Médecins Sans Frontières / Doctors Without Borders (MSF) South Africa
Issue 9 Volume 4 March 2013

mamela

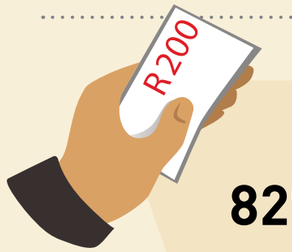
The first new TB drug in 50 years, bedaquiline may revolutionise the treatment of drug-resistant tuberculosis – if patients can get it

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

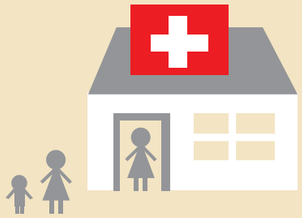
At a Glance...

How your donation works

More than 80 percent of every rand you donate goes right to where it's needed most. Here's how MSF does it



82% Operations



Logistics

Medicines

18%

Other expenses

Administration,
Communication,
Fundraising

Doctors

Materials

mamela

CONTACT MSF
Telephone: +27 (0) 11 403 4440/1/2
Email: office-joburg@joburg.msf.org
Facebook: MSFsouthafrica
Twitter: MSF_southafrica
Website: www.msf.org.za

For donor-related queries, please contact donor services at donorservices@joburg.msf.org or toll-free on 0800-000-031

facebook
www.facebook.com/MSFsouthafrica

twitter
www.twitter.com/MSF_southafrica

YouTube
www.youtube.com/msf

Editorial

What we don't know can hurt us

Little research and even fewer new drugs leave us unprepared to face drug-resistant TB

© MSF Access Campaign

South Africa has one of the world's highest burdens of drug-resistant tuberculosis (DR-TB). As the country continues to diagnose more cases using better, faster technology it's even more important to improve DR-TB treatment. This will mean newer, better drugs.

Internationally, only one new TB treatment, bedaquiline, has been approved in the last 50 years. This drug may play a role in improving DR-TB treatment, which currently takes about two years and includes months of painful injections and about 20 pills per day. Current treatment also has debilitating side effects including deafness, seizures and psychosis.

Along with allies, Médecins Sans Frontières / Doctors Without Borders (MSF) has spent the last decade pushing for more research and development of TB drugs.

Bedaquiline is a start. It will soon be available in South Africa through a special programme for a limited number of patients with no other treatment options. South Africa's national Medicines Control Council had also fast tracked review of the drug for possible use in the country as this magazine went to print.

Looking back

More than a decade ago, we fought to lower the prices of DR-TB treatment, an important step towards increasing diagnosis and treatment of DR-TB. Now, MSF has TB programmes in central and southeast Asia, Africa and eastern Europe. Back home, in Khayelitsha, MSF pioneered low-tech waiting rooms with plenty of natural ventilation to reduce airborne TB transmission. This approach has been replicated elsewhere in southern Africa and in some South African prisons.

More recently, MSF became one of the first organisations to pioneer community-based treatment for multidrug-resistant TB (MDR-TB).

Previously, MDR-TB patients in South Africa could only be treated in TB hospitals. With a limited number of hospital beds and waiting lists, this meant some people were dying before they began treatment.

Together with the South African Department of Health, we arranged for patients to be treated closer to home, helping retrofit people's homes to ensure household members didn't contract TB.

Khayelitsha has also been a pilot site for the roll out of new TB testing technology that allows for quicker diagnosis of DR-TB, increasing a patient's chance of being cured.

The future of TB

But even with these advances, the field of DR-TB is struggling to catch up after years of underfunding, neglect and a lack of research.

Drug-resistant TB (DR-TB) is resistant to at least one of the two most common anti-TB drugs

Multidrug-resistant TB (MDR-TB) is resistant to both of the most common anti-TB drugs

South Africa spends about R2.7 billion annually to respond to TB, which is less than half of what has been dedicated to, for instance, TB vaccine research globally.

Today, we're basing medical practice on experience rather than on empirical data from controlled clinical trials on DR-TB, which are scarce.

South Africa is currently home to 1,544 clinical trials – but only 37 of these are being conducted on TB, according to the South African National Clinical Trials Registrar. In a country where one in 20 people will die of TB, this ratio is unacceptably low.

MSF strongly supports the idea of doing DR-TB clinical trials and we plan to work with specialists to ensure that new studies will be designed to benefit patients most in need in countries like South Africa and Swaziland.

News from the Field

Vaccination rates in South Africa just don't add up

MSF and partners work together to set the record straight on vaccination

Malawi © Nabila Kram

South Africa is paying too high a price for poor vaccination rates and MSF rang the alarm at the first International African Vaccinology Conference in Cape Town.

The Department of Health claims 96 percent of South African children are vaccinated, but the World Health Organisation and UNICEF report that almost a quarter of South Africa's children go without the life-saving innoculations that prevent diseases like polio and measles.

"We want to see the same courage and leadership on vaccination that the Department of Health has shown in fighting HIV," MSF South Africa General Director Daniel Berman told the vaccinology meeting in November.

This low vaccination rate comes in spite of South Africa paying the developing world's highest vaccine prices. Imported vaccine prices are inflated because they are handled by a public-private partnership that levies at least a ten percent fee.

UN agencies say South Africa's child vaccination rate is lower than that of poorer Malawi

"Children are not receiving their basic vaccines and the costs are too high," Berman said. "It's time we have an honest discussion about the challenges."

Recently, the Health Department has called for a stop to subsidising local production through high prices. The department has instead urged the Department of Trade and Industry to offer direct support for real product development instead.

This approach has been successfully used in other countries including India.

Reunited – and it feels so good

Past, present and future MSF South Africa fieldworkers gathered in Johannesburg recently to share their experiences and learn what an MSF career offers those who work on the frontlines to save lives.

From surgeons to clinical psychologists, MSF fieldworkers help people in need in 65 countries around the world. In November, MSF SA hosted a two-day workshop with recruits from the region.

For our fieldworkers, the job doesn't end when they return from field assignments and neither does their relationship with MSF. MSF SA encourages fieldworkers' continued involvement in the organisation through participation in its members association, annual meetings and regular operational debates. We also encourage our fieldworkers to run for seats on the MSF South Africa Board of Directors.

Speaking at the gathering in Johannesburg, MSF SA Board President and former fieldworker, Dr Prinitha Pillay described what first prompted her to join the organisation:

"What appealed to me was that MSF was doing things ahead of everyone else. In MSF you have to be willing to stand up for someone else. For me, that's something very South African."

MSF tackles festive season emergencies

MSF responded to two local emergencies over the festive season, stepping in to save lives and support disaster victims.

In early December, MSF and the Treatment Action Campaign (TAC) received reports of drug-stock outs in the Eastern Cape after essential medicines, including those used for the treatment of HIV and TB, were not delivered to 300 clinics supporting up to 100,000 patients. The disruption was the result of a labour dispute that shut down the Mthatha medical depot.

MSF and TAC stepped in, setting up an information hotline and hiring temporary staff to ensure drugs were ordered, packed and delivered to prevent patients from interrupting life-saving treatment. The intervention averted a crisis that could have impacted thousands.

On New Year's day, fires raged through Khayelitsha, where MSF runs HIV and TB treatment programmes. About 700 households were affected and 3,000 destitute people sought shelter in a local community centre.

MSF provided people with relief items including soap, blankets and baby nappies. MSF teams also conducted a vaccination campaign.

MSF Donors

Run for MSF: One woman, one race, thousands saved

Do you want to support our field teams but you just don't have the cash? Become a fundraising activist

Photo courtesy of Anita Adendorff

Anita Adendorff (left) raised enough money to vaccinate 2,000 children against measles

If you tweet, update your Facebook profile or have your own Tumblr account, 'clicktivism' might be a new way for you to show your support for MSF. Freelance web designer and running enthusiast, Anita Adendorff, spoke to **mamela** about how her love of all things online led her to clicktivism – and to becoming an MSF fundraising activist.

Anita admits she was never athletic at school but, at the age of 24, she took up running. In 2011, seven years later, she decided to run her first Old Mutual Two Oceans Marathon, and paired her love of social media and running with supporting a good cause. Anita became an MSF fundraising activist on GivenGain – an innovative website that helps people raise money for their favourite causes.

Click•ti•vis•m
/klikte, vizem/

Noun
The use of social media and the Internet to advance social causes

Although she had donated to MSF in the past, Anita says a friend helped her decide MSF was the right cause for her to support.

"I'm always wary about which organisations I give to because you never know how the money will be spent," she says. "I had a friend who worked alongside MSF in Haiti so I asked him about the organisation and he was very positive."

So Anita visited www.givengain.com and became an activist with her own page on the site. She sent the link to friends via Facebook and Twitter, which made reaching out to friends, family and even strangers for donations easy.

"People are more comfortable with going to links shared by friends than getting random emails asking for money," Anita adds. "A lot of people don't give to charity , not because they don't want to, but because they think it takes effort."

"If you make it easy to give, people will," she says

Running for MSF also helped her stay motivated during hours of gruelling training along the trails of Stellenbosch's Jonkershoek Nature Reserve.

"You can't expect people to support you if you're not committed to training," she adds.

• Anita raised R3,000 – enough money to vaccinate 2,000 children against measles.

Become a fundraising activist today.
Go to www.givengain.com and search for "MSF"

Swipe and save lives

You can also support MSF SA just by going to the supermarket and swiping your FNB eBucks-linked bank card, or by using Pick n Pay SmartShopper or Woolworths My School cards.

To find out more, ask in-store or at your bank, or contact MSF South Africa donor services at donorservices@joburg.msf.org or 011 403 4440

MDR-TB in South Africa

When all else fails

The first new TB treatment in 50 years may be the only hope for some patients. Here's why MSF and others are pushing for access to this drug

Swaziland © Krisanne Johnson

Despite the tens of thousands of new cases of DR-TB diagnosed in South Africa annually, treatment options for the disease remain limited, expensive, and lengthy.

A new drug, recently approved by the US Food and Drug Administration for use in the United States, may offer these patients new hope – if they can get it.

The drug, bedaquiline, is still in late stage clinical trials but earlier trials have shown it to be safe and effective while reducing treatment time by more than half when added to MDR-TB treatment regimens.

Bedaquiline comes at a time when MDR-TB patients, who only have a 50 percent chance of being cured on current regimens, desperately need more treatment options, according to Dr Eric Goemaere, HIV and TB Advisor for MSF in southern Africa.

"Hopefully, this will be the first of several new therapies for use in combinations that dramatically increase the efficacy of TB treatment and shorten the time people have to undergo treatment," he said.

Current treatment for MDR-TB involves a two-year course of drugs and painful injections, some of which can cause serious side effects including hearing loss, psychosis and seizures.

Although some safety concerns remain, bedaquiline has fewer debilitating side effects than existing MDR-TB drugs and patients may be able to take the drug as little as three times a week instead of the usual daily doses.

Pushing for access in South Africa

Bedaquiline's maker, Janssen Pharmaceuticals, has also applied to register the drug for use in the European Union, although some patients there are already receiving the drug on "compassionate use" grounds. "Compassionate use" allows doctors to prescribe drugs not yet approved to seriously-ill patients who have no other treatment options.

In South Africa, MSF, the Treatment Action Campaign, Southern African HIV Clinicians Society and others have been asking the national regulator, the Medicines Controls Council (MCC), for access to the bedaquiline since July 2011.

During a brief period, the MCC granted such access to only four patients, including South African doctor Dalene von Delft who contracted MDR-TB while working in the public sector.

"As a physician, I knew the possible risks of the new treatment, but compared to the long and toxic alternative, I was glad to be able to take bedaquiline"

"I was faced with potential life-long deafness from my existing TB treatment, which would have meant an end to my career as a doctor, or slow death from TB," von Delft said. "When I heard about bedaquiline as a third option, I did everything I could to get it."

"As a physician, I knew the possible risks of the new treatment, but compared to the long and toxic alternative, I was glad to be able to take bedaquiline," she added. "I still have my hearing. I can still practice as a physician."

Now, the MCC has authorised limited use of bedaquiline through a clinical access programme in four sites where about 100 patients will be able to start bedaquiline and help provide doctors with more data on the drug's safety.

As of February 2013, the MCC had also fast-tracked review of bedaquiline for possible use in the country pending approval.

Five faces of TB

MSF projects worlwide show that TB knows no borders, class or ethnicity. Take a look at some of our patients and read their stories in their own words at **www.blogs.msf.org/tb**

Phumeza Tisile
South Africa

Diagnosed with MDR-TB in 2010

Mariam Davtyan
Armenia

Completed MDR-TB treatment in 2012

Lucky
United Kingdom

Diagnosed with XDR-TB in 2011

Athong
India

Diagnosed with MDR-TB in 2011

TB fast facts:

1.4 million people died of TB worldwide in 2011

R2.6 billion is spent on TB control annually in South Africa

R71 billion will be needed to respond to TB in low and middle-income countries from now until 2015

R27 billion - the annual funding gap for TB care and treatment globally

R18 billion - the current funding gap in TB research

Doctor turned patient

© Arne von Delft

Dr Dalene von Delft contracted MDR-TB as a doctor working in South Africa's public sector. After being initially misdiagnosed, Dalene started standard MDR-TB treatment and soon experienced the hearing loss that often accompanies this. Luckily, she was one of only four South African patients to access a new drug, bedaquiline.

Dalene shared her story with David Bryden, Stop TB advocacy officer with the health advocacy group RESULTS. Below is an edited excerpt.

"I developed a dry cough... I went for an x-ray myself. It was my first chest x-ray and I got the fright of my life - it was clearly TB (given) the setting I was working in. I went to the occupational health specialist at my hospital. He suggested I start (standard) TB treatment. I was concerned because I knew I'd been exposed to MDR-TB patients and I wanted to start the correct treatment.

"I then went to a private pulmonologist. Within 48 hours I had the correct diagnosis and could start the correct treatment, but this was done on a private medical aid - not in the system in place for public sector healthcare workers.

"Treatment started and it was brutal with injections and lots of side effects. I started developing hearing loss at two months. As a clinician in South Africa, you use your stethoscope quite often. If you can't hear, you can't use your stethoscope and you can't practice as a doctor. It was a constant stress. I kept asking myself, 'when will I completely lose my hearing?'

"Then we heard about bedaquiline. I was one of the lucky people that, during a short period, were able to get this drug. I took it for six months. I was grateful because I think it had a huge impact.

"It's been almost two years now and I've completed treatment and practice as a doctor again... but there are a lot of sad stories out there, a lot of people in my country are suffering."

To watch Dalene's full, unedited interview, go to www.action.org/blog

In Focus

Safe Delivery

One thing may stand between life and death for mothers in Sierra Leone

Globally, almost 300,000 women die during childbirth every year. They leave behind children who, without their mothers, are ten times more likely to die prematurely. In two African countries, MSF has found the key to drastically cutting maternal mortality: emergency obstetric care.

Experience shows us that at least 15 percent of all pregnant women worldwide encounter a life-threatening complication during pregnancy.

In a conflict or crisis, pregnant women are even more vulnerable because healthcare services have collapsed, are inadequate or non-existent.

But these women need access to quality emergency obstetric care whether they live in a conflict zone, a refugee camp, or under plastic sheeting after a devastating earthquake.

In fact, they need the same help that all pregnant women facing a complication need: access to appropriate medical assistance – skilled medical staff, drugs and equipment – to save their lives and the lives of their babies.

MSF makes it a priority to provide life-saving, emergency obstetric care in both acute and chronic humanitarian crises.

MSF has been providing this kind of care in Bo district, Sierra Leone since 2008 – two years after we began helping mothers in Burundi's Kabezi district.

Both countries share a history of civil war that ravaged healthcare systems and contributed to extremely high maternal mortality rates.

By providing emergency obstetric care, MSF has decreased maternal mortality in these districts by up to 74 percent.

Take a look at life inside MSF's wards in Bo district through the lens of photographer Lynsey Addario.

"If we have a patient who is in very critical condition, you have to rush to save that life. And the roads are very bad. Sometimes it takes two hours to get to where they are, and the patient is almost about to deliver."

- Foday Kpaka, MSF ambulance driver

R18

how much it costs to save a mother's life in Bo, Sierra Leone

"It's completely different here from the United States, where I come from. Most of the cases are much more severe, urgent and life-threatening. If MSF were not here, many of these women who come to us every day would be dead."

- Betty Raney, obstetrician

Voice from the Field

Clinic deep in the bush: Saving lives in South Sudan's most violent state

South Sudan © Robin Meldrum

MSF clinical officer David Bude examines a patient

MSF clinical officer David Bude works in a remote outreach health clinic in the south-east of South Sudan's violence-plagued Jonglei State. When fighting erupted in August 2012, David fled with many others and used his medical skills to save lives. This is his story

"We ran... when there was shooting. I was frightened and so was everyone else, because of what we had seen – because of the dead people. I said to my wife: 'If we stay, we will also be killed. It is better to run to the bush because we know where we can hide ourselves.'

"We ran, all of us, with our children and families. We didn't have time to take any food, or even any clothes or any medicines. Everything was left behind.

"We were deep in the bush, thick grass and undergrowth everywhere. The area was flooded and most people were without shelter but some had plastic sheeting.

"When it rained, these people would ask other people's children to come sit under the sheeting. People were helping each other because we were all there in the bush together."

Clinic under the tree

"I chose a big tree with plenty of shade and cleaned underneath it. I had a plastic sheet and I gave it to my wife to make a sort of rough shelter... and I made a wooden platform, like a rough bed, to keep the medicines off the ground. This was my pharmacy.

"We cut some poles to make benches, so there was a waiting area and a consultation 'room.'

"We got a message to the MSF base team in a nearby town about where we were, and they sent medicines, rapid malaria tests and dressings by boat as far up the river as they could. They even sent registration cards and a register for keeping proper records.

"Two of the health promoters from my MSF team went around passing along the message to people hiding in the bush to come and see us, and they came.

"Sometimes I saw 50 patients in a day. Malaria, pneumonia, and paediatric malnutrition were common illnesses as was diarrhoea because there was no clean water. I kept going until the supply of medicines ran out in September.

"Then I went back by foot to the MSF base team. The floods had been so bad I had to swim. I walked and swam for two days to get to the teams. I made this trip twice.

"We saved lives. None of the patients I treated died... but this was in a remote place, so it is hard to know how many people died because they fell ill and couldn't come to be treated."

Fix the Patent Laws

High price of your pills hard to swallow?

© Sami Siva

A grassroots campaign called Fix the Patent Laws could change that

If you pay out of pocket for your medication, you probably know what generic medicines are because they are cheaper than brand name drugs, many of which are under patent.

Generic medicines are made up of exactly the same ingredients and work in exactly the same way as patented medicines. For example, both paracetamol and Panado will ease your headache and break a fever, but paracetamol will probably be cheaper at your local pharmacy than branded Panado.

The reason your pharmacist can dispense generic paracetamol is because the drug is off-patent, meaning that many different companies can make and sell it. So you can get paracetamol, Panado and Calpol – all the same drug just made by different companies.

But many other drugs are still under patent, making them expensive and keeping them out of South Africa's public sector.

This is because South African patent laws make it easy for companies to register patents for drugs they didn't invent and didn't even substantially improve.

Great for pharmaceutical companies' bottom lines, but bad for your pocket.

How easy is it to get a patent in South Africa? Very. South Africa grants almost every patent application it receives, making its patent system one of the world's most lenient. While pharmaceutical companies cash in, the government and patients pay the price. Governments spend excessive amounts of money on drugs instead of on improving healthcare while patients suffer as medicines like cancer treatments, some third-line antiretrovirals (ARVs) and DR-TB drugs remain out of reach for many dependent on state-provided healthcare.

Envisioned as a form of intellectual property protection, patents are typically awarded to companies who can prove their product is new.

Not in South Africa, say activists and researchers who claim that the country's lax patent system is allowing pharmaceutical companies to get and extend patents on drugs based on immaterial changes to medicines – like the changing of a pill's colour or adding table salt to a formulation.

The current patent system approves patent applications as long as companies do the paper work and pay the fees, but does not examine the merit of many patent applications.

A study by the University of Pretoria found that 80 percent of patents in South Africa would not have been granted if the country actually interrogated patent applications properly.

With this kind of patent protection, competition is eliminated and drug prices stay high - putting medicines out of reach for South African patients. Third-line ARVs – all under patent - can cost about R 35,000 per patient per year in the private sector.

This high cost means that thousands of patients in need of some of these drugs of last resort have to go without because the public sector can't afford them.

Meanwhile, as many as 27,000 cases of MDR-TB are diagnosed in South Africa annually. One of the few drugs available to treat MDR-TB, linezolid, costs about R22,000 per month of treatment due to patent protection.

MSF and the Treatment Action Campaign are asking government to fix the patent laws because medicines shouldn't be a luxury. To find out more about the campaign, go to www.fixthepatentlaws.org

What is a patent?

A patent allows a company exclusive rights to produce and sell whatever has been patented, from medicines to kinds of seeds, without competition for a 20-year period. Ideally the system helps reward companies who have invented something new or substantially improved a product.

Portions of this article were first published on IRIN/PlusNews, www.plusnews.org

Afghanistan

A return to Khost

Months after an explosion rocked MSF's maternity hospital in Afghanistan's turbulent Khost province, our teams return

MSF medical teams, including three South Africans, have returned to the Khost maternity hospital months after an explosion injuring several people forced MSF teams to leave.

The April 2012 explosion occurred just six weeks after MSF began working at the 56-bed hospital. By then, our team had already delivered 600 babies.

At the time, MSF said teams could not return unless local leaders assured MSF that its medical activities, and the security of its patients and staff, were respected.

The decision to restart medical services followed a meeting between MSF staff and leading community members.

Photo courtesy of Zani Prinsloo

MSF South Africa fieldworker and midwife Zani Prinsloo and her team in Khost have delivered more than 880 babies in one month. This is her first mission with MSF.

This included representatives from all Khost districts, prominent religious figures and scholars who expressed support for MSF provision of maternal healthcare.

"We are re-opening the hospital because of the overwhelming messages of support we received from the community," said Benoit De Gryse, MSF Country Representative in Afghanistan.

"We have been reassured that our patients and medical staff will be safe inside the hospital," De Gryse added.

"This makes it possible for our teams to resume providing free, high-quality medical care for pregnant women, particularly those suffering from complications and those who cannot pay for treatment," he said.

Healthcare under fire

Decades of conflict in Afghanistan have taken a toll on the medical services available.

In the absence of local, public healthcare facilities, many people face long and dangerous journeys to reach hospitals. For those who can't make such trips, private clinics are often the only option, however these clinics are too expensive for most people and quality care is not guaranteed.

The 2012 opening of our Khost project was part of a significant expansion of MSF programmes to meet the Afghan people's medical needs.

MSF teams also work in Ahmad Shah Baba Hospital in eastern Kabul and in Boost Hospital in Lashkar Gah, Helmand Province.

We also run a surgical trauma centre in Kunduz, providing life-saving surgical care to people in northern Afghanistan.

Because of the highly politicised nature of the conflict in Afghanistan, MSF relies only on private funding in Afghanistan and does not accept money from any government for its work.

This maintains our independence and allows us to work in some of the country's most volatile areas.

In all locations, MSF provides medical care free of charge.

Afghanistan

Meeting the medical needs

From war-wounded to newborn babies, here's a snapshot of MSF's work in Afghanistan

Kabul

The number of people living in Kabul has tripled over the past decade as tens of thousands of displaced people flee more insecure areas for the capital and returning refugees resettle in the city. This has put a severe strain on health services. Ahmad Shah Baba, in eastern Kabul, has a growing population of between 200,000 and 300,000 inhabitants. MSF started working in the district hospital in 2009.

MSF staff work in all hospital departments and have focused on improving the quality of, and access to, free medical care with a particular emphasis on maternity and emergency services.

In 2011, new female and paediatric outpatient departments were built. Some 550 babies are now born at the hospital every month while the outpatient department sees an average of 9,000 patients monthly.

Helmand

Helmand province continues to be one of Afghanistan's most volatile, and its one million inhabitants are among those most affected by conflict. MSF started working in Boost hospital, in the provincial capital of Lashkar Gah, in 2009. It is one of only two functioning referral hospitals in southern Afghanistan.

The team at Boost has improved the provision of medical care across the various departments, including maternity, paediatrics, internal medicine, surgery and emergency care.

By the end of 2011, the hospital was equipped with 180 beds and admitted an average of 1,500 patients per month – ten times the monthly figure in 2009.

Kunduz

In August 2012, MSF opened a new surgical hospital in the northern province of Kunduz. This is the only hospital of its kind in northern Afghanistan. Before the hospital opened, patients in need of treatment had to undertake a long, expensive journey across the border into Tajikistan.

The staff in Kunduz provide surgical care for victims of conflict as well as patients with injuries from other causes. Staff also include a full-time physiotherapist who follows up patients and helps with their rehabilitation after surgery.

MSF SA Fieldworkers in Afghanistan

Jeanne "Zani" Prinsloo, midwife - Khost

Originally from Graaf-Reinet and Witbank, Zani's no stranger to working abroad after spending years working as a midwife and training others in the Middle East. On her first assignment with MSF, here's some of the things she's learned while working in Khost.

1. Sleep is a luxury
2. MAC mascara is still the best and can last 36 hours plus
3. There are at least 50 baby girls in the area with my name (And yes, I mean they have "Zani" on their birth certificates)
4. Team work can accomplish anything. Even if we differ, we listen to each other
5. I've become a choc-aholic and Danish cheese addict
6. Even with limited knowledge of the local language, Pashto, I can get a 30-person team to work together
7. Two midwives can deliver 20 babies in four hours, handle post-partum complications, clear the room and be ready for the next patient
8. I am able to do much more than I thought I ever could
9. When things get tough, take a deep breath, smile and go on
10. Saving mothers and their babies is by far the most amazing thing I have ever done
11. This list is getting a bit long now – so in a nutshell, I love every day

Adeline Oliver, operating theatre nurse – Kunduz Province

After a long career in the public sector — including working in Johannesburg's Rahima Moosa Hospital — Adeline is on her third assignment with MSF and has worked exclusively in conflict areas. She returned to Afghanistan for the second time in early January 2013.

"My friends think I'm mad. I quit my job in South Africa to work with MSF because I needed to do something different. This is something I've always wanted to do. I've always wanted to find a way to give back meaningfully in the developing world. Now, I have the opportunity to do just that."

Stefan Kruger, medical doctor – Kunduz Province

A University of Cape Town graduate, Stefan played an active role in the university's Students Health and Welfare Organisation, with whom MSF South Africa has a strong relationship. Stefan is now on his first MSF assignment working in our trauma centre in Kunduz, one of the country's most violent provinces.

Field Updates

Central African Republic: MSF expands emergency response

Central African Republic © Corentin Fohlen /Divergence

Renewed fighting and a rebel advance on the capital Bangui saw thousands of people take refuge in the bush to escape violence. MSF is extending its emergency response

On 10 January, MSF opened an emergency programme in the town of Damara on the frontline of the conflict between northern rebels and the government of President Francois Bozize. A ceasefire deal has since been signed, but fear still grips war-weary citizens.

The MSF team is providing basic healthcare via mobile clinics. Medical staff are treating up to 100 patients per day, mainly for malaria and malnutrition.

"The population of the Central African Republic already suffers from some of the worst health indicators in the world, and mortality rates are alarming even in times of peace," said Sylvain Groulx, an MSF coordinator in the country.

In late 2012, an armed rebel group threatened to march on the capital, Bangui. Following attacks on several towns in the country's north-east, a rebel alliance known as 'Séléka' reportedly halted their advance in early January on the capital and agreed to start peace talks in the Gabonese capital, Libreville, according to IRIN news.

"The recent instability has forced many people to leave their homes. An added burden is the fact that many local health facilities closed when medical staff fled into the bush," Sylvain said. "The few health posts that have remained open are either running out of basic essential medicines or worse, have been completely looted."

Mobile teams are regularly visiting seven health centres in Bangui and training staff in the use of rapid diagnostic tests for malaria and providing malaria drugs. Staff are also on standby, including a team at the Castor maternity hospital, ready to respond in case there is a need for emergency surgical support.

Several tons of medicines have been sent to health facilities that remain open in the areas around Grimari, Bria and Sibut.

Before this conflict, Central African Republic was already in a state of chronic medical emergency. The population has suffered from decades of violence, displacement and insecurity due to clashes between rebel groups and government forces, as well as armed bandits.

Access to healthcare is limited due to a lack of qualified medical staff, few facilities outside the capital city and frequent shortages of essential medicines.

Funding from international donors and aid agencies will likely shrink if there is no guarantee of a stable government or of security for aid workers.

MSF SA fieldworker, Sedi Mbelani, recently returned from an assignment in Kabo, about 500 km north of Bangui, the capital city of the Central African Republic. When fighting broke out nearby, many of the local health workers fled. MSF teams remained behind. This solidarity with people in need inspires Sedi to keep working for MSF, she says:

"My experience is that when everyone else leaves, we stay. That is courage, isn't it?"

Photo courtesy of Sedi Mbelani

Crossing Frontlines

Letter from the field

Gail Womersley
Clinical Psychologist

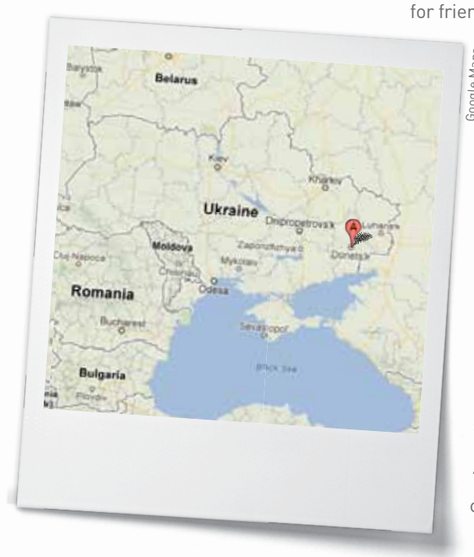
Assignment Location:
Donetsk, eastern Ukraine

Previous MSF Assignment:
Zimbabwe

Capetonian Gail Womersley has traded the sunny beaches of the Mother City to brave her first Ukrainian winter working in the country's prisons with TB patients. In between work and Russian lessons, she wrote home about what it's like to deal with TB behind bars.

"Three days a week, I work at the main prison in our district. When we go into the prisons, we each take a walkie-talkie, security pass, lab coat and protective facemask that must be replaced weekly to prevent possible TB infection.

"One of the biggest challenges is getting patients to adhere to long and often gruelling DR-TB treatment inside a prison. In general, prisoners are characterised by high levels of drug and alcohol abuse, and mental disorders. They also have poor social support structures.



Google Maps

"Many of our patients also have little hope for the future. It's challenging to motivate them to continue months of difficult treatment with often debilitating side effects when their future prospects seem very bleak.

"To tackle poor treatment adherence, nurses and psychologists work to ensure patients understand the importance of sticking to their medicines, and that patients are psychologically prepared to cope with the rigours of treatment.

"Many patients I deal with say their love for friends and family members motivates them to see their treatment through so they can get healthy again.

"We also run emotional support groups and health education sessions for TB patients. We are currently selecting peer educators who can help support fellow inmate patients.

"One of the hardest parts of my job is not being able to speak Russian. Words are a psychologist's tools and it is tough when you face a language barrier.

"I appreciate there is a lot of the cultural context that I cannot understand – and for this I trust our Ukrainian staff who have a deeper appreciation of our patients' lives.

"Being a prison psychologist is also tough because strict security protocols require us to see patients in their cell blocks, often in corridors or consultation rooms where many other patients are waiting.

"This makes it difficult to create a safe, private space for therapy. Infection control measures also require that patients with different diagnoses need to be separated to minimise the chances that patients who are on treatment but may still be infectious do not re-infect others.

"Furthermore, prison life here, as in many other prison settings around the world and in South Africa, means inmates abide by a strict caste system governing their social status. Therefore, it is often not possible to see patients of different castes together, which impacts how we approach our work in treating TB. All these things make our work harder.

"As prisoners, our patients are used to being treated as second-class citizens – many have no families and have fallen through the cracks of society.

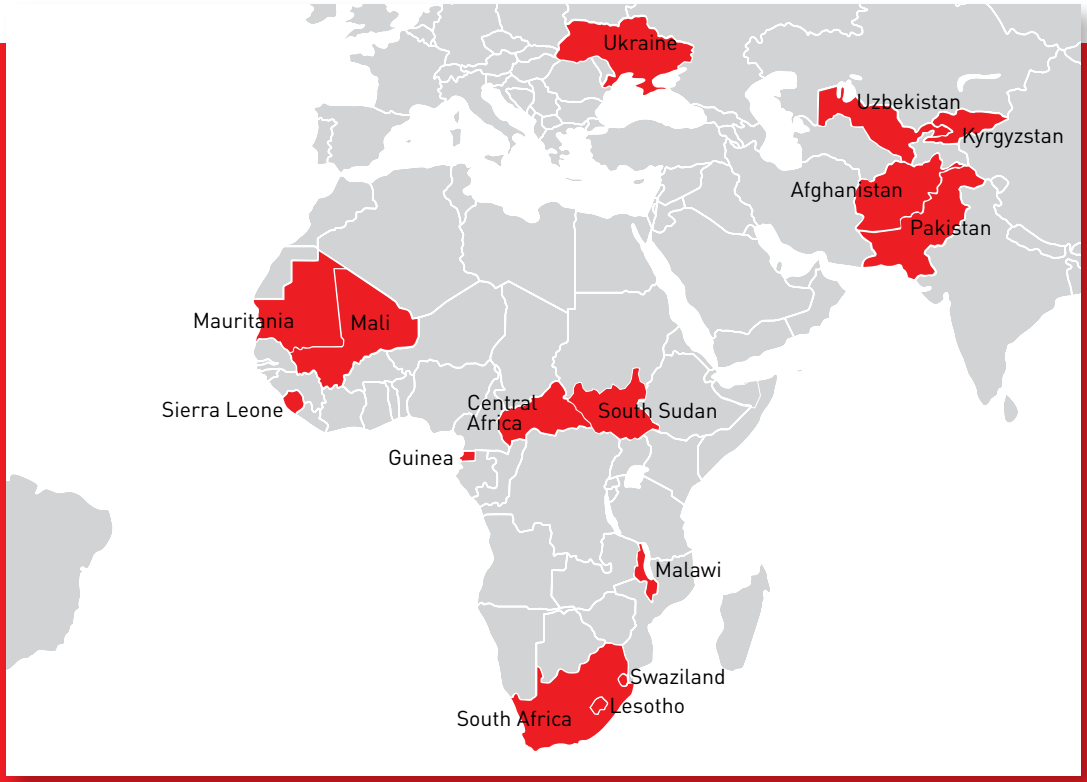
"It's always a privilege to see their reaction when we treat them with dignity. That alone shows me that we are making a difference in their lives – even before they start taking TB treatment."

MSF South Africa thanks all our fieldworkers for their enormous contributions to MSF operations worldwide. MSF always needs medical professionals, in particular doctors, surgeons, nurses, midwives, epidemiologists and laboratory scientists.

Are you qualified and interested or know someone who is?

Apply now at www.msf.org.za or submit CVs and motivation letters directly to recruitment@joburg.msf.org

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS



MSF South Africa: Recruits in the field

- Patricia Nyoni – Kyrgyzstan
- Tabitha Mutseyekwa – Uzbekistan
- Natalie Valhakis – Lesotho
- Bob Bushiri – Malawi
- Danca Paiva – Mauritania
- Sekai Chenai – Sierra Leone
- Nirav Patel – Somaliland
- Sedi Mbelani – South Sudan
- Alain-Godefroid Ndikundayi – Central African Republic
- Emilie Venables – South Africa
- Constant Mompayo – Mali
- Felicite Okambo – Guinea
- Monica Genya – South Sudan
- Guillermo Martinez – Malawi
- Gail Womersley – Ukraine
- Adeline Oliver – Afghanistan
- Jeanne Rene Prinsloo – Afghanistan
- Stefanus Kruger – Afghanistan
- Mohammed Dalwai – Pakistan
- Joyce Njenga – Pakistan
- Duncan Khedive – Yemen

One MSF SA fieldworker [name withheld for security reasons] is also currently working as part of MSF's medical activities to assist Syrians caught in the conflict.