

mamela



Malnutrition: A medical emergency

Ready to treat it, anytime, anywhere

IN FOCUS: Return to abuser
in Papua New Guinea

8

The end of safe refuge
after EU-Turkey deal

12

Vaccinations: Going the
extra mile

13

Surviving the Kunduz attack

15

YOUR SUPPORT

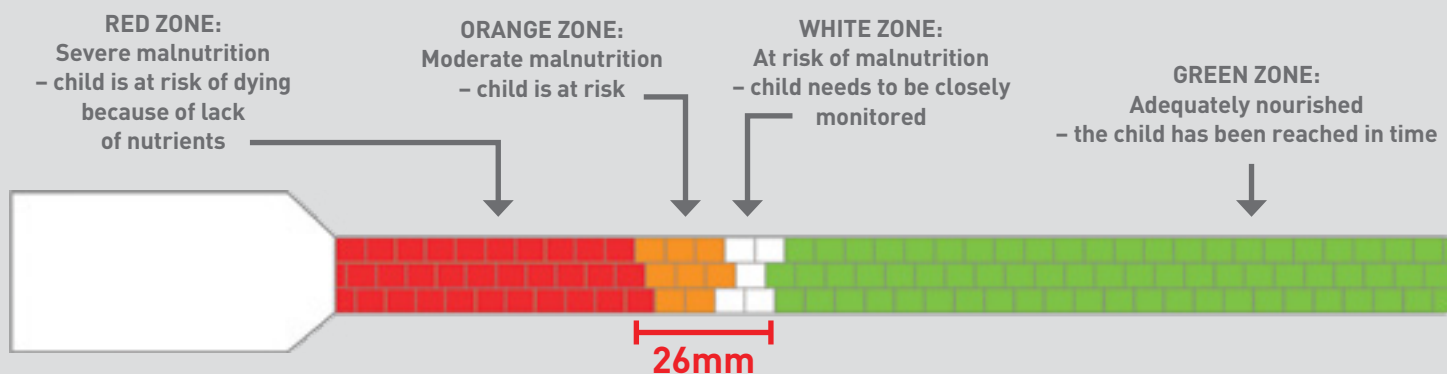
Filling the deadly gap

Malnutrition is a medical emergency. Every year, Doctors Without Borders (MSF) treats hundreds of thousands of children suffering from malnutrition. We couldn't do this without your generous donations which have helped us bring children from severe malnutrition to recovery

About 45% of child deaths worldwide are linked to malnutrition. As a donor without borders, your donations allowed us to treat 217 900 severely malnourished children in MSF inpatient or outpatient feeding programmes in 2014.

It's important that these children are treated quickly because if dietary deficiencies are persistent, children stop growing and become 'stunted' – meaning they have a low height for their age. This is diagnosed as chronic malnutrition. A malnourished child is also more vulnerable to diseases such as malaria and measles and a sick child is more likely to become malnourished.

MSF teams measure a child's mid-upper arm circumference (MUAC) and compare standard weights and heights within a given population to diagnose malnutrition. The MUAC band is a quick way of identifying whether children under five years old are malnourished. There are four coloured zones on the band.



WHAT YOUR DONATIONS DO:



R 100 – can provide a severely malnourished child with ready-to-use therapeutic food (RUTF) for one week. RUTF contains fortified milk powder and is the most effective way to fill the gap between malnutrition and recovery



R 400 – can help one severely malnourished child make a full recovery within four weeks



R 1 200 – can help three severely malnourished children make a full recovery within four weeks

THE GAP BETWEEN SEVERE MALNUTRITION AND RECOVERY.

The gap between severe malnutrition and recovery is as little as **26mm**. That's it. 26mm between a child recovering to normal weight or not making it.

The gap between severe malnutrition and recovery can be just four weeks. That's it. Four weeks for a severely malnourished child to recover to normal weight.

The gap between severe malnutrition and recovery is as little as R400. That's it. R400 between a child recovering to normal weight or not making it.

Fill this gap with a donation to save a child's life.

mamela

CONTACT MSF SOUTHERN AFRICA

Telephone: +27 (0) 11 403 4440/1/2

Email: office-joburg@joburg.msf.org

Website: www.msf.org.za

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

facebook

www.facebook.com/MSFsouthafrica

twitter

www.twitter.com/MSF_southafrica

You Tube

www.youtube.com/msf

EDITORIAL

MSF's withdrawal from the World Humanitarian Summit

On 5 May, MSF announced that it was withdrawing from the World Humanitarian Summit (WHS), planned by the UN Secretary General Ban Ki Moon. Jens Pedersen, the Humanitarian Policy Adviser at MSF's Dr Neil Aggett Unit, explains why



The WHS, held in Istanbul, Turkey in May 2016 gave global leaders a platform to discuss how to effectively respond to major humanitarian challenges and be better prepared to meet future challenges.

In explaining our decision to withdraw from the summit after participating in the initial consultations, we listed a series of concerns and reasons. These were primarily, but not limited to:

- the lack of focus on emergency response in crisis, in particular medical response and response to conflicts,
- the desire to merge the two different approaches to aid – humanitarian and development aid.

MSF's withdrawal from the summit is about fundamental issues, based on our experience in providing medical care to people who need it most, in crises such as conflicts and outbreaks.

Humanitarian response and development are, and must remain, separate things.

The UN Secretary General, in his intentions for the summit, encouraged more of what MSF has witnessed in the field over the past few years: humanitarian organisations expected to do ever more – while not necessarily a bad thing in itself, it is problematic when it pulls humanitarian work away from its core priority.

In 2014 MSF issued a report, titled *Where is everyone?*, based on research into three major humanitarian crises (the conflict in the DRC, Syrian refugees in Jordan and Sudanese refugees in South Sudan). The report highlighted that in contexts of crisis, a growing responsibility for responding to the needs of displaced populations fell on very few organisations, including MSF. No longer were more 'traditional' organisations able to provide

nutrition, healthcare, shelter and clean water. This is either because institutional funders could no longer quickly 'shift gear' and provide funds to emergency programmes, or because the organisations themselves were stuck in slow, long-term priorities of development.

This focus of humanitarian organisations, often by their own will, to merge core life-saving humanitarian activities with long-term development goals has allowed global emergency and crisis response to deteriorate. Such poor response is what MSF witnessed again during the West African Ebola outbreak in 2014; in South Sudan during the conflict in 2013-2015 and in Yemen throughout 2015-2016. During these crises significant humanitarian needs of populations went unmet, leading to suffering.

At MSF we are not against development or building capacities to better withstand crisis in the future. But the process of doing so should not be at the expense of maintaining life-saving humanitarian assistance. Humanitarian aid is about saving lives and alleviating suffering in the moment of crisis. Unlike development programmes, it isn't primarily about ending suffering in the future. Humanitarian aid is not about teaching a person to swim while they are drowning. We believe that these approaches must remain distinct in order to respond to the massive needs created by current crises. Humanitarian response and development are, and must remain, separate things.

Humanitarian aid is not about teaching a person to swim while they are drowning.

MSF's decision to withdraw from the World Humanitarian Summit was not about disagreeing over the issues on the agenda but about disagreeing about what issues should be discussed in the first place. What

a humanitarian summit should have as its ambition is to improve humanitarian aid, for the sake of saving lives and alleviating suffering.

It should not be to dilute and merge a core function of the humanitarian imperative with practices and processes that thwart it. A humanitarian summit should not necessarily be about doing more, but firstly about doing things better, since in many cases currently it's being done poorly.

© Luca Sola



MSF REJECTS EU FUNDING OVER EU-TURKEY DEAL

MSF has decided to stop accepting funding from European Union (EU) institutions and member states because of the EU-Turkey deal's ramifications. It undermines the international humanitarian principle of granting asylum and makes aid conditional to the political objective of stopping the influx of refugees and asylum seekers in Europe. The decision to refuse this funding will not affect any of our current operational projects as we're using emergency reserves to cover the gap. Today 92% of MSF's income is from 5.7 million private individuals whose generous support keeps our work independent, impartial and neutral.

IN BRIEF

Updates from the field

No matter where the emergency,
MSF is quick to deliver healthcare in crisis

Angola and the Democratic Republic of Congo

MSF teams are working in Angola and DRC following the outbreak of yellow fever.

Since the outbreak started in Angola in December and in DRC during February, 298 people have died from yellow fever. By early June 736 cases had been confirmed in Angola and 48 in DRC.

Using the highly effective yellow fever vaccine is key to prevent further spread, and the limited supply of the vaccine must be used efficiently.

Since mid-February 2016, MSF has been working with Angola's Ministry of Health, supporting yellow fever case management. MSF teams also treated yellow fever patients in the capital, Luanda and in Huambo, Huila and Benguela provinces. By early June 2016, MSF had treated 299 patients.

In the DRC, an MSF team worked at vaccinating 350,000 people in the city of Matadi, while treatment and activities to exterminate mosquitos and their breeding grounds were conducted in Kinshasa and in Kongo Central province.

MSF also provided medical supplies to identified health centres and trained staff in yellow fever treatment.

© MSF



DID YOU KNOW?

- Yellow fever is an acute viral haemorrhagic disease transmitted by infected mosquitoes
- The 'yellow' in the name refers to the jaundice that some patients suffer from
- Yellow fever is mostly spread through the *Aedes aegypti* mosquito, which also transmits dengue, chikungunya and Zika
- No treatment for yellow fever exists. Vaccination is the most effective way to prevent it
- Symptoms of the disease include fever, headache and muscle pain. Some patients experience severe periods of high fever and internal bleeding
- Up to 50% of severely affected patients die within 14 days, according to the World Health Organization

South Africa

Very high levels of sexual and domestic violence persist in the platinum mining belt outside Rustenburg. To support survivors, MSF, together with the North West Department of Health (DOH), established the Kgomoitso Care Centre at the Boitekong clinic in June 2015. The project focuses on offering free, patient-centred comprehensive care to survivors of sexual and domestic violence, including post-exposure prophylaxis to prevent HIV infection, vaccinations against hepatitis B virus and counselling and referrals to partner institutions for psychosocial and legal support.

MSF also provides training to nurses who care for survivors of sexual violence and will soon extend the programme to include clinical mentorship of nurses from Bapong and Letlhabile Health Centres.

"The objective of the project is to bring sexual and domestic violence services to the community in a comfortable and confidential way where there was none before," says Junaid Khan, the project coordinator. "The community has responded very positively to it."

Health promotion activities are also conducted to raise awareness of MSF's work in Rustenburg and to emphasise that sexual violence is a

medical emergency for which people should seek care immediately to avert the risk of pregnancy and prevent infection with HIV and other sexually transmitted infections. MSF and the DOH work in partnership with a number of other local partners to support this initiative.

© Caroline Walker



The MSF team in Rustenburg meet with community members as part of a project treating sexual violence.

Syria

© Mahmoud Abdel-Rahman



Syria has become a kill box. Relentless, brutal, and targeted attacks on civilians are the dominant feature of this war. While millions have fled for their lives, many Syrians remain trapped, and are denied the fundamental right to flight.

Deliberate attacks against civilian infrastructure, including hospitals struggling to provide life-saving assistance, are routine. Healthcare in Syria is in the crosshair of bombs and missiles. It has collapsed. Data released by MSF in February revealed 63 MSF-supported hospitals and clinics were bombed or shelled on 94 separate occasions in 2015, destroying 12 facilities and killing 23 staff members.

On 27 May 2016, MSF was forced to evacuate staff and patients from Al Salamah hospital in

northern Syria after an Islamic State offensive in Azaz, near the Turkish border, approached the area. The patients in the hospital, many of whom had landmine blast injuries, had to be referred elsewhere. Out of 150 staff initially at the hospital, only five remained to stabilise and refer patients to other hospitals or to Turkey.

MSF teams also distributed emergency relief items to 185 displaced families around Al Salamah.

"Around 100,000 people remain trapped between the Turkish border and active frontlines. The frontline is only three kilometers from Al Salamah town," Pablo Marco, MSF's Middle East operations manager, says.

MSF called on the Turkish government to open its border and allow those trapped to find a safe haven in Turkey. Following the EU-Turkey deal (read more on p12), which blocks Syrian refugees from Europe, MSF called European leaders out on this. "Instead of fixating on how to stop refugees from reaching Europe, the EU must work with Turkey to speed up the process of granting asylum to Syrian refugees in Europe, starting with those from Azaz," Marco says.

Al Salamah Hospital is the largest of six MSF-run medical facilities inside Syria. It has an operating theatre, emergency room, paediatric care, in- and outpatient departments and maternal care. MSF also supports over 150 Syrian medical facilities, with a particular focus on besieged areas.

Malawi

Since late November 2015, MSF has been assisting refugees fleeing conflict in Mozambique's Tete province and crossing into Malawi. Most of them fled to Kapise village, near the Mozambique border. While the number of Mozambican asylum seekers peaked at nearly 10,000 in April, numbers are now far lower.

MSF highlighted the fact that the Kapise refugees lived in overcrowded conditions, had poor housing and inadequate water and sanitation while being at risk of disease outbreaks. To assist them, MSF teams carried out various interventions, supporting the Ministry of Health, including mobile health clinics and an out-patient medical service. Half of all clinic consultations were for malaria treatment. The team also drilled two new boreholes which substantially increased clean water supply.

The camp is in the process of being relocated.

© James Oatway



R100 provides about 100,000 litres of clean water to provide 5,000 people with safe drinking water for a day.

SPEAKING OUT

Giving children a Fair Shot in life

To help save more children's lives with a pneumonia vaccine, MSF has launched a global campaign to demand that pharmaceutical companies drop vaccine prices for developing nations and humanitarian organisations

Pneumonia is the leading cause of death among children under five, killing almost one million children each year. And according to MSF, this is often because many nations can't afford to vaccinate children against this acute respiratory infection.

Dropping the price of the pneumococcal conjugate vaccine (PCV) can save more children by offering them protection from this childhood killer. MSF has been pushing for GlaxoSmithKline (GSK) and Pfizer – the vaccine manufacturers – to drop their prices. Despite years of negotiations for an affordable pneumonia vaccine, there have been no results and so MSF launched its *Fair Shot* campaign last year.

The price of the pneumonia vaccine has skyrocketed over the past decade. The cost of vaccinating a child in the poorest countries is 68 times higher than it was in 2001. The pneumonia vaccine accounts for almost half the price of vaccinating a child in the poorest countries.

The price of the pneumonia vaccine has skyrocketed over the past decade

The *Fair Shot* campaign is pushing GSK and Pfizer to slash the price of the pneumonia vaccine in developing countries by half from the current US\$10 to US\$5 per child – for all three

doses. The campaign is also urging GSK and Pfizer to disclose what they charge countries for the vaccine. When developing nations and humanitarian agencies can't compare prices, they cannot negotiate better deals with pharmaceutical companies – a reason why vaccination has become so expensive.

"As doctors who have seen too many children die of pneumonia, struggling to breathe, we are asking anyone who cares about children's lives to join our public call on Pfizer and GSK to make sure all developing countries can afford to protect all their babies against this killer disease," explains Dr Greg Elder, medical coordinator for the Access Campaign.

Vaccinating a child in the poorest countries is 68 times higher than in 2001

MSF has vaccinated children against pneumonia in the Central African Republic (CAR), Ethiopia, South Sudan and other countries.

As developing nations struggle with the high cost of the pneumonia vaccine, Pfizer and GSK have reported over US\$30 billion in sales in just five years. They can afford to make the vaccine more accessible to the world's most vulnerable children.

In April, the *Fair Shot* petition gathered signatures of over 400,000 people from

170 countries which were handed to the Pfizer Headquarters in New York. About 70 people who walked to the headquarters, placed 2,500 flowers in a crib to represent the number of kids who die from pneumonia each day.

Pfizer accepted the petition and now they need to take steps to turn it into decisive action and live-saving change.

Fifty-five countries, including Kenya and Pakistan, can obtain pneumonia vaccines at cut-rate prices through a public-private partnership called the Global Alliance for Vaccines and Immunisation (Gavi). However, many officials who don't receive any Gavi support can't afford PCV for their children.

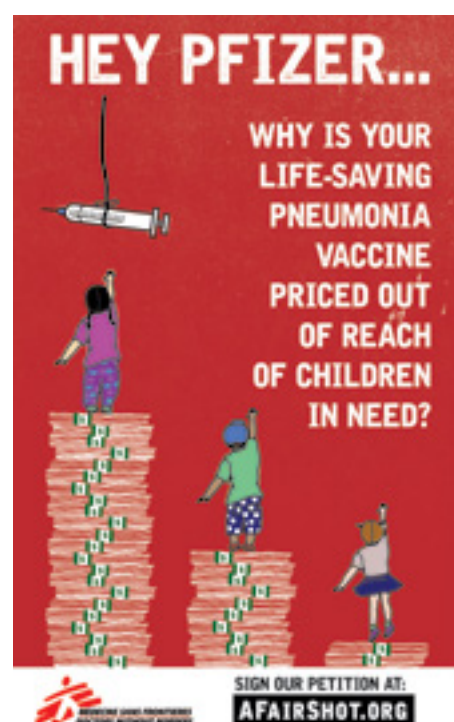
The *Fair Shot* campaign is about ensuring that one day they can.

Read more about MSF's vaccination efforts in CAR and Zambia on page 13

© Edwin Torres



MSF volunteers delivered over US\$17 million in fake cash to Pfizer – the equivalent of one day of profits from the pneumonia vaccine for the pharmaceutical company globally.

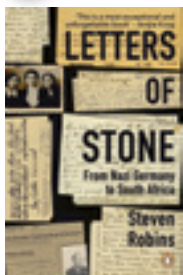


MAKING A DIFFERENCE

Create a fundraising event to save lives

Across the country, people committed to MSF's life-saving medical work are finding creative ways of raising money in support. Here are four fabulous fundraising events our donors undertook to help MSF teams deliver healthcare to people facing crises

1 Family dedicates chronicle to MSF



Professor Steven Robins, of the University of Stellenbosch, recently dedicated the launch of his book, *Letters of Stone*, to MSF. He also donated R1,000 to our work through our *Pledge Your Birthday* campaign.

Letters of Stone chronicles Robins' family's journey as refugees fleeing Nazi Germany in World War II. The resonances between his family's story and the contemporary refugee crises – an issue which MSF is heavily involved in – are striking.

Speaking about his book, Robins says: "Writing this book made me even more aware of what's happening today in South Africa and internationally around refugees and migrants and the work that MSF is doing in this area. My donation was in recognition of the work MSF does."

2 Learning more and giving

The University of the Third Age (U3A) is an international movement providing education and stimulation to mostly retired members of the community through courses on various topics including film studies and literature.

U3A's Cape Town chapter contacted MSF to find a speaker to address their members and in response, Dr Eric Goemaere, HIV/ TB Coordinator at the Southern Africa Medical Unit (SAMU), shared his 35 years of experience working for MSF.

MSF would like to thank the 500 members of U3A for their generous support after the talk in donating R20,000 towards MSF's emergency medical work around the world.

3 Running to save lives

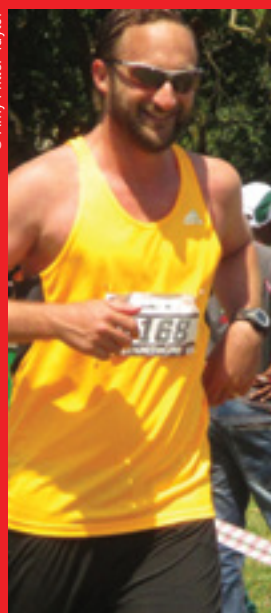
Steve Miller, a former MSF Southern Africa board member, ran the Comrades Marathon on 29 May 2016 to raise funds for our emergency interventions.

By raising funds for MSF through running the Comrades, Steve combined his passion for running with his passion for saving lives.

Steve and his online supporters managed to raise R20,200 for MSF's work.

Steve says that running the 89km marathon goes beyond the physical to become a mental undertaking. "Knowing I was running for MSF motivated me to keep going. When my legs felt like concrete, my organs were rebelling, and the blood pumped heavy in my ears – I thought of MSF and the thousands of people they're helping every day. And I was pushed to keep going and finish."

© Amy Miller Taylor



4 School markets bring in new supporters

MSF donor Sarah van der Waart raised funds for MSF at a market day at her son Noah's school. At the event, Sarah and Noah, aged 6, had a stand with pamphlets and magazines showcasing MSF's work around the world. Those who visited the stand were encouraged to make a difference and donate to the organisation.

"Many people took the pamphlets. I loved the kids coming up and asking questions about MSF and being able to raise awareness about the organisation. I was super surprised when we raised R400 just from a kids' market!

"I'm so happy that my little boy now understands that those of us who are lucky enough to have everything we need, have a responsibility to help others who don't," says Sarah.

© Sarah van der Waart



You too can save more lives by organising an event to raise awareness and funds for MSF. Visit: www.msf.org.za/fundraise-msf

Email: donorservices@joburg.msf.org
Phone: 0800 000 331

Follow us on Facebook: www.facebook.com/MSFsouthafrica
Follow us on Twitter: @MSF_southafrica

IN FOCUS

Papua New Guinea: Return to Abuser



In Papua New Guinea, women and children suffer extremely high levels of family and sexual violence, with the extent of abuse estimated to be some of the highest in the world outside a conflict zone.

MSF began working in Papua New Guinea in 2007 providing free, quality, confidential and integrated medical and psychosocial care to survivors of family and sexual violence in various parts of the country.

Titled 'Return to Abuser', an MSF report uncovers the gaps in services and systems in Papua New Guinea that trap women and children in cycles of severe family and sexual violence. It highlights how a major lack of protection mechanisms, a weak justice system and a culture of impunity endanger the health and lives of women and children as they often have to return to their abuser after accessing medical treatment.

The report draws from comprehensive data from over 3,000 survivors that MSF treated in 2014-15 in its Family Support Centres in Tari, in Hela Province and in Port Moresby.

The findings concluded that the vast majority of patients treated (94%) were female; that the most common form of violence (49%) was at the hands of partners and that over half of sexual violence survivors were children.

Beyond recommending that authorities increase availability of and access to free medical and psychosocial services countrywide, MSF strongly calls for increased access to meaningful protection and alternative accommodation for survivors. This would ensure survivors are no longer forced to return to their abusers after being patched up.

© Jodi Bieber



© Jodi Bieber



© Jodi Bieber

MSF RESPONSE

Since 2009, MSF has treated 27,993 survivors of family and sexual violence in the country, often in collaboration with the National Department of Health. In addition, in Tari hospital, MSF carried out 68,840 major and minor surgeries, one-third of which were for violence-related injuries.

© Jodi Bieber



© Jodi Bieber



THROUGH THE LENS

The powerful, yet sensitive photographs in 'Return to Abuser' were taken by Jodi Bieber, an internationally acclaimed South African photographer. Bieber has won numerous awards for her photography, including the World Press Photo of the Year in 2010.

Left to right, from top
 (1) A woman receives medical care at Tari Hospital, after her husband cut her with a knife.
 (2) Four women wait for treatment outside the surgical ward at Tari Hospital.
 (3) A woman, 25, and her daughter at a safe house - there are only six in the country.
 (4) The hand of a woman whose husband attacked her in front of her 7-year-old son.
 (5) A child in a play therapy session for young survivors at a Family Support Centre.

OUR IMPACT

Helping children to survive malnutrition

Malnutrition is associated with almost half of all deaths in children under five each year. The risk of death is particularly high for those with severe acute malnutrition, up to 20 times higher than for a healthy child

Severe acute malnutrition in early childhood is common in large areas of the Horn of Africa, the Sahel and South Asia — the world's "malnutrition hotspots" where people often can't access highly nutritious foods like milk, meats and fish

© Juan Carlos Tomasi



Malnutrition is not the same as hunger

Hunger: a deficiency in caloric intake – anyone whose daily diet gives fewer than the defined minimum of 2,100 kcal is considered suffering from hunger, or undernourishment. **Malnutrition:** a pathology caused mainly by insufficient essential nutrients, not merely because of too little food.

When children experience weight loss or 'wasting' (low weight for one's height), they are described as suffering from **acute malnutrition**. **Chronic malnutrition** occurs when dietary deficiencies are persistent, causing children to stop growing and become stunted (low height for one's age).

Both of these presentations of malnutrition may be further classified as moderate or severe.

Severe acute malnutrition occurs when reserves of fat and muscle disappear because of inadequate supplies of energy and micronutrients. Severe acute malnutrition has a case fatality rate of up to 21% without effective intervention.

Who is at risk?

Malnutrition typically affects children under two years old, but older children, adolescents, pregnant or lactating mothers, the elderly and those with chronic illnesses are also vulnerable.

Identifying malnutrition

Malnutrition is measured in three ways: weight-for-height, mid-upper arm circumference (MUAC), or by the presence of oedema (a bloated appearance to feet and face). MSF teams use a MUAC band to identify whether the child is suffering from acute malnutrition or is close to suffering from it.

Treating malnutrition

Some children need intense care when they are initially diagnosed, especially if they are very weak and unable to take in solid food or fluids. Once they are stabilised, many children, if there are no complications, can follow RUTF treatment at home.

© Jacob Kuehn



What is RUTF?

Ready-to-use therapeutic food (RUTF) is the generic name given to sachets of mineral- and vitamin-rich fortified milk pastes used to rehabilitate malnourished children. RUTF can be transported easily and produced and stored locally, for long periods. Most importantly, RUTF has revolutionised the treatment of severe malnutrition – providing foods that ensure rapid weight gain and are safe to use at home instead of children needing hospitalisation – so far more at-risk children can be reached.

© Tanya Bindra



Niger and South Sudan

The occurrence of malnutrition among children is often linked to environmental and social factors that are specific to a country or region.

Niger, a relatively stable country, suffers child malnutrition rates of epidemic proportions, peaking during the 'hunger gap' between harvests (May and September) when household food stocks become depleted and don't sufficiently meet nutritional needs.

MSF's work in the Maradi region during 2005 demonstrated the large-scale effectiveness of new strategies using RUTF for outpatient treatment of severe acute malnutrition. MSF teams treated 60,000 malnourished children in just a few months and, by the end of the treatment, almost 80% were cured.

"Prior to the 2005 nutrition crisis in Niger, malnourished children didn't receive treatment and childhood malnutrition was virtually unrecognised," Stéphane Doyon, former nutrition team leader at MSF's Access Campaign, explains.

South Sudan has faced conflict and instability since 2013 which left hundreds of thousands displaced, and disrupting agriculture and food systems. Unlike Niger, South Sudan doesn't necessarily face widespread and chronic rates of seasonal malnutrition. However, very high rates of malnutrition have been identified in specific areas of the country, particularly among displaced populations.

Leer, in Unity State, was attacked in 2014, forcing MSF teams to withdraw and suspend operations. Once they returned, the scale of malnutrition became clear when people came back to the town in May 2014, following months of living in the bush.

"In less than two months after we returned to Leer, the MSF teams treated more children for malnutrition (2,835 for May and June), than we did in the whole of 2013 (2,142 over the entire year)," says Jo Kuper, MSF humanitarian affairs officer who worked in Leer in mid-2014.

The same happened in 2015 when MSF was again forced to suspend its activities after renewed violence, with thousands of people fleeing into the bush.

Meet little Wuk from Aweil, South Sudan

Wuk is a malnourished boy. He is two years old but only weighs as much as a baby of a few months. He was recently admitted for severe malnutrition. On first arriving he was given stabilisation treatment with low caloric milk and antibiotics to treat infection. He then began eating RUTF made of peanut paste and consisting of energy, protein, fats, vitamins and minerals.

It took his mother five hours to reach this MSF hospital from her village, first walking and then travelling by car. Once Wuk was better, she took him home with her four other children.

Wuk is one of numerous children in critical condition who are treated by MSF medical teams in South Sudan. They may not even see the most severe cases because of difficulties people face in reaching the hospital.

Even though not everyone can reach it, the hospital still receives large numbers of malnourished children. According to Florence Okatch, head nurse for MSF in Aweil, in April 2016, at the end of the dry season, an average of 44 severely malnourished children were admitted into the paediatric department, every week.

Finding new ways to fight malnutrition

As part of MSF Scientific Days 2016 (an annual MSF operational research symposium) results from a Niger study on the impact of mothers measuring the MUAC to assess the nutritional status of their own and other children, were presented by Dr Ali Ouattara, from ALIMA, a medical aid organisation in Senegal. This would empower mothers to increase the chances of at-risk children reaching treatment centres on time.

Dr Susan Shepherd, a paediatrician, says: "Malnutrition should be treated anytime and anywhere it occurs, just like any other early childhood illness. Food for a young child is just as important as being immunised and sleeping under a mosquito net!"

© Jean-Christophe Nougaret



Wuk and his mom.

Five lessons learned in a decade of working on malnutrition in Niger

1. Severe acute malnutrition can be treated en masse.

Until 2005, children were systematically admitted for a one-month treatment, introducing RUTF enabled treatment to happen at home. In 2005, 300,000 treatments were sold worldwide; in 2013, the number was about three million.

2. Severe acute malnutrition particularly affects the youngest.

Among children under five, 80% of severe acute malnutrition cases occur in children aged between six and 23 months. Programmes to reduce child death and disease increasingly focus on treating the youngest children.

3. Treat all the illnesses a child has.

Malnourished children have very weakened immune systems which are less resistant to diseases like malaria and respiratory infections. Children with these diseases are also more likely to be malnourished. Programmes are increasingly trying to comprehensively respond to children's needs.

4. Malaria and malnutrition, a lethal combination.

Malaria is a main cause of death in many countries with malnutrition. This occurs concurrently with increased malnutrition, leading to strategies that address both problems. For example, while a child receives seasonal malaria chemoprevention, their nutritional status is assessed and they are referred for treatment if necessary.

5. Decentralise and simplify treatment.

Simplifying treatment of major childhood diseases allows health workers with minimal training to treat children at their closest health facility. Only the most severe cases need to be referred.

PERSPECTIVES

The end of safe refuge?

Africa can lead the way in restoring the world's humanity after the EU's dirty anti-refugee deal, writes Dr Mohammed Dalwai, President of MSF Southern Africa

We are witnessing the greatest displacement of humanity in decades – over 60 million people from countries like Syria and Somalia, forced from their homes by war, misery or oppression.

We are also seeing a rise in institutionalised inhumanity. Asylum seekers and refugees are being pushed back into the peril they escaped from or remain trapped in war zones.

For years my colleagues at MSF have been treating victims of Europe's deterrence approach to people on the move, and we have directly witnessed the horrors they have fled from.

We also witnessed with increasing alarm as the European Union and Turkey signed a deal in March compensating Turkey financially and politically to block desperate people from Europe and accept deportees from squalid prison camps in Greece.

This dirty deal marks a historic abdication of Europe's moral and legal responsibilities to provide asylum to people in great need. Europe is outsourcing the care of refugees to a country that may also deny them the right to claim asylum. Europe is sending a dangerous signal that countries can buy their way out of providing asylum. The ramifications of this deal will likely reverberate globally.

Kenya may be the first to face an acid test for humanity.

On 6 May, the Kenyan Government announced that it is disbanding its Department of

© Alessandro Penso



A group of Syrians set off to cross the Greek border, hoping to apply for refugee status in Europe.

Refugee Affairs as a first step to permanently closing the Dadaab refugee camps for national security reasons among other issues.

Europe is sending a dangerous signal that countries can buy their way out of providing asylum

In South Africa, the ability of refugees to seek asylum is also threatened by the Refugees Act Amendment Bill. Some proposed amendments will increase their vulnerability because it diminishes protections under South African law. It also suggests moving refugee reception offices to South Africa's borders.

MSF agrees with Kenyan Principal Secretary for the Interior, Dr Karanja Kibicho, who recently expressed concern about the international community's weakened refugee response in Kenya and a realignment of resources to Europe's crisis.

We also agree that it is unacceptable for Western nations not to assist refugees fleeing despair, while expecting nations like Kenya to protect them.

Kenya and other African nations, including South Africa, have signed refugee conventions stating that they should protect people escaping conflict and persecution.

Rather than endorsing the inhumane policies of Europe and others, Kenya and South Africa should continue traditions of providing safe refuge.

If potential solutions are not pursued in Kenya, refugees from Dadaab will be forced to return to desperate conditions in Somalia. They face terrible options, among which is perilously crossing the sea to Europe.

In South Africa, refugees' ability to seek asylum is threatened by the Refugees Act Amendment Bill

Kenya, South Africa and Africa as whole, can set an example to others, including Europe, on how to humanely treat people fleeing conflict. It is in the hands of Africans to help the world reclaim humanity.

© Gabriele François Casini



In early June, MSF rescued 1,300 people from boats in the Mediterranean Sea in just 36 hours.

SA's refugee process at borders risks pushing asylum seekers out

In 2011, two main refugee reception offices (RROs) in Johannesburg and Port Elizabeth were closed. The move demonstrates a concerted effort by the South African Department of Home Affairs(DHA) to move all RROs to border areas.

Processing applications for asylum from border areas could, if not well managed, contravene the national and international law on protection of refugees. It may also impinge on the principle of non-refoulement and could affect people's

freedom of movement. Applicants would have to sleep at the border for several days or weeks while their applications are processed.

At this stage, the DHA currently doesn't have any "survival strategy" for refugees who are likely to spend many days at the borders waiting for their applications to be processed. This means they will struggle to access sufficient food, shelter and healthcare in small border towns.

(Extracts from a 2015 submission by the Consortium for Refugees and Migrants in South Africa, on the Refugee Act Amendment Bill)

OUR IMPACT

Vaccinations: MSF goes the extra mile

MSF teams are involved in unprecedented vaccination campaigns in the Central African Republic to protect children against eight diseases. They have also engaged in immunisation in Zambia to halt a cholera epidemic. Vaccines offer a life-saving first line of defense in these cases

Central African Republic

In the face of massive logistical challenges, MSF teams have undertaken our biggest ever preventive vaccination campaign. The catch-up campaign aims to protect 220,000 children under five from multiple diseases: polio, tetanus, diphtheria, whooping cough, hepatitis B, measles and certain strains of pneumonia and meningitis.

Although effective vaccines exist against these diseases, they have continued to kill children in CAR because they haven't been immunised.

There is a severe shortage of health services due to violence and instability which has gripped CAR since 2013. Because vaccination coverage is so low, the risk of epidemics is very high – as are the number of deaths from vaccine-preventable diseases.

Immunisation coverage was already very low before the outbreak of violence. By the end of 2013, only 13% of one-year olds had been fully immunised. Between 2012 and 2014, the number of children in CAR who were fully immunised against measles fell by more than one third, from 64% to 25%. The number immunised against acute respiratory infections fell from 52% to 20%. As part of the campaign, MSF is administering pneumococcal conjugate vaccine, which, because of its prohibitive cost, humanitarian aid agencies have not yet been able to use on a large scale.

MSF's collaboration with the Ministry of Health (MoH) brings a catch-up vaccination campaign to areas not reached before, offering children vaccinations they should have already received. By the end of March 2016, over 73,000 children across several regions of the country had been vaccinated. The vaccination campaign is set to end in 2017.

Zambia

The world's largest single dose oral cholera vaccination campaign ever, kicked off in Zambia's capital, Lusaka, on 9 April during the height of the recent outbreak.

In Lusaka, around 1.2 million people live in overcrowded 'informal settlements' at risk of cholera each rainy season. When the rains came, floodwaters mixed with overfull pit latrines, creating streams of contaminated water that people were forced to wade through, or which they were exposed to when using shallow wells. This created the ideal environment for a large-scale cholera outbreak.

Since Lusaka's last cholera outbreak in 2010, the population has lost its acquired immunity to the disease, leaving a 'blank slate' for cholera transmission in these densely populated, flood-prone areas. By mid-April, 948 suspected cases and 19 deaths were reported in Lusaka, since February.

In response, MSF collaborated with the Zambian MoH and the World Health Organization (WHO) to carry out the

campaign. An eight member MSF team worked with 60 Zambian health staff and over 1,000 community volunteers to target 578,000 people with the single dose of the cholera vaccine.

Typically, the vaccine is administered in two doses. However, the limited number of vaccines available globally and the drive to curb the Lusaka outbreak as quickly as possible, meant a single dose was delivered to twice as many people to be more efficient.

At the end of the vaccination on 25 April, 424,100 people had been reached. Jackson Nyumu Sammy, an MSF medical team leader, said subsequent to the vaccination campaign some townships had no or very few cholera cases.

In the past, MSF has rolled out similar outbreak halting cholera vaccinations in: Tanzania among Burundian refugees and Malawian fishing communities in 2015 and 2016, respectively; in South Sudan during 2015; and first in Guinea in 2012.

MSF and its affiliated epidemiology section, Epicentre, together with the MoH and WHO are now implementing an important study to assess the effectiveness of this single-dose regimen which could be a potential game-changer in cholera epidemic response.



© Magali Deppen



© Laurence Hoenig

FIELDWORKER FOCUS

Insights on malnutrition

Several MSF Southern Africa fieldworkers and their colleagues have witnessed the impact of malnutrition in projects where they've worked. Their skills and dedication have helped save the lives of thousands of children by treating it as a medical condition. Here they share snapshots of their experiences

Elyse Aichatou Yahaya Danzara (Nurse) – Niger



"What is malnutrition? Before starting my work, I had heard people talk about it, but I didn't believe it. It was a popular belief that children became malnourished after having slept on the mattress on which their mother had cheated on her husband.

"We don't think that way anymore. There is still a lot of awareness-raising to do within the community, but thanks to the work accomplished by MSF over the last 10 years, the majority of people have come to understand that a malnourished child is a sick child and that they can recover if they receive the appropriate care. That is a huge change. Before, losing a child to malnutrition was a part of life in the villages. Today, Nigeriens know that their children can recover from malnutrition."

Esther Wanjiru (Medical Doctor) – Sierra Leone



"Where I worked in the Bo district, there were many malnourished children. This meant they were prone to pneumonia, gastroenteritis and pulmonary TB. We use a ready-to-use peanut-based food to treat malnutrition while addressing the infections."

Chenai Mathabire (Nurse and Epidemiologist) – Zimbabwe



"I worked as a nurse and coordinator on an MSF project in Zimbabwe for two years. Most of the cases of malnutrition I treated were among children under five, and also among adults. They developed the condition due to an underlying HIV or TB infection.

"Often, when TB and HIV were diagnosed on time and treatment started, we saw very good outcomes.

"I'll never forget an orphan whose aunt brought her to the project each week for therapeutic food. At the time MSF was intensifying HIV testing among children. She tested positive, so we put her on treatment as soon as we could. I saw she had gained weight and was playing in the yard with the other children! She had never done that before, she always had to be carried."

Ainslie McClarty (Nurse) – Ethiopia



"Where I worked, MSF opened two stabilisation centres and started doing outpatient therapeutic feeding programmes to treat malnourished children. We'd start them on the first phase of treatment to see if their bodies would tolerate fluids, with F-75 formula milk. This is a specially formulated milk mix that helps the child recover without overwhelming them. If the child vomited or refused it, or had a high fever, then we'd insert a nasogastric tube to make sure we provide them with food.

"After a few days, a week, sometimes even two weeks, we put them in the interim phase in a different room of the treatment centre. There we would give them F-100 formula milk – which is high in protein, or Plumpy'Nut (a peanut-based nutritional supplement) depending on their age.

"Mostly children love Plumpy'Nut because it tastes great and can also be mixed into porridge. It has a texture like peanut butter. If they didn't like it, we'd give them another supplement.

"Once they began gaining weight and were no longer ill, we discharged them to the outpatient therapeutic programme to be weighed and assessed. Their mothers are also supplied with Plumpy'Nut sachets to take with them for home feeding."

FROM THE FIELD

Questions still haunt after Kunduz attack

Jonine Lotter is a South African nurse who worked at MSF's Kunduz Trauma Centre in Afghanistan when it was attacked on 3 October 2015. Jonine shares her thoughts, and demands answers



It was my first assignment with MSF, working as an operating theatre nurse. People ask me: "How did it feel when the airstrike hit the hospital?"

But that is not the question I have. For me the question still is: "Why would anyone attack a hospital full of patients and staff?" Why? It goes beyond me. Patients in a hospital can do very little for themselves. They are so vulnerable. And to think someone wants to attack and kill them! I don't understand why...

It was early morning. Two colleagues and I were sleeping in a meeting room after exhausting days of work. When the airstrike hit, it was an unbelievably loud sound. The walls and floor shook with a terrifying force. I cannot put the fear, horror, panic and distress into words...

Our emergency room doctor was injured badly – he needed to get to the operating theatre, where we could operate on him. But we did not have an operating theatre anymore. He needed more than what we could do... More and more wounded arrived.

© Dan Sermand



It was overwhelming. My mind told me: "Forget that you know the wounded person in front of you, your colleague. Block out your emotions. Try and help. Focus."

Our hospital was the only trauma care for hundreds of kilometres. Hundreds and

thousands of people depended on it. Some patients would come in with old injuries. They didn't wait days to come. It took two days of travelling by whatever means to reach us. You quickly realise that this was the only hospital there for them.

In 2014 alone, 22 000 people were treated at our hospital. Ordinary people who had been in car accidents and fractured their legs or arms. Children who suffered head injuries falling off rickshaws. People wounded in crossfire while buying bread for their families. Soldiers and fighters fought each other, but they came to our hospital because it is the only one – and we treated everyone.

Very difficult to accept our hospital is gone. Destroyed in an attack that killed 42 staff and patients.

It's vital that I and other medical workers around the world can keep working in hospitals in conflict zones, treating people who need medical care without being targeted. Because even war has rules.

But first we need answers.

#NotATarget campaign demands stop to hospital attacks



In May, MSF's International President, Dr Joanne Liu, addressed the UN Security Council ahead of a vote on a resolution to reaffirm the protection of health workers, hospitals and civilian infrastructure in conflict zones.

"In Afghanistan, Central African Republic, South Sudan, Sudan, Syria, Ukraine and Yemen, hospitals are routinely bombed, raided, looted or burned to the ground. Medical personnel are threatened. Patients are shot in their beds. Broad attacks on communities and precise attacks on health facilities are described as mistakes, are denied outright, or are simply met with silence.

In reality, they amount to massive, indiscriminate and disproportionate civilian

targeting in urban settings, and, in the worst cases, to acts of terror...

"We physicians take an oath when we join the medical profession... We treat every individual, regardless of who they are, regardless of their religion, their race, or on which side they may fight. Even if they are wounded combatants, or if they are labelled as criminals or terrorists..."

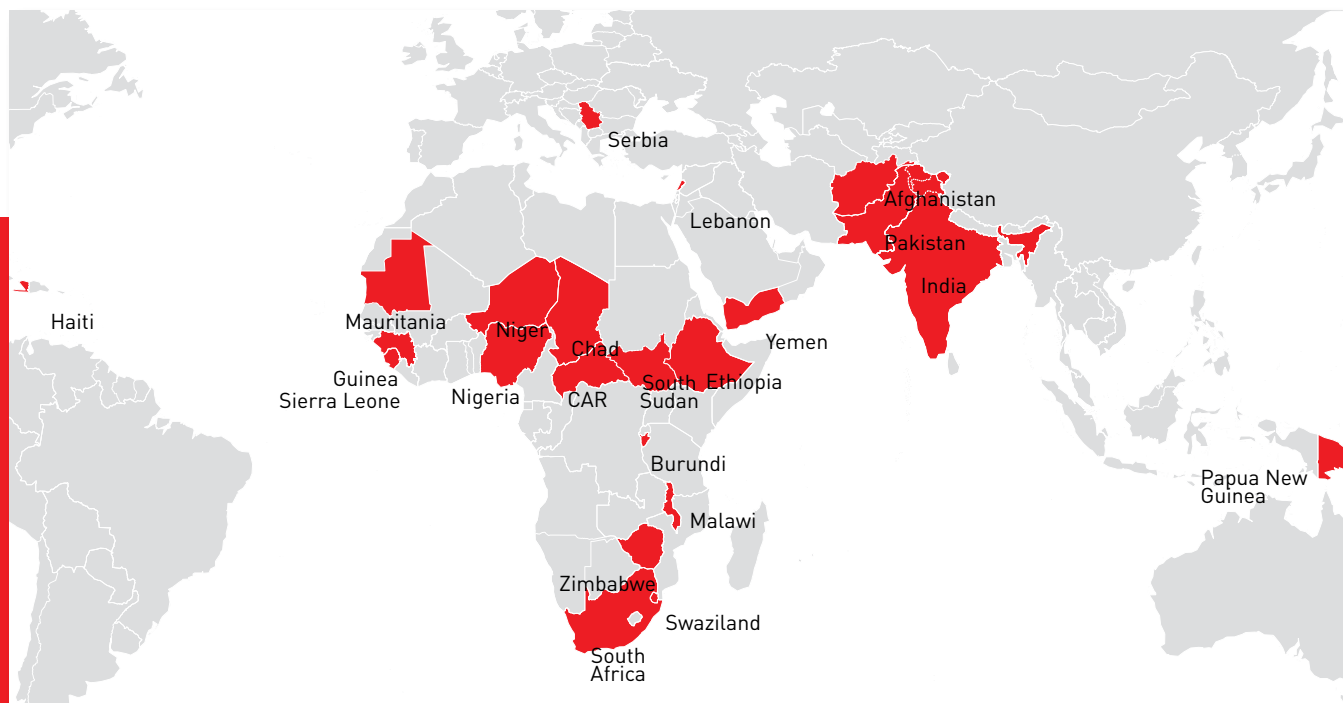
To turn our back on these basic principles is to turn our back on the foundation of medical ethics. Medical ethics cannot be buried by war..."While the nature of warfare may have changed, the rules of war have not... Stop these attacks."

To seek solidarity, MSF launched the #NotATarget social media campaign. Learn more at www.msf.org/notatarget

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

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

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



MSF Southern Africa: Recruits in the Field 65 Fieldworkers, 22 Countries

Adolphe Masu, Anaesthetist – Burundi
 Adeline Oliver, Operating Theatre Nurse – Yemen
 Adelard Shyaka, HIV/TB Medical Doctor – CAR
 Aimable Nkurunziza, Operating Theatre Nurse – CAR
 Aline Aurore, Epidemiologist – Niger
 Aloise Kambaki, Administrator and Accountant – Nigeria
 Ainslie McClarty, Nurse/Project Medical Referent – Ethiopia
 Brian Swing, Finance Manager – Malawi
 Carl Opot, Operating Theatre Activity Manager – Nigeria
 Caroline Masunda, Nurse/Project Medical Referent – Malawi
 Chipso Takawira – Stop Stockout Manager/Epidemiologist – Mozambique
 Chris Eweiler, Public Health Specialist/Project Coordinator – Ethiopia
 Christian Manirakiza, Medical Doctor – CAR
 Christine Ewoi, Midwife Activity Manager – Pakistan
 Clark Mushangalusa, HIV/TB Medical Doctor – Guinea
 Claude Sekimonyo, Surgeon – Mauritania
 Corina Moffat, Administrator – Afghanistan
 Danca Paiva, Logistician/Field Coordinator – Niger
 Didier Butara, Medical Doctor – CAR
 Dodo Kibasomba, Nurse Activity Manager – CAR
 Donatien Ryezembere, Laboratory Specialist – CAR
 Duodeneo Mukunzi, Medical Doctor – Guinea
 Elizabeth Aruwa, HIV/TB Medical Doctor – Swaziland
 Emily Wambugu, Midwife Supervisor – Pakistan
 Eugene Rugwirorusa, Pharmacist – Haiti
 Farai Mpasi, Mechanic Technical Logistician – South Sudan
 Fezile Kanju, Advocacy Manager – Pakistan
 Francine Mukamana, Midwife Supervisor – CAR
 Gabriel Makau, Surgical Nurse/Nurse Activity Manager – South Sudan
 Gilberta Jairos, Nurse Activity Manager – South Sudan
 Huggins Madondo, Water and Sanitation Manager – Malawi
 Innocent Maniraruta, Accountant Finance Manager – Mauritania
 John Sekibibi, Medical Doctor – CAR
 Jean Claude Mwitende, Pharmacist – Mauritania
 Joseph Kaghoma, Medical Doctor – Chad
 Jonine Lotter, Operating Theatre Nurse Supervisor – South Sudan
 Joyce Njenga, Midwife Activity Manager – Lebanon
 Justin Ishimwe, Psychologist – Nigeria
 Kenneth Bastikana, MD (HIV/TB) – Zimbabwe
 Kim Philips, Logistician – Sierra Leone
 Laurent Seale, Logistics Management Supply Coordinator – Serbia
 Laurent Siborurema, Surgeon – Nigeria and South Sudan
 Leonard Ndayisenga, Medical Doctor – Guinea
 Louis Habyerimana, Logistician – CAR
 Luc Emungu, Medical Surgeon – South Sudan and Afghanistan
 Marcel Lomande, Medical Doctor/Field Coordinator – CAR
 Mduduzi Chandawila, Nurse Activity Manager – South Sudan
 Michelin Dusabe, Nurse/Anaesthetist – Mauritania
 Mohammed Abdalgadir, HIV/TB Medical Doctor – Papua New Guinea
 Mukarugwiza Laurence, Activity Manager – Mauritania
 Olesi Pasulani, Clinical Officer/Project Medical Referent – India
 Patricia Mazuru, Public Health Specialist/Field Coordinator – South Africa, Malawi
 Phumelele Trasada, Psychologist/Public Health Patient Support Manager – Malawi
 Providence Dusingize, Midwife Supervisor – CAR
 Rachel Kamau, Midwife – Nigeria
 Rosie Burton, Epidemiologist – CAR
 Sabina Daudi, Project Medical Referent – Sudan
 Sandra Githiaga, Mental Health Activity Manager – India
 Sally Ken Bassingwa, Medical Doctor/Surgeon – Mauritania
 Stella Mumbi, Nurse Activity Manager – Ethiopia
 Themba Sibanda, Logistician – South Sudan
 Towani Mukandawire, Supply Logistician – Sierra Leone
 Venant Niyikize, Gynaecologist and Obstetrician – CAR
 Vincent Ndichu, Logistician Manager and IT Specialist – Afghanistan
 Zani Prinsloo, Midwife Activity Manager – South Sudan, Sierra Leone, Lebanon