Doctors Without Borders (MSF) South Africa
Issue 12 Volume 5 March 2014

mamela

Central African Republic: People on the brink

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Refugees

Caught in the crossfire

MSF provides medical assistance to thousands of refugees and IDPs in Central African Republic and South Sudan.

Millions of refugees remain stuck in horrendous living conditions, often facing further violence, disease, and uncertainty about their futures. They may be dependent on the assistance of local governments and local or international aid agencies to survive.

They are children, women, and men living in temporary shelters, camps, or shanty towns, struggling to survive in new and often hostile environments.

The main causes of serious health problems and loss of life among refugees and displaced populations are measles, diarrhoeal diseases, acute respiratory infections, malnutrition and, in areas where it is endemic, malaria.

More than 70,000 people have fled violence in Bor, the capital of Jonglei State, since fighting broke out in December. MSF has sent emergency teams to Awerial, Juba and Malakal to bring health care to tens of thousands of people.

Following confirmation of measles cases among children in several camps for internally displaced people in Bangui, Central African Republic, MSF is vaccinating 68,000 children in five camps in the city in order to prevent an outbreak.

These situations are ongoing, and we need your help to ensure our continued support to those facing the crisis.

What your support can do

R100 purifies around 200,000 litres of water to provide 10,000 people with safe drinking water for one day

R750 provides measles vaccines for 350 children to prevent potential outbreaks

R7,000 provides a first aid kit to our doctors, enabling them to respond to medical emergencies

R13,000 purchases a dispensary tent where people receive life-saving treatment every day.

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Editorial

Missing in action: Adequate humanitarian response in CAR

Stephen Cornish – a director at Doctors Without Borders (MSF) and a former fieldworker – recently spent time in Central African Republic, where MSF works in 12 locations.

Stephen Cornish in Bossangoa, CAR, with an MSF colleague.

A year ago, few South Africans would have been able to point out Central African Republic (CAR) on a map.

But in March 2013, thirteen South African paratroopers were killed near the capital, Bangui, in the wake of a coup d'état which ousted President François Bozizé – unleashing a year of chaos and desperation.

For years CAR has quietly disintegrated outside the world's gaze, only to be thrust into the international spotlight since December 2013 as a spiraling humanitarian catastrophe plays out amidst horrifying inter-communal strife.

Today, nearly one million of the country's 4.6 million citizens have been forced to flee their homes and reports of gruesome, targeted reprisal killings have become commonplace.

The level of violence MSF teams see daily is unprecedented. International efforts to protect the people of CAR and meaningfully increase humanitarian assistance to meet even the most basic needs of the people have failed.

Although the conflict is complex and all communities are affected by the violence, the minority Muslim community is increasingly targeted. The different armed groups, the ex-Séléka and the 'anti-Balaka', and scores of bandits, prey on unprotected civilians – people living in constant fear for their lives fending for themselves in a climate of terror.

This brutal unravelling of society can be read on the bodies of our patients, both Muslim and Christian, who continue to suffer gunshot wounds and deep cuts from machetes.

At Bangui's Community Hospital, we treated 584 patients, one third of whom required emergency surgery. At the M'Poko Airport camp, where approximately 100,000 people are taking refuge in squalid conditions, teams provided medical care to 265 wounded in January alone, including 100 people in the final week.

Nearly half of Bangui's residents – 410,000 people – are displaced and humanitarian aid remains inadequate in the poorly assisted camps where they seek refuge.

People have access to just 4 litres of water per person per day – as opposed to the 20-25 litres required for emergencies. So far, only 3,400 families have received shelter. The needs are massive: MSF provide well over 12,000 medical consultations every week to people in the M'Poko Airport camp, at two monasteries and in the Muslim district, PK5.

Outside Bangui, in eight different places where MSF works, 15,000 civilians are trapped in hospitals, churches, or mosques, living in fear of being killed by armed groups outside. In the town of Bouar, 6,000 Muslims are trapped, fearful of being targeted if they try to leave. MSF has opened mobile health posts in many of these enclaves, including in Bangui, as people are too fearful to go to the hospital even if it is only a short walk away.

Since January nearly 200,000 Muslims have fled the country, even under the protection of African Union peacekeeping forces. In late January 8,000 displaced Muslims living in Bossangoa, 300km north of Bangui, loaded their families and possessions onto a fleet of hired trucks and fled the country in terror.

Some people thought the bolstering of international armed forces in CAR and President Djotodia's, resignation in favour of Catherine Samba Panza in December, augured well. But the reality is that despite the UN deploying seasoned staff to the country to scale up assistance, and pledges of aid by the European Union and UN, the overall response is a failure and insufficient in the face of the enormous needs.

This is not the first time that MSF has raised the alarm. Since March last year, we've called for an urgent increase in aid and funding. In December we took UN agencies to task over a lack of sufficient response and they have since increased their presence. But they must show that they are capable of meeting the needs.

It's worth remembering that many of history's worst inter-communal atrocities were known about and publicised at an early stage. The world must take notice and act.

Pharmagate

The plot against public health exposed

In January the *Mail & Guardian* published a front page story exposing how a multinational pharmaceutical coalition, under the guise of IPASA (Innovative Pharmaceutical Association SA), intended to delay reforms to South Africa's intellectual property (IP) laws, through an unethical and deceptive lobbying campaign bankrolled internationally.

The goal of the strategy, crafted by US firm Public Affairs Engagement (PAE), was to delay the finalisation and adoption of the draft National Policy on Intellectual Property until after South Africa's general election, and ultimately to ensure the final policy document is more favourable to industry. This, according to PAE's strategy, would also seek to prevent other countries from following South Africa's lead. The strategy required a vigorous counter to the pro-healthcare reforms MSF, TAC and SECTION27 have been calling for –

© Roy Potter

reforms that would improve access to more affordable generic medicines in South Africa.

Following these revelations, IPASA's entire executive committee stepped down.

Health Minister Aaron Motsoaledi called the plan "tantamount to genocide" and a "plot of satanic magnitude", and said that he would prioritise finalising the IP policy.

Julia Hill, of MSF's Access Campaign, explains some of the proposed changes.

"The draft IP policy includes reforms that are not extreme. For instance, the proposed patent examination system would reward truly innovative patents and weed out frivolous applications.

"To have foreign companies willing to spend R6 million on a campaign to dissuade government from pushing legislation that promotes access to more affordable medicines is outrageous. The government is bringing national law in line with international norms, so they have the ability to take action when inflated prices put crucial medicines out of reach," says Hill.

News from the field

Philippines: After the storm

Four months since the devastating Typhoon Haiyan ripped through the Philippines, MSF continues to help people affected by the disaster to rebuild their lives.

"Electricity and water are now available. Shops, businesses and schools are open. Some homes are being rebuilt and temporary shelters are being created for those who were made homeless by the typhoon," says Foura Sassou Madi, Head of Mission.

In both Guiuan and Tacloban, MSF will continue to provide surgery, hospitalised medical care, psychological support, and other medical services until the capacity of the local health service has been restored. MSF is providing healthcare from inside an inflatable hospital in Tacloban.


© Julie Remy

The inflatable hospital in Tacloban.

"Though people are trying to get back to normal, they are starting to realise that 'normal' is just not there anymore," explains Alexander Buchmann, Emergency Coordinator in Guiuan where MSF runs a 60-bed tent hospital. "In Guiuan, there is no one who wasn't affected by the typhoon. People lost their homes, their jobs, their loved ones – these scars will take a long time to heal."

MSF SA fieldworkers, midwife Zani Prinsloo and nurse Mdududzi Chandawila, set off for the Philippines in December, and both worked in Guiuan. On their recent return to South Africa, they reported that, despite the devastation, people were welcoming, and grateful to MSF staff who had arrived to help.

"The people were so warm," says Chandawila. "There were thank-you notes and posters stuck on fences."

Making a difference

Our Johannesburg face-to-face team.

Our passionate face-to-face crews

You may have come across MSF SA's face-to-face (F2F) fundraising teams in local shopping malls where they engage directly with South Africans daily on how to support medical care for people in crisis. You may even have signed up as an MSF donor after speaking to them.

What motivates them to keep telling people about the work MSF does, and what do they get in return?

"As MSF canvassers we don't earn commission. This is a big part of what separates us from other organisations raising funds in South Africa. We don't do this work solely for money, we do this to help a cause we believe in passionately," says Kelly Barlow, F2F coordinator in Cape Town.

Sibusiso Maseko, our team leader in Johannesburg, explains that, while they are canvassing for potential donors, F2F teams are also sharing important information about the medical humanitarian work MSF fieldworkers do.

"Half the job is putting the message out. Even if someone doesn't sign up as a donor, they should walk away more informed about the work that MSF does."

And while the occasional rejection may be difficult to take, Sibusiso remains excited by his work.

"I'm actually quite shy. But I'm there with an important message, so it's easier to speak up. And for every negative person you meet, there are a few more positive people who are genuinely impressed by the work of MSF and really want to help," Maseko says.

"I recently had a woman come up to where we had set up in a mall. We didn't even have to approach her. She told us, 'I've heard about you and have been looking for you'. And she signed up straight away."

Leaving a legacy of lifesaving care

MSF South Africa is fortunate and incredibly grateful to have received a donation of more than R1 million from the estate of Betty Noakes. Noakes passed away in December 2012 at the age of 98 in Makhado, Limpopo.

When people like Betty remember MSF through a legacy in their will, they make a unique commitment to a cause that makes a real and direct difference in the lives of people facing crises. Through her generous gift, Betty has enabled us to continue our life-saving work.

By leaving a legacy to MSF you too can ensure that our financial independence, which enables us to provide medical care where and when it is needed most, continues. Your contribution is invaluable, whatever the amount.

For more information, contact Claire at 011 403 4443 or claire.hawkridge@joburg.msf.org

Update your status to stay informed

We have just implemented a new database. It will allow us to improve our relationships and interactions with all our donors. We encourage you to update your contact details, so that we are able to send out your tax certificates before the start of the tax season. Please contact Chipo at **0800 000 331** or by email: **donorservices@joburg.msf.org**.

In focus: Central African Republic

Rain does not wash the blood away

José Mas Campos, MSF's Emergency Coordinator in Central African Republic's capital, wrote this piece in response to the violence which has displaced nearly 500,000 people and pushed an already fragile state to the brink of catastrophic collapse.

© Juan Carlos Tomasi, MSF

The sudden escalation of sectarian violence has heightened the fear and desperation within communities, with thousands of people fleeing their homes.

The dawn of 5 December in Bangui bore no resemblance to any other day. There were no cicadas buzzing or roosters crowing early that morning. There were no people hustling and bustling in the market or the streets.

Then came the eerie screech of incoming mortars and the deafening thud as they exploded.

The shuddering thunder of anti-aircraft guns and submachine guns went on non-stop in the distance until around midday. At the Hôpital Communautaire, dozens of injured people crowded against the hospital gates, as weapons were cocked threateningly and the men brandishing them took away wounded 'suspects', despite the efforts of unarmed humanitarian workers who risked their lives by stepping in between the wounded and their captors.

That afternoon it rained. We already feared the worst. We feared that armed men, aligned with the Séléka coalition who had taken arbitrary and baneful control over the town, would break loose, aided by the darkness of night, and set off in retaliation. It would be bloody pursuit of everyone suspected to be collaborating with the self-defence militia, the anti-Balaka, who were responsible for the morning's fighting.

The Séléka forces would comb through entire neighbourhoods accused of complicity or cover-up, searching door-to-door. They would torture and execute every male between the ages of 15 and 40 in cold blood. They would burn down houses with entire families inside.

By dusk, the rain had turned into a storm. In a somewhat naïve way, some were comforted by the thought that the weather might appease their thirst for revenge. Others among us, seeing the drained faces of our colleagues who had spent the day fighting against the havoc wrought by war in the operating theatres, were less hopeful.

Much blood was shed that night. Hundreds of victims fell prey to that violence.

The next morning we went out in our ambulances, driving through the town in search of wounded people who might have survived the fighting and the rage unleashed under the cover of night. In that torrential rain we drove through the avenues, past dozens of bodies already piled up in the streets.

My main responsibility was to guarantee the safety and physical integrity of our patients, whoever they were, pregnant women or children, regardless of their origin or which side they were on. With no law in the city, any patient could have been forced out of our ambulance and killed with impunity, right there in the middle of the street.

The marauding mobs' derangement knew no creed or religion. Believers and non-believers followed the same wicked eye-for-an-eye, tooth-for-a-tooth rationale: "This one collaborated with the Séléka, let's destroy his shop", "This one burnt my house, threw a hand grenade which killed my daughter, he deserves to die", "This one is a Muslim, look him in the face and kill him, he isn't from here"...

Fortunately, we did not have to mourn any victims in our ambulances. We picked up people with gunshot, machete and shrapnel wounds. Some were carried to our clinic in wheelbarrows.

We treated open fractures, alleviated the suffering of torture victims and cared for traumatised girls. We witnessed shootings nearby our hospitals, and took shelter in the operating theatres while the walls shook during intense fighting. We worked our way through a flood of injured people. We saved lives.

The marauding mobs' derangement knew no creed or religion.

We helped thousands of terrified displaced people who took shelter in more than 30 sites across the city, addressing their medical needs. We tried to prevent malaria from snatching away the life of yet another child forced to live out in the open. We tried giving the hundreds of pregnant women the chance to give birth in a safe, clean environment assisted by professionals.

It's precisely because so few people in the world, including South Africans, knew about Bangui and the woes of CAR, until this recent wave of brutal violence, that you push your limits and the limits of others.

Here, our work acquires significance. What we do is essential: providing medical care and sounding the alarm to prevent this chain of successive atrocities, violence and revenge from happening – not only before the eyes of international leaders, but also before the eyes of ordinary people in a city on the brink of hell.

This article first appeared in Spanish newspaper, El País.

© Sylvain Cherkaoui, MSF

Local men sit outside the maternity ward at the MSF hospital in Bangui.

© Samuel Hanryon, MSF

More than 40,000 people fleeing the fighting and looting, have massed on the outskirts of Bangui airport.

© Juan Carlos Tomasi, MSF

An MSF support team take cover from gunfire on their way to the Castor Health Centre in Bangui.

TB behind bars

Treating Ukraine's prisoners

At an ongoing tuberculosis project in the Donetsk region in eastern Ukraine, MSF provides treatment and support to inmates suffering from drug-resistant TB (MDR-TB).

This project has faced many challenges over the years. Beyond the difficulties of trying to control a concentrated epidemic in such a claustrophobic and restricted environment, MSF staff have faced suspicion and resistance from prisoners. Locals outside of the prison have also questioned MSF's motives in caring for such a marginalised sector of society.

Successful TB treatment requires that patients adhere to their medication regimens over an extended period of time. While patients within the prison can be monitored, those due to be released need intensive adherence counselling to ensure that they stick to their schedule once they return home to their communities.

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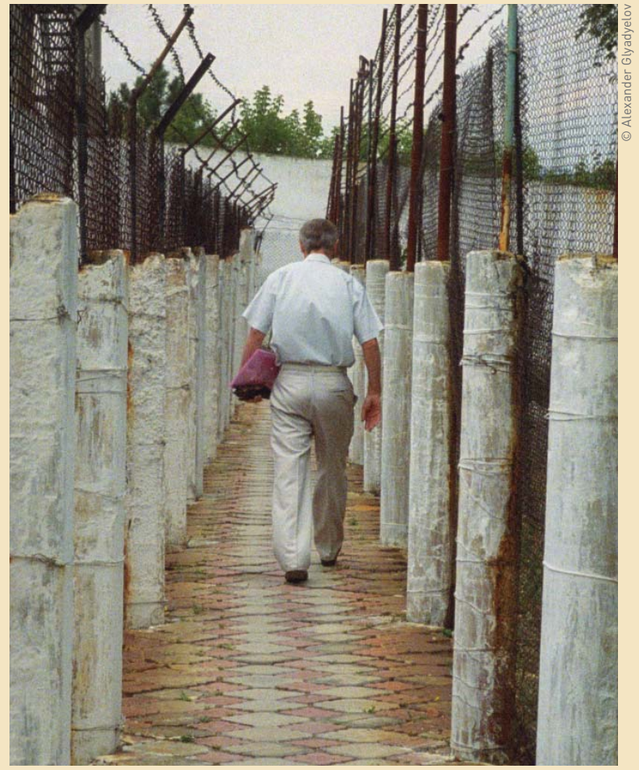

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(Clockwise, from below right): (1) Medical Director of the Colony 3 TB prison, Dr. Nikolai Gopilo, walks to one of the compounds where prisoners with drug-resistant TB are held. (2) A TB patient takes his daily treatment under supervision inside the Colony 3 TB prison. (3) Donetsk is Ukraine's industrial heartland. (4) A DR-TB patient sits inside his cell. He is about to be released from prison on medical grounds, as he has a heart problem and is very ill from DR-TB. (5) A nurse explains to him the necessity of taking his daily dose of medication after his release. (6) Prisoners that are about to be released get information about their release conditions from prison staff.

Perspectives

Speaking a language of healing

Gail Womersley is a clinical psychologist who has worked with MSF in the Ukraine, where she worked at a TB treatment project in a prison, and in South Sudan. She is currently in Central African Republic.

Since I can remember, I have always been fascinated by the sameness and difference of people across culture, gender, age and race. Are we essentially all the same, or unique and complex individuals shaped by our different contexts and experiences? Can we even begin to understand each other? These questions occupy my mind as I navigate the world as a clinical psychologist working with MSF.

Words are the tools of my work in understanding the people MSF treats. The big question is always how best we are able to access the internal world of our patients without even necessarily being able to speak the same language in the different places where we work.

I remember sitting with a group of children in a rural village in South Sudan. Most of them had lost parents due to conflict in the region. All of them had stories to tell of fleeing from armed men and hiding in the bush. I knew very little about this world that had exposed them to so much at such a young age.

Not all children have had to face such traumatic situations, but all children know the language of playing with toys and sharing stories. So I picked up a stuffed toy bird and started sharing a story. Many tiny faces stared wide-eyed up at me with intent curiosity as I introduced them to this bird named "Thomato".

Thomato was a brave little bird who had seen some very scary things. He had lost his father when he ran away from men with guns and into the bush. Thomato had nightmares of war and was too sad to play with his friends like he used to.

I asked who else had a story like Thomato, and then watched all the little hands shoot up. Because Thomato was scared like them, they felt safe to share their stories. They also had nightmares, they also felt sad and they also jumped when they heard sounds resembling gunshots. Children exposed to violence in Afghanistan, Pakistan and Syria would have said the same.

After sharing what made us scared and sad, we turned to what made us happy. Their number one answer? Football!

I learnt that these children in South Sudan are the same as any other. They may not speak English, but they also get sad when their parents shout at them. They would also rather be outside playing with friends than doing chores and they also laughed when I made silly sounds with my voice.

© Phil Moore, MSF

A child in Juba, South Sudan at an MSF facility.

Our patients are people: whether children in conflict-riven South Sudan or fearful Russian-speaking prisoners in snowy Ukraine. Working in Donetsk, I encountered so many people telling me that our inmate patients are "just criminals, nothing more than animals." Yet, I sat with these men, many of whom were convicted of rape and murder, and we spoke about love.

Many missed their wives and children. Many were unsure of whether their girlfriend would still love them when they got home. Many just wanted to make their mother proud. They were uncertain and shy, vulnerable in love, sons, fathers and husbands and hated feeling nauseous due to the medication.

The truth is that we are all human beings who love and who cry and who are scared. This is one of the most important lessons I have learnt – one crucial to accessing the humanity of our patients living in different countries around the world.

Letter from the field

Gunshots in our backyard

MSF SA fieldworker and nurse, George Mapiye, has worked in Zimbabwe and in Somalia. Following MSF's difficult decision to withdraw from Somalia in August 2013, George has been on assignment in South Sudan since November.

George Mapiye
Nurse

Assignment:
Lankien, South Sudan

George Mapiye attends to some of his patients in Lankien.

When the fighting broke out in South Sudan on 15 December, we prepared ourselves to receive a flood of injured patients in Lankien. Even though the major violence, which pitted rival factions within the armed forces against each other, was centred in the capital (Juba). We knew it would come. And it did.

Three days later, while most MSF staff were relaxing after a hard day's work, we heard gunshots not far from our hospital. Inside the MSF compound, we went to our safe room. Then the gunshots drew closer. We could hear people running and screaming around in the village. After about four hours of chaos, things calmed down.

The next day we found out what had happened. When the war broke out in Juba, all the soldiers in barracks near our compound were disarmed to prevent them from fighting among themselves. The soldiers were from the two rival communities, the Nuer and the Dinka. But despite this precautionary measure some soldiers got access to the guns.

Surprisingly we did not receive any gunshot wound patients after this shooting – mainly because there were hardly any survivors.

Among those killed was a woman and her child. The woman was trying to protect her soldier husband from being killed. She begged the attackers not to kill him, but it was in vain. Her young child was caught in the crossfire.

Surprisingly we did not receive any gunshot wound patients after this shooting – mainly because there were hardly any survivors.

In the days that followed, the remaining Dinka soldiers were moved from Lankien to a safer place. Although we were assured that nothing would happen, we couldn't risk being caught in the violence. The whole MSF team, local and international staff, were temporarily evacuated to Nairobi, Kenya.

A few of us have since returned to treat the most serious medical needs. We still hear gunfire at night. When we ask, we are told that this is celebratory gunfire marking that rebel factions in the military have won control in major towns.

I feel glad to have been able to treat the needs of people forced to flee. I am grateful to my team members and our coordinators. When I look back, I can say we did well.

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

Are you qualified and interested, or do you know someone who is?

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

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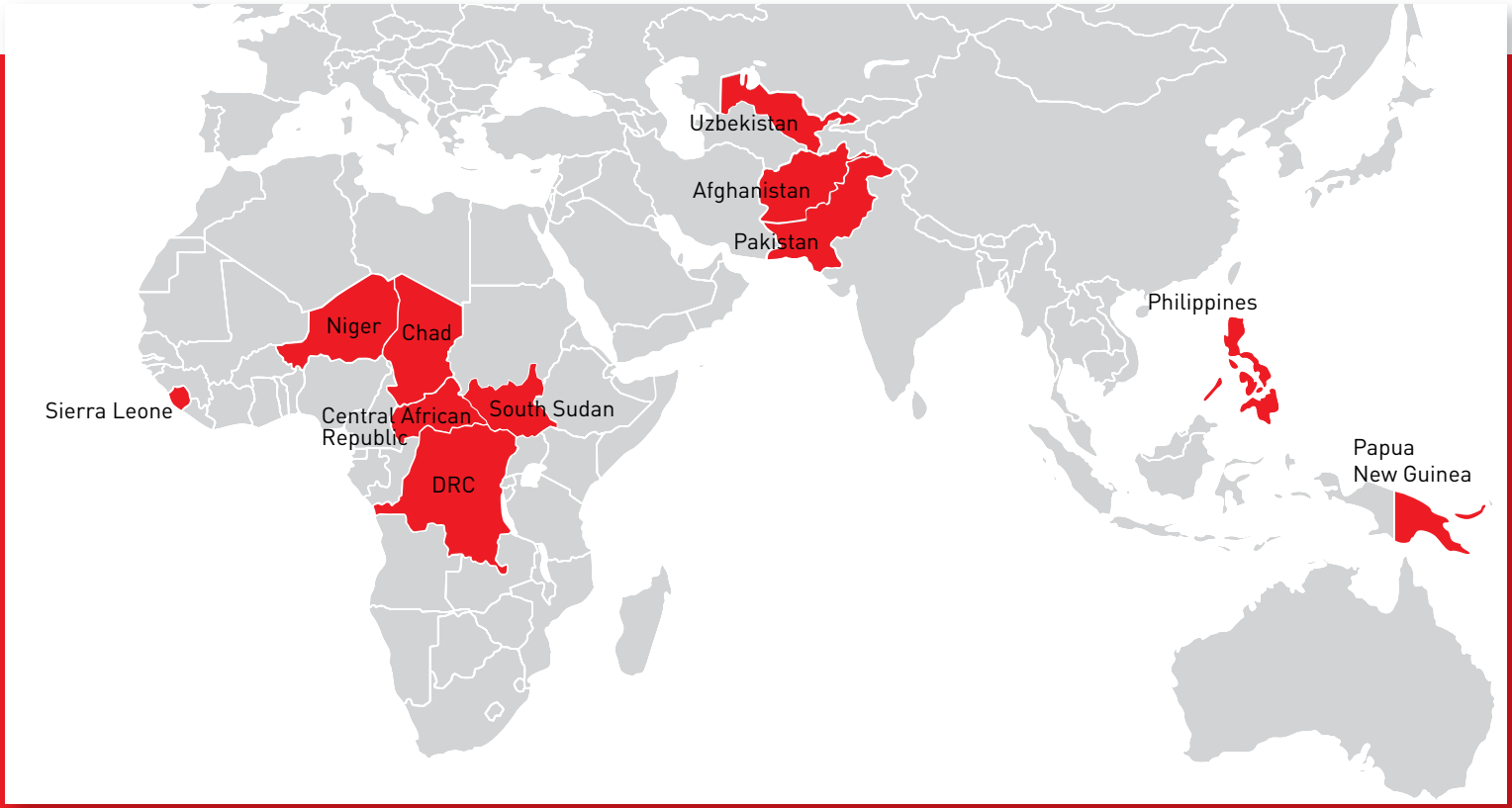

MSF SA Fieldworkers on assignment (November 2013 - February 2014)

Adeline Oliver, Nurse - South Sudan

Alain Godefroid, Nurse - Chad

Anna Cilliers, Nurse - South Sudan

Annick-Berth Ndawana, Medical Doctor / HIV/TB - DRC

Augustine Majiku, Nurse - Central African Republic

Carol Kaburu, Midwife - DRC

Chipo Takawira, Epidemiologist - South Sudan

Christopher Crede, Base Logistics Manager - DRC

Duncan Owino, Medical Doctor - Afghanistan

Esther Wanjiru, Medical Doctor - Sierra Leone

Gail Womersley, Psychologist - South Sudan

George Mapiye, Nurse - South Sudan

Huggins Madondo, Water & Sanitation Manager - Niger

James Simukoko, Pharmacist - Uzbekistan

Jonas Nasenda, Medical Doctor / HIV/TB - Central African Republic

Jorge Gillis, Anaesthetist - Central African Republic

Joyce Njenga, Midwife - Sierra Leone

Juli Switala, Pediatrician - Afghanistan

Mduduzi Chandawila, Nurse - Philippines

Michael Mojeed, Medical Doctor - Afghanistan

Mohammed Dalwai, Medical Doctor - Haiti/ Afghanistan

Patricia Chipo, Nurse/Anaesthetist - Afghanistan

Pierre Kibasomba, Water & Sanitation Manager - South Sudan

Priviledge Ruredzo, Admin & Finance - Sierra Leone

Tabitha Mutseyekwa, Nurse - Papua New Guinea

Zani Prinsloo, Midwife - Philippines / Pakistan

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