# MAMELA

Médecins Sans Frontières / Doctors Without Borders South Africa
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Khayelitsha, South Africa © Samantha Reinders

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Haiti © Julie Remy

# THANK YOU!

Two years after the Haiti earthquake, your support still makes all the difference

In the wake of the devastating earthquake on January 12, 2010 measuring 7.3 on the Richter Scale that shook Haiti it was your support that enabled Medécins Sans Frontiéres/Doctors Without Borders (MSF) to launch our biggest emergency response ever. During 2010 MSF treated 360,000 patients, including 15,000 surgeries, and distributed 50,000 tents as well as over half a million cubic meters of water per day.

The precarious hygiene conditions that followed the earthquake led to a double emergency in Haiti in 2010/2011 as a cholera epidemic swept through the country. Again, due to the dedication of our donors and our field staff, MSF was able to treat 170,000 cholera patients in 75 separate facilities.

Now, two years after the earthquake, the reconstruction needs of the healthcare system in Haiti remain immense and the majority of Haitians continue to face great difficulties in accessing adequate and free healthcare. MSF is still in Haiti today, working hard to improve access to water, sanitation and quality healthcare. We manage over 600 hospital beds in five 24-hour health facilities where all treatments are completely free.

Your dedication to helping the people of Haiti during these difficult times has been much appreciated.

**Steve Miller**
**Head of Fundraising**
**MSF South Africa**

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# STORM CLOUDS GATHER: DONORS TURN THEIR BACK ON HIV

## We have the tools & knowledge to reverse the HIV epidemic. All we need now are the funds.

By Mara Kardas-Nelson, MSF Access Campaign Officer

In November 2011, the Global Fund to Fight Aids, Tuberculosis and Malaria announced that it does not have adequate funds to launch its next round of grants. This is unprecedented in the 10-year history of the Fund, which has placed 3.3 million people on life-saving anti-retroviral therapy (ART); tested and cured 8.6 million cases of tuberculosis; and distributed 230 million insecticide-treated nets to protect families from malaria.

Cancelling a round of grants spells disaster for the millions of people at risk of contracting or living with HIV, TB or Malaria. In the months since the shocking announcement, donors like Bill Gates and the government of Japan have pledged millions to the Fund, but more is needed to ensure that new funding is made available to high-burden countries.

We at MSF have seen first-hand the importance of the Fund in saving lives in Southern Africa and the world. Having worked in many high-burden countries we have seen the Fund and other funding streams help countries to increase their response in providing HIV treatment to more patients. As access to treatment has expanded, a positive diagnosis is no longer a death sentence, but instead a manageable disease.

And yet, given the cancellation of the new round of grants, instead of continuing to move forward, we run the risk of going backwards. While emergency monies will be made available to ensure that current programmes will not be interrupted, programmes are unlikely to be expanded until a new round of funding is launched, currently set for 2014. For the millions of people at risk of or in urgent need of treatment for HIV, TB and malaria, they simply cannot afford to wait.

Even before the November announcement, Zimbabwe expected to experience a funding gap for up to 112,000 HIV positive people already receiving ART by 2014. Cameroon also faces shortfalls for people already on treatment. Because of funding shortages, the Democratic Republic of the Congo severely caps the number of people receiving ART. The Central African Republic has not started new patients on antiretrovirals for an entire year and patients are discontinuing treatment across the country.

Mozambique expects a shortage of first-line antiretrovirals by 2012 and Swaziland has already had to rely on American support for its first-line medicines. How will these countries, already struggling to keep their HIV programmes afloat, be able to cope with further cuts?

The Fund's cancellation of the next round of grants was caused largely because donors were not willing to give the money needed. Donors such as the United States, the Netherlands, Denmark, Italy, Spain and Ireland have either given less than expected; still owe the Fund money; or have not made pledges for 2011 to 2013, the next funding cycle. The Fund has experienced a steady decrease in donor support since 2008: in line with a global trend of increasingly reduced HIV funding, 10% less funds were available in 2011 than in 2009. As other donors start to scale back their response, high-burden countries, such as those in Southern Africa, are more reliant than ever on the Fund to both continue and expand their programmes.

Cancelling the round of grants comes on the heels of a year that provided new scientific evidence indicating that we already have the tools we need to turn the HIV epidemic around. We now know that providing HIV treatment earlier not only saves lives but also prevents new infections. African countries are doing their part to make this science a reality: between 2009 and 2010 the number of people in sub-Saharan Africa receiving ART increased by 20%, and the rate of new infections has dropped by 26% in the region since 1997, in part because of the improvement in access to treatment. We are halfway to our target of universal access to treatment, with just less than 50% of those in need of ART worldwide receiving it. And yet countries such as Malawi, Mozambique and Zimbabwe, which have all committed to ensuring earlier and better HIV treatment, simply do not have the funds to make these policies a reality.

Civil society across Southern Africa and the world is calling on donors to ensure that enough money is given to the Fund to launch a new round of grants before 2014. We have the tools we need to reverse the HIV epidemic. All we need now are the funds to make this vision of an HIV-free generation a reality.



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# NEWS FROM THE FIELD

KwaZuluNatal © Katy Pepper/MSF

## MSF launches mobile HIV testing service in Eshowe, KwaZulu Natal

In December 2011 MSF launched a new "mobile one-stop-shop" unit, or M1SS, in Eshowe, northern KwaZulu Natal, by teaming up with local producer and musician DJ Sox who encouraged the community members to use the new HIV testing service. While his music entertained the gathering crowds, MSF community health workers invited those interested to know their HIV status to get tested. Over 90 people took the test during the launch.

The M1SS is a user-friendly mobile unit consisting of several tents where MSF staff offer a wide range of services, including HIV testing and pre- and post-test counselling, TB screening, CD4 counts, as well as referrals for those in need of antiretorviral drugs to the nearest health facility. The M1SS moves around on a fixed circuit, visiting places like farm health camps and supermarkets, where MSF medical staff and a team of community health workers provide services.

Ruggero Giuliani, MSF's medical coordinator in Eshowe explains: "Together with the Department of Health, we're working on a 'treatment as prevention' strategy, which means detecting HIV early and getting positive patients on treatment early. Most people are lost to treatment after testing positive for HIV. So, beyond simply testing, we're also making sure that people have the support they need afterwards and stay on HIV treatment."

Since opening, the M1SS service tested 674 people in Eshowe in just one month and will soon be joined by another mobile testing unit in Mbongolwane. Both of these initiatives form part of a unique HIV project MSF started in KwaZulu Natal during 2011 with the aim of reducing the number of new HIV and TB infections in the Eshowe and Mbongolwane communities.

## Somalia: MSF closes some medical projects after Mogadishu killings

In January 2012, MSF took the difficult decision to close two separate 120-bed medical facilities for the treatment of malnutrition, measles and cholera in Mogadishu's Hodan district. The closure followed the tragic killings of two MSF staff, Philippe Havet and Dr. Karel Keiluhu, on 29 December 2011. MSF's work in any place depends on the respect for the safety of its personnel, patients and medical facilities, and when this is lacking MSF has little choice but to leave.

"It is hard to close health services in a location where the presence of our medical teams is genuinely life-saving every day, but the brutal assassination of our colleagues in Hodan makes it impossible for us to continue working in this district of Mogadishu," Christopher Stokes, MSF's General Director explained.

In Hodan, MSF was assisting 200,000 Somalis who had fled to the capital in recent months. Since August 2011, treatment was provided to 11,787 malnourished children, 1,232 patients for acute watery diarrhea and 861 measles patients. MSF teams also vaccinated 67,228 children against measles. MSF projects providing medical care in the other districts of Mogadishu and 10 other locations in the rest of Somalia will continue.

Somalia © Yann Libessart/MSF





# UPDATES FROM MSF SOUTH AFRICA

## Face to Face Fundraising: the 'Frontline to Coastline' tour

In recent years, our Face to Face Fundraising teams have been introducing MSF's work to mall shoppers in Cape Town, Johannesburg, Pretoria and Durban. To seek support of MSF's work from outside the larger South African cities, our travelling Face to Face teams set out along the Garden Route in October 2011 to give shoppers there the chance to learn about MSF's emergency medical relief work on the frontlines.

A team of five fundraisers made up the 'Frontline to Coastline' tour, taking the message about MSF's work to nine shopping malls in Mossel Bay, George, Knysna, Plettenberg Bay and Port Elizabeth. The public responded really well with 822 people signing up to become monthly MSF donors.

Face to Face team member Kelly Barlow described the response: "Shoppers were interested in MSF's work in Haiti, DRC and Somalia, but particularly about what MSF does in South Africa – especially with drug-resistant TB in Khayelitsha in the Western Cape. For me, it's rewarding to know that what we're doing as fundraisers is essential to MSF's work in the field. In that way, we're helping to save lives too."

We want to thank all those who decided to support MSF's work by becoming Field Partners after meeting our team. Our sincere gratitude goes to The Point Hotel, Garden Route Casino Hotel & Spa, Protea Hotel Mossel Bay, Protea Hotel King George, The Rex Hotel, Knysna Log Inn, The Russel Hotel, Beacon Island Southern Sun, NH Plettenberg Bay and Protea Hotel Marine PE for sponsoring us with accommodation, thus making this tour possible.

Port Elizabeth © MSF

# WHY I GIVE TO MSF

### Michael Jones, Clover/Fonterra CEO

Johannesburg © MSF

"One of the things that appealed to us about MSF is its neutrality," says Michael Jones, of Clover/Fonterra's decision to support MSF. "There is no agenda in their work, and they have a clear focus – giving healthcare to those who really need it."

Jones, a father of three young children, grew up in a small town in New Zealand, but moved to the city to pursue his studies and favourite sports. After starting at Fonterra in an entry-level job, his determination to succeed saw him promoted in a succession of management positions in the Philippines, Singapore, Australia, United Arab Emirates and finally, South Africa.

Jones' travels have exposed him to extreme poverty and appalling living conditions. "When you've seen people earning a living from a mountain of rubbish or living in a boat surrounded by filthy water, it really makes you want to improve these lives by giving back," he says of his involvement and commitment through Fonterra to continue supporting MSF's work.



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Read Phumeza's blog in full: www.blogs.msf.org/tb/author/pumeza

# PHUMEZA'S STORY: 'THE LONG AND PAINFUL MOMENTS'

Drug-Resistant Tuberculosis is a growing problem with devastating consequences.

Khayelitsha, South Africa © Samantha Reinders

**Phumeza Tisile (above) is 20 years old and lives in Khayelitsha, outside Cape Town. She was diagnosed with Extensively Drug-Resistant Tuberculosis (XDR-TB) in July 2010 and writes about her experience in TB&ME, an MSF-hosted collaborative blogging project by patients being treated for MDR-TB around the world. Read her blog at www.blogs.msf.org/tb Here is one of her recent entries:**

"I was diagnosed with TB in 2010 sometime in May. The ordinary TBdrugs did not work so I had to start with the multidrug resistant [MDR] TB drugs at MSF's Lizo Nobanda clinic in June/July 2010 .

When I first got to Lizo Nobanda I cannot remember, not even one thing. I was way too weak – I could not even talk. Then they transferred me to Karl Bremer Hospital in Parow for further attention.

When I got to Karl Bremer I am sure they thought that I was dead because I remember being in the dark room with no one else there – just me. Alone. In the dark.

That still SCARES THE HELL OUT OF ME.

I stayed there for about 3 weeks and then I had to go to Brooklyn Chest Hospital in Cape Town to continue my treatment there. I had to get these injections for 6 full months > it doesn't get more painful than that, does it?

I was getting used to the drugs in Brooklyn Chest Hospital and adjusting just fine only to find out that I was resistant to Kanamycin [one of three injectable second-line TB drugs]. And worst of all, the most painful part is that it got me DEAF!

Then I was told I am no longer an MDR patient, I am Pre-XDR. I was scared but I did not give up hope, I thought the Pre-XDR drugs were big and all and not the same like the MDR drugs. Oh they are the same – just that you need to take MORE.

But... GUESS WHAT??????... I found out I am no longer a PRE-XDR patient. I am an XDR patient after all.

So I'm back at MSF's Lizo Nobando clinic where they are giving me 2 very expensive drugs, namely LINEZOLID and CLOFAZIMINE. I am still on the injections – not Kanamycin though, but Capreomycin.

My student life at Cape Peninsula University of Technology was coming up and I was about to go attend my 2nd semester sometime in June/July, but I couldn't because I was too weak. Going back to Tech is just impossible, mainly because I am deaf.



Read our report on treating DR-TB in Khayelitsha: www.msf.org.za/publication/scaling-diagnosis-and-treatment-drug-resistant-tuberculosis-khayelitsha-south-africa

## 'This treatment is the last option for Phumeza'

**Jennifer Hughes, MSF's TB medical doctor in Khayelitsha, explains Phumeza's journey to XDR-TB diagnosis and treatment:**

The diagnosis of drug resistant TB is not easy. Typically, patients come to a health centre with TB symptoms and their sputum is sent to a lab for smear microscopy – a quick and simple test for TB. The test will confirm TB, but not if it is a resistant strain. The test for drug resistance can take weeks or months, depending on how long TB culture takes to grow. Because it takes so many resources, not every TB patient is tested for drug resistance.

To make things more complicated, full drug resistance testing occurs in two stages. The first stage tests for resistance to the two most effective TB drugs. If the TB bacteria react to these two drugs, no more testing is done. If the bacteria are resistant to either drug, the patient is diagnosed with MDR-TB and a second stage of testing is done to test for resistance to other TB drugs. This may reveal XDR-TB.

Phumeza was first diagnosed with ordinary TB and received 'normal' TB treatment for some time before the drug resistance test was done. So she became very ill because the treatment was ineffective against resistant TB. She was admitted to hospital to start MDR-TB treatment, yet when the results of the second stage of drug resistance tests came back, they showed Phumeza actually had XDR-TB, which explained why both treatments had failed. Unfortunately, getting ineffective treatment for a long time probably helped develop even more resistance to the TB drugs.

Phumeza is a brave young woman who sticks to her treatment and is determined to be cured. This is why she was offered a salvage treatment regimen by MSF, with drugs which are very expensive and not easily accessible for DR-TB patients in South Africa. This treatment is the last option for Phumeza.

There is a lack of new, effective and easily accessible drugs to treat patients like Phumeza. If there were better, more affordable drugs available to treat this terrible disease, she might have been offered a stronger treatment regimen sooner which would have greatly improved her chance of cure.

Khayelitsha, South Africa © Chelsea Maclachlan

## UNDERSTANDING TB & MULTI DRUG-RESISTANT TB

March 24th marks World TB Day, the same day in 1882 when Dr Robert Koch announced the cause of tuberculosis. It aims to build awareness that TB remains an epidemic which affects millions, mostly in developing countries.

TB is a curable disease that kills nearly 1.45 million people globally each year. It is also the main cause of death for people living with HIV/AIDs. Of the 9.4 million new TB cases each year, at least 440,000 are forms of the disease that are MDR-TB. This means they can't be treated with the two primary antibiotics: rifampicin and isoniazid. And 5-10% of these cases are extensively drug resistant (XDR-TB) meaning resistance to the second-line drugs that treat MDR-TB.

However, less than 1% of the roughly 5 million people who developed drug resistant TB over the last decade had access to the right treatment, and 1.5 million died. Many people go undiagnosed and untreated because of the difficulties in getting a proper diagnosis and the complex and expensive treatment. To treat MDR-TB for example costs R35,000 compared the R150 treatment cost for standard TB.

A vicious cycle has occurred where untreated MDR-TB encourages the disease to spread, yet without enough patients on treatment, low demand for drug-resistant TB drugs means drug companies produce fewer drugs which are more expensive. Many hope that a new diagnostic tool called GeneXpert – currently being rolled out by MSF in seven countries including South Africa, and which reduces diagnosis of DR-TB from several weeks to under two hours – will encourage governments to put more people on treatment, which may in turn encourage drug companies to produce larger quantities of cheaper drugs.

South Africa has one of the highest rates of drug-resistant TB in the world, along with China, India and the Russian Federation.



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To read the full report: http://www.msf.org.za/publication/central-african-republic-state-silent-crisis

# STATE OF SILENT CRISIS - STRUGGLING TO SURVIVE

Central African Republic © Sarah Elliot

## CAR is mired in humanitarian crisis as mortality rates reach three times emergency thresholds

The Central African Republic (CAR) is in the grip of a chronic medical emergency. Four mortality studies conducted by MSF during an 18 month period in 2010/2011 revealed crude mortality rates in some regions are at three times the emergency threshold level – evidence of a humanitarian crisis. The World Health Organisation defines the emergency threshold for crude mortality rates as being above one death per 10,000 people per day.

This landlocked country lies at the heart of one of the most volatile regions in the world and shares borders with Chad, the Democratic Republic of Congo and Sudan.

The CAR has the second lowest life expectancy in the world at 48 years and the fifth highest death rate from infectious and parasitic disease. Most deaths are the result of seasonal epidemics, economic downturn, as well as conflict, displacement, and a poor health system.

Despite clearly being a country facing a widespread medical crisis, both the government and international donors appear to be disengaging from health provision in the country. The government has been scaling down its investments in health, as have international donors, while humanitarian assistance has failed to reduce the widespread medical crisis.

"This is a country where the health system has been torn apart by years of political and military instability, major organisational problems, and a lack of security in the northern and eastern regions of the country... All these factors have had a catastrophic effect on the health of the population and show, to a large extent, how the extremely high mortality rates have come about," says Olivier Aubry, MSF Head of Mission in CAR. "For example, in July 2011, in Carnot, the under five-mortality rate was three times as high as the under-five mortality rate in Kenya's Dadaab refugee camp, where people who fled from Somalia live in dire conditions. But the crisis in Carnot remains largely unknown to the rest of the world."

There is a high risk that CAR will continue to remain in a situation where it is not seen as urgent enough to justify significant emergency aid; and the state not trustworthy enough for meaningful development assistance.

The healthcare system in the CAR is extremely weak and has been for a long time. It was already very poor before the last coup d'état in 2003 and has only worsened since. "It is hugely dysfunctional at every level. The Ministry of Health has virtually no presence outside the capital of Bangui. Few health facilities operate," explains Aubry. Human resources are very limited and skills are rare. More than half the country's population is illiterate. The country has only a very small number of specialist physicians and the total number of doctors in the country is estimated at 300 – for a population of approximately 5 million. Most of these doctors work in the capital in Bangui while the majority of people in remote areas face a catastrophic health situation and extremely limited access to basic medical care persists amid insecurity throughout the entire eastern half of the country.

### MAIN INDICATORS – Condition Critical

**Population:** 4,9 million
**Life expectancy**: 48 years
**Health expenditure:** 4.3% of GDP (2009)
**Doctors:** 8 doctors / 100 000 population (2004)
**Hospital beds:** 1.2 beds / 1,000 population (2006)

- **Malaria:** Every individual in the population is infected at least once a year. The disease is the country's principal cause of death among children and the major threat to its public health. Malaria patients constituted 45.9% (267,471) of MSF's total number of outpatients in 2010.
- **HIV:** Prevalence of HIV among the age group 15-49 years stood at 5.9% in 2010 – the highest HIV prevalence in Central Africa. At present, only 15,000 people are on antiretrovirals – a mere 33.5% of those in need.
- **Sleeping Sickness:** CAR has four of sub-Saharan Africa's few remaining pockets of human African trypanosomiasis (HAT), or sleeping sickness – a neglected parasitic tropical disease transmitted to humans by the tsetse fly. In 2009, the country had 1,054 reported cases, the second-highest in the world.

### MSF in Central African Republic

- MSF essentially provides close to 50% of the health services outside of the capital Bangui.
- MSF's 2011 operating budget for CAR reached 17 million Euros – equal to 75% of the CAR ministry of Health's budget of 23 million Euros.
- MSF operates its second largest country programme in CAR – according to the number of outpatient consultations – 564,457.
- MSF has worked in CAR since 1997 and, at the end of 2010, had 1,243 staff present in the country.
- MSF missions support nine hospitals and 36 health centres and health posts.

Central African Republic © Anna Surinyach

Central African Republic © Sarah Elliot

Read about MSF's ongoing response in Haiti:
www.msf.org.za/publication/msf-haiti-earthquake-two-years

# HAITI EARTHQUAKE: 2 YEARS LATER

Haiti © Marilize Ackerman/MSF

## A dubious future for half a million Haitians amid fears of another cholera outbreak

Two years after the devastating earthquake in Port-au-Prince, nearly 500,000 displaced Haitians are still living in extremely precarious conditions. After 2011's deadly cholera outbreak, which claimed 4,000 lives, MSF is still working to contain the epidemic and to provide emergency medical care. Access to free care in Haiti remains virtually non-existent for most people – especially those who are far from urban centres, or who cannot afford healthcare in Haiti's private facilities.

In the aftermath of the January 2010 quake, MSF launched the largest emergency response in its history, providing care for 358,000 people, conducting 16,570 surgical operations and delivering 15,100 babies over a 10-month period. MSF has supported a Ministry of Health hospital in the Cité-Soleil slum and built four emergency hospitals in the area affected by the quake, serving a population of more than two million since the earthquake.

During the October 2010 cholera epidemic, MSF mounted a huge operation with more than 75 healthcare facilities and 4,000 personnel deployed throughout Haiti at the height of the crisis. Nearly 170,000 patients were treated between October 2010 and November 2011. The threat of a recurring outbreak is very real and MSF has an emergency preparedness plan for a rapid medical response.

## Voice from the Field

Haiti ©MSF

Marilize Ackerman

**Marilize Ackerman (33) recently worked in Haiti for eight months with MSF as a Human Resources and Finance Manager. She worked on two MSF hospital projects in the island nation's capital Port-au-Prince.**

"Most of my mission was spent at Choscal Hospital in the heart of Cite Soleil, the biggest and poorest slum in Haiti. MSF has been supporting the Ministry of Health and Choscal hospital since 2010. By the time I arrived in 2011, MSF was providing a much bigger range of services, 24 hours a day. Working with a very capable team, I was responsible for the administration, finance and human resource management of 290 MSF staff and 150 Ministry of Health staff.

Port-au-Prince is hot, dusty and very polluted. There is no public waste removal system and clean water is hard to come by. Many people still live destitute lives in tents, with nowhere else to go. The rubble and ruins are still there, even the wrecks of flattened cars.

Each of my Haitian colleagues had their own story about the earthquake and could recall the exact moment it hit – where they were, what they were doing, how they felt. Everyone lost someone dear to them.

Even though I had an office job, I loved meeting patients and staff. My favourite patients were the premature babies, called "petit poids" (directly translated from French as 'small weight'), not so far from the word "petit pois" or 'small peas'! Many mothers had extremely poor health, so we had lots of premature babies, some weighing as little as 800g."





# SA MEDICAL EXPERTISE IMPRESSES MSF

South Africa © MSF

Dr Mohammed Dalwai

## MSF to adopt South African triage system after trials in Pakistan

Imagine for a moment you are working in an emergency room after a critical incident – a bomb blast or traffic accident which leaves scores of people injured. They are all brought in at the same time. How will you ensure those most in need get treatment first?

This daily reality prompted the development of triage systems to reduce the waiting times for patients in critical need of care. Triage systems assign priority to patients according to physiological and clinical observations which help to identify critically ill or injured patients on arrival.

Now, the experience of an MSF South Africa recruit working in Pakistan, Dr Mohammed Dalwai, has led to the gradual implementation of the South African Triage Score (SATS) in MSF projects after its initial success in Timurgara Hospital.

Faced with high numbers of critical trauma cases in Pakistan's volatile Khyber Pakhtunkhwa province – like gunshot wounds and complicated deliveries – Dalwai found the SATS was ideally suited to improving patient survival while ensuring smooth functioning of emergency rooms. Following great results – with 96% of patients being correctly triaged – MSF is now considering adopting the SATS as its own standardised emergency protocol in several countries where teams provide emergency medical care. MSF is also testing the SATS in MSF-supported hospitals in Haiti and Afghanistan, and will soon trial it in several African countries.

Dalwai, currently working as a surgical medical officer at Worcester Hospital in the Western Cape, presented the results of his experience implementing the SATS in Pakistan at the annual Emergency Medicine Society of South Africa conference in Cape Town in November 2011.

"Introducing the SATS in Timurgara Hospital was not easy. We had to adapt it to the Muslim culture, overcome language barriers and train staff without imposing too much. I taught one doctor how to use the SATS and he taught the others. In the end, we had good camaraderie and we shared experiences and clinical knowledge," says Dalwai.

"Emergency rooms in the developing world are very much like some South African state-run hospitals: often understaffed, under-resourced, overcrowded and underfunded," Dalwai explains. By contrast, existing triage systems used in developed countries need extensive staff training and are often too labour-intensive, making them unsuitable for effective use in developing countries where MSF works."

The SATS evolved out of the Cape Triage Scale which was established in 2005, thanks to the input of South African paramedics, doctors, nurses and emergency doctors. "South African medics are well equipped to deal with difficult issues because that's what we see every day," adds Delwai.

While many triage systems are based mostly on a physiological score, the SATS includes a 'discriminator' list (which can be adapted to the context) to identify and predict conditions not picked up in the range of physiological signs. Using these two stages, patients are triaged into four levels of seriousness, with target times for treatment.

Pakistan © MSF

Dr Mohammed Dalwai with colleagues at Timurgara Hospital



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Find out more: www.urbansurvivors.org

# URBAN SURVIVORS

## Humanitarian challenges facing the world's rising slum population

In 2009, for the first time in the history of humanity, more than half the world's population lived in cities rather than rural areas. Drawn by economic opportunity, the huge influx of people to urban areas has swelled existing slums and created new ones. More than 800 million people now live in slum conditions.

Through its work in urban areas throughout the developing world, MSF has seen first-hand the public health impact slum environments have for inhabitants wherever they are.

Recognising the unique challenges of urban health problems, MSF is responding in many ways. Urban Survivors is a collaborative MSF photography project which highlights the critical humanitarian and medical needs that exist in slums around the world – Dhaka, Johannesburg, Nairobi, Karachi and Port-au-Prince. Visit the interactive website www.urbansurvivors.org to find out more.

1 Bangladesh © Stanley Greene/Noor

2 Bangladesh © Francesco Zizola/Noor

1. Dhaka | The Kamrangirchar peninsula used to be the dumping ground for Dhaka's trash, but is now home to 400,000 people living in makeshift houses built on toxic water from the city's industries. MSF runs therapeutic feeding programmes for residents wracked by malnutrition.

2. Nairobi | A train slows down as it passes through the sprawling Kibera slum in downtown Nairobi. Despite the high risk of disease, residents have very little access to healthcare. MSF runs three primary healthcare clinics in Kibera, offering integrated care for chronic diseases like HIV/Aids.

3 South Africa © Pep Bonet/Noor

4 South Africa © Pep Bonet/Noor

5 South Africa © Pep Bonet/Noor

6 Pakistan © Alixandra Fazzina/Noor

7 Pakistan © Alixandra Fazzina/Noor

8 Haiti © Jon Lowenstein/Noor

**3, 4, 5.** Johannesburg | Numerous inner-city slum buildings dot the city centre where countless vulnerable migrants seek shelter. These buildings are overcrowded, warren-like spaces, which lack proper waste and sewage management, with poor water supply, and little or no electricity. Thomas Kanuwera (4) arrived in South Africa from Zimbabwe in 2005. In 2010, he was dragged out of his house with his hands and legs tied and tortured. He spent six months in hospital recovering from the burns on his back. MSF runs two mobile health units that move through the inner city slums to provide medical screenings, counseling, HIV testing and referral services to residents.

**6, 7.** Karachi | Displaced four year old Farzana crouches in her family's makeshift roadside shelter at the edge of a sprawling camp slum outside Karachi. She attends a weekly MSF nutritional clinic with her mother. After devastating floods hit Pakistan in July 2010, hundreds of thousands were left homeless and vulnerable. About 100,000 people fled to Karachi, the country's largest city. Responding to the needs, MSF opened mobile clinics and organised the distribution of clean water and relief items.

**8.** Port-au-Prince | Chantale* was assaulted and raped while walking in her neighbourhood. Here she speaks to an MSF psychologist. MSF offers psychological treatment and medical diagnoses to help treat victims of sexual violence, who are mostly women. The 2010 earthquake left in its wake further dislocation, insecurity and abuse of women, particularly in most slum areas. *Name changed.



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# TB & HIV: HELPING PATIENTS FOLLOW THEIR TREATMENT

Patients face many obstacles in taking their TB treatment, requiring a wide-ranging approach

Myanmar © MSF

Dawn is just breaking when MSF counsellor Aung Hein Maw begins his day. Every day, Maw makes the journey to various villages in the Dawei and Myeik districts in southern Myanmar. In the early morning mist, one can just make out the silhouettes of palm trees and women working in the paddies. As the driver avoids the potholes, Maw checks his list of patients to visit. Most of them are "defaulters" or patients who were diagnosed with HIV or TB-HIV co-infection at the clinic who have either failed to come back for their appointment on time or who have problems adhering to the treatment. For people living with HIV, TB is the most common opportunistic infection, and the main cause of death.

Treating HIV-TB co-infection is a challenge when dealing with a moving population. In Dawei, which is home to many migrant workers, MSF runs a HIV clinic and outreach counsellors play a key role in helping patients stick to the treatment, which is critical to their recovery. There are currently four counselors working in villages in Dawei and the neighbouring district of Myeik, where together they track around 300 patients.

When patients first start on a TB treatment regimen, they should come at least once a month to the clinic so that staff can monitor their progress. However, they don't always come. "We go and find them in their villages and offer extra support for them to come back for their appointment. Then we follow up and ensure they are taking their drugs correctly," explains Maw, "but we also visit patients when they are at a critical point of their treatment or are experiencing side-effects and need more support."

Distance is one reason why patients fail to come back. The drive from Dawei clinic to these villages can take several hours, and the road is not good.  MSF covers transport fees when patients are too poor to pay themselves, but in most cases there are other reasons why patients interrupt their treatment.

Some lack a proper understanding about how vital HIV/AIDS or TB treatment is. The local population is poor and made up mainly of fishermen and day laborers working in paddy fields or rubber plantations. "Sometimes patients don't understand the disease well, or how to take their pills; sometimes they find it hard to come or they need to work," explains Maw. "We've had cases where people were in denial or scared of discrimination; other times it can be because of the side-effects the drugs can cause. For this reason, MSF also focuses on general health education about the disease."

Myanmar © MSF

Myanmar has one of the highest HIV-TB co-infection rates in southeast Asia. MSF, which has been working in the country since 1992, is currently the biggest provider of ARV medication, with more than 18,000 people on treatment. Of these, around 2,450 also receive treatment and counseling for TB.

# BACK FROM THE FIELD: GARRET BARNWELL

Assistant Project Coordinator, Somaliland

Garret Barnwell, aged 26, originally from Sedgefield, studied Psychology and Political Science at Nelson Mandela Metropolitan University in Port Elisabeth. After completing a diploma in Humanitarian Assitance with the Liverpool School of Tropical Medicine (hosted by Wits University), he joined MSF South Africa. His initial assignment was to document the experience of Somali refugees in Johannesburg, but he was soon recruited as a fieldworker. Garret's four month mission to Somaliland was his first with MSF and he is currently working in Lebanon.

**Somaliland is often confused with Somalia – can you explain the difference?**

Somaliland, which borders Ethiopia to the south, Puntland to the east and the Gulf of Aden to the north declared its independence from Somalia in 1991 after Somali military ruler Siad Barre was deposed. Although Somaliland is not internationally recognised, it has its own government, political system, police force and currency, and its officials are working hard to win support for it to be acknowledged as a sovereign state. As such, Somaliland has escaped the chaos and violence that continues to plague Somalia, but there is still widespread poverty and unemployment.

**What were you doing with MSF in Somaliland?**

I was the assistant project coordinator with MSF in Burco General hospital in the Toghdeer region in Somaliland. Here MSF works alongside and trains existing Somaliland hospital staff and we provided drugs and medical equipment while also rehabilitating the infrastructure of this old 140 bed hospital. Around 350,000 people in the region depend on the hospital's free healthcare provided through the maternity, paediatric and surgical wards and services.

**There is an impression that most MSF jobs are medical, but what does an assistant project coordinator do?**

I was helping the field coordinator to support the medical activities of the project. This involves everything from paying staff salaries to managing security. A lot of my time was spent meeting with community leaders and hospital staff, solving problems and making sure everything was running smoothly.

Somaliland © MSF

**What was the environment like and where did you live?**

The area itself is extremely dry and dusty with a climate similar to the Kalahari. The people of Somaliland are pastoralists and they depend on the livestock trade to survive. During my time there the rains were very sporadic and this obviously had a huge impact on the people's herds and livelihoods I lived in the MSF compound with other MSF staff in a local village and everyday we'd travel to the hospital down the road.

**What is the most vivid memory from your four months in Somaliland?**

I met a little 6 year-old girl called Feilsa who arrived at the hospital in a coma. The medical staff discovered she had type-1 diabetes and they had to teach her and her family how to manage it. I'm diabetic too, so this really hit home. If Feilsa hadn't made it to our hospital, she would have died. In these very remote places, it's tough to manage chronic conditions like diabetes effectively, and it can easily lead to life-threatening emergencies if timely and correct medical care is not available. Luckily, the hospital was there and the staff knew how to help Feilsa.

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**MSF in South Africa: Our recruits on missions in the field in 2011**

Virginia Kinyajui – Nurse – Nigeria
Tinne Gils – Pharmacist – Lesotho
Adeleine Oliver – Nurse – Afghanistan
Dmitry Staroverov – Anaesthetist – Somaliland
Kokola Kabengele – Doctor – Malawi
Garret Barnwell - Liaison officer – Syria
Vanessa Naidoo – Anaesthetist – Afghanistan
Chenai Sekai – Nurse – Uzbekistan
Chipo Twakira – Water & Sanitation Technician – South Sudan
Everlyn Wachira – Nurse – Egypt
Sedi Mebalani – Nurse – Niger
Natalie Valhakis – Doctor – Lesotho
Patricia Nyoni – Nurse – Swaziland
Luke Gordon – Doctor – Gaza

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