

Doctors Without Borders (MSF) South Africa

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# mamela

This year, South Africa celebrates almost ten years of ARV treatment. However, in other countries where MSF works, it is as if time has stood still.

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**MEDECINS SANS FRONTIERES**  
**DOCTORS WITHOUT BORDERS**

## Philippines emergency

# Typhoon Haiyan

## Unprecedented humanitarian crisis in the Philippines

**Devastation in the wake of super-typhoon Haiyan in the Philippines has left 5,200 people dead, displaced more than 600,000 people and is affecting about 9 million people who now lack access to food, water, medical care and shelter.**

On 9 November MSF staff started arriving on the stricken islands, as well as hundreds of tonnes of medical and relief materials in nine cargo flights.

At the time of publication (25 November), MSF teams using boats, planes, and helicopters were able to access places that had remained isolated from aid and launched medical and relief activities.

MSF's emergency team in the far east of Samar Island, where the typhoon first struck, set up medical services and immediately treated patients. Emergency teams also set up activities on Panay Island, including in Roxas City, and in the coastal areas of Estancia, Concepcion and San Dionisio in the north of Iloilo province.

MSF typically does not ask you to donate to specific crisis response. But given the magnitude of this emergency we expect that the needs will be great. We have to react swiftly, and your donation today will go directly to meet urgent medical needs.

**Help us get aid to where it is needed most: [www.msf.org.za/donate](http://www.msf.org.za/donate)** (choose "Philippines Emergency"). Thanks to the 235 donors who have already helped us to raise R 400,000 within 2 weeks.



### Typhoon Haiyan emergency response

**8+** planes loaded with medical & relief supplies

**100+** emergency response staff on their way



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## Editorial

# Deciding to act

A medical student reflects on the example set by struggle icon Dr Neil Aggett's life and work, and what it means to young medical students today.

**Mariana Khoza, aged 22, is a fourth year medical student at Wits Medical School and attended a symposium hosted by Doctors Without Borders (MSF) on the legacy of anti-apartheid activist Dr Neil Aggett in October. Aggett provided medical care and worked as a union organiser until his death detention in 1982 at the age of 28.**

I must confess that the first time I had heard of Dr Neil Aggett was at the recent MSF-hosted symposium about his legacy as a medical doctor and activist. My immediate impression was of huge gratitude for all those who, like Dr Aggett, fought the unjust apartheid system, and who sacrificed their lives so that what was an ideal for them could become reality for me.

Reflecting on Dr Aggett today, the first thing I think of is the immense courage it must have taken to look at himself and acknowledge that, even though the apartheid system favoured his race, it was not right. It takes bravery to acknowledge your own role in a problem, before you can go about devising a solution.

The perception is that the injustices of apartheid back then were immediate and much easier to identify. But, as Jane Barrett, a trade unionist from the South African Transport and Allied Workers' Union, said at the symposium: *"We say that apartheid was in our face, so obvious – which made it easier for us to do something about it. But today poverty is in our face, and perhaps even more so than apartheid."*

I wonder how many of us today have the same courage that Dr Aggett had: to acknowledge that we are living in a system that affords some of us certain privileges while others are denied their most basic rights.

Some might argue that we pay taxes and thus play our part in the system that should ensure that people's basic needs are taken care of. But what happens when that system fails? Who is held to account when *uGogo* goes to the clinic and her chronic medication is not there?

We need to be wary of accepting inequality today as normal simply because we are too afraid of unmasking ourselves as privileged and content South Africans who are part of that status quo.

We need Dr Aggett's courage to confront ourselves when all we can offer a hopeless child begging at a traffic light is a R2 coin, and then tweet or update a Facebook status to say what a horrible day we've had.

**"We need to be wary of accepting inequality today as normal simply because we are too afraid of unmasking ourselves as privileged."**

As South Africans we've been taught to look further than the immediately obvious, and to find solutions where it seems there are none. A question my friends and I like to ask is: "So what must happen now?"

Four fellow medical students and I are in the process of establishing an organisation which we hope will encourage health science students to be activists for human rights concerning healthcare, and to revive student activism.

We are doing what we can, and so can you. There are many forms of activism that unmask inequality – taking a photo, making a call, telling someone's story – that encourage becoming catalysts for change. Similarly, supporting



Mariana Khoza

the medical work MSF does to end suffering and speaking out about the needs of people in crisis is a significant contribution too.

**"As South Africans we've been taught to look further than the immediately obvious, and to find solutions where it seems there are none."**

We need to be dedicated to the cause, in the struggle for equality and human dignity for all, as Dr Aggett was. It should be part of our daily lives – not just something we do for 67 minutes on Mandela Day to play dress-up in overalls and call into radio stations so we can be celebrated for helping the less fortunate.

We appreciate that we are only at the starting line and have a lot to learn, so we aim to work with existing organisations such as the TRC and Katlehong Aids Council to expose ourselves to the issues that exist and to learn how to approach such situations.

As Jay Naidoo, another speaker at the symposium, said: *"First you must make that choice. If you choose to be part of improving the state of our country, then you stick with it. It is as simple as that."*

Do you feel courageous enough to make that choice?

## Fix the Patent Laws

# Stop blindly handing out drug patents!

MSF and the Treatment Action Campaign, supported by SECTION27, have been working to fix South Africa's patent laws to increase access to affordable medicines.



© Roy Pottier/DTI  
Simphiwe Ncwana and Phumeza Tisile (DTI).

South Africa pays artificially inflated prices for medicines because it blindly hands out patents, without examining applications to see if they meet the Patents Act criteria.

Up to 80% of applications which should be rejected are granted, and pharmaceutical companies are given multiple patents on the same medicine by registering only minor changes. This blocks more affordable generic competitor drugs from markets for more than 20 years.

South Africa, like Brazil and India, is in the process of reforming its patent laws through the *Draft National Policy on Intellectual Property, 2013*. Public

submissions on the draft policy closed on 17 October and health activists marched to the Department of Trade and Industry's (DTI) Pretoria office to hand-deliver their submission.

Phumeza Tisile, a former MSF patient who was cured of extensively drug-resistant TB in August, handed over the submission to DTI's Simphiwe Ncwana on behalf of the campaign. In an MSF pilot DR-TB programme, she was given linezolid – a drug which MSF buys for R676 per daily tablet as no generics are available in South Africa – as part of a strengthened regimen.

"Competition here is not as robust as it

is in many other countries. Consequently we don't have more affordable generic versions of vital drugs that are available elsewhere. When desperately needed drugs are too expensive, people pay both from their wallets and with their lives," explains Julia Hill, MSF Access Campaign Officer.

Having received several public comments from different sectors, the DTI will now edit the draft policy before submitting it to cabinet for approval. After this, the bill will be written and relevant acts amended in 2014.

Learn more:  
Visit [www.fixthepatentlaws.org](http://www.fixthepatentlaws.org)

## News from the field

# Syria's growing crisis

© Aurelie Lachant/MSF



Children playing in Domeez refugee camp.

MSF is scaling up operations to meet the needs of the more than 4 million Syrians that have been displaced or left with no access to medical care.

In August MSF spoke out when three MSF-supported hospitals in the Damascus governorate received about 3,600 patients with neurotoxic symptoms

following a chemical weapons attack. Of those patients, 355 reportedly died.

International diplomatic efforts mobilised support for chemical weapons inspectors to access areas – in stark contrast to the blockade of urgently-needed humanitarian aid.

In Syria's Idlib governorate, MSF has set up a hospital. Alex Buchmann, hospital Project Coordinator, says: "Any medical services that are still somehow operational are focused on war wounded, so for people with difficult pregnancies, chronic diseases or general illnesses, the only options are our hospital and mobile clinics."

In Al Raqqa governorate, MSF has already seen some 300 measles cases,

a clear sign of the collapse of the healthcare system.

MSF teams are running six hospitals in Northern Syria. From June 2012 to August 2013 they carried out more than 66,900 medical consultations, 3,400 surgical procedures and delivered 1,420 newborns. MSF teams have also provided more than 200,240 consultations for Syrian refugees.

Mental health services have also been introduced inside the conflict region, as well as in neighbouring countries, where 2 million refugees, half of whom are children, seek safety.

Ana Maria Tijerino, Mental Health Advisor for MSF says: "Disorders such as schizophrenia and severe depression are becoming more commonplace, and we are seeing many patients who have suicidal tendencies."



## Making a difference

# Help MSF save lives ... right from your office with your company and workmates!

If you're already a regular donor to MSF, you can provide even more support to our fieldworkers by getting your colleagues and employer involved in your passion for helping people in crisis.

MSF's corporate partners help us to continue our life-saving work around the world, supplementing the contributions of ordinary people who make up the bulk of our supporters. Corporates, through their employees, help us save more lives in times of disaster, armed conflict and where exclusion from healthcare is a deadly reality.

In 2012, MSF SA's corporate partners enabled us to save countless lives of mothers and babies during a special appeal that provided medical expertise, equipment and facilities to our projects in Somalia, South Sudan, Nigeria and elsewhere.

Want to get your company and colleagues involved? Here's how:

### Speak to your company about donating to MSF annually as part of your CSI programme

- **Organise a fundraising event.** Staff members can organise fun runs and end-of-year parties, donating the proceeds to MSF.
- **Begin a matched giving or payroll programme.** Your employer/company can pledge to match the contributions of their employees on a monthly or annual basis.
- **Start a cause-related marketing programme.** Your company can help spread the word about the medical care needs of people around the world and support MSF by linking a product or service to a cause-related marketing programme where a

percentage of sales is donated to MSF.

- **In-kind donations:** Your company's support can make a huge difference by donating products or services to the MSF SA offices or to our field teams.

MSF SA's fundraising team in Johannesburg works closely with interested and committed companies and corporate partners to develop individually tailored support and recognition programmes. We can also help you to set up your own online donation page.

### Reach out today and learn more about how to support MSF's corporate programmes:

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Web: [www.msf.org.za](http://www.msf.org.za)

## Why I give to MSF

**Anne d'Aussy is a businesswoman with a passion for caring for people – no matter where they are. The owner of The Perfect Health Centre, a holistic medical practice in Johannesburg, explains why she became one of MSF SA's corporate donors.**



Anne d'Aussy at the Crossing Frontlines benefit event

"I've always been strongly committed to caring for others, and have my own charity in Eshowe. One day I travelled there and came across local people who were involved with a Doctors Without Borders HIV project and that's how my involvement started," Anne explains.

Anne felt MSF's medical work was a suitable match for her business. "We didn't have any care projects in place. For about two years I had been looking for a charity project or humanitarian organisation to support. Being a medical practice, it made sense to donate to a medical cause, so MSF was a natural choice for me," she says.

Originally from Belgium, Anne grew up with an awareness of the work of MSF, but it was discovering local South African operations that encouraged her to become a regular donor. She appreciates that MSF's local work means that her clients can see exactly what their support means in the field.

"With the MSF HIV project in Eshowe, it made sense. I could tell my clients that if they ever wanted to see the work or get in contact, they could do so." She feels that it is easy to be a corporate donor supporting MSF's work, and that it takes a minimal amount of effort to make a big difference. "It's no work at all. From every sale we make, no matter the size, we donate R10 to MSF, which we put together in a monthly donation. I also had flyers printed for waiting rooms and doctors' rooms. We have client evenings and promote MSF's work that way too.

We promote the fact that they can become individual MSF donors too, over and above the contribution they make through using our services."

For Anne, knowing that she is making a difference is a reward in itself. "I'm doing it because I strongly believe in the work of MSF. I've known MSF since my childhood in Belgium. For me, it's about the giving."

## New technologies

# Zimbabwe rolls out effective new tool in fight against HIV

More than 30 years into the fight against HIV, millions are on treatment but, in many countries, clinicians lack crucial tests needed to monitor these patients. A global MSF initiative, starting in Zimbabwe, could change that.

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More than 570,000 Zimbabweans are currently on antiretrovirals (ARVs) and clinicians in the country finally have access to the only test that can accurately monitor their progress – HIV viral load testing.

Until now, few in Zimbabwe had access to viral load testing, given the test's high costs and difficulties in transporting blood samples for testing across the country. Working in Zimbabwe since 2002, MSF teams were forced to send patients' samples across the border to South Africa for viral load testing, using dried blood spots in private labs.

To improve access to HIV viral load testing for patients on ARVs, MSF recently placed a new viral load testing machine in Harare. Unlike previous machines, this device will be able to test easy-to-transport samples of dried blood which are easier to handle. Using dried blood does away with the need to use cold chain-equipped transport. Cold chains, which maintain blood samples at the right temperature to preserve them, can be difficult to manage in developing countries like Zimbabwe, where equipment required to maintain samples at the right temperature over long treks is often lacking.

### Better tests save lives – and money

Without access to viral load testing, doctors in countries like Zimbabwe rely on CD4 count tests to monitor patients. These tests, which measure the immune system's strength, are used to determine whether HIV patients are sick enough to start ARVs.

While CD4 counts are helpful for initiating treatment, they don't provide the best information early enough to ensure patients get the best care. This is because CD4 count tests – unlike HIV viral load testing – may only pick up signs of drug resistance or ARV treatment failure too late.

## What is viral load testing?

HIV viral load tests measure the amount of HI virus in a patient's blood, which can indicate whether ARV treatment is working. If patients adhere to treatment – and have not developed drug resistance – patients' HIV viral loads should be so small that tests cannot detect the level of HIV in their blood.

Elevated levels of the virus in the blood may signal that patients have developed resistance to their current ARV regimens, but could also indicate that patients are having trouble adhering to their medication and require support.

"If a patient is failing treatment, you'll often detect this much later with CD4 testing," says Emmanuel Fajardo, MSF Laboratory Adviser. "We know that if patients are failing treatment, their chances of developing opportunistic infections, or dying, are much higher, so it's critical that you switch them to second-line treatment as quickly as possible."

Drug resistance and, ultimately, treatment failure, can develop if patients skip daily ARV doses. Once this happens, they need to be moved to more expensive and less-readily available treatment regimens.

Early results, gathered through routine viral load testing, can allow doctors to identify patients who are having problems sticking to treatment sooner, before they develop resistance. These patients can then receive intensified adherence counselling so that they can remain on their first-line ARVs, instead of being switched to more costly second-line treatment.

Malawi has already dropped routine CD4 count monitoring for HIV patients from its national guidelines in favour of viral load testing and, as of early June, South Africa was considering similar moves.

Currently, the World Health Organisation recommends ARV patients' viral loads are tested annually.

For patients who are already adhering, seeing positive results on paper following an HIV viral load test can be a source of motivation, according to Dr Sandra Simons, MSF Medical Coordinator in Zimbabwe.

"Patients have really understood CD4 counts and have come to use them as a marker of how they are doing on treatment," she says. "If their CD4 counts are good they will say, 'see, my soldiers are strong'."

"Now, with viral load testing, we can also tell them how the enemy itself is doing," she adds. "This is really motivating for them."

### One project, big impacts

Malawi, South Africa and Zimbabwe are just three of the seven countries to receive HIV viral load test machines as part of an MSF project funded by a US\$28 million grant from the international medicines financing mechanism UNITAID. Countries receive either traditional laboratory-based viral load tests, as Zimbabwe has, or newer, point-of-care tests like those to be rolled out in South Africa and Mozambique, depending on country needs.

"In Zimbabwe, we decided to go with a lab-based test because of the sheer volume of tests the country needs to conduct," Fajardo explains. "To test a lot of people, point-of-care testing can be very expensive."

"When we thought about how to make viral load testing more cost-effective in Zimbabwe, we agreed with the ministry of health to start testing in Harare, and to decentralise the service through collecting blood samples via paper strips and then sending these to the lab."

The three-year UNITAID-funded project is expected to increase demand for viral load tests, creating a new, bigger market for this type of test in the hope of driving down the cost per test and making it available to other developing countries. The knowledge

MSF gains in piloting these new machines alongside UNICEF and the Clinton Health Access Initiative will also help countries choose the best HIV viral load strategy for them in the future.

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A nurse at Gombe clinic in Buhera district, Manicaland Province, Zimbabwe explains to Loved Mupandanana that her first line treatment for HIV seems to be failing and her viral load is now over 61,000.

## Why viral load testing is best

### From the doctor...

*Dr Steven van den Broucke is MSF's HIV coordinator in Zimbabwe. He explains how HIV viral load testing not only helps patients, but also their communities:*

"When a person is tested several months after they start treatment and their viral load is undetectable, it's one of the biggest motivators for a patient to keep taking their drugs.

"From the community perspective, there are clear advantages to using viral load. If we manage to suppress viral load in the community, we will also manage to reduce transmission of the virus to other people because patients with undetectable viral loads are less likely to transmit the virus to their partners.

"If we manage to get all the patients on ARVs to stick to treatment, in the end, we will win the battle against HIV by avoiding new infections."

### From the patient...

*Fanelwa Gwashu has been on ARVs for seven years. She now runs an innovative community-based adherence group for long-time ARV patients in Khayelitsha, South Africa. These groups not only help patients stay on treatment, they also allow patients to collect their ARVs outside of clinics and closer to their homes.*

*Fanelwa explains what HIV viral load testing means to her – and her future with her two children:*

"My latest viral load count, taken in June 2011, was undetectable. ARV treatment is life-long, so it's encouraging to be told that the treatment is working well for me. It helps to know that, whatever the difficulties, I am controlling the virus. I am proud that my viral load is undetectable, and I tell others about it. It helps me plan for tomorrow and I am confident I will live a normal life in the future."



## Forgotten epidemics

# HIV epidemics hidden in plain sight

**This year, South Africa celebrates almost a decade of antiretroviral treatment. However, in other countries where MSF works, it is as if time has stood still for 10 years and patients, without treatment, still come by wheelbarrow to die in clinics.**

In 1999, a group of MSF doctors arrived in South Africa. They had already been working to save lives in Thailand and Cameroon, which were beginning to grapple with treating HIV. In South Africa, treatment was not yet available in the public sector and more than 330,000 South Africans without access would lose their lives over the next six years.

Attempts to start a mother-to-child transmission (MTCT) programme in Alexandra township in northern Johannesburg were blocked by the national department of health. But by the end of 1999, MSF was supporting a MTCT programme in Khayelitsha, near Cape Town, with the understanding of provincial authorities, and, during 2001, started to dispense generic ARVs.

"Every patient who arrived for treatment was eligible, but we were given funding by the MSF board in Brussels for only 120 treatment slots – not one more," says Dr Eric Goemaere, who led the Khayelitsha team. "There was no way MSF could have ever provided enough treatment to meet the need because as we went along, we started to draw more cases from outside Khayelitsha as more people heard HIV treatment was now available."

After plenty of harassing of the late National Minister of Health, Manto Tshabalala-Msimang, South Africa would



A patient at the Centre Hospitalier de Kabinda in Kinshasa.

finally begin its national treatment roll-out three years later.

### Now and then

From just 120 patients in MSF's Khayelitsha clinic in 2001, HIV treatment in South Africa now reaches about 1.8 million people today, 12 years later. When Goemaere arrived, only 420 HIV tests had been conducted annually in Khayelitsha. The South African Department of Health recently tested more than 15 million South Africans as part of its national HIV testing campaign – a feat made possible in part by the promise of treatment for those who tested positive.

Goemaere now works as MSF's senior regional advisor on HIV and TB, regularly travelling to countries throughout Africa to provide assistance to MSF teams.

**"When you go to places like Kinshasa, you have the impression that you are going back in time, that you are seeing re-enactments of the same scenes we saw in Khayelitsha and elsewhere ten years ago."**

He says that, while South Africans can be proud of the progress their country

has made, places like the Democratic Republic of Congo (DRC), Central African Republic and South Sudan remain frozen in time where people come to die at clinics.

In the DRC's capital, Kinshasa, MSF runs the only referral hospital to provide free ART treatment care to severely sick HIV patients.

"When you go to places like Kinshasa, you have the impression that you are going back in time, that you are seeing re-enactments of the same scenes we saw in Khayelitsha and elsewhere ten years ago," he says. "People arrive at the clinic extremely sick, hardly walking and transported by stretcher or wheelbarrow. Many people die within 48 hours of admission."

### A dangerous intersection

According to Goemaere, thousands continue to die in countries like the DRC and in most of central and western Africa because they lie at the dangerous intersection of poor access to ARVs and low HIV prevalence rates among the total population.

"Low prevalence rates actually bring very high levels of stigma because very few people are affected by HIV," he says. "It's not like South Africa, where there is not



Dr Eric Goemaere



a single family that hasn't been affected and therefore more reason to be open about the reality."

More than one million people are living with HIV in the DRC today. Of these, 350,000 people are estimated to be in need of treatment, but only about 15 percent of them are currently receiving the ARVs they need. This ARV coverage rate is one of the lowest in the world. Only Somalia and South Sudan have similar rates in Africa.

"If nothing is done, it is highly likely that the 15,000 people currently on the waiting list and in urgent need of ARV drugs will be dead within three years," says Anja De Weggheleire, MSF's DRC Medical Coordinator. "As horrifying as that number is, it represents only the

tip of the iceberg. Most people living with HIV in the DRC do not know their HIV status, and will likely die in silence and neglect."

#### Treatment does more than just save lives

"With this kind of stigma, people are not keen to go for HIV tests. And if they do test positive, treatment is expensive and difficult to access," Goemaere says. "If there's one lesson we learned in South Africa, it's that you need to make treatment, and treatment literacy available to start changing things."

Treatment literacy educates people about HIV transmission, prevention and treatment, but crucially, it also makes people aware of their right to treatment, empowering them.

**"Most people living with HIV in the DRC do not know their HIV status, and will likely die in silence and neglect."**

"If people understand the disease and are aware that there is treatment, I don't see why there can't be more HIV testing," he says. "The problem is that in places like the DRC and the Central African Republic, areas of the country remain insecure due to conflict and that makes accessing patients difficult."

"In countries like these, MSF plays a tremendous role in kick-starting HIV programmes – that's the hard part," Goemaere adds. "Once you get these programmes running, it's relatively easy to keep them going – it just takes the will of the government and HIV donor states."

## How Madiba helped bring ARVs to South Africans

MSF's Ubuntu Clinic began dispensing ARVs in 2001, but, just a year later, the clinic remained under threat of being shut down. MSF Regional HIV and TB Advisor, Dr Eric Goemaere, credits former president, Nelson Mandela, with helping the clinic survive and with introducing HIV treatment nationally.

"Even after we began providing treatment in Khayelitsha, those were difficult years. The programme was not recognised by the national department of health and some people within the department actively tried to block the programme. When President Nelson Mandela came to visit us in 2002, it was fortunate. I'm not sure that, without his support, we would have been able to stand our ground much longer. The government had threatened to close us down.

"Without the slightest hesitation, President Mandela knew which side to stand on. He wore the 'HIV-Positive' T-shirt, and the image was broadcast around the world. It was then that we felt something had shifted in the halls of power.

"From our first, short meeting at Treatment Action Campaign leader Zackie Achmat's house – Mandela showed he understood what patients and organisations like MSF and TAC were saying. HIV treatment was feasible even with limited resources in townships, like Khayelitsha, and that it could be made affordable by introducing generic drugs."

President Mandela – and the Mandela Foundation – went on to play a pivotal role in the establishment

of an MSF's clinic in Lusikisiki, in the rural Eastern Cape, which was featured in the book *Three Letter Plague* by Jonny Steinberg.

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**In Focus**

# Afghans' perilous road to healthcare

**Afghanistan is a country still very much at war. Afghans suffer some of the worst health indicators in the world – it is still one of the riskiest places to be a pregnant woman or a young child.**

Deadly disease outbreaks are recurrent, and the country is prone to natural disasters. Many rural health clinics are dysfunctional. Qualified health staff have left insecure areas, and access to supplies is irregular or non-existent. Insecurity can prevent entire communities from travelling freely to reach hospitals.

MSF works in Ahmad Shah Baba Hospital in eastern Kabul and Boost Hospital in Lashkargah, Helmand Province. In Kunduz province, MSF runs a surgical trauma centre providing lifesaving care to people in northern Afghanistan, as well as a maternity hospital in Khost in the east of the country. MSF provides free medical care and refuses money from any government for its work.

Since 2007 MSF SA has recruited 18 southern African doctors, nurses and midwives to work in Afghanistan.

©Francois Dumont/MSF



(Clockwise): (1) MSF emergency room medical team at Lashkargah's Boost hospital examine an injured Mohammad Zaher, aged 70. Mohammed was sitting in front of his shop in the town centre when a bomb exploded. (2) A mother cradles her newborn baby in the Ahmad Shah Baba maternity unit where MSF has been providing free healthcare since 2007. (3) Patients waiting in the male outpatient department of Boost hospital, Lashkar Gah, Helmand province. Every day, MSF carries out a total of 300 to 400 medical consultations in the hospital's OPD. (4) Ali, aged 11, sits in his bed in the in-patient ward at the MSF trauma center in Kunduz, northern Afghanistan. He discovered a discarded detonator in the street, which exploded, severely wounding his face and hands. (5) Kabul's population has tripled in recent years as refugees and economic migrants from rural areas flock to the capital. MSF launched mobile clinic activities in six camps to provide medical care to displaced people facing a harsh winter. (6) Babies born prematurely receive treatment under the watchful eyes of staff at MSF's neonatal ward of the maternity unit at MSF's hospital in Khost, Afghanistan.

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**Perspective**

# In India, HIV history repeats itself

MSF SA's Sharon Ekambaram took to the streets with AIDS activists in India, protesting their government's inability to protect people living with HIV from discrimination. She writes about the familiar battle these activists are waging.

Recently, I joined Mumbai AIDS activists rallying in protest against the Indian government's failure to protect people living with HIV from discrimination. More than 20 years after South African activists took up the same fight, the protests are a stark reminder that the battle for equality, dignity and access to life-saving care is not over.

This protest was a response to Indian parliament's failure to ratify the HIV Bill. This bill would make it illegal to discriminate against anyone based on their HIV status, ensure the provision of free HIV treatment and legalise HIV prevention services – like needle exchange programmes for drug users – aimed at stigmatised and criminalised populations.

South Africa and India are alike in that they face large HIV epidemics. In South Africa, about 17 percent of people between the ages of 15 and 49 are living with the virus. Although India's general HIV prevalence rate is much lower than South Africa's, the size of its population at 1.27 billion means that it remains one of the world's largest epidemics in terms of numbers, trailing only South Africa and Nigeria.

However, unlike South Africa, India's epidemic remains concentrated among already-marginalised communities such as sex workers, men who have sex with men and injecting drug users. This makes India's HIV Bill all the more urgent because India has no existing anti-discrimination legislation which would cover prejudice on the grounds of HIV.

Marching alongside protesters, and feeling the anger and pain of people discriminated against because they have a virus, reminded me of South Africa's struggles to eliminate discrimination.

## Lessons from South Africa

In 1992, Judge Edwin Cameron helped draft South Africa's AIDS Charter, which addressed discrimination on the basis of HIV status. The document guided the work

© Mudit Mathur



of the AIDS Consortium, which Cameron co-founded, and the AIDS Law Project where he served as director.

In 2000, the organisation successfully challenged South African Airways' discrimination against a potential job applicant based on his HIV status. In 2003, public pressure and activism led insurance companies to remove discriminatory clauses limiting benefits to people living with HIV.

Landmark cases such as these were the bedrock of the South African struggle for dignity and respect for all with HIV.

## When words fail

India's HIV Bill has its origins in a 2002 conference attended by high-level delegates from South Africa, Kenya and Nigeria, among others. At this meeting, participants signed the Delhi Declaration, which states: *"The HIV/AIDS epidemic constitutes a global health emergency of unprecedented magnitude that impacts economic and social development worldwide and in particular the developing world. To combat this global tragedy, a comprehensive strategy is needed to focus on issues including health care, prevention, support, and treatment within a legal framework designed to protect human rights."*

Sadly, this text is now worth no more than the paper on which it was printed.

Following the 2002 meeting, a national advisory group, chaired by India's national AIDS council, was formed. Comprised of representatives from civil society, people living with HIV and government, this group approached the Indian public interest law organisation, the Lawyers Collective, to prepare a draft HIV law. A little more than one year after the Delhi Declaration, a draft bill was presented to government.

This draft bill has languished in Indian parliament since 2006. Seven years later, Indian civil society has said "enough is enough" – spearheaded by the newly re-launched Mumbai AIDS forum that MSF helped establish.

## India needs South African solidarity

The struggle for survival facing India's vulnerable is much the same as it is in South Africa – just on a much greater scale. South Africans must support Indians in their struggle to ratify the HIV bill and their broader fight for equality and humanity. People's lives depend on it.

*Ekambaram is the head of the Dr Neil Aggett Unit at MSF South Africa. She has been an AIDS activist since the 1990s when she became the Treatment Action Campaign's first provincial coordinator for Gauteng.*



## Day in the life

# 24 hours in Bo, Sierra Leone

MSF SA nurse Chenai Mathabire recently returned from Sierra Leone's Bo District. She told **mamela** what a typical day working in the field was like.

Chenai began working for MSF in her hometown of Harare as a nutrition coordinator, counsellor and nurse treating gender-based violence. Sierra Leone was Chenai's second international MSF assignment. There, she helped run the ambulance service that has helped MSF teams lower maternal mortality by 61 percent in the district, by providing obstetric care.



Chenai Mathabire

**7:00am** – I struggle out of bed, have a hasty three-minute (cold) shower, a cup of coffee and a small piece of bread for breakfast. The “breakfast”, I must say, has been forced upon me by my caring housemates. Not in any words per se, it was all in their looks... Normally it's too early for me to eat, but I have since realised the benefits.

**7:45am** – The team gets in the car and heads to the MSF hospital where the fun begins. In the car, I mentally plan

the day and check my diary to remind myself of the day's priorities. There is never enough room in my planner to fit in all the activities I have to do.

**8:00am** – On arrival, I greet my colleagues arriving for work or coming off the nightshift and practise my Mende and Krio, the local languages. I have a brief chat with the nightshift team so they can share their experiences, including any challenges or interesting events I need to know about. I talk with the ambulance team leader and we review the plan for the day.

**9:00am** – I check the ambulances to make sure they are clean, that proper infection control measures are being followed and that they are well stocked. Then I let the team get on with their work preparing the ambulances for the day while I settle down to do administrative work – writing reports, responding to important emails, and follow-ups with colleagues from other departments, like water and sanitation, the laboratory or logistics.

**10:00am** – I usually go to the Gondama clinic, which is 10 minutes away from the hospital by foot. There, I follow up on activities we are implementing in the clinics, like new treatment protocols. I

take time to talk with the team leaders and we conduct supervision rounds together and discuss what has improved, what has not improved and why.

At the clinic, I also follow up with other staff members including the nurses, registrar, health promoters and cleaners. Every day, I also speak with the ministry of health officials in charge of the clinic. Towards lunch time, I make my way back to the hospital where we have lunch.

**After lunch** – I check up on the referral system's functioning. I talk to our radio dispatchers, sharing a few jokes and checking how many referrals to the facilities have been made so far. If there are no catastrophes I grab my computer and go to a small corner in the hospital, which I call the “ambulance office” and fill out all the necessary paperwork to document the day. I use this time to think about problems and how to solve them. I analyse the data we collect and speak with colleagues before writing up proposals about how to solve the problems.

My normal work day ends at 6:00pm or 7:00pm – even later if I'm on call, which is often. But it's a great job and I love every minute of it.



Nyema Foday, 30, delivers her second child by cesarian section at the Gondama Referral Center, in Bo District, Sierra Leone

**Where are they now?**



# Life after MSF

In 2011, Dr Nikki Fuller, head of the department of anaesthesia and intensive care at Wynberg's Victoria Hospital, needed a break. She traded her 158-bed hospital and Cape Town seascapes for the bustling Pakistani town of Dargai.

"I wanted to work in a foreign environment with an established, respected organisation without a political agenda and with a focus on health needs," Nikki says. "I'd been interested in MSF since I heard a former fieldworker speak at my medical school, so when I decided to take time out, MSF was a natural choice."

MSF started work in Dargai in 2007, setting up emergency and operating rooms, a maternal and child health clinic and a 40-bed inpatient department. By 2009, staff from MSF and the Pakistani Ministry of Health were providing more than 700 medical consultations and delivering 150 babies every week.

When Nikki arrived in 2011, she took up a supervisory role and helped develop protocols around the use of drugs and equipment to improve the hospital's efficiency. In many ways, the challenges of running a hospital in rural Pakistan were very similar to those of running a hospital back home.

**"Working with MSF really showed me that having the right equipment or drugs are much less important than having good people working with you."**

"The job that I have as head of a department is quite challenging. You have to think about how you use resources, personnel, drugs and equipment most effectively."

**"One thing that will always stay with me is a respect for culture. I don't only mean tolerance of other people's cultures, but an understanding and appreciation of how culture influences each person you are dealing with."**

"In South Africa, you can't just be a doctor," she adds. "You have to think beyond that... and that's mostly because of limited resources. If I spend all my time and resources to treat one patient, then that limits the number of other people I can help. When you have just two doctors to look after 100 patients, that becomes important."

In Dargai, Nikki was tasked with evaluating and mentoring staff, which meant hours working side-by-side with local Pakistani staff. Nikki often worked alongside older male doctors to help improve the hospital's processes. Working in a place where the culture observes strict traditional gender roles, she was never sure how male doctors took to criticism from a much younger woman – until the day she left.

"As a woman, you can't hug a man publicly in Pakistan," Nikki says. "But when I said goodbye, one of these doctors reached over and touched the top of my head and said, 'it's not a hug, but we will miss you'."

Being on assignment with MSF opened her eyes to a range of cultures in the workplace and at home.

"One thing that will always stay with me is a respect for culture," she says. "I don't

only mean tolerance of other people's cultures, but an understanding and appreciation of how culture influences each person you are dealing with.

"If you don't acknowledge that, you'll suffer in providing healthcare because you won't understand why people make the choices they do, why patients come or don't come or why people won't take their pills."

When Nikki returned home to South Africa and Victoria Hospital in late 2011, she brought with her a fresh perspective that led her to re-evaluate some of the hospital's systems.

Most of all, Nikki returned home with a deep commitment to teaching.

"Working with MSF really showed me that having the right equipment or drugs is much less important than having good people working with you. You have to spend time on training people, not just doctors and nurses, so the whole team works to improve patient care."

"Asking for more equipment and drugs has now become much less important to me than insisting we have enough good people to do the work."

Nikki is now pursuing a Masters in health science and education through the University of Stellenbosch.

*MSF handed over medical activities in Dargai to local health authorities in 2012. Between 2007 and 2012, teams provided care to more than 280,000 patients and performed more than 4,600 surgeries. MSF doctors and midwives delivered more than 9,000 babies, about 20 percent of whom were born after complicated deliveries.*

## Crossing frontlines

# Letter from Kyrgyzstan

Patricia Nyoni  
Nurse

Assignment location: Osh, southern Kyrgyzstan  
Hometown: Morija, Lesotho

**Nurse Patricia Nyoni joined MSF in 2006, having worked in Zimbabwe and South Africa. Earlier this year, she traded the sunny skies of southern Africa for the cold winter of Kyrgyzstan.**

"Kyrgyzstan has one of the world's highest TB burdens, concentrated in the south of the country, and much of the caseload is drug-resistant TB (DR-TB)."

"DR-TB can be transmitted directly, but it can also develop when patients don't take their medication properly, or have received the wrong drugs. In Kyrgyzstan, anti-TB medication is available over the counter, which means that the few who can afford this treatment may not always be getting the correct treatment, or taking it properly."

"MSF offers the only free service in the country offering consultations, diagnostics, treatment and social support. MSF is also pioneering the use of outpatient care for DR-TB patients who need not remain in hospital. This has greatly reduced long waiting lists for treatment and the number of patients who die before a bed is available for them in the few crowded hospitals."

"Osh is grey and a bit dull in comparison to southern Africa, but the countryside is so beautiful that it reminds me of home. The people are very welcoming. I find their curiosity about a person of a different colour fascinating – in a good way."

"My work in the community is especially interesting. It's great when people accept advice and their conditions improve."

"My day starts at 5:30am at my computer, reading news from southern Africa. At 7:30, I leave for the office and after a team meeting I jump into an MSF truck for an hour-long ride to Kara Suu Hospital, where MSF provides in-patient care."

"There I perform procedures, most often on crying children. Adults with pulmonary TB cough and produce sputum, which is tested to confirm TB. Because most children can't produce sputum, gastric aspirations are used to mechanically gather samples. These can be painful and the hardest part of my job is seeing children suffer."

## From Africa, with love

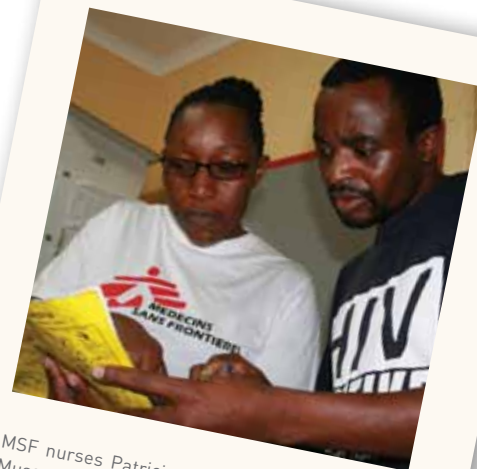
"Working in southern Africa taught me that, as a nurse, I could make a difference. I was teaching nurses to initiate antiretrovirals in Lesotho in 2007."

"Unfortunately, in this part of the world, services remain centralised with doctors. It's sad to see capable nurses side-lined because they don't hold a medical degree."

"Nursing really is the most rewarding profession in the world. The best part of my job is that we are saving lives."

## What's the best part about working for MSF?

- Patients believe in me
- I make a small difference in the world
- I am able to pass my knowledge to others



MSF nurses Patricia Nyoni and James Muzuva Musonza at St Banabas clinic in Lesotho.

## A different kind of nurse

Patricia spent two years working with MSF teams in Swaziland where, as TB coordinator, she managed budgets, advocated for policy change to improve patient care and trained staff on drug-resistant TB.

"I loved training and empowering local staff to take care of their own people," says Patricia.

Patricia took a special interest in one little boy who passed through her ward.

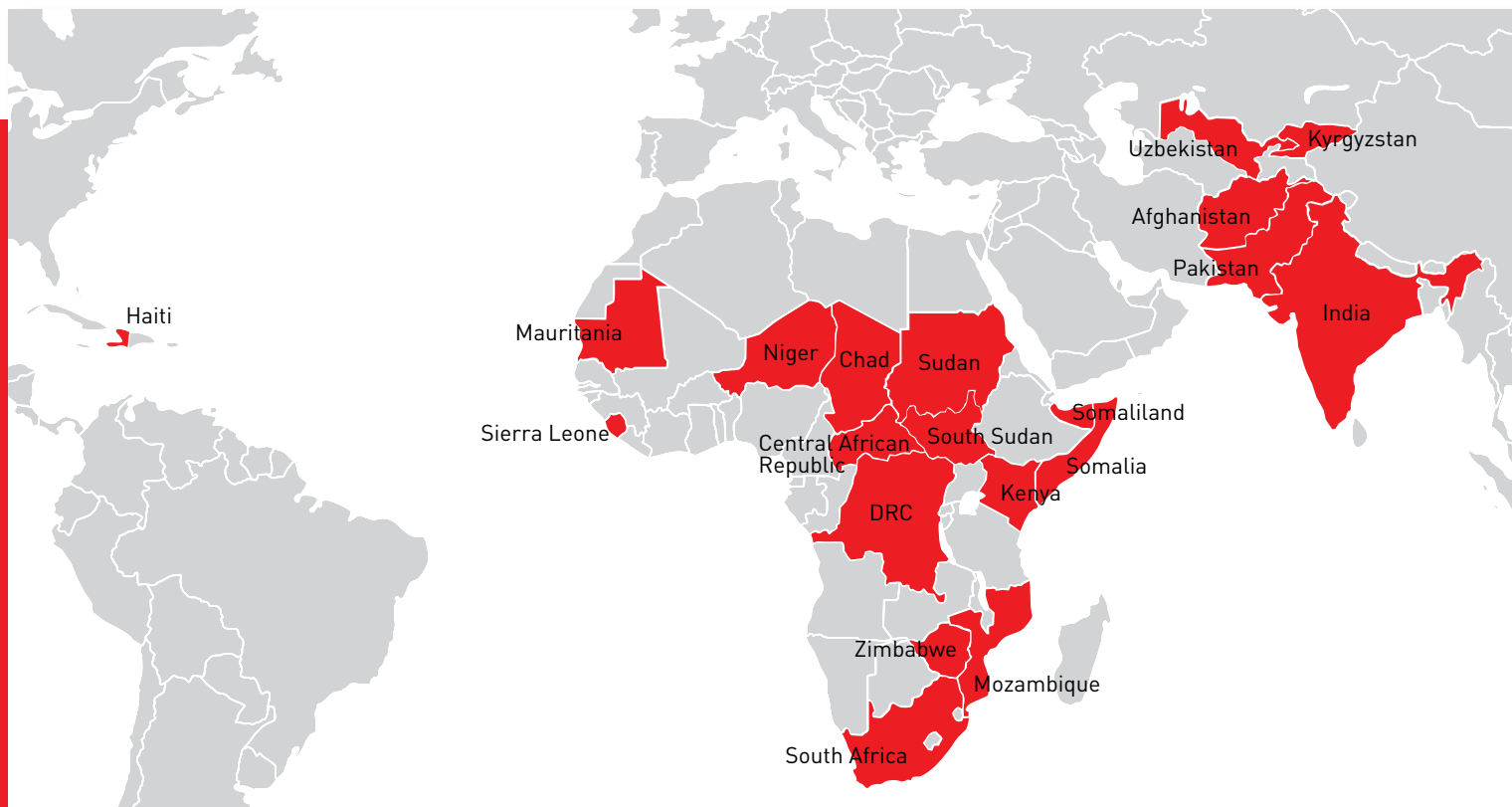
"He was 12 years old but looked more like an 8-year-old. Both his parents had died, so he stayed with his grandmother. He came to us with lymph nodes that were so swollen they looked like they might explode. We diagnosed him with DR-TB and admitted him, but his grandmother lived far away and couldn't come and visit him. He had been in the ward for three months and no one had come to see him."

"I bought him an ice cream cone every Saturday and would sit with him. He was so appreciative, so sweet. I've met nurses who think, 'as long as this boy has drugs and is dressed, he's okay'. If you think like that, you're not looking at the person. You're just looking at the disease."

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](http://www.msf.org.za) or submit CVs and motivation letters directly to [recruitment@joburg.msf.org](mailto:recruitment@joburg.msf.org)**



## MSF SA Fieldworkers in the field (June - October 2013)

**Adeline Oliver**, Operating Theatre Nurse - Afghanistan

**Alain Godefroid**, Nurse - CAR

**Alec Mkwamba**, Epidemiologist - Mozambique

**Aline Niyibizi**, Epidemiologist - Chad

**Anna Cilliers**, Nurse - Pakistan

**Annick Berthe**, Medical Doctor HIV/TB - DRC

**Augustin Majiku**, Nurse - Niger

**Bashir Ahamed**, Medical Doctor HIV/TB - Uzbekistan

**Caroline Masunda**, Nurse - Afghanistan

**Caroline Tamburai**, Nurse Director - Afghanistan

**Christopher Crede**, Administrative & Financial Logistician - India

**Danca Paiver**, Logistician - Mauritania

**Dodo Kibasomba**, Nurse - Mauritania

**Evaristo Dira**, Dep HR.Co - South Sudan

**George Mapiye**, Nurse - Somalia/Kenya

**Huggins Madondo**, Water & Sanitation Manager - South Sudan

**Jean Paul Kimenyi**, Epidemiologist - Niger

**Jeremy Blakeney**, Medical Doctor - Chad

**Jorge Enrique**, Anaesthetist - Haiti

**Joyce Njenga**, Midwife - Pakistan

**Kim Phillips**, Logistician - South Sudan

**Mduduzi Chandawila**, Nurse - South Sudan

**Nirav Patel**, Emergency Room Doctor - Somaliland

**Patricia Chipso**, Nurse/Anaesthetist - Afghanistan

**Patricia Nyoni**, Nurse - Kyrgyzstan

**Privilege Ruredzo**, Administration & Finance - South Sudan

**Sedi Mbelani**, Nurse - Sudan

**Seraphin Nongo**, Nurse - Niger

**Stefan Kruger**, Medical Doctor - South Sudan

**Sveltana Luchoo**, Obstetrician Gynaecologist - Afghanistan

**Tabitha Mutsyekwa**, Nurse - Uzbekistan

**Teresa Bonyo**, Medical Doctor HIV/TB - Zimbabwe

**Towani Mkandawire**, Supply Logistician - Sierra Leone

**Vanessa Naidoo**, Anaesthetist - Afghanistan