a preventable and treatable condition— affects 195 million children worldwide, the majority of whom live in areas not effected by armed conflict. Malnutrition is also the underlying cause of at least one third of the eight million annual deaths of children under the age of five, and is not merely the result of too little food.

The first two years of a child's life is a critical growth period, with children needing access to a diet consisting of high-quality protein, essential fats, carbohydrates, vitamins and minerals, in order to avoid impaired growth and development; increased risk of death from common illnesses; or lifelong health and developmental impairment. For the most part, food aid does not include these essential ingredients for early childhood growth and development. MSF has already begun operating emergency nutrition programmes—and reinforcing existing ones—in Niger, Mali, Burkina Faso, Somalia, Sudan, Bangladesh and other countries.



Why MSF treats malnutrition

“Treating malnutrition in children under the age of five is essential. This improves their chances of survival while their immune system is still developing. When children are severely malnourished they cannot resist the infections and diseases most likely to claim their lives. If not treated in time, the damage malnutrition leaves on their physical and mental state is irreversible.” – Dr Ahmed Mukhtar, MSF Medical Coordinator.

How MSF teams determine malnutrition in the field

MSF teams conduct rapid screening tests using the middle-upper arm circumference or “MUAC”, a colour-coded bracelet that loops around the arm of a child younger than five. When the arrows point to the red zone – a circumference of less than 110mm – it is an indication of severe and acute malnutrition.

How MSF treats malnutrition

In the field MSF operates Intensive Therapeutic Feeding Centres which often provide around-the-clock support to children on an inpatient basis. Teams also provide nutritional care through Ambulatory Therapeutic Feeding Centres, while MSF outreach teams provide systematic medical check-ups and a week's supply of ready-to-use therapeutic food (RUTF) in sachets. This paste, made from peanuts and milk, is enriched with vitamins and micronutrients that children need to recover quickly.

MSF nutrition programmes

In 2009, MSF medical teams treated 250,000 children suffering from acute malnutrition in 116 programmes in 34 countries, primarily with nutrient dense ready-to-use therapeutic foods which, while more expensive than foods currently provided by the food aid system, actually work to prevent and cure severe malnutrition, and can be used on a very large scale.

So far in 2010, MSF is operating 120 nutrition programmes in 36 countries, including massive emergency interventions in Niger and Chad.

View the multimedia documentaries: www.starvedforattention.org

REWRITE THE STORY OF MALNUTRITION

Support MSF’s Starved for Attention Campaign

Many families cannot afford to provide nutritious food—particularly animal source foods such as milk, meat, and eggs—that their young children need to grow and thrive. Instead, they struggle to survive—far from the media spotlight—on a diet of little more than cereal porridges of maize or rice, amounting to the equivalent of bread and water.

MSF and VII Photo present *Starved for Attention* – a multimedia campaign that aims to rewrite the story of malnutrition through a series of multimedia documentaries from some of the most accomplished and award-winning photojournalists working today.

VII photojournalists Marcus Bleasdale, Jessica Dimmock, Ron Haviv, Antonin Kratochvil, Franco Pagetti, Stephanie Sinclair, and John Stanmeyer travelled to malnutrition “hotspots” around the world—from war zones to emerging economies—to shed light on the underlying causes of the malnutrition crisis and innovative approaches to combat this condition.

Get involved, take action

Sign the petition, organise a local event, recommend to your friends on Facebook, and more by visiting www.starvedforattention.org/take-action.php



DISPLACED AND DESPERATE: PAKISTAN FLOODS

At the end of July 2010, unrelenting monsoon rains in Pakistan's four provinces caused flooding that devastated villages, washing away infrastructure and the livelihoods of many people who were already struggling to survive. The floodwaters have had a massive impact, displacing over 14 million people, leaving them without shelter and clean water, vulnerable to the outbreak of disease and the knock-on effects of displacement, including malnutrition.

MSF has been working in Pakistan since 1988, providing medical assistance to Pakistani nationals and Afghan refugees suffering the effects of armed conflict, poor access to healthcare and so-called 'natural' disasters. Thanks to independent funding from private individuals the world over, MSF is able to respond immediately, setting up diarrhoea treatment centres, conducting mobile clinic activities and providing clean and safe drinking water to hundreds of thousands of flood-affected people.

1. The recent floods across Pakistan caused immense human suffering, exposing the dire situation people faced before the monsoons and exacerbating existing extreme vulnerability. People already living on the brink lost homes, family members and livelihoods.

2. MSF nurses carry a severely dehydrated man suffering from acute diarrhoea to a waiting ambulance to transfer him from a mobile clinic in Jamshoro in the flood-affected Sindh province.



Pakistan © Ton Koene



Pakistan © SEB GEO

Watch the video: www.msf.org.za/viewnews.php?n=757



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4

3. A Pakistani family waded through the floodwaters on their way to a camp for flood-displaced people near the highway between Charsadda and Peshawar.

4. A girl fills her bucket at an MSF water distribution point in Khyber Pakhtunkhwa province. With no access to clean water people were left vulnerable to waterborne diseases.

5. MSF doctor Mauro D'Ascanio and his team perform consultations during mobile clinic activities in Jamshoro in Sindh province.



5

TREATING THE TRAUMA — MENTAL HEALTHCARE AT THE HEART OF MSF

“I fell to the ground, and when the armed men caught me, they raped me. One of them was going to shoot me, but they cut me with knives instead.”

MSF doctors and nurses are often seen treating physical ailments: bandaging the war-wounded, rehydrating a cholera patient, performing an emergency caesarean section. But, for more than 20 years, MSF has also been caring for patients’ mental health, treating the debilitating invisible wounds caused by ongoing conflicts and disasters.

For the people who live through such terrible events, depression and anxiety can immobilise them at a time when they need to take action for themselves and their families. MSF’s mental healthcare aims to reduce people’s symptoms and improve their ability

to function. Specially-trained local counsellors often combine their services with the technical support and clinical supervision of MSF psychologists or psychiatrists. Where appropriate, MSF’s counselling services reinforce or complement mental healthcare approaches that already exist in the local community. Last year, MSF’s mental health teams performed more than 100,000 consultations worldwide. People sought help for many reasons — the agonising loss of a child in an earthquake, the trauma of sexual violence or getting caught up in a violent conflict. The following articles document MSF mental health programmes in Kashmir, Democratic Republic of Congo and Iraq.

Kashmir: People traumatised by decades of violence

MSF counsellor Madina Bukhari works in Kupwara district, where the population suffers the consequences of the ongoing Kashmir conflict.

“I’ve had women telling me how they were having dinner with their families when someone burst in and shot their husband in front of their eyes. Others have lost family members or witnessed violence. All these memories are often very vivid in their minds,” Madina says.

Gulam suffered from depression, headaches, sleep disturbances and memory loss for years before being referred to MSF.

“Since I’ve seen a counsellor, I have started writing about my emotions regularly and it helps me to express them. Now that I’m reading and writing a lot, I can concentrate very well and I’d like to continue studying. I know I can do it now.”

In 2009 MSF’s mental health programme in Kashmir provided more than 5,800 consultations.



DRC © Martin Beaulieu



Listen to the Podcast of mental healthcare in Kashmir: <http://www.msf.org.za/viewnews.php?n=785>

Kashmir © Giulio Di Sturco/VII Mentor



Democratic Republic of Congo: “Talking about trauma”

The people of eastern DRC have suffered through decades of brutal armed conflict. Since mid-2009, psychosocial counselling has been part of the range of health services offered by MSF in Kitchanga and Mweso, in DRC’s north Kivu province. More than 1,000 people started counselling during the first six months of the programme. The counsellors, recruited among the local people, are often victims of the conflict themselves.

Many of the women who come for counselling have suffered physical abuse or sexual violence. A woman from Kitchanga, 54, recounts what happened to her before she came to see MSF:

“I was out with a group looking for food when we heard gunshots. I was with two young people and they were killed right there in front of me.

“I fell to the ground, and when the armed men caught me, they raped me. One of them was going to shoot me, but they cut me with knives instead.

“Since then, I’ve been living here in the camp. I spend sleepless nights and then I’m tired in the mornings. I think about the people I’ve lost and about my children who have died. I think about my child, who is still missing, and I don’t know whether he’s alive or dead.”

Iraq: Finding new ways to bring mental healthcare to people in Iraq

Overall levels of violence may have decreased in Iraq, but highly volatile areas remain, and many people continue to die in bombings and assassinations.

MSF established that few counselling services were available in central and southern Iraq – an area hard hit by violence. But due to the poor security situation, MSF is forced to manage its Iraqi programmes from Amman in neighbouring Jordan.

MSF’s international teams are only able to visit the counselling programmes in Iraq once a month, due to security restrictions. The rest of the time, the team relies on technology to connect the Iraqi counsellors with MSF mental health officers in Amman.

Initially forced to rely on erratic mobile technology, in mid-2010 the team began using a videoconferencing system that has greatly improved supervision and collaboration.

“Using the videoconference, I am more connected to the counsellors,” says one of the MSF mental health officers. “I am also able to get a clearer indication of the attitudes and skills of the counsellor.”



HIV PATIENT GROUPS: IMPROVING TREATMENT, REDUCING COSTS

“Many patients didn’t have enough money for travel. Some stopped taking their medicine and died.”

In Mozambique there are less than five doctors per 100,000 people, while 11.5% of the adult population live with HIV. In rural areas, health centres are few and far between. MSF teams working here recognised the need to leverage the scarce resources available to empower patients to create vital support networks.

In MSF’s HIV project in the Tete district of northern Mozambique, patients are divided into groups of around six people who live near each other. Each month the group chooses one person to go to the health centre to collect refills of their life-saving antiretroviral (ARV) medication. On return, the representative distributes the ARV drugs, checks that the members have been taking their medication correctly and relays this information to the health centre.

It is a simple idea but the effectiveness of this alternative strategy on patient management has already paid off and has the potential to save many more lives.

“This model has led to a reduced burden on healthcare services, as fewer patients need to queue to get their drugs,” explains Tom Decroo, MSF’s Medical Focal Point in Tete. “It has the potential to facilitate the scaling-up of ARV treatment – something that is desperately needed in

Mozambique, where one in three people who need treatment get it.”

The model has also made it simpler for patients in remote areas to obtain their medication, as they only pay the transport costs of the designated group leader and do not need to sacrifice a day’s work to travel to the health centre. Yet another advantage is that it enables group members to support each other in overcoming problems related to the stigma associated with HIV/AIDS in their communities.

“The Community ARV Group model is good for all patients,” says Margarida Smith, one of the group leaders. “We come together and support each other. In the past, many patients didn’t have enough money to pay for travel. Some stopped taking their medicine and died as a result. Now, each member pays me seven meticals (R1,70) and I bring the medication to their house.

“It’s great to be able to help others take care of their illness. I’m also taking medication but I am healthy and working. I want other HIV-positive people to join me and enjoy life,” says Margarida.

During 2009, MSF medical teams carried out 240,500 consultations and provided ARV treatment to 25,500 patients. MSF has worked in Mozambique since 1984.



Mozambique © Niklas Bergstrand



Mozambique © Niklas Bergstrand



Read about a new treatment centre in Upper Nile state www.msf.org.za/viewnews.php?n=792



©MSF

BACK FROM THE FIELD: CANDICE CRONJE

Nurse-Midwife, southern Sudan

Candice Cronje, 26, is a Johannesburg-based nurse who spent six months in Gogrial, in southern Sudan's Warrap state during her first mission with MSF. At the time, Gogrial had no formal hospital in which to treat people requiring urgent surgery, so many were forced to travel great distances for adequate care. To meet the medical needs of the 250,000 people living in Gogrial, MSF built a brand new primary healthcare centre with inpatient wards, a pharmacy and laboratory.

What was your working environment like?

When I arrived in Gogrial our facilities consisted of white tents (not yet raised on platforms for the rainy season) subdivided by plastic sheeting. We didn't have the operating theatre or the maternity ward that we do now. We provided only basic medical services – medical consultations and immunisations from a dressing room; a small dispensary; Ambulatory Therapeutic Feeding Centre (ATFC); a basic sterilisation tent and an antenatal clinic. We stayed in rented huts and old MSF tents on a rented compound. We had a pit latrine with plastic sheets for walls and a plastic bucket shower. By the time I left we had proper buildings for the lab and sterilisation, a laundry, kitchen, waste zone, pharmacy, logistics department and *tukul* (hut) offices.

What healthcare services does MSF offer there?

The focus for the Gogrial project is on providing hospitalisation for adults and children; urgent medical assistance to patients in need of life-saving surgery; and management of obstructed labour. The project offers an upgraded primary healthcare clinic with a temporary operating theatre, outpatient department, 20-bed inpatient department and 10-bed maternity ward. Treatment of tuberculosis will also be offered as the project grows and develops. The Gogrial project has also previously run a mass measles vaccination campaign.

What are the greatest challenges in Gogrial?

The MSF clinic is the only health structure that serves the 250,000 people of Gogrial. It is difficult for people to get healthcare because few people have access to transportation and many have to walk long distances to get to the clinic. Women also run the risk of being raped if they walk alone with their children, and many people have no option but to carry their frail and sick family members to the clinic. Sometimes patients die on the way.

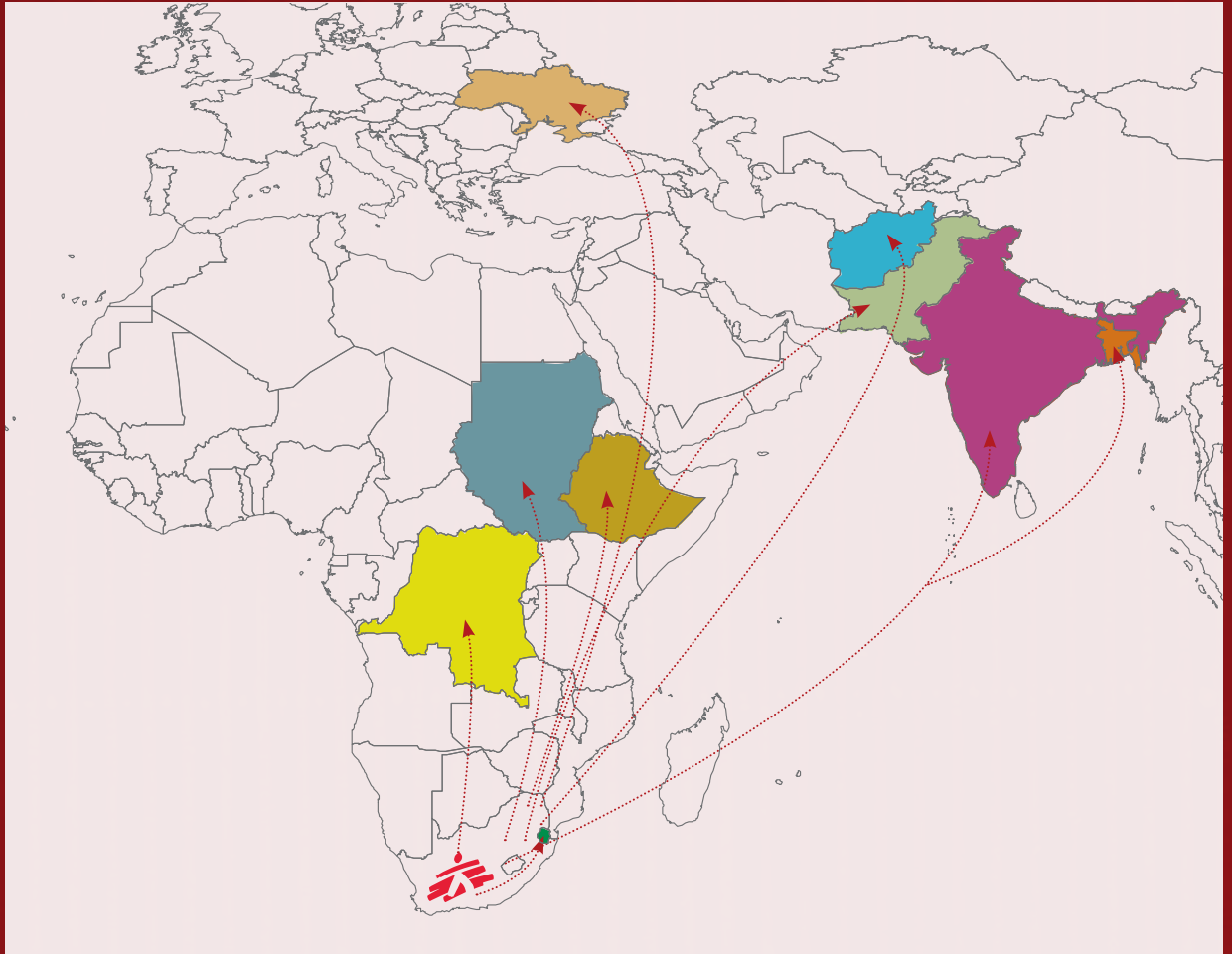
How is working as a nurse in Gogrial different from working in a Johannesburg hospital?

Working with MSF in southern Sudan, I took on a supervisory and management role. I had more responsibilities in southern Sudan because I had to supervise staff and set up and establish our services according to MSF protocols in a very rudimentary setting. In Johannesburg I had less responsibilities while working as a junior nurse-midwife and could always rely on the support of the more experienced nurses. I gained a lot of new work experience in training the Sudanese staff to develop new skills and procedures and I had to learn a few of these skills myself (like assisting during surgeries). In Sudan we only had basic structures to work in, basic medications and equipment to use, very limited referral possibilities and very few (if any) specialists to assist with difficult cases.



Médecins Sans Frontières / Doctors Without Borders (MSF) is an independent and international medical humanitarian organisation providing medical assistance to people affected by armed conflict, epidemics, natural or man-made disasters without discrimination based on race, religion, politics or gender. MSF is committed to bearing witness and speaking out about the plight of the populations in distress we assist.

For more information visit www.msf.org.za



MSF in South Africa: Our recruits on missions in the field in 2010

Africa

1. Dr Hermann Reuter – **Swaziland** – HIV/TB Doctor
2. Dr Martha Bedelu – **Swaziland** – MDR TB Doctor
3. Jaquiline Dallimore – **Swaziland** – TB Nurse and Mobile Clinics
4. Marilize Ackermann – **DRC** – Administrator/Finance Legal
5. Dr Kathryn Chu – **DRC** – Surgeon
6. Mohammed Faheem Araie – **Southern Sudan** – Supply Manager
7. Virginia Kiyanjui – **Ethiopia** – Nurse-Midwife
8. Dr Prinitha Pillay – **Southern Sudan** – Medical Focal Point

Asia

9. Kate Ribet – **Afghanistan** – Communications Officer
10. Brendan Curie – **Pakistan** – Logistician
11. Jonathan Whittall – **Afghanistan** and **Pakistan** – Deputy Head of Mission
12. Mohammed Golo Abdi – **Pakistan** – Operating Theatre Nurse
13. Dr Yashoda Manickchund – **Pakistan** – Emergency Room Doctor
14. Borrie La Grange – **Pakistan** – Emergency Communications Officer
15. Emmanuel Fajardo – **India**, **Bangladesh** and **Ukraine** – Laboratory Expert

