MAMELA

Médecins Sans Frontières / Doctors Without Borders South Africa
Issue 5 Volume 2 December 2011

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Kenya © Brendan Bannon

THANK YOU!

... for supporting MSF South Africa's Somali Emergency Relief Fund


Kenya © Feisal Omar

In this edition of Mamela you will read about the nutritional crisis that has been unfolding in Somalia and the surrounding region over the past few months. In July, MSF South Africa responded to this crisis by launching an Emergency Fund to support our operations in East Africa. We were overwhelmed by support from our dedicated donors who once again demonstrated their solidarity for people suffering in far-away places.

I would like to extend my heartfelt appreciation to everyone who contributed towards the emergency fund. Your donations meant that we were ready to scale up our existing projects at a moment's notice, assessing needs and mobilising staff, equipment, drugs and supplies so that we could begin treating patients as soon as possible.

But very importantly, your donations and those of thousands of other people around the world allows MSF to act with complete independence and neutrality when working in a place like Somalia where aid has become politicised.

In South Africa, MSF donors raised close to R500,000 which was used to respond to the nutritional crisis. Your support helped us save lives and bring treatment to those who need it most!

Steve Miller
Head of Fundraising
MSF South Africa

MAMELA

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

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SOMALIA: A NOT-SO-NATURAL DISASTER

Dr Unni Karunakara, International President, Médecins Sans Frontières/Doctors Without Borders [MSF]


Somalia © MSF

The unfolding Somali crisis has been portrayed by many aid organisations and the media in one-dimensional terms – as "famine in the Horn of Africa" or "worst drought in 60 years". Only blaming natural causes ignores the complex geopolitical realities exacerbating the situation and suggests that the solution lies in merely finding funds and shipping enough food to the Horn of Africa. Unfortunately, glossing over the man-made causes of hunger and starvation in the region and the difficulties in addressing them will not help resolve the crisis.

What I and my MSF colleagues see in Somalia, Kenya and Ethiopia is profoundly distressing. In Mogadishu, I recently met a young woman from the southern region of Lower Shebelle who is now living in one of the many makeshift camps appearing all over the city. She left home with her husband and seven children because of a bad harvest and her inability to afford food and water. During her trek, she had to leave her husband and three children behind – they were too weak to complete the five-day walk. Sadly, her story echoes those of thousands of other families in southern and central Somalia who have been ravaged by conflict for years and were tipped over the edge by drought.

Today, the most urgent needs are concentrated in southern and central Somalia. Even if we do not have a full picture, we know the situation is dire from the large numbers of Somalis arriving in weak condition in Mogadishu, and at refugee camps in Kenya and Ethiopia.

The failed harvests worsened what was already a catastrophe. Somalia is the theatre for a brutal war between the Transitional Government, strongly backed by Western nations and supported by African Union troops, and armed opposition groups, most notably Al-Shabaab. In a failed political landscape, it is this war, combined with the internecine rivalries of the various Somali clans that has kept independent international assistance away from many communities. The Somali people remain trapped between various forces who deprive them of assistance – either for their own political reasons, or in an effort to weaken opponents. There is virtually no access to healthcare across the country.

MSF has been working in Somalia for two decades and has projects in nine locations on both sides of the front lines – in areas under the control of the Transitional Government and Al-Shabaab. We are doing everything we can to scale up our activities to meet the growing needs. We already have more than 38,000 acutely malnourished children in our feeding programmes, and many children have caught measles in addition. Thousands of displaced people in overcrowded, unsanitary conditions already have skin and eye infections, watery diarrhea and respiratory tract infections. Some are too weak even to seek food or healthcare.

The reality of providing aid in Somalia today is about as grim as it gets. Our staff runs a constant risk of being shot or abducted while they provide lifesaving medical assistance. In spite of our constant negotiations with all parties to the conflict to gain access, we may have to live with the reality that we may never be able to reach the communities most in need of help or that we will have to compromise some of our independence when we do reach them.

Amid this hostile climate slogans like the "Famine in the Horn of Africa" are being used to raise impressive amounts of money for food and other supplies being sent to the region. But our concern is the last mile: getting assistance and supplies from the ports of Mogadishu to people in urgent need. Unless all parties remove the barriers that stand between organisations with the capacity to save lives and the people who rely on them for survival, thousands more may continue dying preventable deaths.

NEWS FROM MSF SOUTH AFRICA


© Guy Hall

‘Malaria in Context’ exhibit creates a buzz

Yvonne Chaka Chaka, South African superstar singer, Roll Back Malaria Goodwill Ambassador partnered with the Adler Museum of Medicine at the University of the Witwatersrand and MSF South Africa to open an exciting new exhibition titled Malaria in Context.

“Every 45 seconds a child in Africa under five years old is killed by malaria,” Chaka Chaka told 200 attendees in June during her rousing opening address. “We want to see fewer children dying every year until we can eradicate malaria completely. But we need all governments to come to the party.”

The exhibition forms part of MSF South Africa’s recent push to inform South Africans about the heavy toll of malaria in Africa where 90% of the 800,000 malaria-related deaths occur. A combination of video, photos and text, guide visitors through the history, causes, diagnosis and treatment and control of the disease.

Malaria remains endemic in almost 100 countries and only about a third of them are close to eliminating the parasitic disease. “For MSF, the major problems involved in tackling malaria are not just technical, medical or scientific,” says Dr Liz Thomson, General Director of MSF South Africa. “We have the tools – like artemisinin-based combination therapies (ACT) – but we need urgent political action for them to reach people in need.” (For more about ACT and Malaria, go to page 6).

Malaria in Context is open to the public from Monday to Friday, 10:00 to 16:00.

Adler Museum of Medicine, Medical School, Faculty of Health Sciences, University of the Witwatersrand, 7 York Road, Parktown, Johannesburg

Call 011 717 2067 for more information.

Mozambique: Against HIV, life wins

To raise awareness about HIV/AIDS and the challenges in treating the epidemic in southern Africa, MSF hosted the INTERVALO! sporting event in Maputo, Mozambique on 14 September, midway during the 10th All Africa Games. The event brought together 24 athletes, made up of patients living positively with HIV along with MSF staff involved in HIV care from 5 Southern African countries – Malawi, Mozambique, South Africa, Swaziland and Zimbabwe.

INTERVALO! highlighted the determination and commitment of people on the front lines of the fight against the HIV/AIDS epidemic, and demonstrated the positive impact of antiretroviral drugs in fighting a disease that wipes out 2 million people worldwide each year.

After 10 years of hard work and success in the match against HIV/AIDS, MSF is saying: Progress has been made in getting life-saving antiretroviral [ARV] drugs to people in developing countries – but it is no time to quit when millions of people are still in urgent need of treatment.

Each of the fun sporting events symbolised challenges ahead and successful ways to address them. The hurdles race, for example, showed the obstacles to fighting HIV, such as funding shortfalls, health worker shortages and stigma. In another event, every basketball shot symbolised a step to reaching the target of putting 15 million people on ARV treatment by 2015.

MSF staff and participants told invited guests and journalists about their personal and professional challenges to overcoming HIV and called on global leaders to honor funding commitments and Southern African presidents to lead the HIV/AIDS fight.

View the Intervalo! album on our Facebook page: http://on.fb.me/qjxhd7


Mozambique © Alain Kassa

Watch MSF teams battling a deadly combination of measles and acute malnutrition in Mogadishu
www.msf.org.za/publication/somalia-measle-vaccination-and-malnutrition-mogadishu

NO TIME TO WASTE IN MOGADISHU

Somalia has suffered 20 years of conflict, a desperate lack of development and the most basic of services. MSF has been working uninterrupted in Somalia since 1991, and with the onset of the nutritional crisis, has also been responding to the growing needs of hundreds of thousands of people displaced by hunger and violence to Mogadishu – this despite harsh restrictions by armed groups which is preventing aid from reaching people.

In August, MSF Emergency Coordinator David Michalski and Field Coordinator Said Hassan set up new activities in Mogadishu, which have since seen medical teams treating over 6,000 children in MSF therapeutic feeding programmes and 40,000 children vaccinated against measles. Here David and Said describe the humanitarian situation and the initial steps MSF took.

David Michalski: I arrived in Mogadishu with two colleagues on 31 July and immediately we began to look at the situation in the IDP camps. They are everywhere in Mogadishu, some with just a few families and some with hundreds of families. Most of the vacant land in Mogadishu has been taken over by these densely-crowded camps.

Said Hassan: Just walking down one of the streets you can find 30 or 40 crowded camps of small makeshift huts. There isn’t even space to walk between the shelters. Some camps have latrines, but the majority don’t. During our visit to the camps, we were told that a lot of people are outside begging because they don’t have enough food to eat or anything to sleep on or in. In the camps you always see some people who are so sick they are just lying on the ground.

People are flocking to Mogadishu because of the drought, as their animals have died and they have nothing to live on. For many of them, the food that international agencies are sending to Somalia has not been reaching them, because they live in areas where the aid hasn’t gotten through.

Michalski: We immediately saw three main priorities for MSF. We found a large number of people with measles, so we commenced a treatment and prevention programme along with the distribution of relief items like plastic sheeting and soap. There are a lot of people – mainly very sick children – who are malnourished, so we’ve opened feeding centres and a stabilisation centre where the most malnourished are being given around the clock nursing supervision.


Somalia © MSF

We are also focusing on acute watery diarrhea and cholera. We had a number of positive cholera tests, and we’ve certainly seen a lot of acute watery diarrhea and dehydration among patients. So we have set up a cholera treatment centre to deal with this. The needs are really massive.

Hassan: This is an emergency situation and we need to move very fast. There is no time to waste.

Michalski: As soon as we saw what the situation was like, we were able to get supplies in. We brought in material from our base in Nairobi, and our supply centre in Brussels also flew in two full airplanes of supplies. Nevertheless, it is difficult to have a global overview of the situation in Mogadishu due to security constraints that restrict movement.

Looking forward, I think MSF is going to be faced with some major challenges here. The situation is quite bad and for the foreseeable future it probably won’t get better. The harvest has failed and the outlook for the coming months is bleak. The scale of needs and the fact that the situation will likely worsen is very worrying – as is the security situation, which is extremely volatile and is hampering the delivering of aid, just as it has for the past 20 years. We have to keep working to ensure we are getting help to people in need.

MSF has worked continuously in Somalia since 1991 and currently provides free medical care in eight regions. Over 1,400 Somali staff, supported by approximately 100 staff in Nairobi, provide free primary healthcare, surgery, treatment for malnutrition, as well as support to displaced people through healthcare, water supply and relief items distributions in nine locations in south and central Somalia. MSF is also providing medical care to Somali refugees in Kenya (in the Dagahaley and Ifo camps) and Ethiopia.

ELIMINATING MOTHER TO CHILD TRANSMISSION OF HIV – LOOKING AT BETTER OPTIONS


Zimbabwe © Kenneth Tong

Donela Besada, Advocacy Manager, MSF in South Africa and Lesotho

Of the 410,000 infants estimated to have been newly infected with HIV globally in 2010, virtually none came from developed countries. Developed countries have nearly eliminated transmission of HIV from mother to child through comprehensive Prevention of Mother-to-child Treatment (PMTCT) programmes while in developing countries, especially sub-Saharan Africa, transmission remains very high. Here most of these children get the virus from their mothers during pregnancy, during delivery or while breastfeeding.

In North America for example, pregnant women with HIV are automatically given highly active anti-retroviral treatment (HAART) for life. By contrast, developing countries have far less resources to do this and consequently high infection rates persist.

There is now global commitment expressed by the Millennium Development Goals that no new children should be infected with HIV by 2015. Research shows that infant HIV infection can in fact be prevented. But the question remains: how to achieve this in places where resources are very limited?

In South Africa, which has the highest number of people living with HIV/AIDS in the world – around 5.6 million people – 30% of pregnant women are HIV-positive and nearly 40,000 children are infected with HIV every year.

South Africa's PMTCT programme started in 2002, with an approach called 'Option A', where a single antiretroviral (ARV) drug is given to the mother from the 14th week of pregnancy and during labour, and also to the infant during breastfeeding to prevent infection. Nine years later, a national PMTCT survey found that as a result, overall transmission rates had dropped to 3.5%. In Khayelitsha, for example, where MSF has worked with the Provincial Health Department since 1999 to pioneer models of HIV care, including PMTCT, the drop in infections was dramatic: from 12.5% in 2002 to just 2.5% in 2011.

Although the PMTCT survey results were widely celebrated at this year's International AIDS Summit in Rome, it also showed important differences in transmission across South Africa, where less well-off provinces like Mpumalanga and Free State report transmission rates of 6%. And this means effective policies need to be implemented especially in the most under-funded areas.

South Africa has now committed to reducing mother-to-child transmission rates to less than 2% by 2016. To achieve this it will mean stepping up its PMTCT programme significantly, increasing both the access to PMTCT and the level of care that pregnant women with HIV will get. These new steps are included in the National Strategic Plan (NSP) for HIV, AIDS and STIs for 2011 – 2016, to which MSF has recently given input.

Moving from 'Option A' to the more comprehensive 'Option B' in the new NSP has been widely discussed. 'Option B' initiation is guided by CD4 counts, which is the amount of HIV virus in the bloodstream. Women who have CD4 counts of 350 and above are given triple-therapy ARVs (or HAART) during pregnancy and up until one week after breastfeeding stops. Those with CD4 counts below 350 are put on HAART for life. The benefits of HAART over 'Option A' are considerable. A three-country trial that compared the benefits of a single ARV drug vs. HAART showed that HAART resulted in a significant reduction in HIV transmission from mother to baby and much better survival rates of both mother and child after birth.

Despite these advantages, MSF continues to push for the even more inclusive 'Option B+' – the same PMTCT treatment that is available in North America – meaning life-long HAART for all pregnant or breastfeeding HIV-positive women, regardless of their CD4 counts.

MSF believes the long-term benefits of 'ARV care for life' would far outweigh the initial extra cost. Firstly, 'Option B+' is simpler to put into practice and needs far less resources. Identifying HIV-positive pregnant women, monitoring their CD4 counts and measuring when to give ART and for how long needs effective health facilities and enough human resources – both of which South Africa has in short supply. But by putting a pregnant woman with HIV on a continuous treatment plan (Option B+) means she can be managed like all adult HIV patients, in a way that is simpler and encourages her to stick to the treatment.

Furthermore, stopping and starting ART encourages drug resistance, which means a higher risk of infection and early death. Considering that many women in developing countries have multiple pregnancies, many experts are now calling for continuous treatment so that subsequent pregnancies will also be protected from the start.

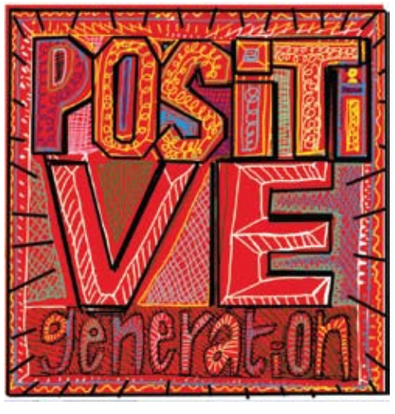
Finally, starting HAART earlier and keeping it up for longer also has much better outcomes for the baby.[1] Implementing 'Option B+' means the chances of HIV-transmission are even lower, both before birth and during breastfeeding. New mothers have the choice to exclusively breastfeed or formula feed, but in practice, due to a number of factors most HIV-positive mothers often do both, which is associated with a significantly higher risk of HIV transmission. However, it is well known that breastfeeding is incredibly important for helping infants to thrive and survive. And with the South African health department's recent recommendations for exclusive breastfeeding, even for HIV-positive mothers, Option B+ would therefore be the most sensible route.

[1]The Kesho Bora Study Group. 5th IAS Conference on HIV Pathogenesis, Treatment & Prevention. Cape Town, South Africa, 19 – 22 July 2009. Abstract LBPEC01.

Visit www.positivegeneration.org for more information.

POSITIVE GENERATION GIVES A NEW BEAT TO LIVING WITH HIV

With music, life is easier and powerful messages spread faster



In December 2011 MSF launches *Positive Generation* – a new music and HIV project to raise awareness about living positively. In Zimbabwe where HIV/AIDS prevalence is high, MSF has 34,000 patients in antiretroviral care and runs support groups to keep people adherent to treatment.

In rural Tsholotsho these support groups have become choirs visiting communities to spread a message through song. Their songs are about treating and beating HIV and living a full life.

These simple songs bring hope to Zimbabwe's remote areas which have inspired *Positive Generation* – a group of international and African musicians who have recorded exclusive songs to spread the message further. Spanish singer, Alejando Sanz, leads the Positive Generation group, which includes: Oliver Mtukudzi, Femi Kuti, Chiwoniso, Estelle, Youssou Ndour and Andy Garcia.

The music will be available for download from 1 December to celebrate World AIDS Day.

Read the report: www.msf.org.za/publication/making-switch-ensuring-access-improved-treatment-severe-malaria-africa

MALARIA: THE CASE FOR MAKING THE SWITCH TO ARTESUNATE

For decades quinine has been the main drug used in the battle against severe malaria across sub-Saharan Africa and other endemic regions. Now there is a newer treatment available to fight the severe form of the disease which claims 800,000 lives each year.

The medicine is called artesunate and has recently been found to be more effective, easier to administer to patients and causes fewer side effects than the standard treatment, quinine. Young children under the age of five are at much greater risk of dying from severe malaria, which is why MSF is keen to encourage African states to roll out the new drug targeting this age group with the newer medication in their malaria treatment programmes.

Earlier this year, MSF released a report called "Making the Switch: A more effective treatment for severe malaria for young children". The report explains why African governments should switch from the far less effective quinine to artesunate, and calls on donors to support governments so that this change can happen quickly.

DRC © J.B. Russel

Artesunate: more effective, safer and much easier to administer

In 2010, the results of a landmark clinical trial carried out in nine African countries pointed the way to a better treatment for young children suffering from severe malaria. Artesunate is a very powerful medicine that reduces the risk of death by nearly a quarter. It is also much safer than quinine, with fewer side effects and, perhaps most importantly, can be administered by injection not infusion – when the drug is dissolved in a glucose solution and given through the vein in a drip – as quinine is normally given.

MSF paediatrician Dr Anja Juncker explains how this could really open up access to better treatment for severe malaria.

"Giving quinine infusions to a small child can be very tricky and difficult. Even when the drip is given properly, each quinine infusion takes four hours and you need three infusions a day. It's a very skilled task to accurately monitor the dosage of quinine that each patient is receiving through the infusions over a 24-hour period. In remote health centres these skills are often not available. A wrong dosage can cause the patient to experience a wide range of side effects – dizziness, hearing loss, vertigo, nausea and vomiting. And if the patient doesn't get enough of the drug, the malaria parasite will not be wiped out.

"By contrast, the artesunate injection takes just four minutes and delivers the exact dose of medicine to the patient. The time needed to give the correctly administered medicine is reduced from four hours to just four minutes! This is a huge difference for the staff taking care of a patient. For young children with malaria this is much better – they get one injection and it's all done in four minutes, rather than having to lie completely still for hours.

Malaria

Uganda © Brendan Bannon

"Because artesunate is easier to administer and monitor, it means that it could be made available in remote health centres so patients don't have to travel great distances to hospitals to get time-consuming treatment."

Malaria Facts and Figures

1. Malaria is the leading cause of death in African children – every 45 seconds, a child under 5 dies of malaria in Africa – that's 600,000 children.
2. World-wide, malaria kills 1 – 2 million people – 90% of which are in Africa – and affects around 225 million yearly.
3. Malaria-related illnesses and deaths cost Africa's economy around US$12 billion every year.
4. People living with HIV/AIDS are also more susceptible to malaria – a huge concern in sub-Saharan Africa where 22 million people live with HIV.
5. In 2010, MSF treated nearly one million confirmed cases of malaria in around 30 countries world-wide.

Making the switch to artesunate a reality on the ground

The scientific and medical case for bringing in artesunate as the main treatment for severe malaria in young children has been forcibly made. Now the battle starts to get malaria endemic countries to adopt artesunate into their malaria treatment guidelines. But old habits die hard and some countries in Africa, some of which have stockpiles of quinine laid up for years to come, still need persuading that artesunate is better than the treatment they have used for decades.

Nathan Ford, medical coordinator for MSF's Campaign for Access to Essential medicines thinks it's a battle that can be won: "This switch to artesunate is a very precise intervention that could save 200,000 lives a year. It's not going to be an expensive policy change – it's estimated that it will cost around US$30 million per year to implement – as long as there's clear international weight put behind the change from the World Health Organisation," he says.

Watch Jonathan Whittall, speaking about the migrants trapped in the conflict
http://www.msf.org.za/publication/aljazeera-foreign-migrants-risk-libya

SOUTH AFRICAN MSF STAFF ON THE FRONTLINE

"Almost all of the hospitals in Tripoli are receiving wounded"
Jonathan Whittall

"I felt deeply connected with their stories"
Dr Mohammed Dalwai

Libya

Libya © Niklas Bergstrand/MSF

On the eve of anti-Gaddafi forces making their final advance on Tripoli Dr Prinitha Pillay, President of MSF South Africa, and Jonathan Whittall, MSF South Africa's Humanitarian Advisor arrived in the capital on July 31 to conduct a three-week assessment of medical facilities in the midst of the conflict. While MSF had already been working mainly in eastern Libya since February – including Misrata, Zintan, Yefren, Al Zawiyah, Zlitan, and Benghazi – previous attempts for MSF to set up programmes in Tripoli were unsuccessful.

By mid-August, medical supplies had arrived in Tripoli and Jonathan was coordinating a three-person medical team to support facilities that are now overwhelmed with patients wounded in the fighting. Speaking from Tripoli in late August, Jonathan offers a snapshot of the situation on the ground.

What is the situation like?

What we're dealing with at the moment are health facilities in Tripoli that were already stretched even before the clashes erupted in the capital. Many foreign medical staff who worked in the health system had already fled Libya. And hospitals had shortages of medical supplies because of the sanctions imposed on the country. The health system was already struggling to deal with the wounded coming from the frontline outside of Tripoli.

For the last three weeks, medical staff have been focusing almost exclusively on emergency cases and just haven't been able to deal with any other medical problem the population has faced, such as chronic diseases, emergency C-sections, and other medical conditions. The care really just hasn't been available.

What is the situation like in the hospitals you have been able to assess?

The hospitals that I've been to have been full of wounded – mainly gunshot wounded – in the emergency departments as well as the other wards. In one health facility that I visited, they had converted some houses next to the clinic into an inpatient department. For example, in the one house I went into, patients were lying on the floor, lying on the desks that were left inside the house and had been converted into a makeshift ward for patients. But because of the shortage of staff, there were no nurses and the patients were essentially caring for themselves. In another facility, I saw wounded people waiting outside the hospital to get into the emergency room.

Are there other obstacles to providing aid beyond the fighting?

The problem that's facing ambulances is that there's a massive fuel shortage in Tripoli. The fuel is not able to come in yet across from Tunisia. This is a big concern because the electricity supply is very sporadic, so generators are being used to run hospitals, but hospitals have quite limited reserves of fuel.

Has there been any let up in the intensity of the fighting?

Now it's quieter. Three days ago I wouldn't have been able to talk to you on the phone because of the constant gunfire and shelling outside. Today, the fact that I can speak to you without hiding behind a wall, is progress.

Cape Town doctor, Mohammed Dalwai, 28, worked in Tripoli for three weeks during August and September, shortly after MSF began their medical activities on the eve of rebel fighters overrunning the Libyan capital. Here Mohammed describes the role of MSF teams in dealing with medical shortages and treating desperate migrants trapped in the fallout of the recent conflict.

"By the time I arrived in Tripoli on the 25th August, things had changed since our first assessment. We had first seen a chronic lack of drugs and medical staff during the fighting. Now hospitals were starting to function again and the medical staff was slowly returning. The biggest problem we found, however, was a backlog of patients waiting for surgery or follow-up care – here MSF could really help.

"A Libyan doctor allowed us to use his private clinic which had been closed during the fighting. We opened the surgery again, and trauma patients were referred to us. Most injuries were from gunshot or bomb-blasts, which Libyan doctors weren't used to seeing. This young boy [see photo on facing page] had been incorrectly fitted with an external fixator on his arm for a fracture – but the metal pins were in the muscle instead of the bone. He was screaming in agony when we moved his arm. Our orthopaedic surgeon was able to reset the fixator correctly.

"Our teams had also come across a group of about 800 African migrant workers – including Somalis, Nigerians and Sudanese – living in a derelict port under upturned boats. They had no water, sanitation, food or protection. We heard countless stories of abuse and intimidation by rebels who believed they were pro-Gaddafi fighters because they were African. It was an awful situation for them – stuck in dreadful living conditions but too scared to leave.

"We were the first international NGO to arrive and see what was happening. We started distributing clean water and set up a temporary clinic in a nearby building immediately. Most of the medical conditions we saw were related to poor hygiene – so a lot of diarrhea, skin disease and infections. Some had wounds that hadn't been seen to for days. There was a lot of psychological trauma too, so our psychologist started holding group counselling sessions. I met a man who had lost his wife and family, everything basically, including the will to live.

"However, because MSF is a medical organisation, we don't provide protection or security. So we wanted other organisations to get involved too. Bringing international attention to this neglected group meant getting global media coverage – I did a number of interviews and shared the stories of the migrants I had met. I felt deeply connected with their stories."

Libya © Ron Haviv/VII

MSF teams continue to provide medical support in Libya.

In Tripoli, medical consultations and water distribution continue for around 1,200 migrants in two locations, as well as orthopaedic surgery in Ben Ashour clinic. In the east of the country, MSF provides surgical support in two hospitals in Misrata, as well as staff and material support in two others. In Benghazi, patients requiring reconstructive surgery are being referred to an MSF-run hospital in Amman, Jordan. In Zintan and Yefren, MSF is delivering staff, medical supplies and equipment to several hospitals. MSF is also providing psychological support to groups and individuals in most of the above locations.

SOMALI CRISIS – DISPLACED AND DESPERATE

Drought and conflict force Somalis to flee into Kenya and Ethiopia.

These mostly semi-nomadic shepherds and small-scale farmers – and their families – waited as long as they could for rains that never came. Further propelled by the ongoing conflict and climbing food prices, thousands have streamed into already overflowing refugee camps in neighboring Kenya (Dadaab) and Ethiopia (Liben). In one week in September, nearly 7,000 Somali refugees arrived in Dadaab, the world's largest refugee camp.

In Somalia itself, camps for the displaced are popping up as people try to reach help. Almost a million Somalis have flooded into the capital Mogadishu in recent months, many from the southern regions that were worst-hit by drought.

In response, MSF has scaled up their activities to respond to rising levels of malnutrition, as well as diseases like cholera and measles that come from a lack of access to healthcare, food, clean water and sanitation.

1. Liben, Ethiopia: Somali refugees line up at an MSF clinic in Kobe camp in Liben on the Ethiopian border. It takes up to twenty days to reach the border. MSF assesses the health of refugees as soon as they arrive to transfer the most serious cases to health centres.

2. Liben, Ethiopia: A Somali mother holds bags of therapeutic food, flour and a blanket distributed by MSF . Additional food is given out so that the therapeutic food for a malnourished child is not shared out with other siblings or other members of the family. 55% of children under the age of five who arrive at the Liben camps in Ethiopia are malnourished.

3. Dadaab, Kenya: Somali refugees carry their sick and malnourished children to an MSF feeding centre on the outskirts of one Dadaab's three sprawling refugee camps.

www.msf.org.za/publication/dabaab-kenya-somalis-fighting-survival

4. Dadaab, Kenya: A man digs the grave of a 35 year old female refugee from Somalia. She arrived 2 months ago at Dadaab refugee camp after a 290 km journey from Somalia. She is survived by her five children.

5. Dadaab, Kenya: An MSF doctor examines the mother of a malnourished Somali child in MSF's therapeutic feeding centre in one of Dadaab's refugee camps. The woman was diagnosed with measles. Many of the adult Somali refugees were nomadic and may not have been immunised during childhood.

6. Mogadishu, Somalia: MSF doctors and nurses examine displaced Somalis in a makeshift clinic in the Howlwadaag district. Due to lack of access to healthcare, food, clean water and sanitation, thousands are now highly vulnerable to multiple diseases.

7. Galcayo, Somalia: Children eating a nutritious paste called Plumpy Nut, distributed in an MSF feeding programme.

8. Liben, Ethiopia: Bokolmayo camp is one of the longest running camps, set up in 2009. Although it only has a capacity for 20,000 people, it is currently sheltering double this amount.

www.livinginemergency.com/

LIVING IN EMERGENCY

Stories of Doctors Without Borders

'Living in Emergency' is a critically acclaimed, no-holds barred documentary about MSF at work. Filmed in multiple locations in 2005, the film was launched in 2007. Already screened widely throughout Europe and North America, it was shown for the first time in South Africa recently at Johannesburg's independent cinema, The Bioscope. We welcome requests for further screenings, so please contact Kate Ribet, Communications Officer on kate.ribet@joburg.msf.org for further information.

Review taken from: Variety (www.variety.com)
By Ronnie Sheib, June 1, 2010

"Living in Emergency," is director Mark Hopkins' documentary about humanitarian health organisation MSF, concerns itself less with the NGO's salutary effect on communities than with the tremendous toll on the borderless MDs, who must address constant suffering with inadequate facilities. With rare candour and a refreshing lack of piety, first-timers and combat-weary veterans exhibit their camaraderie, euphoria and burnout as the camera documents their struggles with logistics, horror, death and self-doubt.

Hopkins was granted unique access to the Nobel Peace Prize-winning French organisation, which had hitherto refused in-depth coverage. And Hopkins rises to the occasion by refusing to make a heroic feel-good film about saving the world one life at a time. Instead, he zeroes in on two countries: the Congo, still mired in a protracted war, and Liberia, undergoing the after-effects of its finally resolved civil conflict.

Hopkins focuses on a cast of four doctors: Tom Krueger, a Tennessee surgeon on his first assignment; Chiara Lepora, an Italian toxicologist in charge of the mission in Monrovia, Liberia; and two Australians – Congo-based Chris Brasher, an anaesthetist in his ninth consecutive year of service, and Davinder Gill, a rookie stationed at a remote Liberian clinic.

Emergencies abound. With no means of X-raying the damage when treating a man arbitrarily shot in the head, a doctor bores a hole in the man's skull, despite having the wrong-sized drill bit, and is visibly astonished when the patient survives. Time and supplies are woefully inadequate, so life-saving procedures administered to select recipients necessarily spell death for those not chosen.

In the isolated clinic, night rounds and admissions are done by flashlight, and amputations by piano wire (Hopkins neither avoids nor dwells on surgical gore). Gill attends to unimaginable maladies with equanimity, only to break down over the shortage of sterilised gloves.

Relations with local doctors and nurses sometimes function smoothly, and sometimes teem with unresolved echoes of colonialism and cultural difference. Doctors can never feel godlike, or even content with their actions, when patients show up only after their conditions have become acute or terminal.

Several recent documentaries about humanitarian health groups, such as "Beyond the Call" or "Back Home Tomorrow," have loudly radiated messages of hope while capturing only mitigated triumphs over difficult odds. What distinguishes Hopkins' film is its immersion in the day-to-day pile up of impossible decisions that make any success fleeting and every mistake haunting.

Perhaps the hardest decision falls to Lepora, who must determine when to shut down Liberian operations: The immediate crisis may have passed, but no structure remains in place to care for the sick, leaving locals unprepared to take up the slack.

The more Hopkins accentuates the doctors' admitted foibles and shortcomings, the more his film resonates, particularly given his subjects' lack of puritanical moralising. The attractive Lepora openly confesses to the life-affirming importance of sexual intercourse, while Krueger chuckles over being asked whether he minded if his colleagues smoked an occasional joint.

Sebastian Ischer's camerawork captures both the beauty of landscapes and the menace of masked soldiers without undue lyricism. Bruno Coulais' excellent score unobtrusively revs up tension on the soundtrack, with well-chosen indigenous songs interwoven.

Watch: www.msf.org.za/publication/our-reality-photos-photojournalist-kate-holt

BACK FROM THE FIELD – KATE RIBET

Communications Officer, Afghanistan

Kate Ribet (33) is from East London, South Africa. Originally an acupuncturist, she later developed an interest in humanitarian work and communications. A Masters in Communication and Media from the School of Oriental and African Studies (SOAS) helped her along the way. She recently returned from 14 months with MSF in Afghanistan, and is now Communications Officer for MSF South Africa.

What was your position in Afghanistan and what did it entail?

I was a Field Communications Officer – which means I was working and living with the operations team in Kabul, and travelling out to see the MSF projects, then in east Kabul and Helmand province. Initially, my task was to research and develop relations with Afghan media to explain who MSF is and what we were doing in Afghanistan. For this I hired an Afghan assistant to help me. I also produced material about MSF projects for our websites and publications. Later, because Kabul is packed with international news bureaus and correspondents, I started arranging media visits to projects and interviews with MSF staff.

What are the issues that define MSF programmes in Afghanistan and that teams have to deal with?

Security is a vital concern, and linked to that, the difficulties people face in accessing medical care. To avoid the dangers of roadside bombs or attacks, MSF doesn't travel by road. Our staff work in hospitals in major towns instead. But despite our best efforts it still means we often can't reach those most in need, and they can't get to us because it's too dangerous. Maintaining our neutrality is also crucial – it's a war and nothing we do must be seen to support either side of the conflict. This is critical for our staff and patients.

What were the most vivid experiences of your time in Afghanistan?

Sitting on the roof of an ancient Afghan fort watching the sun set over a dusty Kabul rates among the best. On the negative, watching a little boy in Boost hospital, Helmand province, with advanced septicaemia hallucinate about buying an ice-cream with his friends. He'd been on the back of a motorbike with his father and two siblings when they hit a deadly IED (Improvised Explosive Device). As the only survivor, he had horrific injuries that had essentially been stapled up. His mother sat in a corner watching him, weeping uncontrollably.

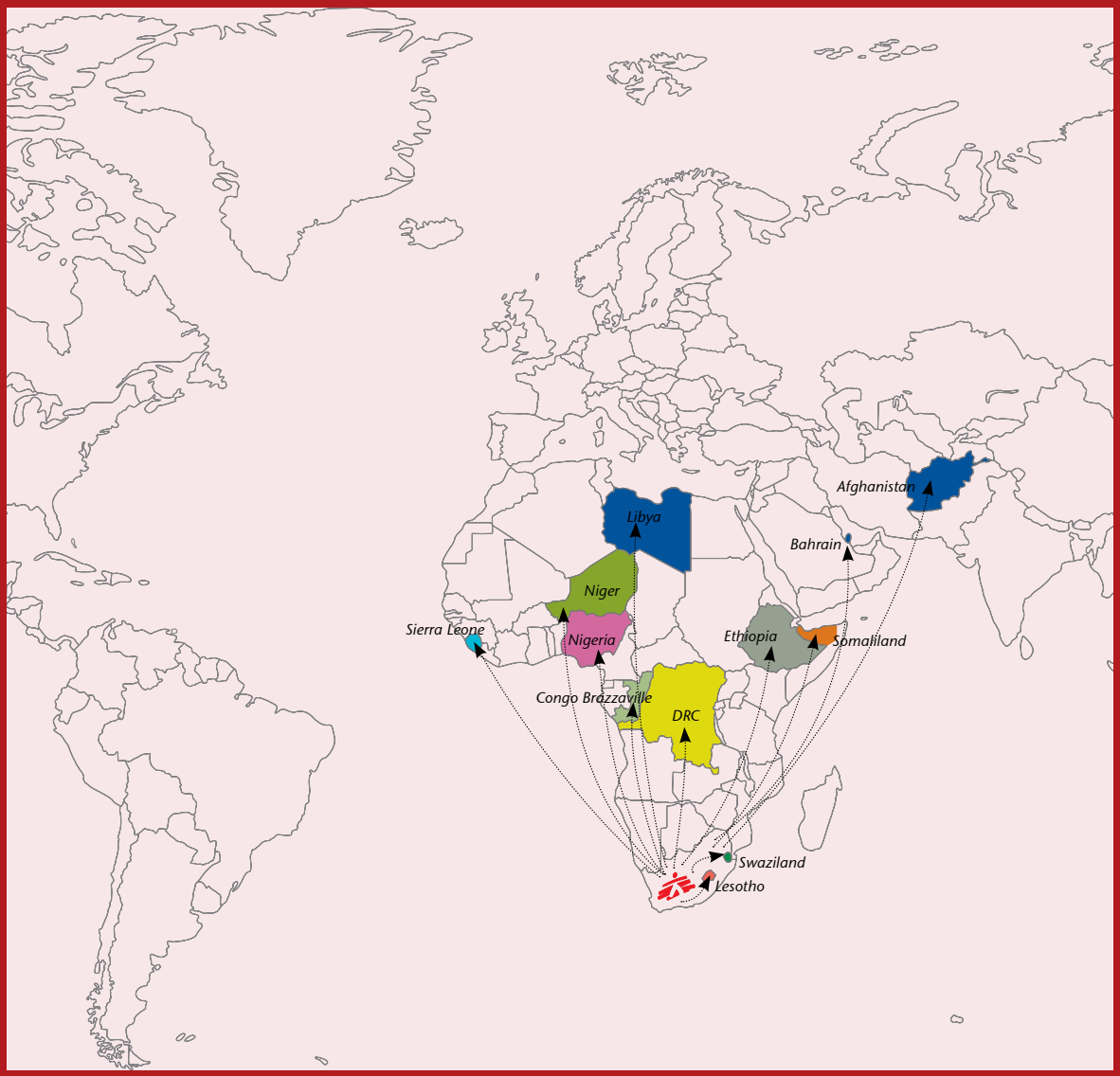
Working in Afghanistan presents fundamental challenges to MSF's principles of neutrality and impartiality as well as people's right to access medical care. How did these values drive your communications work?

Words are incredibly powerful tools, particularly in a conflict setting. I learned to avoid politically loaded words, like "terrorist", and write in a way that didn't give opinions – unless it was about the right to unhindered care. One important lesson was about the word "civilian": MSF doesn't distinguish between those who fight and those who don't – we simply treat those who need help the most.

People who take up MSF missions in Afghanistan are very concerned about security. What was your experience of this?

MSF takes security incredibly seriously. I'd say we're at the very conservative end of the risk management scale when it comes to rules and restrictions. Every risk is assessed and nothing is taken for granted. We also have a strictly "No Guns" policy in our hospitals, offices, cars and homes which I personally felt safer with. That said, nothing is certain and you accept this risk when you agree to go.

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 2011

1. Mohammed Abdi Golo – **Somaliland** – Nurse
2. Marilize Ackerman – **DRC** – Financial Administrator
3. Garret Barnwell – **Somaliland** – Assistant Field Coordinator
4. Kokola Kabengele – **Congo Brazzaville** – Doctor
5. Virginia Kinyanjul – **Nigeria** – Nurse
6. Yashoda Manickchund – **Ethiopia** – Doctor
7. Sedi Mebalani – **Niger** – Nurse
8. Isabelle Munuagaju – **Swaziland** – Doctor
9. Patricia Nyoni – **Swaziland** – Nurse
10. Santhuri Pillay – **Sierra Leone** – Doctor
11. Natalie Vlahakis – **Lesotho** – Doctor
12. Jonathan Whittall – **Bahrain, Libya, Afghanistan** – Head of Mission, Emergency Coordinator, Field Coordinator