Issue 1 Volume 1 January 2010

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Pakistan © Jodi Bieber

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SILENCE KILLS, SO LISTEN UP

You are holding this copy of MAMELA in your hands because like Médecins Sans Frontières / Doctors Without Borders (MSF), you want to make a difference in the lives of people around the world who are directly affected by conflicts, epidemics, natural and man-made disasters. And like us, you also believe that their race, religion, politics or gender does not matter in the face of emergencies and crises.

Although much of the work MSF fieldworkers do is often in forgotten corners of the globe, news of what MSF teams witness, and what our patients tell us must reach the ears of the world.

That is why the title of this quarterly magazine, MAMELA, has profound meaning for us – it is the Xhosa word imploring you to "listen up!"

A decade ago when MSF was awarded the Nobel Peace prize in 1999 in recognition of its pioneering humanitarian work the Nobel Committee praised MSF for speaking out and drawing the world's attention to the causes of deadly crises and man-made disasters, in order to help influence public opinion.

"We are not sure that words can always save lives, but we know that silence can certainly kill," Dr James Orbinski, then MSF international president, told the world.

Since MSF's inception in 1971, and perhaps now more than ever the need persists for a neutral, politically independent organisation, which is biased only to the plight of its beneficiaries based on the medical evidence witnessed by doctors and other international expatriates working all over the world.

In MAMELA, you will hear voices from the field; those of MSF fieldworkers and those of our patients. From an emergency room in Pakistan, to the dense jungles where a chronically under-reported conflict in northeastern Democratic Republic of the Congo and South Sudan are on the increase. Our actions in Pakistan are aimed at bringing normalcy and quality medical care to the people living on the frontline of the war on terror. In the DRC and South Sudan our aim is to help people whose lives have been ripped apart, having been displaced due to an ignored and often complex conflict which has direct and violent impact on their personal integrity.

In Zimbabwe, MSF works within a collapsed healthcare system in order to help some of the estimated 2 million people living with HIV, by providing antiretroviral treatment (ART) to both adults and children. These are just some of the more than 60 countries where MSF is present and active.

South African Dr Joe Starke who worked in Pakistan's North West Frontier Province, has become an inspiration and motivation for all of us, and his vivid description of acting in emergency to save a life sums up the MSF experience in the field.

The same goes for Dr Hermann Reuter, president of the board of MSF South Africa. He is well-known for the work he did in providing medical scientific evidence demonstrating that even in resource poor settings it was possible to initiate ART and to keep people alive on treatment. Working in Lusikisiki in the Eastern Cape, he managed a comprehensive HIV program treating 750 people on ART at primary health care level when the South African government was still in denial about HIV and AIDS in the early 2000's.

Also, we are proud to express satisfaction at the success of MSF in South Africa's involvement in the first ever Diploma on Humanitarian Assistance in Africa, alongside the renowned Liverpool School of Tropical Medicine which offered training to future humanitarians.

Lastly, we would like to warmly welcome back our recently returned fieldworkers; Dr Prinitha Pillay who worked in Sierra Leone, and Brendan Currie who shared his experiences as logistician in Zimbabwe with MAMELA.

Sincerely yours,

Sharon Ekambaram

General Director, Médecins Sans Frontières / Doctors Without Borders in South Africa

Pakistan © Jodi Bieber

Read Dr Joe Starke's blog: http://msf.ca/blogs/jstarke/

Letter from the field

THE LATE NIGHT CALL

Dr Joe Starke, MSF Medical Doctor, Pakistan

Why do we do this work?

Well, today, the reason is the late night call. Working in emergency, you get to know this one. It is the situation that won't wait, the one that needs immediate action if a life is going to be saved. But a late night call in Pakistan's North West Frontier Province has a character all of its own.

It had already been a long day: a busy emergency room (ER), a full ward, and some important paperwork that couldn't wait. We had just arrived home and, with my first weekend off in a while about to begin, I was looking forward to a relaxing evening. But Pakistan had other plans.

The first call of the evening was about a newborn baby who had been brought into the ER earlier. Though initially stable, her condition had started to deteriorate and we needed to prepare for transfer.

With an undisguised weariness in my voice, I gave some instructions to the ER nurse on shift, advising him to update me soon. It seemed like I had just put the phone down, when it rang again. The baby must be worse, I thought as I answered ... (sigh).

Instead, there was another patient, the sort of late-night call we get quite regularly here: *"Gunshot chest. Doctor, the patient is in shock."*

Well, this is what we are here for! The time had come to mobilise the team.

With two acutely ill patients, the ER staff would need help.

Luckily I live and work with an excellent surgical team: two great ladies from the Philippines named Lynette (our trauma surgeon) and Margarita (our anaesthetist). They know the drill and we were ready to go within minutes.

But life isn't quite that simple here, of course. Despite the seriousness of the situation, there would be some delay before our transport could be safely arranged – security is paramount here, especially at night. So I found myself with some time, as I waited, to ponder things.

As I stood in the failing light outside, I realised that the tiredness I had felt only moments before was gone. Instead, I felt the familiar tightening in the stomach that over the years has evolved from fear into a calm, enlivened readiness.

This work is sometimes soul-destroying, often infuriating, but, almost always, it is exhilarating. What it demands in effort and time, it rewards by the knowledge that one can make a real and lasting impact in the life of another person.

Through a dedicated team effort involving MSF staff and our colleagues in the Pakistan Ministry of Health, we went on to save two lives that night.

There are thousands all around the world who we cannot save, despite our best efforts as individuals and as an organisation. We are painfully aware that hundreds of thousands of people suffering from disease or the tragic consequences of war are in need of medical care but remain beyond reach – essentially slipping through our fingers. This is hard to accept, and it is part of what drives this organisation.

But saving a newborn baby and a gunshot victim that night is enough to keep me going for now.

After all, in this work – as in life – all we can ever do is what we can; that which is possible. The rest isn't up to us.

Pakistan © Jodi Bieber

Pakistan © Jodi Bieber

Dr Joe Starke treating patients in the Dargai THQ hospital

MSF does not accept funding from any government for its work in Pakistan and chooses to rely solely on private donations. MSF has been working in Pakistan since 1998.

SOUTHERN SUDAN:

"In the morning they gave us 25 lashes each. That was breakfast."

MSF has worked in Sudan since 1979. Across Southern Sudan, MSF provides care to hundreds of thousands of people in six states.

Mboli (16) was abducted from his school along with 20 fellow students, including his brother, Muka, during an attack on his village in the northeast of the Democratic Republic of Congo (DRC). His village was just one of scores targeted in a relentless series of attacks by Ugandan rebel group, the Lord's Resistance Army (LRA) during 2009.

"In the morning they gave us 25 lashes each. That was breakfast .They made us carry what they stole from our school and village," says Mboli. "They beat us. I had to carry spare bicycle parts, in a waist-high sack. Others were hauling kilos of ground nuts, bags of rice, even a guitar, and the solar energy system from our church."

A joint military offensive by the national armies of Uganda, the DRC and Southern Sudan against the LRA, exacerbated the situation, sparking more violent reprisal attacks by the rebel group against civilians in northeastern Congo. During these attacks, entire Congolese villages are looted, often burnt to the ground, people hacked to death with machetes, women and children abducted for use as sexual slaves, or forced to carry looted goods or recruited to the conflict.

"They killed people we passed later on the road, right in front of me," Mboli continues. "They beat them with sticks, stabbed them with bayonets, and threw their bodies into the river. I was afraid that if I stopped to rest they would kill me too, so I marched and marched under the weight of that heavy sack."

According to official estimates, up to 250,000 Congolese have been displaced from their lands and livelihoods. Entire families have been ripped apart and a toxic climate of fear reigns. Tens of thousands

Southern Sudan © Brendan Bannon

Mboli, aged 16, was abducted during a violent attack on his village by fighters from the Ugandan rebel group, the Lord's Resistance Army (LRA).

See more photos: www.msf.org.za/southsudan_slideshow.flv

have fled as refugees to neighbouring Southern Sudan, seeking safety and assistance in the Sudanese border-states of Central and Western Equatoria. However, the LRA are present in those states too, where sporadic attacks have also displaced thousands of Sudanese. The United Nations Office for the Coordination of Humanitarian Affairs estimates that there are 50,000 Congolese refugees and Sudanese displaced in Western and Eastern Equatoria.

After three days in captivity, the LRA ordered Mboli and some other boys to leave, but not his brother. Mboli was ordered to run, without time to even say goodbye to Muka. He returned to his family home, but everything was destroyed, everyone had fled.

In the frenzied panic of fleeing a direct attack, there's often no time to wait for the slowest and the oldest, no time to bury the dead. Others, like Mboli and his parents, who flee ahead of new bouts of violence and bloodshed, frantically gather what family and possessions they can, abandoning homes and livelihoods to begin the treacherous journey across the border.

Once in Sudan they either seek assistance in the new refugee camps, or build temporary shelters within Sudanese communities.

However, Southern Sudan itself is a region fraught with tension, with increasingly violent clashes in several areas, deep poverty and an acute lack of access to basic services.

"It's sad that these people must come looking for safety in a region that is not even secure itself," says Karl Nawezi, Médecins Sans Frontières / Doctors Without Borders (MSF) Head of Mission for Southern Sudan. "Our medical teams across Southern Sudan already battle to cope with the huge needs that exist for the Sudanese. Yet, Congolese patients tell us that they somehow feel a little safer here, despite the fact that the LRA is also active in the region."

As the refugees began to stream across the border and the displaced Sudanese began to move within the southeastern border states, MSF teams already providing medical aid in the country quickly established emergency projects to provide healthcare, shelter and sanitation for the displaced and refugees. In September 2008, MSF teams in Western Equatorial State (WES) began to assist a population of more than 15,000 refugees and displaced people. Then in early 2009, MSF started a second emergency programme in Central Equatorial State (CES) to assist another 7,000 refugees.

Karl continues: "People who flee have urgent needs. The first week we opened our clinic in one of the refugee camps we received 500 people. Imagine a heavily-pregnant woman fleeing through the jungle, to a country she doesn't know, then having to give birth. We are here to offer her somewhere safe to deliver her child, somewhere she can be cared for to ensure she and others like her can be treated with dignity."

Southern Sudan © Brendan Bannon

Southern Sudan © Brendan Bannon

Life for Mboli and his family remains bleak. *"I'm so worried about Muka, about our future. The LRA are in my home in Congo. I am a refugee in Sudan, but they are also here. There is nothing to think about the future. What future?"* Mboli says.

THE MIRROR OF WAR

In this first edition of MAMELA, our photo feature page portrays the consequences of armed conflict in different countries where Médecins Sans Frontières / Doctors Without Borders (MSF) provides medical assistance to people in dire need. Today more than a third of all MSF projects are located in areas of armed conflict, while over 40% of these interventions are triggered by armed conflicts in areas that include the Democratic Republic of the Congo (DRC), Sudan, and Pakistan.

This is the daily reality of what MSF medical and non-medical staff witness in the field as they ensure care and treatment for patients who have no other options left in the wake of strife that has forced thousands of people to flee their homes and livelihoods. The knock-on effect of conflict leads to deteriorating health conditions for displaced people and increased vulnerability to sexually transmitted diseases, cholera and malnourishment while the mental health consequences are also laid bare.

1 DRC © Martin Beaulieu

1. A severely dehydrated patient, suspected of suffering from cholera, is transferred from an MSF vehicle to be treated in the remote rural clinic at Kirima, near Nyanzale, the DRC's North Kivu Province, where MSF runs weekly mobile clinics.

2 Pakistan © Jodi Bieber

2. MSF doctor Samarat Khan prepares to dress patient Muhammad Wahab's injuries in Mardan in Pakistan's Northwest Frontier Province. Hundreds of thousands of people fled the heavy fighting between the military and armed opposition groups in their native Swat in 2009 seeking refuge in Mardan. Samarat was among the thousands of people who sought refuge there.

3 Pakistan © VALI

3. A distraught elderly woman from Bajaur in Pakistan sits among her meagre possessions in the Kacha Ghari camp in Peshawar. Her home was destroyed by the Pakistani Army during protracted fighting with armed opposition groups, which displaced hundreds of thousands of people leaving them without shelter and medical care.

4

Southern Sudan © Brendan Bannon

4. MSF nurses attend to a young boy in Nyori refugee camp, Southern Sudan. Inside this camp MSF has set up a health facility with inpatient capacity and a pharmacy. This facility provides an average of 500 consultations a week, antenatal care, deliveries and treatment for malnutrition.

5

DRC © Martin Beaulieu

5. Françoise Kavira is comforted by her mother while recovering from severe burn wounds after bandits set fire to her house in North Kivu Province in DRC. Banditry is rife due to the instability and continued fighting between government forces and various rebel groups in North Kivu. Thousands of people have been displaced, while others like Françoise have been caught up in the violence in the wake of armed conflict.

6

DRC © Martin Beaulieu

6. Two women stand on a slope in the Kitchanga refugee camp, North Kivu in DRC. Fighting between government forces and various rebel groups in North Kivu has left thousands of people homeless, desperate and vulnerable.

7

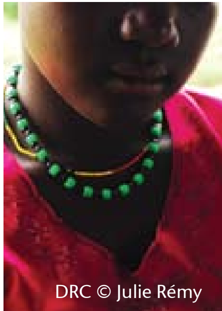
DRC © Michael Goldfarb/MSF

7. A man with a gunshot wound to his leg is treated at an MSF-supported health clinic in the village of Muheto, North Kivu Province, DRC. He was wounded the previous night in a shooting incident under unclear circumstances. Fighting between government forces and various rebel groups in North Kivu has been ongoing for several years.

DRC © Julie Rémy

SURVIVING VIOLENCE IN A CONFLICT ZONE: PIERRETTE'S STORY

"These men killed people next to me, I try not to think about it anymore."


DRC © Julie Rémy

Pierrette does not know her exact age, but she shyly suggests "around 15". She was kidnapped by armed men, and held captive for two months. She became what is known as a "forced wife" – given to a man to spend nights with him...

"Two and a half months ago, I'd left to work in the fields. I was with my mother and my brother's wife. [The men] burst out of the bushes – there were lots of them, and they were armed. They were aggressive. They took us into the forest by force. They let my mother and sister-in-law go, but they kept me with them in the forest."

This was the start of about two months of captivity for Pierrette, in the thick of the tropical forest and the armed conflict.

"We walked a lot during the day. We carried rice, peanuts, salt. I slept with a man at night. It was always the same one. During the day, others would hit me, and he would act as if he didn't know me. He spent his days with another woman, a mother with children. And at night, he slept with me."

"These men killed people next to me. I was scared, but we weren't allowed to cry. If we cried, they hit us on the back," Pierrette recalls, showing the scars that criss-cross her back and feet. "There were other people who cried with me. They spoke Zande, like me, so we could talk, even if we didn't know each other."

After two months, Pierrette escaped. She came to the health centre. She was then referred to the hospital, where she received medicine and food, and she managed to talk to the MSF psychologist.

"I try not to think about it all anymore," Pierrette says. "I block it from my mind. I don't talk about it to anyone. But when my mother asked me questions, I told her everything. When I described everything that had happened, my mother and father cried."

Since late 2008, the people of Haut-Uélé and Bas-Uélé in north-eastern Democratic Republic of Congo have been caught up in a dramatic cycle of violence linked to attacks perpetrated by the Ugandan rebel group the Lord's Resistance Army and the Ugandan and Congolese offensive against the LRA. As the situation deteriorates, civilians also find themselves facing increasing violence.

"The local population is the target of violence: murder, kidnapping and sexual abuse. We are talking about tactics of violence aimed at instilling fear in the people. Our patients have told us the most brutal stories." – Luis Encinas, coordinator of MSF operations in Central Africa.

Médecins Sans Frontières / Doctors Without Borders (MSF) is currently working in Dingila, Doruma, Dungu, Duru, Faradje, and Niangara, providing over 9,000 medical consultations a month in hospitals and health centres. MSF has also distributed relief items to some 16,000 people displaced by violence, as well as vaccinations and mental health support. Twenty-seven international staff work alongside 140 Congolese colleagues in MSF projects in Haut-Uélé and Bas-Uélé.

ALL-WOMEN FOOTBALL TEAM SCORES A GOAL AGAINST HIV STIGMA AND DISCRIMINATION

"Even though we are HIV positive, we can still kick that football."

THE POSITIVE LADIES SOCCER CLUB

Zimbabwe © MSF

Zimbabwe © MSF

Kicking a football sounds like child's play. But in Epworth – one of the poorest townships in Zimbabwe – it takes on a whole other dimension if you are woman living with HIV in a community that believes you are better off dead.

In Epworth, more than one in four people are infected with HIV, but this does not mean that there is acceptance for those infected – in fact, the opposite is true. The stigma against people living with HIV is massive and it is women who bear the brunt. They are scorned, ostracised, laughed at, and even kicked out of their homes by their landlords, husbands and families.

In Zimbabwe, out of a total population of 10 million, approximately 2 million people are HIV positive. Of these Médecins Sans Frontières / Doctos Without Borders (MSF) is taking care of 45,000 HIV-positive patients. In total , fewer than 120,000 in whole country are able to access treatment, and it is estimated that, in Zimbabwe, 500 people die from AIDS every day.

But despite the odds stacked against them, a group of brave HIV positive women, all seeking treatment at an MSF clinic in Epworth, decided to form a football team – the ARV Swallows – to give the red card to the stereotypes that HIV is a death sentence and that women cannot play football.

At first, the idea of an all-girl team was met with derision from the local population. Men and schoolboys poured scorn on the idea of women playing football.

"They thought we were just playing games. They would laugh at us and say, 'How can women play football? Will you be good at it? How can you sick people play soccer?', " recalls defender Meria Kabudura.

And the first training sessions seemed to prove the men right – the Swallows were hopeless; the coach walked off the field in despair. But true grit kept the women motivated, and they trained intensely before competing in an HIV-positive women's football league. Their training regime was tough, and just trying to fit in time for exercise and football practice in between their daily responsibilities, church, and childcare was a real test.

Attending regular football practice is not easy for Meria. Her HIV-positive husband suffers from tuberculosis and needs daily treatment at the clinic. The only way for him to attend the clinic is for Meria to push him there in a wheelbarrow. After she has wheeled him back from the clinic, she has to find enough firewood so she can cook a meal for her family. Finding the energy to go to practice is a real struggle, but she is spurred on by the support of her teammates.

After an initially shaky start, the Swallows started winning matches and made it through to the finals of the league. But, despite their successes, the women have to carry on with their treatment and daily lives. The difficulties of living with HIV are ever-present for these women.

Team striker Janet 'China' Mpalume became so ill that she nearly died. Her son revived her and sought treatment after she tested positive for HIV. Janet now makes a living selling firewood she collects. But on some days when there is not enough money for food, they light a fire so that the neighbours think they are cooking – yet they go to bed on empty stomachs. She is self-disciplined and determined. On discovering she had HIV, she chased her promiscuous husband away because he had no self-control. Her

Watch the documentary trailer: www.thePositiveLadiesSoccerClub.com

position as the team striker has given her a sense of pride.

"Playing soccer makes me feel like I am somebody. Somebody who is seen amongst others," says Janet.

HIV-positive women are so stigmatised in Zimbabwe that many are afraid to tell even close family members about their status, and as a consequence, many HIV positive patients suffer from depression and discrimination.

When team captain Annafields Phiri discovered that she had HIV, her landlady taunted her, telling her she would die soon. But she was adamant that the disease would not be a death sentence and winning the football tournament would prove this to the community.

After her HIV diagnosis, defender Nyarai Mambera recalls how other people told her she would be better off taking poison and killing herself, but being part of the team has provided her with support and given her a place to talk about her problems and seek comfort and advice.

"Now people appreciate us even though we don't have anything. They see us as people who have done something glorious in our lives," Meria says.

MSF Field Communications Officer Joanna Stavropoulou heard about the ARV Swallows and decided to film their travails and victories. She directed a film about their inspiring heroism. The MSF documentary *The Positive Ladies Soccer Club* was released in September 2009 and it has already been hailed in the media.

Zimbabwe © MSF

ARV Swallows team captain Annafields Phiri and striker Janet "China" Mpalume.

©Baikong Mamid/MSF

BACK FROM THE FIELD: BRENDAN CURRIE

Logistician, Zimbabwe

Brendan Currie, 31, was born in Harare, Zimbabwe, and grew up in East London in the Eastern Cape, South Africa. His first mission with Médecins Sans Frontières / Doctors Without Borders (MSF) was in 2008 when he worked in Ethiopia as a logistics coordinator for an MSF nutrition programme. He recently returned from Zimbabwe where he spent nine months working as an MSF Project Logistician. Brendan worked in Murambinda and Birchenough Bridge on MSF's HIV/AIDS projects that addressed dire humanitarian needs following economic collapse and years of political turmoil in Zimbabwe.

Tell us about how your missions with MSF have differed, from a logistician's perspective.

In Ethiopia, I worked in one of the biggest nutrition interventions MSF embarked on in 2008. It was challenging but, at the same time, it was not really that complicated. As a logistician, I need to make sure that there are enough supplies. In Zimbabwe, they always used to say that an HIV/AIDS mission is not very exciting because it's not like the emergency projects, where there is a lot of pressure. But it still was fulfilling. The economic collapse, political violence, the complete breakdown of the health care system, and the cholera crisis in 2008 meant that the needs and vulnerability of the population had increased and MSF had to respond to their medical needs. There were many things to do. We built shelters, health facilities, ensured drugs stocks were adequately maintained and we coordinated the transportation and staff movements.

Tell us more about the situation in Zimbabwe when you arrived in January 2009.

The situation is not as bad as in 2008, when there was nothing in the shops and constant food shortages were a crisis. Things are getting better gradually, but the HIV epidemic and its impact is massive.

What are the biggest challenges you faced as an MSF fieldworker working in Zimbabwe?

MSF operates in 23 different clinics in Murambinda and Birchenough Bridge, as well as the Buhera district. The vast distances between the clinics made our work difficult. Every day, the team needs to visit all these clinics transporting the medicines and other items so that our doctors and nurses can treat patients.

What motivated you to continue making a difference with MSF?

I don't think I am the typical person who would volunteer to work with a non-profit organisation. But it really has been fulfilling time. The driving force in working with MSF is that you just don't go to work to earn an income like everyone else. It's not about money, but it's about helping people. It is fantastic to wake up every day because you want to make a difference and help. That is the satisfaction you get.

Find out more: www.liv.ac.uk/lstm/dha_africa/

TRAINING TOMORROW'S HUMANITARIAN WORKERS IN SOUTH AFRICA

MSF-supported Humanitarian Diploma to be run annually following massive success in South Africa

Médecins Sans Frontières / Doctors Without Borders (MSF) in South Africa has been instrumental in helping to host a humanitarian aid training course, the first of its kind in Africa, together with the renowned Liverpool School of Tropical Medicine (LSTM).

The first Diploma in Humanitarian Assistance (DHA) Africa programme was held in South Africa from July to August 2009 and is an expansion of the LSTM's diploma course in Liverpool. MSF took a leading role in adapting the original course, giving it a regional focus that addresses the most pressing humanitarian issues on the continent.

The programme provided quality training to participants from some of the most crisis-affected countries in Africa, improving in-the-field practice and stimulating debate among those who took part. The intensive six-week professional diploma explored assistance in humanitarian crises from a critical perspective, creating a rare opportunity for participants from non-governmental organisations, the United Nations and governments from across Africa to sit down together to learn and build on their experiences of humanitarian action in the region.

DHA Africa was a major success. Its launch received overwhelming support from international humanitarian organisations across the region – affirming the need for greater formal training of people who work in such emergencies. DHA Africa attracted more applications than any previous DHA – and nearly 80% of the 43 students who attended the course in 2009 were from countries in Africa. Teaching was interactive and of a high standard, delivered by 20 lecturers from 14 different organisations, including Liverpool professors, MSF staff and expert trainers from groups operating in the region.

DHA Africa will be handed over to the University of the Witwatersrand post-graduate school of Public and Development Management by 2011, to further develop humanitarianism in the region by building academic institutions. Ultimately the goal is to expand the training initiative to several universities across Africa and beyond.

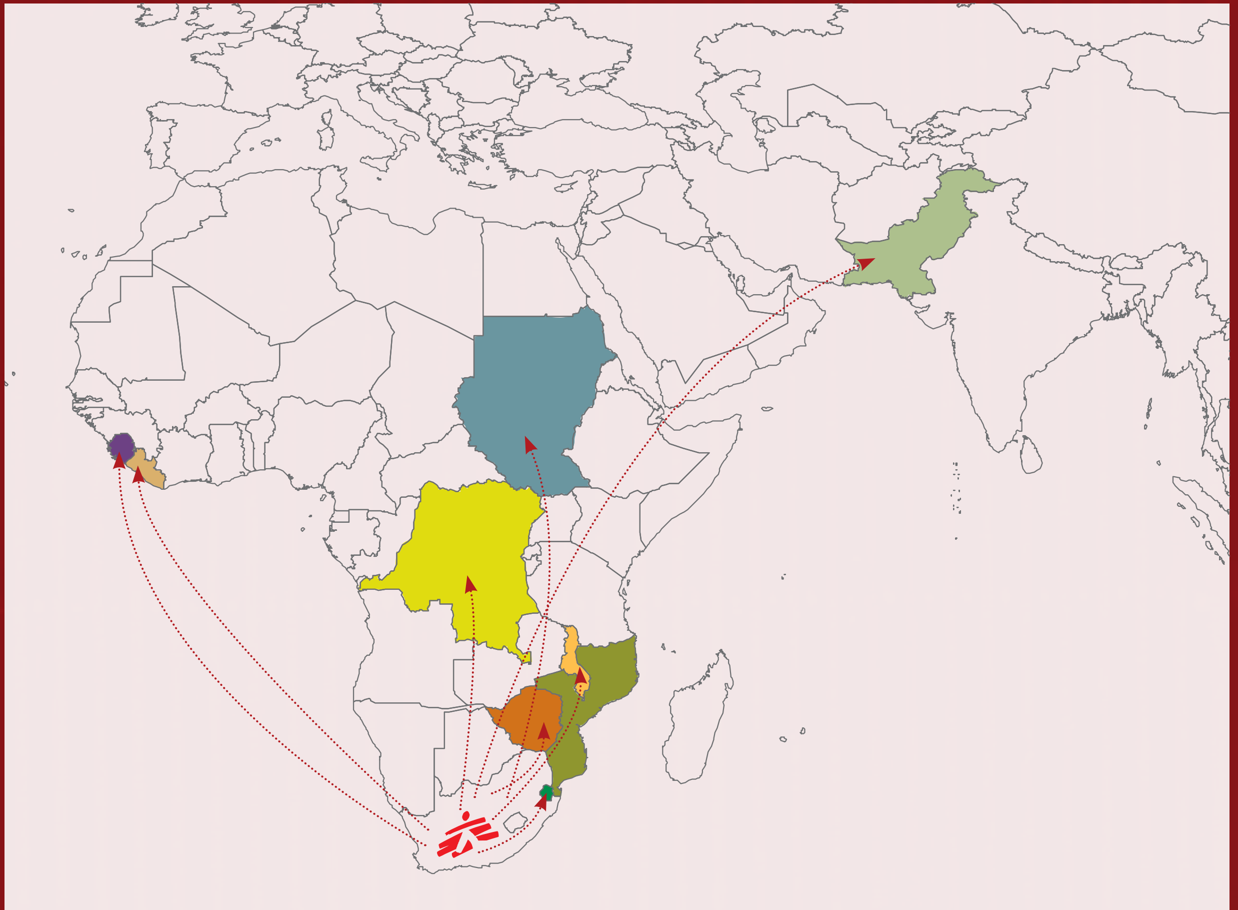
> *"Seeing how involved the participants were in the issues covered on the programme, it was clear how important it was to set up a DHA for the African region. Having participated in the DHA myself four years ago, I know how empowering it is to be able to use the skills learnt during the course to have a positive impact on the lives of people experiencing crisis,"*
> – Bridget Steffen, MSF DHA-Africa coordinator and DHA alumni

©Henrik Glette/MSF

MSF in South Africa provided medical services to scores people during the height of xenophobic violence that ripped through Gauteng in May2008. People who fled their homes during the wave of violence targeting foreigners, sought shelter and about 1,600 lived in tented camps in parts of the city until they were removed.

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 mission in the field 2009/2010

Asia

1. Patrick MacGoey, **Pakistan**, Medical Doctor - Emergency Room
2. Joe Starke, **Pakistan**, Medical Doctor - Emergency Room
3. Fahad Hendricks, **Pakistan**, Medical Doctor - Emergency Room

Africa

4. Virginia Kinyanjui, **Darfur**, Nurse Midwife
5. Prinitha Pillay, **Sierra Leone**, Medical Doctor and Field Coordinator
6. Angela Murikuri, **Liberia**, Medical Doctor Out Reach
7. Dr Kathryn Chu, **Democratic Republic of Congo**, General Surgeon
8. Thomas Van Der Akker, **Malawi**, Field Coordinator
9. Themba Ginindza, **Malawi**, Epidemiologist
10. Marjolien Berrings, **Malawi**, Human Resources Researcher and Lobbyist
11. Danson Macharia, **Mozambique**, Medical Doctor HIV
12. Marcelle Balt, **Mozambique**, Field Finance Officer
13. Hermann Reuter, **Swaziland**, Medical Doctor HIV/TB
14. Martha Bedelu, **Swaziland**, Medical Doctor MDR TB
15. Brendan Currie, **Zimbabwe**, Logistician
16. Jonathan Whittall, **Southern Sudan**, Interim Head of Mission
17. Candice Cronje, **Darfur**, Nurse Midwife