Doctors Without Borders (MSF) SA
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mamela

A lifeline on the frontlines

MSF fieldworkers deliver healthcare in the face of conflict, disaster and crisis

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DOCTORS WITHOUT BORDERS

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The right tools for the job

MSF teams in the field are faced with life-and-death situations every day. Ensuring they have the right medicines and equipment means they can find solutions to their medical and logistical challenges. Your donations give MSF fieldworkers the tools they need to save lives

Innocent Muleya

MSF doctor, joined the Ebola response in Sierra Leone's Bo district

"Vaccines prevent childhood illnesses such as polio, measles, and tetanus. In Sierra Leone, I treated sick children that were often malnourished and orphaned. With a simple needle, syringe and vaccines, I can help MSF protect children against deadly diseases every day."

Kim Phillips

MSF logistician, worked in South Sudan and Afghanistan

"In emergency situations, people often don't have access to clean water. I use chlorine tablets to purify water for hospitals, primary care facilities and refugee camps. With a basic item such as chlorine, MSF can provide clean water for thousands of people in need in conflict and crisis."

Mohammed Dalwai

MSF doctor, worked in Pakistan, Afghanistan, Libya, Syria and Sierra Leone

"An emergency kit is the one item I can't do without in the field. It enables doctors in emergency situations to treat patients on the frontline. The kit is filled with supplies that can treat anything from trauma, to hypertension. Sometimes it's the only thing we have with us in the field to save lives."

Carli Britz

MSF midwife, worked in Maban refugee camp in South Sudan

"As an emergency midwife for MSF, I helped mothers deliver babies safely in a refugee camp with the help of a delivery kit. The kit is made up of two umbilical cord clamps and a pair of sharp scissors used to cut the cord. The kit allows midwives like me to help women deliver babies in remote areas."

Esther Wanjiru

MSF doctor, worked in Sierra Leone in 2014

"In Sierra Leone, I treated malnourished children prone to infections. We fed them Plumpy'Nut – a peanut paste fortified with vitamins and minerals. After a few days of using it, the children gain weight and are on their way to recovery. This simple item helps me bring sick children back to health."

Find out how you can push the limits like our fieldworkers on the frontlines. Visit www.msf.org.za/pushthelimits

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EDITORIAL

Responding on many fronts

While offering assistance throughout Ebola-hit West Africa and maintaining medical action in crises around the world, MSF was stretched thin. But our dedicated teams and donors keep us flexible and innovative. Daniel Berman, General Director of MSF SA, reflects on the year past and the challenges to come

The Ebola outbreak has been a defining moment for Doctors Without Borders (MSF). When faced with an unprecedented outbreak and slow responses from other emergency responders we reacted swiftly with new creative strategies. In addition to sending experienced medical and non-medical people from our Southern Africa fieldworker pool, we also drew on a number of MSF SA staff who work in our Cape Town and Johannesburg offices who volunteered to be re-deployed.

"This work is emotionally difficult, but our teams get inspiration from their patients"

We are proud that MSF SA has sent more than 34 highly experienced people to join the massive Ebola response. It's the dedication of those individuals and others recruited from other MSF offices around the world that enabled our response.

This work is emotionally difficult, but our teams get inspiration from their patients. Read about an extraordinary mom and her son who are Ebola survivors on **page 10**. Most indications are that the number of new cases are dropping and the outbreak finally seems to be getting under control in many places. We are a long way from being able to declare victory but at least normal activities, such as kids returning to school, are resuming in Liberia and some parts of Sierra Leone and Guinea. Although we are maintaining a very significant presence in West Africa we are now refocusing on supporting regular health services and addressing deadly diseases that have been neglected during the crisis, such as malaria. In the last few weeks, for example, MSF distributed 1.8 million malaria treatments in Sierra Leone.

Closer to home, when the floods struck in Malawi, our people were well positioned to respond quickly as we have been working in Malawi since 1986. In the past few years we have been supporting people living with HIV in collaboration with the ministry of health.

To respond to the floods we immediately sent a Malawi-based team to the worst impacted area. The leader of the team described the floods as a "slow tsunami" with the river swelling progressively downstream. Most of the Nsanje and East Bank districts in the south of the country were submerged under two to three meters of water, creating a lake engulfing everything including houses. An estimated 37,000 people were cut off from the rest of the country when roads and bridges were flooded or destroyed. International staff including people from MSF SA have joined the emergency response efforts.

Immediate response included setting up tents, distributing non-food items such as water treatment kits and building latrines to prevent water-borne diseases.

In this issue of ***mamela*** we also explore the difficult situation in the young nation of South Sudan. In 2013 clashes between government forces and opposition groups displaced nearly a million people. Many civilians have been caught up in the violence and some have had to flee their homes and are living in precarious displacement camps.

While international efforts have largely focused on state-building, immediate needs of food, shelter and healthcare are going unmet. MSF runs projects in the country and is the only source of healthcare in most of the places where we work. You can read about the wide diversity of projects we run in South Sudan, including mass vaccination campaigns and primary healthcare clinics, on **page 11**. South Sudan is one of the top two assignment destinations for fieldworkers recruited by MSF SA. Although conditions are difficult we have many people who have returned as they find this work incredibly gratifying. They have no doubt that they are making a difference in peoples' lives.

"Our fieldworkers have no doubt that they are making a difference in peoples' lives"

And in the midst of conflict, MSF continues to provide a lifeline in even the most high-risk areas such as Syria and Ukraine.

Thank you for your continued support: the generosity of donors like yourself humbles us. We hope that you stay in the know through the updates on our activities outlined in this issue of ***mamela***.

©Mira Demachkié

*Thanks to the work of MSF staff in Ebola-hit communities, Aminata Sankoh and son were discharged as survivors of the disease from the Ebola Treatment Centre in Freetown, Sierra Leone. See **page 10**.*

IN BRIEF

Updates from the field

From Malawi to Ukraine, MSF makes #ToughDecisions during crises

Syria and Lebanon

The crisis cannot be forgotten

After a brutal winter, Syrian refugees in Lebanon's Bekaa Valley still struggle in dire conditions in informal tented settlements. In winter they contend with snow, in summer, heat. Rains bring floods at any time. Syria's 2011 Arab-Spring-inspired protests turned into a bloody ongoing conflict. Children and the elderly suffer most. In isolated settlement Khoder, eight-year-old Asma is treated at MSF's Baalbek clinic for respiratory issues and fever. "The snow is melting and we live in the mud. I'm cold and scared," she says. "We don't have wood for fire." MSF staff see patient numbers rise with harsh weather – their ailments a reflection of the situation into which the war drove them. "Assistance to this vulnerable population should remain constant," says Thierry Coppens, MSF Head of Mission in Lebanon. "This crisis cannot be forgotten."

©Ghazal Sotoudeh

A pregnant woman peers into freezing fog around her tent in Lebanon's Bekaa Valley.

The crisis by numbers

- 200,000 people killed
- 7.6 million people displaced within Syria
- 3.2 million refugees registered outside Syria
- 260,000 primary healthcare consultations provided to Lebanese, Syrian and Palestinian patients in Lebanon in 2014

MSF response

- MSF has projects in Syria, and supports over 100 medical facilities
- MSF helps those who have fled to Jordan, Lebanon and Iraq
- MSF provides healthcare and relief items in Lebanon

Nigeria

MSF assists survivors of deadly Boko Haram attack

©Line Geyer

An MSF fieldworker looks on the remains of a burnt market in Tudun Wada in Jos (Jigawa state).

More than 2,000 people were presumed dead after a Boko Haram attack on the town of Baga in Nigeria, in the north of Borno state. After the deadliest attack in five years a team from MSF assisted those who fled their homes in Baga to the city of Maiduguri in Borno. Between May 2013 and November 2014, the Nigerian government declared a state of emergency in three of its northeast states to try combat Boko Haram. MSF has worked in Maiduguri since 2014. MSF donated food, drugs and medical supplies to the health centre in Teacher Village, which was short of supplies after attacks. MSF supports the health centre with a focus on pregnant women and children, who are particularly vulnerable.

Democratic Republic of Congo

A mother dies every 25 minutes

©Pau Miranda

MSF encourages mothers in DRC to seek healthcare before and during childbirth.

In 2013, 21,000 women and more than 100,000 new-borns died in DRC due to complications in pregnancy and childbirth, according to the World Health Organisation. In DRC, a dysfunctional healthcare system, decades of violent conflict and lack of investment means rural areas lack basic healthcare. Many pregnant mothers are unable, or choose not, to go to health centres before childbirth. With bad roads, unsafe conditions and large distances to medical facilities, travel is difficult and mothers must walk for hours to receive care. MSF provides healthcare by supporting hospitals and running mobile clinics. But traditions prevent women from seeking medical help. Beliefs that mothers should deliver at home, like their ancestors, still prevail. Many traditional healers believe diseases are witchcraft. But MSF, authorities and humanitarian organisations are slowly increasing awareness of the need for healthcare before childbirth. Safi, a young mother, went to the maternity unit in Numbi to deliver her fifth child. "I've delivered all my children in health centres," she says. "Before, delivering at home was normal. But more people are realising that women and their babies are properly looked after here."

©Manu Brabo

Men clear debris after a shell landed near their apartment in the centre of Donetsk province, Ukraine.

Ukraine

A lifeline in the war-torn east

Fighting in eastern Ukraine has devastated those on both sides of the frontline. MSF supports hospitals in Donetsk receiving thousands of war-wounded patients. Many have lost loved ones; with homes and schools hit by shells. Most fear renewed clashes between Ukrainian and rebel forces. Local doctors struggle to meet medical needs with health services strained. "In July, the hospital was shelled and destroyed," says Reva, a nurse in Debaltsevo, Donetsk. Svetlana lives in Debaltsevo, close to the frontline. "A shell hit close," she says. "My husband was hurt. Shrapnel hit me. I called an ambulance, but they wouldn't come. My husband died in the yard." Svetlana receives counselling from MSF. With banks closed and pensions cut, most can't afford medication or transport. Basics like painkillers are unavailable, and specialised items like insulin in short supply. MSF is expanding to health centres in rural areas, such as at Ambulatory #6 in Novostroika, which assists 7,000 people from nearby villages. Many state institutions rely on volunteer support for food, as well as medical supplies and aid from MSF.

Malawi

A slow road to recovery

©Wilfred Masebo

Flood survivor Chambuluka stands in what used to be his garden.

In the wake of floods in Malawi, thousands of people in the southern tip of the country were cut off without food, healthcare and sanitation. In response, MSF provided support to local health authorities in the worst hit areas. Thousands of flood victims lost their homes, possessions, crops and much-needed medicines. Turn to our special photo report on the floods on **page 8**.

SPEAKING OUT

©Taryn Arnott

The right shot

Immunisation reduces preventable child deaths. Yet, every year one child out of five is not fully vaccinated, putting them at risk of disease. MSF is calling on companies to slash vaccine prices in developing countries. Julia Hill, MSF's Access Campaign Officer, explains the implications for South Africa

In a pharmaceutical market shrouded in secrecy, vaccine prices are skyrocketing. A new report from MSF's Access Campaign, *The Right Shot: Bringing Down Barriers to Affordable and Adapted Vaccines*, reveals that a handful of pharmaceutical giants are overcharging for vaccines that already earn them billions of dollars, while keeping pricing information secret.

"Pharmaceutical giants overcharge for vaccines that earn them billions"

Today, the cost of vaccinating a child is 68 times more than it was in 2001. In South Africa, adding the newest vaccines against pneumonia (PCV), diarrhoea (rotavirus or RV) and cervical cancer (HPV), all of which are disproportionately more expensive, means that the cost to vaccinate a child is higher than ever before.

As the cost of buying vaccines rises, South Africa struggles to deliver the best coverage for a greater number of children due to expensive new vaccines. New vaccines (HPV, PCV and RV) make up 86% of the cost of the total vaccination package while nationally, South Africa only manages vaccination coverage rates at a low 65%.

These high prices exist because there are only two manufacturers for each vaccine. Globally, market prices for new vaccines remain high because of lack of competition. GlaxoSmithKline (GSK) and Pfizer are the only companies producing a vaccine for pneumococcal conjugate. Likewise, the human papillomavirus (HPV) vaccine, and rotavirus vaccine are only produced by GSK and Merck.

Because of the astronomical cost of new vaccines, many governments are facing tough choices about which deadly diseases to protect their children from.

While the South African Department of Health negotiated a reduced price of R157 per dose of Cervarix (GSK's HPV vaccine), the cost per dose is still three times more than the lowest global price the Vaccine Alliance (Gavi) pays in poorer countries like Mozambique and Malawi.

South Africa contributes funds to Gavi, but does not qualify for its reduced prices because it is classified as a middle-income country. Ironically, South Africa's economic status has not prevented it from accessing the lowest global prices for ARVs to treat its high prevalence of HIV. We still pay high prices for vaccines, despite experiencing a significant burden of diseases that could be prevented through vaccination.

If South Africa were to access the Gavi price for HPV, it would save over R214 million every year. This saving could go toward buying vaccines to cover a broader age range of girls, or improve the reach and delivery of services.

Country health budgets are also stretched by high prices because there is limited information to inform negotiations with companies. The Right Shot report – one of the only sources of comparative vaccine pricing available – shines a light on the secretive vaccine industry and the striking lack of data on vaccine prices. The pharmaceutical industry purposely conceals prices, there is a lack of market competition, and pharmaceutical companies charge wildly different prices in different markets for the same product.

"SA struggles to deliver expensive vaccines to children who need them"

In the report Dr Yogan Pillay, Deputy Director General of South Africa's Department of Health, describes the difficulties of negotiating the HPV vaccine price with so little information about true production costs.

To prompt change, South Africa must continue to be a leader in calling for increased price transparency. Rather than basing pricing on arbitrary economic indicators, we need to focus on public health needs.

A R1,500 donation vaccinates 500 children against measles. Our fieldworkers use these to push limits every day. Visit www.msf.org.za/pushthelimits

©Ikram N'gadi

Children are at risk of disease that can be prevented by immunisation.

HPV vaccines in South Africa

- The human papillomavirus (HPV) is a major cause of cervical cancer, the second most common cancer among South African women
- HPV kills over 3,000 women a year
- HIV-positive patients are more likely to be infected with multiple HPV types
- There are approximately 6 million South Africans living with HIV
- In 2014 the Department of Health rolled out a free HPV immunisation campaign to girls in grade 4 and those older than 9 in public schools – aiming to cover around 520,000 girls with a two-dose schedule

MAKING A DIFFERENCE

Donors reach out and engage

The support from individual donors ensures MSF's work is neutral, independent and impartial. Their donations meant MSF teams were ready to respond to floods in Malawi, while continuing Ebola projects and providing medical care in conflicts in Central African Republic, South Sudan, Ukraine and Syria, among others. We spoke to a few of our donors about their dedication to MSF

Demetri Liversage recognised MSF's name from all the media reports on our work to treat Ebola. Being able to help save lives was not a #ToughDecision for Demetri.

Martin Chirwa decided to stop at the MSF stand, listen to our story, and answer MSF's call by becoming a donor.

Mae Pretorius said she made the decision to donate because it's for a good cause. Mae was passionate about signing up and joining us in our work to help buy the medication, vaccines and surgical equipment that enable our doctors and nurses to operate.

Rozalia Ohlson and her daughter Simone didn't hesitate to sign-up when she realised it was MSF she would be supporting. Her donations help us lead the way to better healthcare for people in crises.

Karabo Mashego decided he was not going to passively sit back anymore. Instead, he took a stand and became a MSF donor to help people who are denied access to medical care.

Tyrone Arnold joined our MSF family by contributing to independent medical action. His donation allows us to offer assistance during conflicts and war, like Ukraine and Central African Republic.

Email donorservices@joburg.msf.org
Follow us on Facebook: Doctors Without Borders/MSF South Africa
Follow us on Twitter: @MSF_southafrica

YOUR SAY

Every year our donors offer countless words of support, online and in person. We listened to what you had to say on social media and in our recent survey. Your feedback helps us to work better and keep you informed in the best way we can.

Keep on doing the very necessary work you do. I admire the risky, difficult, and heart-breaking decisions you make every day. ***Nicky Flint***

I am a Malawian living in South Africa. I started donating to MSF in South Africa because of the good work and assistance MSF provides in Malawi. I'd like to keep up to date with the work you do. You are definitely making a difference. Thank you! ***Jacinta Nandolo***

Proud of you guys and honoured to help you serve the less fortunate, oppressed and helpless. Keep doing what you do. Best wishes for the future!
Gaenor Rowan, via email

Keep up the good work. Not many of us are strong enough to do what MSF does in the field. In the meantime, we'll do what we can to support the cause to get fieldworkers out there doing what they do best: fixing our world. It is an honour to support such a worthy cause.
Lee-Zandra de Vries

Thank you for this great platform where ordinary South Africans like myself can become a part of something this huge.
Emily Mihloti

I think MSF is doing great work and has earned my trust, and the trust of millions across the continent and the world. MSF does sterling work.
Mickey Madoda Dube

I hope it is a blessed 2015 for the entire fleet at MSF. May we save many, many more lives this year and bring love and hope to those desperately in need.
Venesia Oxford, via email

IN FOCUS

Malawi: After the floods

In the aftermath of Malawi's worst floods in living memory, thousands of people have lost their homes, possessions and livelihoods

Malawi was hard hit by floods in January. MSF operates HIV projects in the country, where HIV rates are among the highest in the world: more than one in 10 people are estimated to be infected.

After flooding from heavy rains, up to 37,000 people were cut off from the rest of Malawi for weeks with little food and healthcare. The flood wiped out everything in its path: from crops – the livelihood of most families – to healthcare centres, medicines and patient treatment records. Families were forced to relocate after their homes and farmlands were destroyed.

In East Bank, flood victims gathered in M'bawa primary school, where they stayed in classrooms for days. Others seek shelter in factories and buildings unaffected by flooding. Many were separated from loved ones when the floods hit. Grace Mailosi, 20, took her two children to the school in East Bank after losing her husband in the floods. Yohane Paulo and his family spent four days in a tree to escape the floods. "That's when we saw canoes. They came because floods had created a lake for them," said Yohane. He and his brothers hired a boat to get to James Village to salvage what was left of their possessions. Makhanga-resident Berita was eight-months pregnant when the floods hit. She didn't leave, because she had nowhere to go. Makhanga is on slightly higher ground, so many sought refuge there. For days, Berita and her family stayed in a tree to escape rising waters. But 13 days after the flood, she gave birth to her daughter, with the help of MSF nurse Clive Kasalu who arrived by helicopter. After the floods, Makhanga was only accessible by air.

With medical centres and patient records swept away, maintaining HIV care through antiretroviral treatment for patients will be a major challenge. HIV prevalence reaches 16% in the flood-affected south of the country. In Nsanje there were 21,000 registered patients on ARVs at the end of 2014. Disrupted HIV treatment means complications such as resistance to drugs and higher risk of infection in communities.

MSF response:

- Mobile clinics set up in Chikwawa, Phalombe, Nsanje and East Bank
- MSF provided medical care in Makhanga, where 5,000 people found refuge
- MSF supplied water treatment kits, mosquito nets, latrines and surveillance to curb malaria and waterborne disease

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Left to right, from top: (1) After escaping the floods in a tree, Yohane Paulo and family relocate to East Bank with their only possessions. (2) Dr Suzana Sattia examines a child with dysentery in Sorgin camp. (3) Over 300 people take shelter in a factory in Nsanje, sleeping on the floor. (4) A pregnant woman in Makhanga is evacuated by helicopter. After surgery, mother and child survive. (5) Berita Tcheleni holds her baby, born days after the floods. (6) In Nsanje, people gather at newly-formed Ruo river bank to watch volunteers search for bodies of flood victims.

Your R100 supplies 5,000 people a day with clean water. Fieldworkers use chlorine to push limits in emergencies. Learn more at www.msf.org.za/pushthelimits

OUR IMPACT

Ebola: The emergency is not over

A year after the Ebola outbreak, new cases are still emerging. The already-weak public health systems in West Africa are collapsing under the damage wrought by Ebola, with many hospitals shut and few places for the non-Ebola sick to turn for help

The public health systems in Sierra Leone, Liberia and Guinea are in paralysis. Longstanding challenges have left all three countries ill-equipped to meet pre-existing healthcare needs.

New cases still emerge

While there was a significant drop in the number of new Ebola cases at the beginning of the year, cases are still emerging in West Africa. Many new patients are not on the list of known contacts, and the origins of their cases are unknown. Even with just one case of Ebola, the outbreak and emergency are not over. Re-launching and strengthening the paralysed health sector in the aftermath of Ebola will be a major challenge.

©Anna Surinyach

Hygienists head to disinfect an ambulance outside a MSF Ebola Treatment Centre.

©Agnus Morales

Tombo Town: MSF distributed 1.8 million antimalarial treatments in Sierra Leone.

The other deadly epidemic in Sierra Leone

Isatu Koroma and Ibrahim Sesay live in Freetown, Sierra Leone, where communities are acutely aware of Ebola. But they live in fear of another deadly disease. In 2013, Sierra Leone registered more than 1.7 million cases of malaria.

"I had malaria several times," says Isatu. There are 24 people crammed in the building where she lives, in a space where the everyday nightmare is not Ebola, but malaria. "This girl had malaria. And this guy," says Ibrahim, pointing around the room.

Isatu was one of the 1.8 million people who received antimalarial treatments from MSF and the Ministry of Health in January. The goal was to reduce malaria cases, and thus decongest the healthcare system overwhelmed by Ebola. Since malaria and Ebola have similar symptoms (fever and fatigue), many patients with malaria go to Ebola Treatment Centres fearing they have contracted Ebola. They are turned away at local clinics as health staff fear the same.

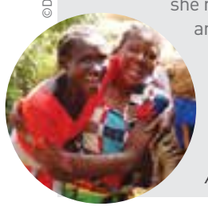
Isatu and Ibrahim talk about the possible end of the Ebola outbreak with their neighbours. "When will this Ebola epidemic be over?" asks one. No one knows, but everyone in Freetown knows that when Ebola goes away, malaria will still be there.

From patients to survivors

As MSF provides Ebola treatment in West Africa, patients inspire medical teams

Aminata: patient turned caregiver

Aminata Sankoh was very sick from Ebola when she arrived at MSF's Ebola Treatment Centre in Freetown with her Ebola-positive son Ishmael. While five-year-old Ishmael was critical, Aminata's health improved. Aminata stayed by his bedside, helping him eat and drink. Seeing that a boy in a bed nearby also needed help, Aminata took over his care, bathing him, and encouraging him to eat. She helped other children and teenagers around her persevere. Aminata cared for others while she regained strength. On Christmas Day, Aminata and Ishmael were discharged as survivors. Staff and patients cheered as the two left the centre for good. Donning a festive Christmas mask, Ishmael clung to his mother and his new toy car as they returned home.



©David Conteh

Family members celebrate Ebola-survivor Aminata 's return home on Christmas Day.

Adama: Against the odds

Adama Kargbo, 18, fell pregnant in 2014. Months later she was infected with Ebola. Adama was the first patient admitted to MSF's newest maternity unit in Kissy, Freetown. The unit for suspected and confirmed Ebola patients offers care for pregnant women. Little is known about Ebola and pregnancy. The unit will bring understanding of the effects of Ebola on this vulnerable group. Pregnant women with Ebola have had little chance of survival. Staff have been reluctant to let them deliver in existing health facilities out of fear of being contaminated. Most unborn babies of Ebola-infected mothers don't survive. Adama lost her baby, but against all odds, made a full recovery. As she left the centre, Adama left a painted handprint on the "survivor's wall", as has become tradition. Hers was the first blue stain on Kissy's wall.

A donation of R600 helps a midwife push the limits and bring five babies into the world, safely. Learn more at www.msf.org.za/pushthelimits

South Sudan: A country mired in crisis

More than a year after conflict started in South Sudan, the situation is dire. The population lacks food, security and healthcare, and is in desperate need of increased humanitarian relief efforts

South Sudan gained independence from Sudan in 2011. In 2013, violent clashes broke out between government forces and opposition groups. People displaced by conflict are at risk from violence, malnutrition and disease.

MSF response and the crisis by numbers (2014)

- 1.5 million displaced in South Sudan
- 500,000 seek refuge in neighbouring countries
- 803,694 outpatient consultations
- 46,078 inpatient admissions
- 3,249 war-wounded treated
- 166,298 children vaccinated for measles

Thousands displaced need humanitarian aid

"When militia attacked I fled my village. They attacked in the night and I lost my children and husband in the chaos. I don't know if they are alive," says Abok Mawein from Unity State in South Sudan. Abok now lives in a camp in Calek, Aweil North County in Northern Bahr el Ghazal.

"They attacked in the night and I lost my children and husband in the chaos"

Over 1,500 families arrived in Aweil North County since October last year, fleeing violence and attacks in the contested border area of Abyei between Sudan and South Sudan. They left with nothing and walked for weeks to reach this scorched corner of South Sudan, where they have settled in camps for internally displaced people (IDPs).

People fleeing violence are in desperate need of food, water and medical care. Most arrive in Northern Bahr el Ghazal empty-handed. In North Aweil, where MSF has a primary healthcare clinic and outreach community services, families share scarce water and food. In order to survive they are forced to gather wild fruits, desert dates and leaves for food. New arrivals survive on water from hand-dug wells and build basic huts from sticks and grass.

The lack of water and sanitation is increasing the risk of waterborne diseases. MSF provides medical services and runs vaccination programmes. MSF also distributes essential items such as jerry cans to transport water, cooking pots, soap and blankets.

"They walked for weeks to reach this scorched corner of South Sudan"

Families with young children receive a food supplement to help stave off malnutrition. But more assistance is urgently needed for this vulnerable population. The nutritional situation may deteriorate even more if urgent aid is not brought to the people of South Sudan.

©Andrew Zadel

Newly displaced people gather to collect relief kits in Aweil North County.

Ash fell from the sky as Malakal burned

MSF nurse Siobhan O'Malley provided healthcare in Malakal and Bentiu – towns hardest hit by the fighting in 2014.

In South Sudan I help vulnerable women and children, but not always in the ways I would expect. I arrived in Malakal in Upper Nile State at the height of conflict. I saw streams of people heading towards the United Nations (UN) compound in search of safety. One woman had nothing with her, just a baby in her arms. We were forced to abandon our base in town and move into the UN compound for security reasons. For days we heard gunshots. Then, the town was attacked in the night. The ground shook as shelling started and we ran to the bunker with the women and children around the compound. When we finally left the bunker and drove through crowds of rioters to the compound's hospital, ash fell from the sky as Malakal burned. I saw a terrified girl with a wild look in her eyes swinging a machete to protect herself. For the next few months we treated those wounded in war.

Later that year I went to Bentiu in Unity State, where MSF runs healthcare services and mobile clinics. We cleaned up an outbuilding of a destroyed hospital and set up a temporary clinic with special sessions for pregnant women. One day, a woman who had been raped arrived. She was relieved to discover she wasn't pregnant. She asked that her visit not be documented. Sexual violence is difficult to address in South Sudan: many women worry they won't be able to get married if people find out. One woman raped by armed men told me, "If you don't accept, they kill you". But there were better moments. I told a woman who'd been raped she was HIV-Negative. Her face lit up with a smile. Working in South Sudan, I've seen how important MSF's work is to peoples' survival in times of conflict.

© Victoria Russell

MSF nurse Siobhan O'Malley

PERSPECTIVES

A radical change in discourse

While talks on humanitarian aid are necessary, what is lacking in current discourse is discussion about dramatic reform that enables real action, says Jens W Pedersen, Humanitarian Advisor at MSF SA

A humanitarian talk shop blind to its own shortcomings?

The needs of the world's most vulnerable people in precarious circumstances are repeatedly going unmet. In an attempt to improve humanitarian responses, the United Nations Secretary General in 2014 tasked the UN Office for the Coordination of Humanitarian Affairs to seek solutions which will culminate in the World Humanitarian Summit (WHS), a global gathering in Istanbul in October 2016.

"Calls for concrete humanitarian response in many situations have fallen on deaf ears"

The process will include a wide array of organisations including the United Nations, states, humanitarian organisations, the private sector and civil society organisations and importantly, the people and communities affected by disaster and conflict.The summit will focus on four issues: humanitarian effectiveness; serving the needs of people in conflict; managing risks and reducing vulnerability; as well as transformation through innovation.

Although some of these issues are pertinent there is a critical element still missing from the process: a plan for radical transformation to improve the inadequate humanitarian responses in recent years.

Recent humanitarian emergencies have suffered from an inadequate response by the "humanitarian community". Needs of people in crisis were not adequately met. Last year, there was weak humanitarian action in Central African Republic in response to violence displacing nearly a quarter of the country's population. Only a few medical organisations were left to assist the people in areas outside the more easily accessible capital, Bangui. After conflict erupted in South Sudan in 2013 and 2014, many organisations downscaled for the Christmas holidays, some taking months to return to areas in the country where hundreds of thousands of displaced people had sought refuge. While MSF provided medical care in ill-adapted and managed camps where tens of thousands of people sought safety, many more who fled into the bush seeking safety remained out of reach.

Last year during the Ebola outbreak in West Africa, many humanitarian NGOs only sprang into action once asked to do so by donor governments – months after the outbreak had been declared. The Ebola emergency showed that existing humanitarian and medical structures of the UN system were inadequate to respond to the outbreak, prompting the establishment of an entirely new and separate UN structure.

"How many lives were lost as a result of the slow response ill-adapted to reality on the ground?"

Case management, health promotion, safe burials, active case finding, and contact tracing all were scaled up too late and organisations are still struggling with a lack of coordination.

So far, calls for concrete humanitarian response in many situations have fallen on deaf ears. In 2014 MSF teams stretched to their limits called for improved responses and aid in crises in CAR and South Sudan so humanitarian agencies would provide basic services to refugees and displaced people. There were also loud calls for the entire UN and NGO system to urgently respond to the largest outbreak of Ebola ever recorded. The Ebola response was finally scaled-up, but how many lives were lost as a result of the slow response that was often ill-adapted to the reality on the ground?

Considering this reality, the World Humanitarian Summit process should acknowledge the deadly gaps created by the lack of emergency humanitarian capacity and timely response. Discussions about how to improve response have so far been absent from regional WHS consultations. Many organisations and individuals representing the humanitarian system attended the WHS regional consultation for East and Southern Africa in Pretoria in 2014. Here, however, there was little focus on the real issues facing humanitarian aid and the critical link between capacity, preparedness and concrete action on the ground.

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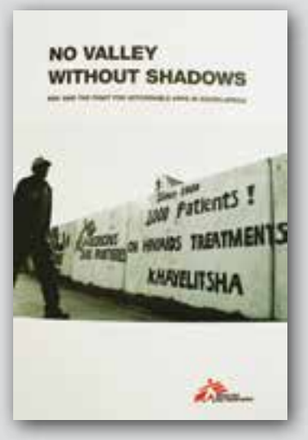
People waiting to be treated at a MSF primary healthcare centre in South Sudan. There are still many who are out of reach in a country that is in dire need of humanitarian assistance.

By the end of regional consultations, a few recommendations were made. These include an increased role for states/ governments and regional organisations, a greater role for the private sector, as well as a reduction of the negative impacts of counter-terrorism strategies on humanitarian action. A higher allocation of funds for sustainable development was recommended to mitigate risks and there was a call to improve the understanding of, and respect for, humanitarian principles. But these issues are external to the direct reality of humanitarian operations. None of these discussions so far have cut to the core: the humanitarian system needs radical change to increase capacity, improved response time and effectiveness to save lives and alleviate suffering.

As humanitarians, we need to caution against palming off responsibility for years of poor response onto others.
But mostly, we need to find solutions that address the inherent failure of humanitarian organisations to assist people in acute need.

BOOK REVIEW: No Valley Without Shadows

MSF and the fight for affordable ARVs in South Africa



Just as South Africa shook off the oppression of apartheid in the late 1990s, this era also ushered in a deadly new crisis that left 1,000 people dead every day as HIV ripped through communities. Until 1998 South Africa experienced among the world's fastest growing HIV epidemics and the South African government, shockingly, refused to act.

To fight HIV required battles on many fronts: replacing fear and ignorance in communities with empowerment and support, forging coalitions between doctors, patients and activists for treatment protocols and fighting for affordable life-saving medicines kept out of reach by profiteering pharmaceutical companies.

"They changed the course of the HIV pandemic in South Africa"

No Valley Without Shadows is a warts-and-all account which brings the story alive through blunt truths and colourful anecdotes of impossible encounters by the people who joined forces to change the course of the HIV pandemic in South Africa and the world. Back in 2000 MSF began providing antiretroviral therapy to a small number of people living with HIV/ AIDS in projects in Thailand, South Africa and Cameroon. At the time, treatment for one person for one year cost more than $10,000 – 99% more expensive than the price paid today thanks to generic drugs being available.

Shrouded in stigma, HIV was deemed a death sentence in communities while it was hardly part of the country's political discourse as South Africa became a leader in AIDS denialism. At the time, some in the MSF community sought to prove to the world that ARVs could be safely administered in an African context, outside of hospitals. The goal was to set up a small project testing Prevention of Mother-to-Child Transmission. With the highest number of people living with HIV in the world, South Africa and its infrastructure and medical resources made it the most opportune country to attempt such a project.

But what MSF doctors did not anticipate were the many obstacles that lay ahead: from ignorance and fear, to pharmaceutical companies hell-bent on protecting their profits and illogical patent laws, to a government fiercely opposed to ARV treatment. When MSF's Dr Eric Goemaere arrived in Johannesburg in 1999 to find a partner clinic for the simple PMCT programme, he assumed that the enormity of the HIV epidemic in South Africa would make treatment a number-one priority for the South African government. Instead, the government denied life-saving treatment to its poor and vulnerable citizens.

No Valley Without Shadows documents the collaborative effort between MSF and its partners including the Treatment Action Campaign and tells the story of people fighting for their rights and dignity, while initiating change on grass-roots level. Informative and entertaining, the book chronicles poignant moments ranging from the ridiculous to the sublime. Look out for former UN Special Envoy for HIV/ Aids in Africa, Stephen Lewis's tale of a maniacally screaming health minister Manto Tshabalala-Msimang trying to run him out of Khayelitsha. Lewis had come to see MSF's project and learn about the community's battle to encourage government to deliver HIV treatment.

Without access to affordable HIV drugs locally, air stewards were tasked with "importing" small quantities of branded ARVs in their hand luggage at a fraction of the cost. Another anecdote talks of the TAC's Zackie Achmat doing the same with cheaply-bought Thai ARVs leading to his public arrest and effective protest that grabbed the world's attention. Almost surreal by today's standard, another section explains how MSF was accused of fomenting biological warfare in South Africa by experimenting with toxic drugs on the black population.

No Valley Without Shadows illustrates just how a handful of irrepressible activists, doctors, patients and ordinary people changed the course of the HIV pandemic in South Africa with a narrow victory – against the odds and near-undefeatable opposition of government and pharmaceutical companies.
Turning the last page, readers will find new appreciation for the marvel of South Africa's HIV treatment programme which now just over a decade later has nearly 3 million people on antiretrovirals. They'll also understand that progress remains fragile without the never-say-die efforts of ordinary people united with common purpose to save lives as the fight continues.

FIELDWORKER FOCUS

They've got what it takes

When MSF SA fieldworkers met at an annual gathering in Johannesburg, they reflected on working with MSF in difficult contexts. They share thoughts on why they push the limits with MSF in the world's most troubled areas

Human resources coordinator Corina Moffat worked with MSF in Sierra Leone.

"I was working in a regular project with MSF in Sierra Leone when Ebola broke out. I was faced with the choice of leaving the area, or staying to join the Ebola emergency response team. All the risks were clearly explained, but I decided to stay and help set up the treatment centre to fight Ebola. I'm proud I was part of the team that initiated the fight against Ebola in Sierra Leone early on, despite the risks. I want to keep making a difference in peoples' lives."

Admin and finance coordinator Claire Waterhouse worked in CAR.

"When the opportunity arose to join MSF, I jumped at it. There is no better way to push yourself, challenge limits, and learn – all while making a difference in this chaotic world. MSF's work is vital because ensuring quality healthcare means improving the standard of living and opportunities for people in developing countries. It's not just about saving lives: it's about what those saved lives can go on to become."

Doctor Mercy Kaudresi works at the Eshowe project in KwaZulu Natal.

"I met a 36-year-old HIV patient who was so emaciated, her bones were sticking out and her skin was sagging. I admitted her to the hospital, changed her ARV regimen and discharged her when she stabilised. Two months later she came back to the hospital, and I didn't even recognise her. She was radiant – healthy, full of life and happy. She hugged me and asked for a photo. I knew that working with MSF I'd be able to make this kind of difference. I want to change the world by helping where it's needed – something I can do with MSF."

Nurse Augustin Majiku wa Majiku worked in Mauritania, Niger, South Sudan and CAR.

"I joined MSF because I am a humanitarian. After working with MSF for years, I've come to realise that this is more than a job. It's about making a personal sacrifice to help people and save lives."

Doctor Annick Bethe Ndawana worked in Zimbabwe, DRC and Myanmar.

"Seeing my first patient complete his MDR-TB treatment in DRC was one of my most memorable experiences with MSF. We organised a small function for him and invited patients, staff and members of the community to celebrate. It showed other patients that, even though the process is difficult, there is hope after treatment. To save a life brings a great sense of fulfilment – especially in difficult contexts where there are many challenges to overcome."

Nurse Melt Ndlovu worked in Sierra Leone.

"I grew up in a marginalised tribe in Zimbabwe. I understand what it means to be discriminated against with no access to healthcare. MSF assists people in distress. I joined MSF so that I could too. My passion for saving lives and bringing hope to people is what motivates me."

Nurse Alain Godefroid Ndikundavyi worked in CAR and Mali.

"I joined MSF after witnessing the work they did in my home country of Burundi. I wanted to help overcome the healthcare challenges that communities in other countries face. MSF helps the forgotten, providing healthcare to the vulnerable."

Do you have what it takes to push the limits like our fieldworkers? Visit www.msf.org.za/pushthelimits

FROM THE FIELD

Understanding culture and affecting change

When anthropologist Emilie Venables discovered she could work with MSF to help translate cultural knowledge into life-saving action, she packed her bags and put her skills to the test

I'm often asked, "What does an anthropologist do...?" As an anthropologist, I ask people questions about their everyday lives. I learn about different cultures. But I also look for social solutions to medical challenges. An anthropologist is a translator: we explore different cultures and societies. We analyse how these societies function while decoding and making sense of people's lives and words as we go.

"I spent time with people in fields, in forests, on floors and in taxi ranks"

I had considered applying to MSF for a long time, but wasn't sure how my studies would translate into humanitarian aid work. I considered applying to work as a logistician even though I'm not very good at fixing things: I panic when my washing machine makes a strange noise. But as luck would have it, I was able to work in the discipline in which I trained. (As an aside, my ideas about what MSF logisticians do were very ill-informed and they are far more varied and complex than I ever imagined.)

MSF employs people from different professions including anthropology, epidemiology and psychology. These profiles complement the medical teams and offer additional support and insight around the globe on health issues from HIV, to Ebola and cholera. My field-based work is often very practical - and muddy - but I've also spent long hours looking through files and analysing patient data at my desk.

As an undergraduate anthropologist-in-training I lost myself in vivid ethnographies that described the lives of people in places that seemed so far away, yet equally very familiar. But I realised how an in-depth understanding of another culture could improve the health and livelihood of individuals. Anthropologists seek to understand people's belief systems to improve health outcomes: they do not tell a community of people that what they are doing or believing is wrong.

Working for MSF, I'm able to do the kind of detailed exploration I've always dreamed of. Having just spent two years in the heart of KwaZulu Natal, my day-to-day work meant talking to people about HIV and trying to understand an aversion to HIV testing and ARV treatment. I spent time sitting in fields, in forests, on floors and in taxi ranks asking people about their lives. I tried to unravel the complex web of stigmatisation, migration and gender that is an interwoven part of the epidemic in this community. This kind of applied anthropology is very immediate: I replace lengthy essays with bullet-point recommendations. The recommendations I make to the medical teams need to be easy, immediately relevant, and quick to implement.

"My field work is often very practical – and muddy"

My work also involves what is known as health promotion: finding culturally appropriate ways of passing on information about health-related issues to communities.

This may be information about the importance of using mosquito nets, on the need for washing your hands during a cholera outbreak, or on how to prevent the transmission of HIV.

Rather than agonising over theoretical debates that I never really saw as relevant, as an anthropologist with MSF I use and apply the tools of my discipline where they matter. And there's no better way to put everything I've learnt into action: action that actually makes a difference.

Fit in the field

It's difficult to lead a life of routine in the field. But fieldworkers still find a way to stay fit - and even train for Comrades - amidst the chaos

Doctor Juli Switala first worked with MSF in a maternity hospital in Khost, Afghanistan. In 2014, she joined MSF in Sierra Leone.

"I've been running for more than 20 years, so it's more a part of my routine than brushing my teeth! Exercise is a stress and fear reliever in tense situations, and offers a bit of alone time. On some assignments, the fieldworkers like to play volleyball together, too. In Sierra Leone, I ran through jungles, river beds, villages, farmlands and over hills. What I saw in the villages gave me a much better idea about the real lives of the patients I saw at work.
I had to dodge chickens, race against kids, and wait in line to use a bridge made of sticks – all the while watching out for motorbikes, snakes and giant potholes. I was in the midst of training for the Comrades Marathon on my first assignment in Afghanistan.
There, we weren't even allowed to leave the compound, let alone run down the street unaccompanied in training gear.
Fortunately, there was a treadmill. I did more than 1000kms in the three months I was there – all while staring at the same spot on the wall. I even had to push myself to do a 60km treadmill run on my only day off. It was the toughest mental challenge I've ever taken on. But I did it, and finished Comrades too."

MSF SA 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 letters directly to recruitment@joburg.msf.org

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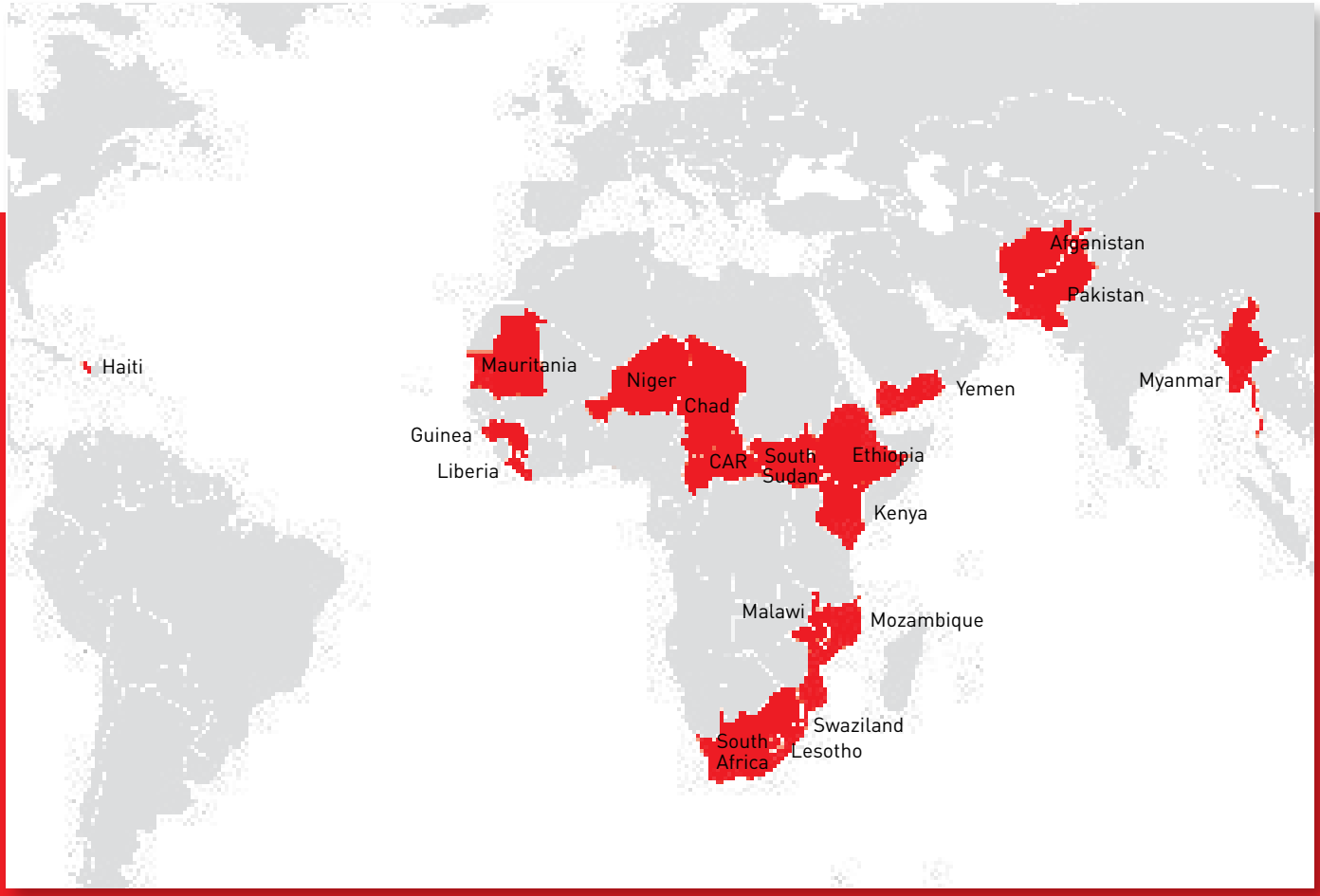
DOCTORS WITHOUT BORDERS



MSF SA: Recruits in the field

Alain Godefroid, Nurse - Niger
Alec Mkwamba, Epidemiologist - South Africa
Aline Aurore, Epidemiologist - Kenya
Anaclet Mugali, Doctor - Mauritania
Annick Bethe Ndawana, Doctor - Myanmar
Augustin Majiku wa Majiku, Nurse - CAR
Camren McAravey, Administration and Finance Manager - Mozambique
Caroline Masunda, Medical Focal Point - South Sudan
Chenai Mathabire, Nursing Activity Manager - South Sudan
Chipo Takawira, Epidemiologist - South Sudan
Christine Ewoi, Midwife - Pakistan
Christopher Crede, Deputy Field Coordinator - Haiti
Christopher Eweiler, Field Coordinator - Pakistan
Claire Waterhouse, Administration and Finance Manager - Liberia
Constancia Tambudzai, Project Medical Referent - Mozambique
Cyprian Njururi, Electrician - South Sudan
Daniel Tabaro, Doctor - Chad
Dieudonne Jean Damscene, Doctor - Mauritania
Dodo Kibasomba, Medical Focal Point - South Sudan
Dominique Savio, Pharmacist - CAR
Elaine Yip, Anaesthetist - South Sudan
Emilie Venables, Anthropologist - Kenya
Esther Wanjiru, Doctor - Malawi
Evaristo Dira, HR Coordinator - Mauritania
George Mapiye, Medical Team Leader - Yemen
Gilberta Jairosa, Nurse - Afghanistan
Innocent Muleya, Doctor - Lesotho
Israel Mushore, Electrician - South Sudan
Jean Paul Kimenyi, Epidemiologist - Mozambique
Job Nyagah, Water and Sanitation Specialist - South Sudan
Joyce Njenga, Midwife - South Sudan
Laurent Siborurema, Surgeon - CAR
Leonard Ndayisenga, Doctor - Mauritania
Marcel Lemonade, Doctor - CAR
Mercy Kaudresi, Doctor - South Africa
Michael Mojeed, ER Doctor - Yemen
Michael Wangombe, Mechanic - South Sudan
Mikhail Barday, ER Doctor - Afghansitan
Mukarugwiza Laurence, Midwife - Guinea
Patricia Mazuru, Health Policy Advisor - Lesotho
Patricia Nyoni, Medical Team Leader - Swaziland
Penelope Cox, Mental Health Activity Manager - Liberia
Priviledge Ruredzo, Finance Manager - South Sudan
Sedi Mbelani, Medical Team Leader - Ethiopia
Simon Njoroge, Electrician - South Sudan
Stanley Babu, Nurse - Liberia
Stefan Kruger, Doctor - Liberia
Themba Sibanda, Supply manager - Afghanistan
Towani Mkandawire, Warehouse Manager - South Sudan
Vincent Ndichu, IT Logistician - Pakistan
Virginia Kinyanjui, Midwife - Lesotho
Zani Prinsloo, Midwife - South Sudan