MAMELA

Médecins Sans Frontières / Doctors Without Borders South Africa
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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Libya © Mattia Insolera

THANK YOU!

... for supporting MSF South Africa's Face-to-Face Fundraising teams

Thank you to all of you who have taken the time to stop and talk to our MSF Face-to-Face Fundraising representatives in shopping malls in Cape Town, Johannesburg, Pretoria and Durban about becoming an MSF Field Partner.

Every year Médecins Sans Frontières / Doctors Without Borders (MSF) sends thousands of medical and support staff to different countries where vulnerable people are in distress and without proper healthcare. Because not everyone can work in the field we recognise our monthly donors as Field Partners who make it possible to treat over 8 million patients a year.

Field Partners' monthly contributions go towards bringing vital emergency medical care and humanitarian assistance to people in the greatest of need.

Working among members of the general public every day, our representatives get to hear many different comments about MSF and the work our teams do. Here's a sample of the responses we've heard in recent weeks around South Africa:

"I heard about Doctors Without Borders on that M-Net drama, Binneland/Sub Judice. Is it a real organisation?

I thought it was something they made up for the TV series."

"The work that you do in emergencies all over the world is fantastic. I would love to become a supporter!"

Our knowledgeable representatives then explain that the work that MSF doctors and nurses do in over 60 countries depends on the support of private individuals, people like you and me, from around the world. All these monthly gifts enable MSF to remain independent from international political forces and to respond immediately during emergencies. It also means our teams can plan ahead for the period following disasters.

For our Face-to-Face representatives it is a reward every time a new Field Partner walks away from a conversation with a receipt, a Thank You card and a proud smile on their face. It is because they know that someone just made an important decision to get involved and they know what a difference their donation makes in the lives of the people MSF assists.

Sofia Svensson, MSF SA Project Coordinator Face-to-Face Fundraising

MAMELA

Get in touch with us:

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

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MAKING CHANGE HAPPEN

Dear Friends;

Circumstances change so rapidly and time passes very quickly when working for an organisation like Médecins Sans Frontières / Doctors Without Borders (MSF). This is often not the case for the people we serve. It is now well over a year since the Haiti earthquake. This was the biggest emergency in the 40 year history of MSF, and was compounded after a few months by the outbreak of cholera. MSF mounted a huge response to this double emergency. We are now moving on to a reconstruction phase. MSF's plans for building a large container hospital that will serve the people of Haiti for years to come are well under way. For ordinary people in Haiti the outlook is still grim. Despite the vast amounts of money both promised and raised internationally, many of them are still living in the same circumstances that they found themselves in a few weeks after the earthquake. The threat of a resurgent cholera epidemic became a reality in May.

It is because of these circumstances that we publish an article by MSF's International President on the failure of aid in Haiti. It is important that MSF not only helps people, but also speaks out about the failures we see, in the systems that should be helping them.

The events of the Arab Spring were a surprise but MSF was able to mount a rapid response, especially since we already had a program operating in Cairo, Egypt. These social conflicts occurred in different environments to those where MSF is used to intervening. Usually we find ourselves working in resource poor countries with few healthcare workers. In Egypt, Tunisia and Libya there are well trained local health workers eager to help their own people. MSF's role was to provide supplies and assistance where needed and to show solidarity with all victims of the conflict.

Of particular interest to South Africans is the situation in Bahrain. Here protesters are shot at with birdshot and if they come to hospitals for treatment, they are arrested for having been part of the protests – the same thing that happened in South Africa in the 1980s during apartheid. This is clearly a violation of the right to impartial healthcare. The outspoken article by Christopher Stokes, General Director of the MSF Operating Centre in Brussels, has brought this violation of medical ethics to the attention of the world.

A revolution of a different kind is taking place in the diagnosis of tuberculosis (TB). TB is the biggest killer of people living with HIV. One of the biggest problems has been diagnosing TB in HIV-infected people.

People living with HIV, whose immune systems are compromised, often have very few TB bacteria in their sputum – meaning that their TB cannot be detected using the 100 year-old technique of peering through a microscope to see the bacteria. A new diagnostic tool, GeneXpert, using the best new technology, is now able to provide a diagnosis – including whether the TB is drug resistant or not – in a matter of hours. This means people will start TB treatment much sooner and the death rate will decrease. The good news about the GeneXpert is that it is a robust little machine that can be used in very simple laboratories. MSF has rolled out the new machine in Khayelitsha clinics – doing what we did in the case of antiretroviral drugs (ARVs) to show that with commitment and ingenuity, the best international standards of care can be used in health projects to benefit poor people.

In Mamela we also give you a glimpse of our daily work – finding doctors and other health workers prepared to go to far off places to help run MSF projects together with the local staff of the country. They communicate to keep the plight of people living in poverty, often in conflict areas, in the mind of those of us who, by comparison, lead lives of unimaginable privilege. They advocate to make people aware of issues that are present in our own communities, such as xenophobia and the inhumane conditions under which people live in Johannesburg's slums. Without the support of our donors none of this would be possible so we also want to thank everyone who contributes to MSF's work.

Yours sincerely,

Liz Thomson.

Dr Liz Thomson
General Director, MSF South Africa

FIELD NEWS AND UPDATES FROM MSF SOUTH AFRICA

In Memoriam: Evans Tendayi Kuntonda

(15 July 1980 – 4 March 2011)

In March MSF South Africa was devastated at the news of Evans' sudden death. We lost a dear friend and colleague – a man whose passion for helping others inspired us and ensured that people marginalised and excluded in South Africa were not left without a voice or much needed medical care. Living through the most difficult times in Zimbabwe's recent history Evans' quest to improve the lives of his family, as for so many led him to South Africa. He joined MSF as a Health Promoter and he worked diligently with MSF to build trust and mutual respect with local community leaders in order to gain access to some of the most difficult to reach slum buildings in the inner city. Evans is survived by his wife, Pricilla, and two children, a boy and a girl.

Libya: MSF expands its support to war-torn Libya

Heavy fighting continues in Libya and the situation of civilians caught up in the conflict is becoming increasingly difficult. Since the conflict began on 17 February, 800,000 people – mainly non-Libyans – have fled the country, the majority towards Egypt and Tunisia. Thousands have risked their lives by fleeing north across the Mediterranean to Europe; over 11,000 have reached the Italian island of Lampedusa. More than 60,000 people have also fled south through the desert to Niger and beyond.

MSF has been assisting the victims of the Libyan conflict since February, with medical teams working in Libya (Misrata, Benghazi and Zintan); along the Tunisia-Libya border; Italy (Lampedusa); and in Niger.

MSF surgeons have provided training to Libyan medical staff lacking experience of trauma surgery and MSF staff have trained a team of 20 psychologists, who are now delivering psychological care to medical staff and patients in four hospitals in Misrata. MSF has also expressed its alarm about the situation of refugees stranded in temporary camps and exposed to violence.

Watch a video about MSF's evacuation of wounded from Misrata: www.msf.org.za/publication/libya-war-wounded-evacuation

Solidarity for Survival: An exhibit breaking down borders

In April, MSF South Africa launched a thought-provoking exhibition, entitled Solidarity for Survival, to focus attention on the plight of thousands of people who survive displacement and migration, and come to South Africa where they face discrimination and xenophobia.

The exhibition, hosted at Constitution Hill in Johannesburg, portrayed the plight of African foreign nationals fleeing their home countries for South Africa. Solidarity for Survival probed the reasons why people leave their countries of origin, focussing on five countries where MSF operates in sub-Saharan Africa: the Democratic Republic of Congo, Somalia, South Sudan, Zimbabwe and South Africa.

Solidarity for Survival garned significant media coverage and had over 1,000 visitors in April and May. Its call to action to inspire collective responsibility among South Africans continues through ongoing work with migrant and diaspora communities and we have plans to create a travelling exhibit in order to reach more people.

Visit www.solidarity4survival.org/ to learn more and follow Solidarity for Survival on Facebook to find out about upcoming events

Haiti: Cholera stalks Haitians again – despite massive aid response

One year after a devastating earthquake killed an estimated 222,000 people and left 1.5 million people homeless, Haitians continue to endure appalling living conditions and now face a resurgence of a nationwide cholera outbreak.

There has been a recent sharp increase in cases in Port-au-Prince and new outbreaks have been reported elsewhere in the country.

MSF teams have seen an increase in cases since mid-May and reopened emergency cholera treatment centres to prevent existing treatment centres in Carrefour, Delmas, Martissant, Cité Soleil and Drouillard from being overwhelmed. By the end of May MSF teams treated almost 2,000 patients in the capital, and were requested to intervene in other areas in the interior of the country. By June, the cholera death toll neared 5,000 people among the 300,000 cases reported in the country. Three percent of the country's population have contracted the disease. MSF has treated 130,000 Haitians for cholera (43% of total cases).

Read MSF's report on its humanitarian operations in Haiti for 2010 to 2011: www.msf.org.za/publication/haiti-one-year-after

Paediatric HIV: MSF and Zip Zap Circus gives HIV+ children confidence to soar

As a complementary part to MSF's paediatric HIV treatment service in Khayelitsha, outside Cape Town, the renowned Zip Zap Circus School offers a social programme, called Ibhongolwethu, or "our pride". The Ibhongolwethu project involves children living with HIV who are treated by MSF in a series of circus arts workshops by Zip Zap Circus School instructors who travel to Khayelitsha to teach the children circus acts including tumbling, juggling, mini-trampoline and trapeze.

This innovative partnership between MSF and Zip Zap Circus School means that children living with HIV are able to get support through skills training, team building and enhancing their self-confidence through acrobatics and performance training. Every year the Ibhongolwethu project culminates in a performance in Khayelitsha on World Aids Day when the community is invited to attend. The performance is aimed at raising awareness on HIV/AIDS but also in to engender acceptance among community members of children and people living with HIV.

Watch a video of the Ibhongolwethu troupe's 2010 World Aids Day performance here: www.msf.org.za/publication/msf-and-zip-zap-south-africa

"Why I support MSF": Singer James Blunt explains

British singer James Blunt, internationally known for his hit song "You are beautiful" is an MSF supporter. In a recent interview, Blunt said he came to know MSF while he was serving as a soldier in the British Army during the war in Kosovo in 1999. "*I thought I was at the forefront of everything, but I kept on bumping into people who were ahead of me the whole time – and that was Médecins Sans Frontières...*"

"*My commitment to MSF has borne a real passion and real belief in what they do. If you know a little about MSF you should take the time to read everything you can to discover the incredible and selfless work they do around the world by helping civilians in human and natural disasters. And given the opportunity, I hope you'll find your own way to get involved and help,*" the singer says. Blunt is touring South Africa in August.

Watch a short MSF interview with Blunt in Zurich: http://bit.ly/lTau7H

ZipZap © Finbarr O'Rielly

Watch the video: www.msf.org.za/viewnews.php?n=842

Letter from the field

BETTER DIAGNOSTIC TOOLS & TREATMENT IS WHAT PATIENTS NEED

Dr Prinitha Pillay, Medical Doctor & President of the Board of MSF South Africa


Southern Sudan © Baikong Mamid

I recently spent nine months working in Gogrial, Southern Sudan, where, MSF runs a new modest healthcare centre providing 250,000 people with primary and secondary healthcare, including life-saving surgeries.

The recent measles outbreaks among the returnees living in transit sites highlighted the low vaccination coverage they have had in the North, while the spread of the disease from returnees in urban transit sites to the resident population exposed the equally low vaccination coverage here in Southern Sudan. The overwhelming "yes" vote to affirm Southern Sudanese independence passed relatively peacefully in January 2011. But today more than 120,000 people have been displaced and several hundred feared dead due to violent clashes in the contested border region of Abyei in the run-up to Southern Sudan's official separation from northern Sudan in July.

MSF has long sought to draw attention to unmet medical and humanitarian needs of vulnerable populations in Southern Sudan, where an alarming 75% of people do not have access to basic healthcare. In the wake of the referendum, almost 250,000 returnees from the North have compounded these needs. This in a place where basic vaccination coverage is very poor, the need for affordable, simple diagnostic tests and better treatments is all the more urgent as Southern Sudan is currently in the midst of a kala azar outbreak eight times bigger than previous years, while the level of insecurity hampers our ability to adequately react to the needs of this population.

While my experience in Southern Sudan helped me to understand that many complaints of generalised body pain were actually hidden extra-pulmonary TB or Brucellosis, and that diagnostic capacity for hard-to-spot diseases like these remains poor. When needed, these vital tests can cost a prohibitive R1,000 per test. In very remote places like Gogrial, where the scarcity of skilled human resources is a reality, the need for simple tests that can be carried out at the primary healthcare clinics is critical. Unless we diagnose we cannot treat.

In Gogrial, I had to treat a patient suffering from kala azar with sodium stibogluconate (SSG) – the only available but toxic, painful and archaic drug. MSF's Campaign to Access Essential Medicines is appealing for better treatment at lower prices. We cannot accept a second-rate therapy for our patients and we urgently need more affordable treatment for kala azar that is better adapted to the reality of the field conditions in which most of our patients live.

What is kala azar?
Kala azar, or visceral leishmaniasis, is a parasitic disease spread by the bite of the sandfly. If untreated, kala azar is fatal in almost all cases within four months, but timely treatment has a 95% success rate. The disease can lead to fever, weight loss and ulcers in the mouth and nose; in children, it can cause vomiting, diarrhoea and abdominal discomfort. Kala azar remains a neglected disease, principally affecting poor communities in isolated regions and often results in devastating epidemics.

www.msf.org.za/publication/health-services-paralyzed-bahrain's-military-crackdown-patients

FROM HOSPITAL TO PRISON

By Christopher Stokes, General Director of MSF

"In Bahrain today, the reality is that hospitals are being used to catch and imprison wounded people."

In the kingdom of Bahrain, to be wounded by security forces has become a reason for arrest and providing healthcare has become grounds for a jail sentence. During the current civil unrest, Bahraini health facilities have consistently been used as a tool in the military crackdown, backed by the Gulf Cooperation Council, against protestors. The muted response from key allies outside of the region such as the United States – who has significant ties to Bahrain, including a vast naval base in the country – can only be interpreted as acceptance of the ongoing military assault on the ability to provide and receive impartial healthcare.

While the government and its supporters in Bahrain continue to refer to the protestors as 'rioters', 'criminals, 'extremists', 'insurgents' or 'terrorists', the label that remains conspicuously absent for those who are wounded is 'patient'. Since April 7, when MSF first raised the alarm about the situation, our team has seen patients in villages across the country who were severely beaten or tortured in jail; and patients in urgent need of hospitalisation who refuse to be referred due to the high risk of their arrest.

The militarisation of the only public hospital, Salmaniya, persists. Tanks and security checkpoints are still manned by masked soldiers at its entrances, searching cars and people. The wounded tell MSF that they are still too afraid to go to the hospital in case of being arrested or beaten in the wards.

Doctors and nurses also continue to be arrested during raids on health facilities, or on their homes at night. In fact, 47 medical staff are being prosecuted by the authorities. The medical community itself is polarised, while the impact of this on patients is often disregarded.

By dragging the health system deeper into the political crackdown on dissent, Bahraini authorities continue to undermine patients' trust in health facilities. All of the 88 people that MSF has managed to see in their homes are at risk of being arrested if they were to present themselves at health facilities – simply for being wounded in protests by government forces. Some of them need to go to hospitals for surgery or x-rays – but MSF is unable to safely refer them.

In Bahrain today, the reality is that hospitals are being used to catch and imprison wounded people. This is because hospitals have received directives that any patient who presents with wounds associated with the current unrest must be reported to the police by health staff.

Our medical teams then face the impossible choice of knowing that patients who need medical attention risk arrest and a serious deterioration of their health condition in prison. MSF has seen the results of violence and torture: beatings with iron rods, boots, hoses and cattle prods on the back, legs, buttocks, genitals and soles of the feet. MSF has also seen the serious impact of psychological abuse on those arrested, including extreme anxiety and fear as a result of sexual harassment and humiliation.

Ensuring the safe and impartial provision of treatment for the wounded is a basic legal obligation under humanitarian law. It is entailed in mandatory provisions of Common Article 3 to the 1949 Geneva Conventions – and is valid at all times. Thus, as a state party to these Conventions, the Bahraini authorities must respect its obligations regarding the protection and provision of healthcare to the sick, injured and prisoners.

The national security agenda of Bahraini authorities must not come at the expense of the lives and health of wounded people, whether in hospital or prison. Doctors and nurses must be allowed to provide healthcare in line with medical ethics, without the fear of reprisal. This is impossible when health facilities are used as bait for arrest and torture, with the support of Bahrain's closest allies.

www.msf.org.za/publication/msf-alarmed-resurgence-cholera-haiti

HAITI: WHERE AID FAILED

By Dr. Unni Karunakara, President of the International Council of MSF

"...the aid community at large has failed to prevent unnecessary deaths, in a population already so tragically affected by one catastrophe after another..."

Haiti should be an unlikely backdrop for the latest failure of the humanitarian relief system. The country is small and accessible and, following last January's earthquake, it hosts one of the largest and best-funded international aid deployments in the world. An estimated 12,000 non-governmental organisations are there. Why then, did more than 3,000 die of cholera, a disease that's easily treated and controlled?

Last year when I went to Haiti's capital, Port-au-Prince, in the wake of the cholera outbreak, I found my MSF colleagues overwhelmed – having already treated more than 100,000 cholera cases. We and a brigade of Cuban doctors were doing our best to treat hundreds of patients every day, but few other agencies seemed to be implementing critical cholera control measures, such as chlorinated water distribution and waste management. In the 16 months since the quake, little has been done to improve sanitation across the country, which allowed cholera to spread at a dizzying pace.

Haiti © Aurelie Baumel

During the outbreak in Port-au-Prince's Cité Soleil slum, the inhabitants had no access to chlorinated drinking water, even though aid agencies under the UN water-and-sanitation cluster had accepted funds to ensure such access. We began chlorinating the water ourselves. There is still just one operational waste management site in Port-au-Prince, a city of three million people.

Before the quake, only 12% of Haiti's 9.8 million people received treated tap water, according to the US Centres for Disease Control (CDC).

It is against this backdrop that many non-governmental agencies have launched fundraising appeals, even while their post-earthquake coffers remain filled. The UN's Office for the Co-ordination of Humanitarian Affairs (OCHA) has repeatedly claimed that underfunding of its U$174m cholera appeal, launched primarily to benefit private groups, is hampering the response – despite the fact that Haiti is the top-funded UN appeal for 2010. As nearly a million Haitians remain homeless in the face of a full-blown public health emergency, arguments that existing funds are tied up in longer-term programmes ring hollow.

The inadequate cholera response in Haiti – coming on the heels of the slow and highly politicised flood relief effort in Pakistan in late 2010 – makes for a damning indictment of an international aid system whose architecture has been carefully shaped over the past 15 years.

Haiti © Aurelie Lachant

Throughout the 1990s, the UN developed a significant institutional apparatus to provide humanitarian aid through the creation of the Department for Humanitarian Affairs in 1992, later renamed OCHA, all the while creating an illusion of a centralised, efficient aid system. In 2005, after the Asian tsunami, the system received another facelift with the creation of a rapid emergency funding mechanism (CERF), and the "cluster" system was developed to improve aid efforts.

The aid landscape today is filled with cluster systems for areas such as health, shelter, and water and sanitation, which unrealistically try to bring aid organisations – large and small, and with varying capacities – under a single banner. Since the earthquake, the UN health cluster alone has had 420 participating organisations in Haiti.

Instead of providing the technical support that many NGOs could benefit from, these clusters, at best, seem capable of only passing basic information and delivering few concrete results during a fast-moving emergency.

Co-ordination of aid organisations may sound good to government donors seeking political influence. In Haiti, though, the system is legitimising NGOs that claim responsibility for health, sanitation or other areas in a specific zone, but then do not have the capacity or know-how to carry out the necessary work. As a result, people's needs go unmet.

While co-ordination is important, it should not be an end in itself. It must be based on reality and oriented towards action to ensure that needs are covered.

What is clear, though, is that the aid community at large has failed to prevent unnecessary deaths, in a population already so tragically affected by one catastrophe after another.

www.msf.org.za/publication/southern-sudan-people-are-way-too-used-suffering

MATERNAL HEALTH MATTERS

"Awien suffers from malnutrition, not because of famine or lack of food but due to her mother's inability to get healthcare services during pregnancy."


Southern Sudan © Marcell Nimfuehr

More than two decades of civil war and chronic underdevelopment have left up to 75% of Southern Sudanese with no access to healthcare, with disastrous consequences for the youngest citizens of a country poised to claim independence.

After a referendum early this year in which the Sudanese voted to allow the south to secede from the north, Southern Sudan is set to gain its independence in July 2011 – but the advent of independence is unlikely to change the dire health situation in the new country.

Started in December 2009 as an outpatient clinic, MSF's hospital in Gogrial in the western state of Warrap, provides free, comprehensive healthcare to hundreds of patients daily. Common conditions include diarrhoea, malaria, severe malnutrition and infectious diseases like Buruli Ulcer, a bacterial condition that can leave debilitating ulcers, usually on the arms and legs.

Many patients arrive at the hospital at dawn, having walked through the night; 29-year-old Aluel Atem Kat walked for five days to reach the hospital with her small daughter, Awien Ayam Gum, in her arms.

Awien suffers from malnutrition, not because of famine or lack of access to food but due to her mother's inability to access healthcare services during pregnancy.

"*I remember being badly sick. I had a fever for a week then recovered, but then the fever came back,*" Aluel recalls. "*I let my sickness take its course, and I wasn't able to get treatment because there was none available in the village where I live. Awien has been sick ever since she was born.*"

Unable to access medical care, Aluel turned to traditional healers, the first port of call for patients facing an inadequate health system. When patients finally seek hospital treatment, it is usually as a last resort.

"*I brought Awien to the traditional healer, believing that it would make a difference. I followed the advice, but nothing happened. Awien was still sick and kept losing weight.*"

Today, Awien is being seen by MSF's Dr Prinitha Pillay.

"*When we got Aluel's medical history, we found out that she had chronic fever during her pregnancy, which was probably malaria,*" says Pillay, adding that low birth weight is a common complication among babies born to mothers who become infected with malaria during pregnancy.

Before starting treatment at MSF's hospital, Awien weighed just 3.3kg, and is as still as tiny as a two-month-old baby.

"*As a one-year-old, she should be standing and starting to try and walk, but she has never been able to catch up on her weight and remains fragile,*" adds Pillay, who still remains hopeful. "*Awien has been in the nutrition programme for six days now and is doing reasonably well. She has put on 600 grams, is eating well and doesn't have any other complications.*"

"*As for the child's development; she's clearly a bit delayed. She is able to sit, but she isn't able to stand, or walk yet,*" adds Pillay. "*Preventative health services like antenatal care are so important for newborns but also for their mothers.*"

MDR-TB patients from around the world share their experiences and stories on the TB&ME blog to highlight the serious global impact of the disease: www.msf.ca/blogs/tb/

FINALLY... A NEW TEST FOR RAPID TB DIAGNOSIS TO SAVE MORE LIVES

Milk-crate sized modern TB mini-lab cuts waiting time for detection of difficult TB cases from months to just 2 hours, writes Dr. Peter Saranchuk, TB-HIV Adviser, MSF South African Medical Unit.

Clinicians in southern Africa have long struggled to accurately diagnose tuberculosis (TB), especially in people living with HIV, using only the traditional TB tests of microscopy and x-ray. This problem has two important consequences:

- TB disease in many people has either gone undiagnosed or treatment has been unacceptably delayed, leading to serious illness and death
- Clinicians find themselves having to put people on TB treatment before confirmatory TB tests, and such 'empiric' treatment is not always appropriate

Accurate diagnosis is especially a problem when it comes to multidrug-resistant (MDR) TB. This is very relevant for South Africa, which has one of the highest burdens of MDR-TB globally. Although close to 10,000 people were diagnosed with MDR-TB in 2009 alone across the country, many more cases went undiagnosed and untreated.

Fortunately, a new TB test called Xpert MTB/RIF (also known as GeneXpert) has recently been developed, which has the potential to dramatically improve the diagnosis of TB in southern Africa and beyond. This new diagnostic tool gives rapid TB results that are more accurate in people co-infected with HIV, and more informative compared to the traditional TB tests.

Within two hours, a sputum sample processed using Xpert MTB/RIF can simultaneously detect the presence of TB and resistance of the germ against rifampicin. Since 90% of TB strains resistant to rifampicin are also resistant to isoniazid, the Xpert MTB/RIF test can therefore be used to rapidly diagnose MDR-TB.

In addition to its ability to rapidly diagnose TB and MDR-TB, Xpert MTB/RIF has two other important features that justify its use in decentralised clinics closer to where patients live:

- Simplicity and safety of design, which allows for staff, such as nurses, to be trained to perform the test
- High sensitivity and specificity in diagnosing 'smear-negative' pulmonary TB, which is commonly seen in people living with HIV

Xpert MTB/RIF has already been endorsed by the World Health Organization (WHO) for diagnosis of pulmonary TB in adults and children. Although the current cost of R115 per test is high, the price will inevitably decrease as the demand for this test grows; current estimates are that the cost per test will drop to about R75 by 2014.

MSF has just finished introducing Xpert MTB/RIF testing in projects in Kenya, Mozambique, Zimbabwe, Malawi, Cambodia, Colombia and Abkhazia, and there are plans to implement it later this year in new MSF projects in South Africa's KwaZulu-Natal province and Lesotho.

Multidrug-resistant tuberculosis (MDR-TB): Facts & Figures

What is it? Multi Drug-Resistant TB (MDR-TB) refers to a TB germ resistant to the two most important and commonly used anti-TB drugs: rifampicin and isoniazid. MDR-TB can emerge during the course of regular TB treatment; it can also be found in people who have never been treated for TB before (as a result of inhaling drug-resistant strains coughed up by others).

Burden: MDR-TB is an increasing threat. The WHO estimates 440,000 cases of MDR-TB arise each year around the world. The vast majority go undiagnosed, because modern methods used to detect MDR-TB are complex, expensive, and not available in most laboratories.

Treatment: During the last decade roughly 5 million people developed drug-resistant TB, of which less than 1% were treated with quality-assured medication according to international standards. This resulted in approximately 1.5 million people dying from MDR-TB.

FROM INJURY AND PAIN TO HOPE: TREATING OBSTETRIC FISTULA

MSF surgeons give women injured during childbirth a new lease on life

In Africa the majority of women give birth at home, and labour is dangerous for newborns and mothers unable to reach hospitals.

Women surviving this ordeal often emerge with obstetric fistula, a consequence of obstructed labour occurring when the soft tissues of the pelvis are compressed by the baby's head. The lack of blood flow causes the tissues to die, creating a hole between the vagina and bladder, the vagina and rectum, or both. It results in urinary and/or faecal incontinence. Women with fistula live in shame, and are often rejected by their own families and communities.

Worldwide, about two million women live with fistula, and today, MSF treats obstetric fistula in three permanent centres in Burundi, Chad and Nigeria.

1. Women relax in one of the tents at the MSF fistula camp in Boguila, Central African Republic. 65 women had their fistulas repaired during the six week-long camp in 2010.

2. Fistula patients wait outside the operating room for a consultation at MSF's fistula camp.

3. Esther Feibouko (28) walks with her two-year-old daughter Abigail. Esther has had four pregnancies and developed a fistula in 2008 after being in labour with Abigail for 12 hours.

4. MSF midwife Sigrid Kopp sits with a fistula patient to make sure she drinks enough water to prevent her urine from becoming very concentrated.

5. A new fistula patient arrives at the MSF fistula camp in Boguila, Central African Republic. Women with fistulas are often outcasts from their communities because of the smell associated with the leaking of urine/faeces, and in some cases they are abandoned by their husbands.

6. Robertine Djoumaze (32) has seven children and suffered a fistula when she was in labour for 24 hours. "After I began leaking, my husband left me and my children. In the village no one wants to see me or will come to my home. Even if I make food, no one will come. People in the village do not like the smell. I feel more confident and welcome in the fistula camp," Robertine says.

7. An MSF anaesthetist administers an anaesthetic to numb the patient from the waist down for the procedure. The patient, Martine Nambousso (45), has had ten pregnancies, but has no surviving children. She has had a fistula for over 20 years.

8. After seven days of painful labour Zanaba Amidou (16) reached a clinic. MSF doctors performed a caesarean section but the baby was stillborn. "I have suffered a lot; I didn't lose much blood, but I suffered. I am very happy to have had this operation. When I go home I will dance and sing and pray every day. I will pray and thank God for this doctor."

A HIDDEN NIGHTMARE

Providing healthcare for thousands of survival migrants struggling in Johannesburg's inner-city slums


South Africa © AlonSkuy

Johannesburg, a city of nearly 4 million, is the economic and financial hub of Africa. But it is also home to a growing humanitarian situation hidden in the inner-city slums, due in part to rapid urbanisation, and the political-economic decline of neighbouring countries.

Every year Johannesburg attracts thousands of people fleeing unlivable conditions in their home countries on a quest for survival and a better life in the 'city of gold'. But for many survival migrants the hope of subsisting turns into a nightmare of destitution and disease when they find themselves with nowhere else to go but the city's more than one thousand slum buildings.

MSF has operated a primary healthcare clinic in Johannesburg's central business district since 2007, and has developed urban outreach programmes bringing health services to the inner city slums. In 2010, MSF's mobile medical activities identified 45 'abandoned' buildings where more than 30,000 people live precariously in abject conditions. These buildings have an appalling lack of sanitation, sewage and waste disposal, little or no water and electricity, and are densely overcrowded. Consequently living conditions there pose numerous health risks to residents. "Think of it as a hidden informal settlement in the middle of the city," explains Melt Ndlovu, a nurse coordinating MSF's outreach programme.

Some buildings have water, electricity and residents people pay rent despite conditions of severe overcrowding. In the "bad buildings" as Ndlovu and the teams call them, there is no electricity, running water or waste removal. People have constructed shacks inside the buildings while slumlords collect money without ensuring any improvement in conditions.

In these cramped buildings, poor hygiene leads to skin diseases and respiratory infections. Inadequate ventilation and natural light create a perfect breeding ground for the spread of tuberculosis (TB) and severe levels of poor nutrition persist among children. Out of desperation many women living in these buildings resort to casual sex work to generate income, and levels of HIV and sexually-transmitted infections are high.

"The slum residents don't see health as a priority. They are focussed on their day-to-day survival and making what little money they can. They feel they cannot afford to be absent from work and lose wages. They sacrifice their health in order to pay their rent and in the hope of sending some money home to the relatives they are supporting," Ndlovu says.

Lack of access to public healthcare services compacts this already dire situation for vulnerable survival migrants – most of whom have travelled far from Zimbabwe, Malawi, Mozambique and other parts of South Africa with few belongings and resources.

Many patients have reported discrimination from staff in the public health system, while systematic and cultural barriers also discourage survival migrants from seeking healthcare despite provisions in South Africa's Constitutional enshrining rights of access to healthcare for all.

MSF teams now focus on providing regular health, HIV and TB screenings in the derelict buildings. Upon diagnosis, MSF staff are able to refer patients for further treatment. Educating residents about healthcare, ensuring access to services and tracing TB treatment defaulters is also part of MSF's work.

BACK FROM THE FIELD: YASHODA MANICKCHUND

Medical Doctor, Pakistan

Dr Yashoda Manickchund (28) hails from Durban, South Africa. Inspired by her late father to study medicine, Manickchund completed her degree at the University of Cape Town Medical School. She recently returned from her first MSF mission to Pakistan's Khyber Pakhtunkhwa Province, where she worked in the emergency and resuscitation rooms. After returning from Pakistan Yashoda joined MSF's medical teams working in Libya.

Pakistan, in particular the Khyber Pakhtunkhwa Province, has a reputation for being very conservative – quite a contrast to South Africa. How were you able to integrate?

In Pakistan, women inhabit a completely different world, unlike in South Africa. In Pashtun society, men are protective, and defensive about women and their honour.

Although I needed to integrate myself and accept Pashtun society's cultural norms in order to live and work, I had to keep a distance.

People accepted me because I tried fitting in by wearing a veil, or dupatta, and the traditional long pants and shirt or shalwar kameez, when I went to work.

Because of my appearance, I was often mistaken for an Indian or Pakistani woman, but I made sure that I always reminded people that I was South African and that's how I was able to distance myself from local cultural norms.

In Pashtun culture, physical contact between unmarried men and women is forbidden. How did you deal with this in the emergency room (ER)?

Staff and patients understood that expatriate female doctors were foreigners, sent there because of their expertise - I was treated as such. Local female doctors were not regarded in the same way.

I was able to treat both men and women, but there were restrictions: I couldn't touch male patients below the waist; male staff were not permitted to perform procedures involving women's chests. Female patients also had to be examined behind curtains in the presence of a male relative, who monitored whether medical workers were handling the situation correctly.

From a medical perspective, it was an advantage having a female expatriate doctor in the ER and resuscitation room. The men in Timergara knew they could bring female relatives in because I was able to treat them and didn't have to risk waiting until it was too late for fear of male doctors treating their women.

Working in the ER and resuscitation room, what sort of medical conditions did you encounter?

The bulk of the injured were hurt in big traffic accidents but there were usually a lot of violent gunshot trauma cases resulting from domestic disputes or family feuds. Interestingly, we have many cases of chronic diseases such as heart conditions, asthma and epilepsy. Among the tropical diseases we treated were malaria, typhoid fever and cholera.

You've practiced emergency medicine in South Africa, what was new to you working in Pakistan and particularly in Timergara?

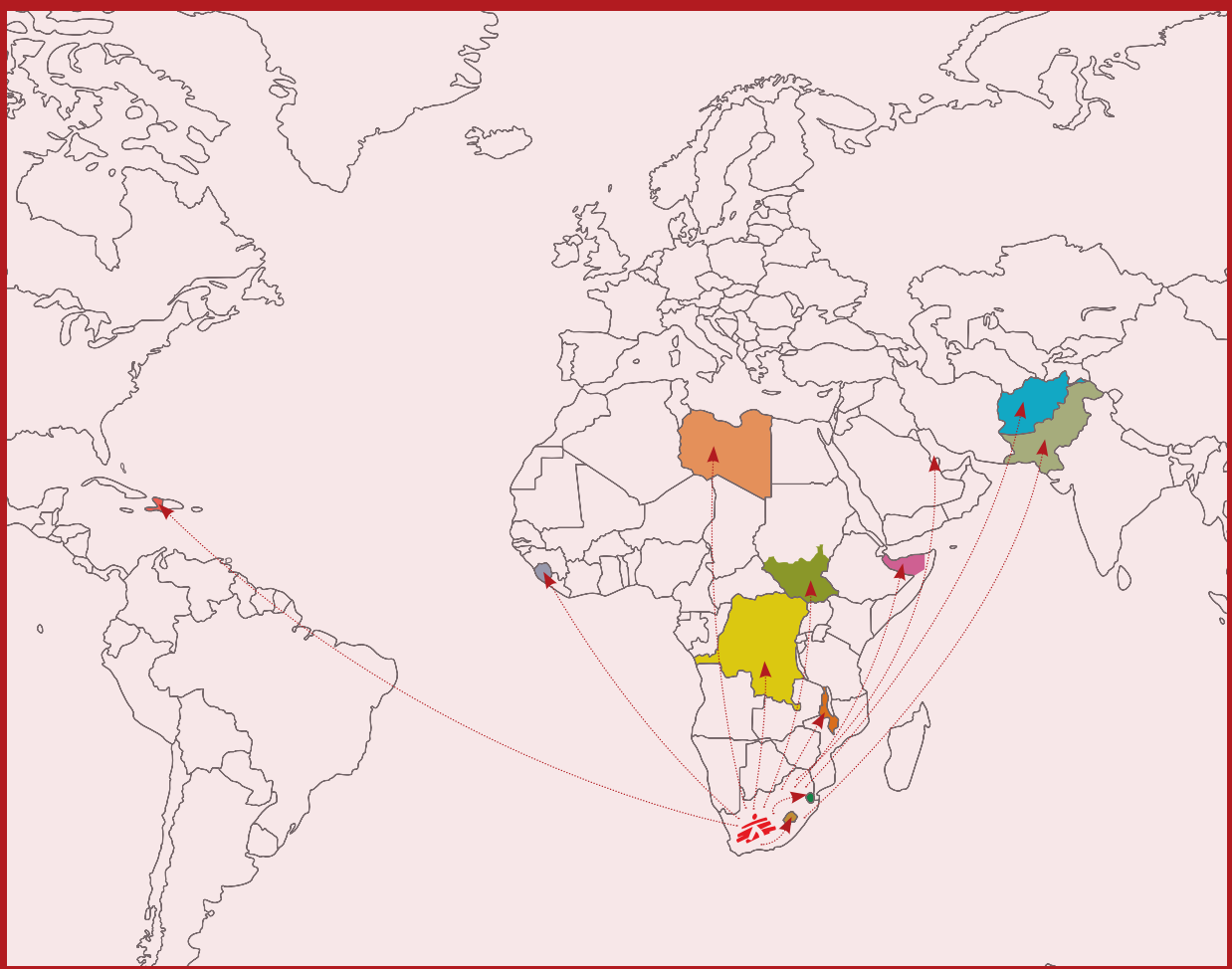
One of the main lessons I learned was in dealing with patients' families, who always accompanied the ill or injured to guarantee things were handled in a culturally correct manner.

In Timergara, while doing CPR to revive a patient, the relatives were standing right there watching - it was an uncomfortable situation. In South Africa, family members are not permitted inside the resuscitation room.

Although it made work difficult sometimes, it helped the community accept us. Because relatives were right there, they could see that we were working hard to save patients' lives and they were happy with our service. When we had to deliver bad news about the death of their kin, it was accepted wholeheartedly without question. As a doctor, it made explanations easier because of that acceptance.

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. Virginia Kiyanjui – **Malawi** – Nurse-Midwife
2. Dr Prinitha Pillay – **Southern Sudan** – Medical Focal Point
3. Patricia Nyoni – **Swaziland** – Nurse
4. Natalie Vlahakis – **Lesotho** – Doctor
5. Santhuri Pillay – **Sierra Leonne** - Doctor
6. Isabelle Munyangaju – **Swaziland** – Doctor
7. Mohammed Golo Abdi – **Somaliland** – Operating Theatre Nurse
8. Garret Barnwell – **Somaliland** – Assistant Field Coordinator
9. Caroline Robertson – **DRC** – Anaesthetist
10. Dr Yashoda Manickchund – **Pakistan, Libya** – Emergency Room Doctor
11. Marilize Ackermann – **Haiti** – Administrator/Finance Legal
12. Kate Ribet – **Afghanistan** – Communications Officer
13. Jonathan Whittall – **Bahrain** – Head of Mission
14. Nikki Fuller – **Pakistan** – Anaesthetist
15. Dr Mohammed Dalwai – **Pakistan** – Emergency Room Doctor