Doctors Without Borders (MSF) South Africa
Issue 13 Volume 6 August 2014

mamela

South Sudan:
A perfect storm

The growing crisis in South Sudan is leaving the population at risk of violence, malnutrition and disease.

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

A little goes a long way

Malnutrition is one of the most common problems affecting many of places where MSF works. But it does not cost a lot to save a life.

In some countries, such as Niger, food insecurity is a chronic problem due to a combination of adverse climate conditions and political instability. In others, such as South Sudan, violence and conflict, and the effect these have on communities, mean that seasonal planting or harvesting is disrupted. This leads to a dangerous "hunger gap" – a situation where the available food resources cannot support the population, or, in the worst-case scenarios, nutritional emergency.

MSF teams routinely include feeding programmes as part of their interventions, with a particular focus on the feeding of children under 5, who are most at risk for secondary complications or death resulting from malnutrition. Children are also more at risk of developing measles or malaria, both of which are more deadly if a child is malnourished. MSF runs measles vaccination programmes to counter this, and to protect whole families.

It does not cost a lot to feed a child. A small donation can make a big difference.

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

mamela

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

For donor-related queries, please contact donor services at donorservices@joburg.msf.org or toll-free on 0800 000 331

facebook
www.facebook.com/MSFsouthafrica

twitter
www.twitter.com/MSF_southafrica

YouTube
www.youtube.com/msf

Editorial

African conflicts: What role for South African civil society?

Dimitri Eynikel, MSF South Africa researcher, reflects on local and international responses to the crises playing out in Central African Republic and South Sudan.


MSF © Yann Libessart

In Carnot, around 900 displaced Muslims are staying at the Catholic Church in crowded and unsanitary conditions, guarded by African Union soldiers from Cameroon. MSF provides medical care, water and food supply and sanitation.

The people of Central African Republic (CAR) and South Sudan are subjected to high levels of violence where armed groups often intentionally target civilians with deadly force. This has led to high levels of displacement as people flee their homes, sometimes across borders into neighbouring countries. Intensely vulnerable, these traumatised people struggle with a lack of security, medical care, drinking water and food.

As a medical organisation, the first priority of Doctors Without Borders (MSF) is to provide healthcare to people in severe need. Through our presence and through caring for the sick and wounded, our doctors and nurses are often first-hand witnesses of brutal violence directed at people. Speaking out about abuses, MSF extensively uses these eyewitness accounts in the media and for our advocacy, urging the parties responsible (governments or armed groups) to respect the safety of civilians and aid workers, while we urge governments around the world to provide more assistance.

The sad reality is too few international efforts are made to help the people in distress in CAR and South Sudan. According to the UN, only a small percentage of pledged financial aid has been delivered, and humanitarian aid provided in the form of food, water, sanitation equipment and medical care is largely insufficient - or delivered only in very confined areas. In CAR, despite the presence of international peacekeeping troops, violence rages throughout the countryside and precious little political progress has been made to appease and contain the armed actors responsible for the violence.

The sad reality is too few international efforts are made to help the people in distress in CAR and South Sudan.

Because of this intransigent situation, MSF South Africa has urged other South African civil society organisations and influential leaders to step in, each with their own experience and in their own capacity. MSF has had deep and positive relations with many different civil society organisations in South Africa for many years. MSF and the Treatment Action Campaign (TAC) were on the forefront of putting an end to HIV-denialism, demanding quality medical care and protecting patient rights. In 2008, MSF worked with multiple civil society organisations in providing care during the xenophobic violence which broke out in South Africa and addressed the problems fuelling xenophobic sentiments.

On 17 March 2014, MSF organised a public discussion with a panel of experts and a recently returned MSF doctor on the causes and consequences of the conflict in CAR and the failing international response to the crisis. A crowd of 120 people gathered on a Monday evening - clearly demonstrating the interest among South African civil society in the situation in CAR. Throughout the lively discussion, the question, "what can we do?" was raised repeatedly. Taking the discussion further on Twitter, we used the #ActForCAR hashtag to keep engaging people and to promote awareness about our appeal. In a recent follow-up meeting, MSF hosted a follow-up discussion with a smaller group of interested civil society organisations to help define which course to take.

The civil society organisations expressed a clear willingness to publicly show their solidarity with the people of CAR and mobilise their networks and constituencies to create more attention and a better public understanding for the human tragedy.

With actions like these, MSF South Africa shares insight and a deep understanding of the problems based on our experiences from the field. MSF does not have all the answers. But we wish to empower our counterparts in different organisations to develop their own opinions and provoke a community-wide discussion on where and how South Africa and the African Union can make a positive impact on crises besetting CAR and South Sudan. We hope that this approach, coupled with our own lobbying efforts, will eventually lead to a more active and constructive involvement of the South African government and the African Union.

Africa cannot shy away from its responsibility to act, and cannot look to the West or East for solutions.

The conflicts playing out in CAR and in South Sudan are African problems. Africa cannot shy away from its responsibility to act, and cannot look to the West or East for solutions. Our governments, as leaders and representatives of our society, have a responsibility to use what is in their capacity to help people caught in these conflicts. South Africa, as a major state on the continent, cannot opt out. South Africans should speak out about our duty to act urgently.

TB Manifesto update

Phumeza triumphs in Geneva

XDR-TB survivor Phumeza Tisile has delivered the more than 55,000 signatures she collected for the Test Me, Treat Me TB Manifesto to the World Health Assembly, which took place in May.

The Test Me, Treat Me DR-TB Manifesto which she co-authored with MSF doctor Jenny Hughes, calls for urgent reforms to the testing and treatment options available to DR-TB patients around the world – reforms which could improve the rate of diagnosis, as well as make it easier for patients to adhere to treatment.

Phumeza, who is now permanently deaf as a result of the medication she had to take while she was ill, received a standing ovation from high-level delegates when she spoke of her own battle to overcome the disease.

"During my three-year ordeal battling XDR-TB, I saw more friends die of this horrible disease than any person should have to. I'm here in Geneva with a clear demand for Ministries of Health: we demand action, we demand accountability, we demand a better chance at survival. Do everything in your power because we can't wait any longer for change to happen," she said.

Despite the gravity of her task, to represent the interests of patients around the world as well as supporters who signed the TB Manifesto, Phumeza remained unshaken.

In a blog post about her experience, she said, "My turn came and I read my speech, I was so calm too while reading it, speaking truth to power."

MSF ©

As health ministers from around the world gathered in Geneva, Switzerland for the 67th World Health Assembly, Phumeza Tisile worked to turn their attention to the "Test Me, Treat Me" DR-TB Manifesto campaign's call to action.

News from the field

Five MSF staff released after detention in Syria

On January 2, 2014, five MSF staff were taken by an armed group in northern Syria, where they were working in an MSF-run hospital to provide essential healthcare to people affected by the conflict. Three of our colleagues were released on April 4, and the other two on May 14.

We strongly condemned this abduction, which forced MSF to permanently close one hospital and two health centres in the Jabal Akkrad region in northwestern Syria. In 2013, MSF medical staff in these three facilities performed 521 surgical operations, many for trauma wounds, 36,294 medical consultations, and safe hospital deliveries for more than 400 mothers.

"The relief of seeing our colleagues return safely is mixed with anger in the face of this cynical act that has cut off an already war ravaged population from desperately needed assistance," said MSF International President, Dr Joanne Liu. "The direct consequence of taking humanitarian staff is a reduction in lifesaving aid. The long-term victims of this abduction are the Syrian population."

"This incident is representative of the complete disregard shown toward civilians throughout Syria today," said Liu. "While millions of Syrians need assistance for their survival, among some of the armed parties to the war, the very idea of independent humanitarian presence is rejected. We should be running some of the largest medical programmes in MSF's 40-year history, in line with the massive needs of the Syrian people; but in the current environment our capacity to respond is painfully limited."

Syria © Nicole Tung

A logistics coordinator loads blankets, diapers, and other basic necessities on to a truck in preparation for a distribution to internally displaced Syrians in Northern Syria, 2012.

Fundraising

Your support is MSF's independence

Relying on private donations for our income means MSF's work is neutral, independent and impartial. But what does that all mean?

MSF was created in the unshakeable belief that all people should have access to healthcare regardless of gender, race, religion, creed or political affiliation. MSF's principles of action were enshrined in our charter, which to this day underpins all our activities.

Our commitment to these principles, and the impact of the organisation built on them, was recognised in 1999 when MSF was awarded the Nobel Peace Prize.

When MSF was founded in 1971, impartiality was a key aspect of its founding principles. The group of doctors and journalists who founded the organisation had witnessed the Biafran war, and had experienced first-hand the way aid workers attempting to reach a population under siege were attacked by those on opposing sides of the conflict.

They concluded that a new aid organisation was needed that would ignore political and religious boundaries and prioritise the welfare of victims above all else.

Our reputation as an independent organisation also enables us to better serve patients, by allowing us access to politically volatile settings.

Jonathan Whittall, the head of humanitarian analysis at MSF, explains the difficult position aid workers sometimes find themselves in.

"It is difficult trying to explain to all warring parties that you want to be able to deliver babies and treat injured civilians wherever they might be.

"In South Sudan, Afghanistan, Syria, there is always the feeling from one party or another that by agreeing to aid delivery to areas under control of their enemy they will be boosting their enemy's credibility and capacity."

It is vital, therefore, that MSF continues to promote its impartiality. Wherever we are working, we make sure that local people understand that MSF is politically neutral and will provide assistance to anyone who needs it.

To maintain this neutrality and independence, we rely on the generosity of individual members of the public. We rarely take funds from governments or institutions for our work. Over 90 percent of our income comes from private donors around the world giving small amounts every month.

This means that when there is an emergency, we don't need to wait for official funds to be released or for the media to generate interest; we can act fast to save people's lives based on need alone.

We do not accept funding from any entity which could call into question our complete independence, neutrality and impartiality - especially in situation of armed conflict situations. Our financial independence means the aid we provide cannot be used to further any government's political or military goals.

Regular donor Mpho Sello explains that this aspect of MSF's approach is important to him. "When I first heard of MSF, my attention was caught by the "without Borders" part of the name. I'm not an advocate of man-made borders, and anything that defies borders in the name of helping humanity is appealing to me."

It is important that, with the wellbeing of patients as our most important consideration, we are able to assess situations and contexts objectively, and, in turn, to independently decide on the best course of action for treating people in need.

It is only thanks to the decision of private donors that we are able to do our job independently.

Private donors who share our vision are vital to all of this. It is only thanks to the decision of private donors that we are able to do our job independently.

© Peter Casaer

MSF hospitals are weapons-free zones. This helps to ensure that MSF structures are recognised as neutral places where patients can feel safe, even in environments where weapons abound.

© HJ Burkard

An MSF health worker negotiates with an armed soldier in Angola.

Ebola in West Africa

“The epidemic is out of control”

Ebola is a disease that strikes fear into the hearts of many. It has inspired Hollywood films about uncontrolled outbreaks of deadly disease. Images of health workers covered from head to toe in protective suits, entering isolation units where patients lie dying, certainly seem like something taken from an apocalyptic thriller.

© Sylvain Cherkaoui/Cosmos

In the treatment area. Despite their protective gear, the medical team tries to maintain human contact with patients by talking with them at length and getting close enough to be able to look into their eyes.

But for the patients and doctors facing the current Ebola outbreak in West Africa, these images have become part of a terrifying daily reality.

This current outbreak was first confirmed in Guinea in March, the first appearance of the disease in West Africa for 20 years, and the first time it had been confirmed in the country. So far, there have been 660 deaths and 1,093 cases seen in specialised centres across Guinea, Sierra Leone and Liberia. Since the beginning of the epidemic, about 30 patients treated by MSF in Guinea have survived the disease.

The scale of the current Ebola epidemic is unprecedented in terms of geographical distribution, people infected and deaths.

Ebola kills up to 90% of people who contract it. Patients develop fever, muscle pain and headaches, followed by vomiting, diarrhoea, rashes, impaired kidney and liver function. In some cases sufferers experience both internal and external bleeding.

There is no cure for the virus, and no vaccine which can protect against it. It is highly contagious and can be passed on to humans through contact with the bodies of people killed by the virus. This makes isolating suspected cases, and educating communities about how to handle the bodies of loved ones, essential to halting its spread.

“Ebola scares people but people can overcome it”.

“The epidemic is out of control,” says Dr Bart Janssens, MSF Director of Operations. “With the appearance of new sites in Guinea, Sierra Leone and Liberia, there is a real risk of it spreading to other areas.” The scale of the current Ebola epidemic is unprecedented in terms of geographical distribution, people infected and deaths. MSF is currently the only aid organisation treating people affected by the virus.

Marie-Christine Ferir, MSF Emergency desk Manager, explains that MSF’s intervention goes beyond providing material support to overstretched national and regional health structures. “The spread of the Ebola outbreak is due to the mobility of the population who attend funerals without adequate infection control and to the fact that the disease still scares people, so they remain reluctant to be hospitalised. If measures are not taken, the Ebola outbreak may continue to expand and settle over time.

“Ebola is a disease that scares people and that is perceived as mysterious, but people can overcome it”. “Earning people’s trust is essential in efforts to fight the epidemic.”

Life in the isolation zone

Pascale Piguet, MSF emergency coordinator in Guinea, details how an Ebola isolation clinic operates.

At the beginning, you’re doing crisis management. You’re discovering new things every day and you have to improvise. You have to pay attention to the little details that would seem inconsequential in any other emergency response.

You can’t go back on your decisions. For example, you can’t reduce the size of the area where you’re treating the confirmed cases – once the area is infected, that can’t be undone.

At first, none of the members of the team wanted to go into the treatment facility. So one of the challenges is to sensitise the local staff about the facility so that they feel comfortable with the idea of going to work inside.

Each time we go in, we have to plan it down to the finest detail; the protective suits are so stifling that it’s hard to stay inside for more than 30 or 40 minutes, and we can only go in three or four times a day. When the medical staff ask us to move a patient, 15 minutes of discussion follow about which patient exactly, where the bed needs to go, and so on, just to make sure we’re doing it right. To prepare to go in, we have a 30 minute briefing about what we’re going to do, and we get all the equipment ready outside beforehand.

With the Zaire type of Ebola, up to 90% of people suffering from the disease die of it – so we know that most people in isolation will not come out. We do the most we can for them, so whatever the patient wants, the patient gets. Up until now, the requests have been reasonable: special foods, new items of clothing... it’s easy to do and it does them some good.

Personally, I’m not afraid to go into the isolation zone. I think you get more confident the more you do it. And I’m really focused when I go in. We’re like astronauts in there: movements are slower, and I am always checking that there isn’t anybody around me. A metal bar that I’m moving could easily put a hole in a protective suit and put somebody in danger.

Ebola in Guinea: Finda Marie’s story

Following a phone call, an MSF team went to the home of Finda Marie Kamano, 33. She reported extreme weakness, vomiting, and dysentery. These symptoms, along with fever and nosebleeds, are typical of those caused by the ebola virus. With her eyes glazed over, Finda Marie showed obvious signs of fatigue. The MSF team decided to take her to the treatment centre and isolate her from the rest of her family and test her for ebola.

Wearing a protective suit, a doctor checks Finda, who complains of severe stomach pain.

Two days after testing positive for ebola, Finda Marie Kamano died. The sanitary team dresses the deceased to present her to her family to show them that she is indeed the one in the sealed body bag.

Finda Marie’s funeral. Traditional funerals are one of the causes of the propagation of the Ebola virus. Finda had previously prepared the body of a victim, and that was most likely how she contracted the disease.

Central African Republic

In focus: Fear and terror in CAR

Acclaimed *Sunday Times* photographer, James Oatway, recently visited the CAR with MSF, where he documented some of the devastation and violence that communities face daily, as well as the human face of the ongoing conflict.

In the past year, violence has ripped the country apart, leaving communities displaced, terrified and desperate. Political conflict has descended into bitter and brutal inter-communal violence and revenge killings. Although all communities are affected, the minority Muslim community has been particularly targeted.

Armed groups, former Séléka fighters and the self-defence groups, called anti-Balaka, as well as scores of opportunistic bandits, prey on unprotected civilians who are trying to survive in a climate of terror.

Nearly 1 million people have been displaced inside CAR and 300,000 Muslims have fled the country in terror to neighbouring Chad, Cameroon and DRC. MSF teams are now working hard in these neighbouring countries to bring relief.

©James Oatway

©James Oatway

©James Oatway

©James Oatway

South Sudan

A perfect storm

Since conflict broke out in December last year, the population of the world's youngest nation has been left displaced, scared, and at risk from violence, disease and malnutrition.

© Nick Owen

MSF nurse Charles Mpona Kalinde comforts Gatluok, a child who was brought to the Leer hospital suffering from severe malnutrition.

In July, South Sudan turned three years old. It gained independence from Sudan in 2011 as part of a peace deal that ended Africa's longest-running civil war.

But in December 2013, violent political clashes broke out across the country, mainly between government forces and opposition groups.

1.5million people have been forced to flee their homes across the country.

To date, about 1.5million people have been forced to flee their homes across the country. Communities find themselves hiding in the bush as villages are looted and sacked by armed groups. Thousands fled to UN bases seeking protection where living conditions are squalid. They are now completely reliant on aid from international organisations and the protection of UN forces. More than 200,000 have fled across the borders into Ethiopia, Uganda and DRC where they face an uncertain future in refugee camps or host communities.

Malnutrition, common in South Sudan from June to August when the main crops are planted but not yet harvested, has become a growing crisis. Displacement and violence has disrupted the planting of crops, and markets and food stores have been looted, or destroyed.

During the violence of the last six months health facilities have become a target for armed groups:
58 people have been killed on hospital grounds – 25 of them patients; six hospitals have been ransacked, looted and burnt down. Consequently, structures which offered life-saving medical care and hope of survival have become places to be feared.

During the violence of the last six months health facilities have become a target for armed groups.

In April MSF was informed about gruesome targeted killings, some of which occurred in Bentiu State Hospital during and following a battle in the town. "What I saw in Bentiu - bodies of civilians strewn through the streets in grisly states of damage and decay, being eaten by dogs and birds—was an affront to humanity," said Raphael Gorgeu, MSF head of mission. "The violence in South Sudan has taken a particularly ugly turn, stripping people of their most basic human dignity. It is a terrible thing to witness."

"It is a very challenging environment. More aid is needed to avert a catastrophe."

With no medical supplies, and medical staff having fled for their lives, the population is left without a response to their basic needs in their most desperate hour. As a result, people are at increased risk of death from easy-to-treat diseases – some of which, like cholera, can quickly become endemic in the conditions of crowded camps for displaced people. A cholera outbreak in Juba, the country's capital, has affected more than 1,306 patients, and 29 people have died.

"People came here for safety but they are facing life-threatening conditions inside the camps," says Nora Echaibi, medical team leader of an MSF hospital in Bentiu. "It is rapidly becoming catastrophic."

Heavy rains exacerbate an already grim situation, flooding latrines and making it impossible for water trucks to use the roads for deliveries. Medical facilities and other areas where aid organisations provide services have been flooded. MSF recently addressed an open letter to the United Nations Mission in South Sudan (UNMISS), highlighting the appalling flooded conditions in an UNMISS camp.

"It is a very challenging environment. More aid is needed to avert a catastrophe. MSF is currently increasing its hospital's capacities and sending additional emergency medical teams to try to tackle the situation," says Gorgeu. "We call on aid organisations to do everything they can to improve conditions here, especially water and sanitation. We also call on armed groups to allow aid to travel freely on the roads."

Central Equatoria, Jonglei, Upper Nile and Unity states are the most affected areas in South Sudan since the fighting started. As a result, MSF increased operations in these states by starting new emergency projects and providing non-food items - such as mosquito nets and blankets - as well as water and sanitation support. In Kenya, Ethiopia and Uganda, MSF has set up emergency projects to provide assistance to thousands of South Sudanese who have sought refuge across the borders.

By July 2014 MSF has enrolled 11,685 children into therapeutic feeding programmes since the start of the crisis in December 2013, and treated 157,297 children as in-patients. Specialist cholera treatment centres have been set up in different states following outbreaks. MSF teams have vaccinated 44,650 children in camps across the country against measles and polio.

MSF has set up emergency projects to provide assistance to thousands of South Sudanese who have sought refuge across the borders.

With over 3,500 local and international staff, including a number of MSF SA fieldworkers, in the country, emergency projects have been set up to respond to the growing needs of people directly affected by the crisis. MSF has built tented hospitals, or is working under temporary shelters and in inflatable hospitals. Teams are also carrying out outreach activities, helping those too scared to leave their hiding places.

© Robin Meldrum

MSF SA doctor Stefan Kruger checks on a young gunshot wound victim at MSF's clinic in Gumuruk, Pibor County, Jonglei State.

© Nick Owen

A young soldier wrapped in AK-47 ammunition in Leer, South Sudan.

© Andreea Campeanu

Ongoing insecurity in South Sudan has forced tens of thousands of people to flee their homes. This picture was taken by emergency coordinator, Jean-Pierre Amigo, who was forced to evacuate Bentiu, amid insecurity, along with the MSF team and thousands of displaced South Sudanese people.

© Michael Goldfarb/MSF

MSF's hospital in Leer, South Sudan, was looted, burned and destroyed, along with most of Leer town in early February, 2014. Hundreds of thousands of people were cut off from critical, lifesaving medical care. Opened by MSF 25 years ago, it was the only secondary healthcare facility in Unity State.

© Emily Gerardo/MSF

More than 75,400 South Sudanese refugees have settled in Adjumani district, in northern Uganda. A number of refugees are still arriving. Upon their arrival, they stay in a transit centre before being transferred to a permanent settlement.

Rwanda genocide: 20 years on

The great evil that sucked up a tiny country

Rachel Kiddel-Monroe was head of mission for MSF during and after the 1994 Rwandan genocide. Here, she reflects on her experiences, and on her return to Rwanda, and neighbouring DRC, 20 years after the disaster unfolded.

The experience changed me completely. My innocence died there.

In April and May 1994, I was working just across the border in Goma, Democratic Republic of Congo (DRC), receiving refugees fleeing the violence. Eight hundred thousand people died in 100 days. The rivers were full of mutilated bodies. Most of the corpses were headless, except for those victims who had paid a dollar to be murdered with a bullet.

I remember some Rwandan boys who came across the border and told me what had happened in their village. While they hid in the bushes, they saw their mother raped and murdered, their sisters killed and their father taken away. Then they ran and ran for days until they reached the border. One of the boys had been badly injured. He died in his brother's arms.

These were the images that I brought back with me when I returned to Rwanda. But on arriving in Kigali, the capital, I found a prosperous African city full of cars, commerce and people living their lives. My memories of a post-apocalyptic ghost town, of bullets, blood and hastily dug mass graves, the air heavy with death and fear, seemed a lifetime ago.

The former MSF hospital in Ruhengeri, northwest of Kigali, is now a beautiful, bustling referral facility, treating a normal range of human ailments. No more patients with war wounds and landmine injuries, like those who came to us in the days and weeks following the genocide. Only people's mental trauma persists as evidence of the horror they suffered.

Simple memorials and mass grave sites testify to the great evil that sucked up this tiny country. I stopped in Butare to pay my respects to the hundreds of Rwandan MSF aid workers who were slaughtered in April and May 1994. A mass grave has been constructed on the grounds of the University of Butare opposite the hospital – a simple memorial, with photos of the dead. It was here, in this quiet and lovely spot that I was finally able to cry.

© Klaas Fopma

Rwandan IDP's near the Zaire (DRC) border. The spring of 1994 marked the most tragic period in the Rwandan history as between 500,000 and one million men, women and children were brutally murdered during a violent campaign of genocide committed by forces loyal to the Rwandan government. (Klaas Fopma)

There could not have been a greater contrast between the peace and calm of present-day Rwanda and what I found when I crossed the border into DRC.

Just outside Goma, terrible roads took us past camps for displaced people that litter the hills and roadsides. The improvised shacks in these camps are home to hundreds of thousands of people, about 80 per cent of them displaced by the armed conflict and violence in Masisi Territory.

> "My memories of a post-apocalyptic ghost town, of bullets, blood and hastily dug mass graves, the air heavy with death and fear, seemed a lifetime ago."

Every day in Congo armed men are pillaging towns and villages and forcing people to flee. Every day children are dying from preventable diseases like pneumonia. Every day mothers are dying in childbirth and every day women are victims of sexual abuse.

As we remember the Rwandan genocide of 20 years ago, my hope is that we will look to DRC and the everyday emergency that is bringing a people to its knees. These people deserve our help.

© Robert Maletta/MSF

1994. Kibuye, Rwanda. Hutu children play in the ruins of a Catholic church. Much of Rwanda's health infrastructure was either destroyed or badly damaged during the period of killing.

Notes from the field

"Malnutrition can break up and destroy families"

MSF South Africa recruit, Dr Anja Reuter, recently returned. recently returned from South Sudan, where she worked as a doctor in a camp for displaced people in Juba. Her experiences highlight the often-overlooked psychological impact of malnutrition.

© Anja Reuter

Dr Anja Reuter

Malnutrition and the mother-child relationship is incredibly complex and intertwined, and it was something I really tried to understand during my time in South Sudan.

There is often a very damaged bond between mothers and malnourished children. It is sometimes difficult to establish which led to which. Was there a poor mother-child bond and this resulted in the child becoming malnourished? Or did the child get malnutrition, and did the child's resulting chronic illness and repeated hospitalisation damage the mother-child relationship?

Malnutrition can break up and destroy families. Recurrent hospital admissions (some can last weeks or even months) separate mothers from their other children who are left at home, and might make it impossible for her to work and earn any sort of income for the family.

We counsel mothers extensively about malnutrition and the importance of food and maintaining regular feeding. It can be extremely frustrating, as, illogical as it may seem, malnutrition makes children lose their appetite, and it can take weeks to "teach" a child to eat again.

One of the boys I grew most attached to during my work in South Sudan was Wayile. His mother was shot when she tried to bring him to the hospital after conflict broke out in December. After this, Wayile was hospitalised for inpatient feeding for over a month. His mother, who recovered from her injuries, was extremely angry with Wayile. She believed his illness was the reason why she was shot, and why she was separated from her other children. Wayile could sense his mother's anger, and refused to accept any food from his mother, but ate any food any of the MSF staff offered him. This escalated the mother-child tensions even more. This was a very complex case, and we spent days trying to work on Wayile's relationship with his mother until he finally started to eat some of the food she offered him.

> It is a miracle watching severely malnourished children go from being miserable and near death to happy, playful kids.

A major personal challenge was discharging the children from our inpatient therapeutic feeding centre. It is a miracle watching severely malnourished children go from being miserable and near death to happy, playful kids. And then you have to discharge them, and put their future back in their mothers' hands. You can only hope and pray that the mother understands the importance of ongoing nutrition, that she will have access to food, and that she will follow up with the child's outpatient appointments.

The amazing thing about treating malnutrition is that, most of the time, when the children start to eat and recover and play and smile, the relationships also make a major turnaround. Mothers lose their resentment about having been separated from their families while the malnourished child undergoes feeding hospitalisation. And they begin to play with and be proud of their healthy strong child again.

© Anja Reuter

Dr Anja Reuter visiting patients in Jub

MSF SA General Assembly 2014

A shared vision for MSF

Every year, the MSF Southern Africa Association members come together for a General Assembly. The meeting is an opportunity for past and present MSF staff, whether they be fieldworkers or based in headquarters, to share their ideas and goals for MSF's work and projects, as well as update the Association on the work being done in specific projects. New board members are also elected. With MSF's commitment to operational transparency in mind, the financial report is shared with members. For the financial year 2013, MSF SA is pleased to confirm that we received a clean audit as our financial management practices were found to be sound.

This year's event took place in May. The two-day event was attended by over 200 members from South Africa, Mozambique, Zimbabwe, Malawi, Zambia, Swaziland and Lesotho. As usual, it was a lively mix of serious discussion and debate, as well as a chance for some serious socialising and fun.

Field updates from various projects in the region left members energised and inspired by the work of their colleagues.

New board members were also elected: Dr Mohammed Dalwai, Dan Sermand and Karsten Noko. Having former MSF fieldworkers and colleagues from the southern African region on the board ensures that decisions are based on operational knowledge and the interests of patients.

Throughout the meeting, it was clear that all MSF staff, whether they be seasoned fieldworkers with many assignments to their name or enthusiastic newcomers, share MSF's passion and vision of providing healthcare to people in crisis and those who need it.

One of the key points raised was the idea that Southern African staff have a great deal to offer the movement as a whole. There is a great deal of expertise in the region, particularly in the areas of HIV treatment and advocacy, and members debated how this could benefit MSF internationally. The security of national and international staff in the field was also discussed, and there was a moving tribute held to honour colleagues who had been killed while working in CAR.

MSF SA president Garrett Barnwell addresses Association members.

Attacks on humanitarian workers

Remembering colleagues killed in CAR

It is with great sadness that MSF mourns the deaths of three staff members killed in the Central African Republic on 26 April. Our colleagues were killed in a violent robbery by armed men from the former Séléka opposition force at a hospital where MSF works in Boguila. Thirteen other members of the local community were also killed in the attack.

Daniel Torbe was a supervising nurse who worked for MSF since 2008. He leaves behind his wife and 11 children.

Jean-Paul Yainam had worked as a head guard with MSF from 2008. He leaves behind his wife and nine children.

Bertrand-Junior Feizokazoui worked as a guard.

"We are extremely shocked and saddened by the brutal violence used against our medical staff and the community," said Stefano Argenziano, MSF Head of Mission in CAR. "Our first priority is to treat the wounded, notify family members and to secure the safety of our staff, patients and the hospital."

To protest the killing of civilians and our colleagues, MSF scaled down all operations in CAR and neighbouring countries for one week. We demanded that the government and the commanders of the militia publicly denounce the attack, which they subsequently did.

We have spoken out about the failure of international efforts to protect the population, violence against civilians and the targeted killing of minority groups.

MSF is the only international humanitarian organisation working in the Boguila area to assist a population increasingly exposed to deadly and indiscriminate attacks by armed groups operating in the area. These deadly events constitute an unacceptable attack not just on civilians but also on the ability to provide medical and humanitarian assistance.

Notes from the field

Intervening in Europe

Europe is a rich and relatively peaceful continent. But refugees fleeing conflict who see it as a potential safe-haven face countless risks.

Since January, MSF teams have provided medical and mental healthcare, distributed essential aid and made improvements to buildings and facilities in three reception centres for asylum seekers since January.

The centres, in Harmanli, close to the Greek and Turkish borders, and in the Bulgarian capital Sofia, are currently home to 1,500 asylum seekers, many of whom have fled war-torn Syria, making long often dangerous journeys to Europe in search of safety and protection.

MSF started working in Bulgaria in November 2013 after finding appalling conditions that included lack of food, shelter, and limited access to medical and psychological care. Despite the winter, people were sleeping in unheated tents, and up to fifty people were sharing one toilet.

MSF is handing over the provision of medical and mental healthcare services to the Bulgarian government, and has called on the authorities to continue to ensure access to healthcare for refugees living both inside and outside the Bulgarian reception centres.

"These centres are a real example to the rest of Europe that authorities can and should mobilise to improve reception conditions for migrants"

"Though problems still remain, these centres are a real example to the rest of Europe that authorities can and should mobilise to improve reception conditions for migrants," says Stuart Alexander Zimble, MSF Head of Mission.

"We hope that these improvements continue and that standards are maintained after our departure."

Since the beginning of the year, MSF has provided more than 7,700 consultations in Bulgaria, including 1,725 to children under five, and 990 were for women during or after a pregnancy.

MSF has also provided psychological consultations to more than 60 patients, many showing very serious effects of past trauma including violence and torture. Under European Union minimum reception standards, asylum seekers should be provided with medical and psychological care, as well as specialised care for vulnerable groups such as victims of torture, sexual violence or for people with a disability.

"Psychological support is incredibly important for people who have fled war, conflict and violence. Some of our patients in Bulgaria have been tortured, others have fled for their lives after members of their family have been kidnapped or killed. Then they have made long, dangerous journeys to Europe, knowing that they face an uncertain future when they arrive." says Carla Peruzzo, MSF's Medical Coordinator in Bulgaria.

"Psychological support is incredibly important for people who have fled war, conflict and violence."

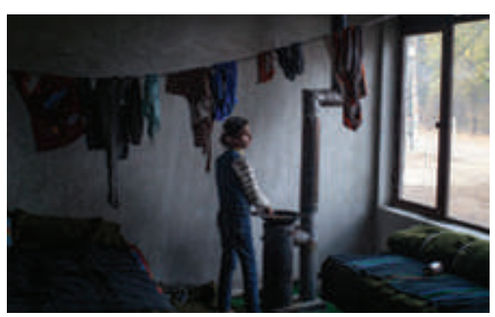
This year, Bulgaria – with tacit support from the EU - will complete construction of a 30km fence to further close its land border, a strategy also pursued by Greece which closed its land border in 2012. Consequently the number of arrivals to Bulgaria have also drastically reduced in the last months - forcing vulnerable refugees to find other ways into Europe.

While things have improved in these reception centres, the wider issue of how Europe treats migrants and refugees at its borders remains far from resolved. EU polices are supposed to ensure minimum standards and adequate protection, but member states still continue to take restrictive and repressive steps that cause additional suffering.

"In summer months, the number of migrants and refugees trying to reach Europe peaks," said Aurelie Ponthieu, Humanitarian Advisor for migration. Most of Europe's land borders have been closed. Thousands of people fleeing crises in Syria or Eritrea will make a desperate journey across the sea, risking their lives. When they reach Europe, they are rarely treated humanely. This needs to improve urgently.

© Alessandro Penso

20-year old Amar Alshaer from Aleppo. After losing everything in Syria, she wants to go to Germany, where her uncle lives. Her family crossed the border during the night by paying money to a people-smuggler.



© Alessandro Penso

The centres where MSF worked are currently home to more than 1,500 refugees, many of whom have fled war-torn Syria.

© Alessandro Penso

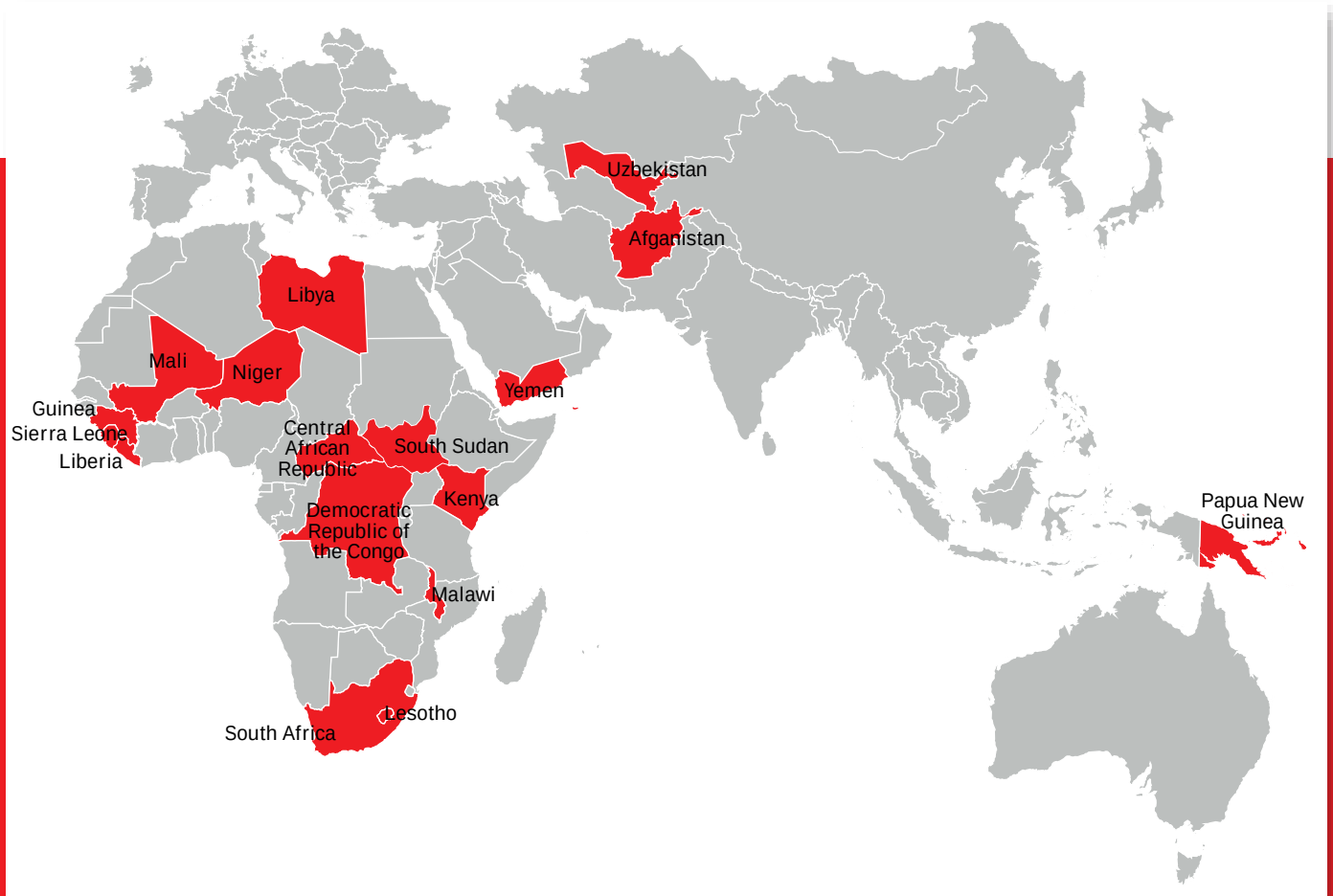
Refugees from Syria inside the Harmanli camp.

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

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS



MSF South Africa: Recent recruits in the field

Adeline Oliver, Nurse - Afghanistan
Ainslie McClarty, Nurse - Afghanistan
Alain Goderfroid, Nurse - Mali
Alec Mukwamba, Epidemiologist - South Africa
Aline Aurore, Epidemiologist - Kenya
Andrew Medina Marion, Epidemiologist - Liberia
Anja Reuter, Doctor - South Sudan
Anna Cilliers, Nurse - South Sudan
Augustine Majiku, Nurse - South Sudan/CAR
Ballah Ngormbu, Doctor- Liberia
Camren McAravey, Finance - Malawi
Carl-Eric Opot, Nurse - Yemen
Christopher Eweiler, Field Co - Libya
Claire Waterhouse, Admin/Finance - CAR
Constancia Tambudzai, Midwife - South Sudan
Corina Moffat, Human Resources - Sierra Leone
Danca Paiva, Logistician - DRC
Dimitri Enyikel, Field Coordinator - South Sudan
Dodo Kibasomba, Nurse - Niger
Erick Kaluma, Nurse - South Sudan
Esther Wanjiru, Doctor - Sierra Leone
Evaristo Dira, Human Resources- South Sudan
Gail Womersley, Psychologist - DRC
Indira Govinder, Doctor - South Sudan
James Simukoko, Pharmacist - Uzbekistan
Job Nyagah, Water and sanitation - South Sudan
John Sikibibi, Doctor - CAR
Juli Switala, Paediatrician - Sierra Leone
Kim Lee Philips, Logistician - Afghanistan
Lambert Nthihemuka, Nurse - Niger
Laurent Siborurema, Surgeon - CAR
Levi Nyaboro, Nurse - South Sudan
Levina Britz, Midwife - South Sudan
Lissele Botha, Doctor - South Sudan
Luzinda Kenneth, HIV/TB Doctor - Lesotho
Marcel Lamonde, Doctor - CAR
Marilise Ackerman, Human Resources- Guinea
Mduduzi Chandawila, Nurse - South Sudan
Mercy Kaudresi, Electrician - South Sudan
Patricia Chipo, Anaesthetist - Afghanistan
Patricia Mazuru, Policy advisor - Lesotho
Pierre Kibasomba,Logistician - South Sudan/Sierra Leone
Stefan Kruger, Doctor - Sierra Leone
Tabitha Mutseyekwa, Nurse - Papua New Guinea
Vanessa Naidoo, Doctor- South Sudan
Virginia Kinyanjui, Midwife - South Sudan
Wondemu Tadesse, Nurse - South Sudan
Yonie Yowa, Doctor - South Sudan