Quarterly news from Médecins Sans Frontières UK Issue no 52 Spring 2009

DISPATCHES

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Médecins Sans Frontières is a leading independent humanitarian organisation for emergency medical aid. In over 60 countries world-wide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

"Tomorrow might be too late"

Cholera in Zimbabwe

An MSF doctor checks on a cholera patient in the treatment centre at Mudzi in northeastern Zimbabwe

"Before I came to Zimbabwe, I never imagined how cruel cholera can be," says MSF nurse Pia Engebrigsten. "What made the strongest impression on me was meeting parents who had lost their whole families. I think many of them felt guilty for not having brought their sick family members to the health facilities earlier. But the barriers are so many: lack of money; lack of transport; lack of knowledge; huge distances..."

In Beitbridge there were too many cholera patients to fit in the hospital buildings
© Joanna Stavropoulou/MSF [2008] Zimbabwe

Cholera in Zimbabwe

Zimbabwe's economy and health infrastructure have completely collapsed, resulting in a health crisis of enormous proportions and severity. Many hospitals and health clinics have closed their doors and those that remain open have largely run out of medical supplies and have no reliable electricity or water supply. Where there are medical services, the charges being levied put most treatment out of reach of all but the wealthiest. Health worker salaries, running into the hundreds of millions of Zimbabwean dollars, often do not even cover the transport costs of getting to work. Many health staff have left the country. They are among the estimated three million Zimbabweans to have fled abroad – Africa's most extraordinary exodus from a country not in open conflict.

In August last year, as the health system was descending into total chaos, a huge cholera outbreak erupted. With more than 85,000 confirmed cases so far, the outbreak has swept through all ten regions of the country, affecting both cities and rural areas. In December Joanna Stavropoulou, part of the MSF team on the ground, wrote in her diary about one of the places where MSF has been working:

"**5am**: Yesterday we got a report of a new cholera outbreak in the town of Chegutu, about 100km west of Harare. Since we haven't heard anything about this place having cases before, I imagine an outbreak of 20 to 30 cases, enough to justify setting up a small cholera treatment centre (CTC). We load up the car with intravenous (IV) fluids, rubber boots, buckets and medicine.

"**7am**: On the road everything is green and lush. The first rains have come – good for the land, bad for spreading cholera. Over the VHF radio we hear that yesterday's advance emergency team has already left Chegutu and is heading back to Harare. They were supposed to wait for us and then head out, so why the rush?

"**8:15am**: We see the emergency team's car up ahead. We stop and all do a cholera handshake (closed fist barely brushing knuckles of the other's fist, to avoid contamination). Gerum, our Dutch logistician, is looking pale and drawn. He tells me that things are bad, worse than in Beitbridge, that's why they left so urgently to load up with more supplies.

"I get back in the car with a cold feeling in my stomach. I have just been in Beitbridge and saw too many people die there. I thought that was going to be the last time I was going to experience something like that.

"Fifteen minutes later we are in Chegutu. At the CTC set up by the Ministry of Health there is chaos. Next to a health clinic some dark green tents have been set up haphazardly in which people are lying side by side on the ground. All kinds of people are milling around. Then I see Luis, our emergency medical coordinator. His hair is dishevelled and he has dark circles under his eyes. He looks at me shaking his head – 'Prepare yourself, this is bad.' He explains that there have already been 600 cases, probably starting from about two weeks ago.

"I go to entrance of the clinic building, from which a powerful nauseating smell is coming. Inside there are more patients lying on the cement floor. At the end of the corridor two health workers in green robes are leaning on their hard wire brooms. I greet them and they reply lethargically.

"I pass them and then see something so horrible my brain at first just stops in shock. The room in front of me is filled with dead bodies that are lying everywhere on the floor. All that day Luis took care of the bodies. Nobody else would do it. He cleaned and disinfected 39 bodies in total. I would come back to the room every so often and steel myself and ask if he needed any help. He would just look up at me, 'No, everything under control, doing well.' It had to be done and he did it. Uncomplaining."

This cholera outbreak is just the tip of Zimbabwe's health crisis iceberg. Read MSF's

What is cholera?

Cholera is a highly contagious diarrhoeal disease spread mainly through water or food that has been contaminated by faeces. Patients show symptoms of acute diarrhoea or vomiting, and must be continuously rehydrated, orally or through an IV drip, until symptoms disappear. The most severely affected must be treated in special isolation units called cholera treatment centres (CTCs), where chlorine is used to disinfect everything in an attempt to control the spread of the disease.

"Cholera can kill within hours as a result of dehydration," says Nurse Pia Engebrigsten. "So you have to make very quick decisions. Tomorrow might be too late. In rural areas, we found a lot of patients in a very severe state; many unconscious. Then, after a few hours with intravenous fluids, they would be able to sit up and talk. The days were long; we normally worked until after midnight evry day. But you really feel that you are saving lives. Most patients would stay in the centre for two to three days, then go home completely cured."

MSF has years of experience treating and containing this difficult disease. Since the start of the outbreak in Zimbabwe MSF has treated more than 55,000 cholera patients, which is around two thirds of all the cholera cases treated in this outbreak.

Pia Engebrigsten checks an intravenous drip in a cholera treatment centre
© MSF [2009] Zimbabwe

"When we drove to isolated villages we would ask the community leader to gather everyone so we could explain what cholera is, how to prevent it and what to do when a person becomes ill. We also asked them to agree on who would provide an 'ambulance donkey service' for the village, since most people have no means of transport." **Pia Engebrigsten**

One of the first places to have an outbreak was the southern town of Beitbridge, on the border with South Africa. Thousands of people gathered there in an attempt to flee Zimbabwe's political and economic collapse, and an MSF team was providing basic medical assistance. With this massive influx of people, no rubbish collection, sewage running through most streets, and almost daily water and power cuts, the conditions were optimal for cholera to spread.

On November 14, local health authorities contacted MSF's team in Beitbridge with news of five cholera cases. Within two days, that number had risen to more than 500; by the end of the week, to more than 1,500. When the MSF team arrived at the local hospital, the scene was devastating. Patients were being moved to lie on the dirt outside the hospital, so that their bodily excretions could be absorbed directly into the ground. The toilets were backed up and overflowing. Patients lay in the dust in the scorching heat, asking for treatment and water. But there was no water to give them, since the water supply for the hospital, as everywhere in town, was cut on most days.

An MSF doctor, Veronica Nicola, described the scene awaiting her: "There was a man lying next to one of the trolleys under the sun. By the time I got to him, he was in shock. We tried to get a vein 10 times, but then he started gasping and he died right there in front of our eyes. If I had seen him half an hour before, we might have been able to do something about it, but there were so many people lying there, calling out. It was very bad."

Within three days, MSF had shipped in enough medicines and supplies to set up a CTC with 130 beds, sent in a 16-strong team, and hired more than 100 additional health workers, cleaners, and day workers. By the fourth day, the mortality rate had dropped from 15 percent to less than one percent. With more than 500 staff on the ground in Zimbabwe, MSF teams have set up scores of CTCs like those at Chegutu and Beitbridge and saved tens of thousands of lives.

When this boy was brought in a wheelbarrow to the MSF CTC in Kadoma, he was so dehydrated that the doctor had to start an intravenous drip immediately, before even finding him a bed
© MSF [2009] Zimbabwe

MSF teams work in some of the most conflict-ridden areas of the world. In most cases civilians are able to flee to safer areas but inside the locked-down borders of Gaza – one of the world's most densely populated areas – there was no way out. From December 27 to January 19, sustained bombing, shelling and a land incursion by Israeli forces left thousands of people wounded and an estimated 1,300 killed.

"A state of panic" emergency

Abu Abed, one of MSF's Palestinian doctors, recalls how it began: "It was 11am when the bombing started; it was a Saturday. Within hours there were lots of casualties. It was chaos. We visited hospitals to find out what they needed most. Because MSF had emergency stocks in the area, we were immediately able to donate drugs and medical supplies."

At Al Shifa, the main referral hospital in the Gaza Strip, 500 wounded people arrived in the first 24 hours of the bombing — as well as 180 dead bodies. As the bombs continued to fall on Gaza City, the MSF clinic took in casualties who had undergone emergency surgery in hospital and needed post-operative care. MSF attempted several times to reopen other clinics in the Strip. But each time, the attempt was cut short; one bomb attack forced the MSF team to suspend its work only two hours after starting. The team provided essential medical supplies to six hospitals in Gaza, but insecurity made deliveries extremely difficult. "Because of the bombing it was very difficult for patients and MSF staff to move around," explains Sana Rajab, an MSF nurse.

"We gave our colleagues emergency medical 'kits' so that they could give medical assistance right at the heart of their neighbourhoods," she continues. By the second week of January, about 20 MSF staff were visiting nearly 40 people every day in their local communities. But this was extremely risky—the World Health Organization estimated that 16 health personnel were killed while working in Gaza during the conflict.

On January 7, the Israeli army announced a daily, three-hour pause in the fighting so humanitarian aid could be delivered. But this limited window of opportunity was restricted to Gaza City and it was insufficient to make any major progress. "There were children who would wait for this relative calm to go to the toilet!" exclaims Adeb. "Can you imagine a child of five, so terrorised that he's holding it in and asking his mother when the lull in the fighting will be so that he can go to the toilet?"

"It's hell here," said Cécile Barbou, medical coordinator for MSF's programs in Gaza, in a live phone interview to the world's media on January 16. "Even people carrying white flags are being shot at. The emergency departments and

Two-year-old Eshgen Karabi being treated in MSF's inflatable hospital for burns on her face and body, sustained when her family's house was shelled
© Bruno Stevens/Cosmos [2009] Gaza

In a tank assault, this girl sustained a broken leg and hip © Bruno Stevens/Cosmos [2009] Gaza

intensive care units are overwhelmed, especially at night. Surgical departments are working around the clock. Sometimes two operations are performed simultaneously in the same operating room and hospital staff are exhausted."

Throughout the worst of the conflict, a five-person MSF surgical team was ready in Jerusalem with inflatable hospital tents and tons of supplies, but could not get the security guarantees needed to pass through the Erez border crossing. Eventually, on January 18, they managed to enter Gaza with a 21-ton shipment of medical materials.

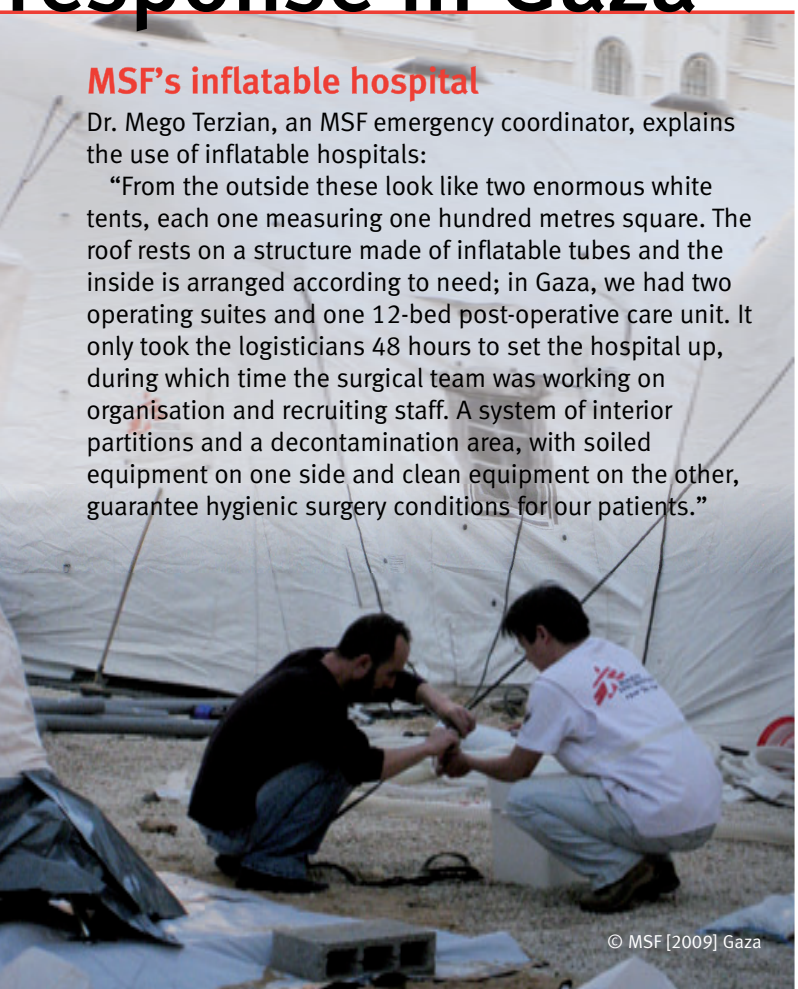
Today, the priority is dealing with the aftermath of the war, and MSF specialists are providing post-operative care and mental health counselling. "Young or old, rich or poor, black or white, Muslim or any other religion, we've all been affected," Abed concludes. "So many people have been injured; others have lost a brother or a friend; still others have had their home destroyed... Every inhabitant of the Gaza strip, without exception, has suffered in this war."

response in Gaza

MSF's inflatable hospital

Dr. Mego Terzian, an MSF emergency coordinator, explains the use of inflatable hospitals:

"From the outside these look like two enormous white tents, each one measuring one hundred metres square. The roof rests on a structure made of inflatable tubes and the inside is arranged according to need; in Gaza, we had two operating suites and one 12-bed post-operative care unit. It only took the logisticians 48 hours to set the hospital up, during which time the surgical team was working on organisation and recruiting staff. A system of interior partitions and a decontamination area, with soiled equipment on one side and clean equipment on the other, guarantee hygienic surgery conditions for our patients."



© MSF [2009] Gaza

Riyad is 19. On January 5 he was seriously wounded by a rocket and doctors had to amputate his left leg. He is now receiving physiotherapy at the MSF post-operative clinic in Gaza City.

Riyad in the MSF post-operative clinic in Gaza City.
© Frederic Sautereau [2009] Gaza

"I was at home with my family. There was no sound of planes or tanks so we decided to go outside. I went to a nearby shop to buy some things. When I came back home, there was a sudden knock at the door. I saw the neighbour's kids. They were in a state of panic. I asked them what was going on. 'They're attacking, get inside' they warned. I don't know what happened next. I fell to the floor.

"When I came to, I saw my father on the floor, his legs covered in blood. But he got up and lifted my brother and me inside. He tried to call for help, but no one answered. I stayed on the floor, bleeding.

"My father and mother were running around screaming for help, but no one responded. Then my father came back home, lifted me up and took me outside to look for help, or an ambulance. But there weren't any cars or ambulances. We waited in the street for nearly an hour and a half.

"By chance, a neighbour came out and saw us. He had a small tractor. He wanted to help us, but his mother stopped him and asked him not to go. He pushed his mother away and helped the seven of us onto the tractor. We piled on, one on top of another.

"We started driving slowly. We crossed one road, then another. Then they opened fire on us. We went back and started waving a white flag.

"I'd lost a lot of blood. When I eventually got to Al Shifa hospital in Gaza City, they gave me a blood transfusion. Five of us had been hit; one of us – my neighbour – died.

When I woke up in the hospital my leg had already been amputated. Of course when I see other people walking, it's painful, but it could have been worse. I'm not going to stay at home. I plan to graduate in geography and I really hope I can get a good job."

“I get to see them smile and say

caring for women in Papua New Guinea

“We’re on the way back to base after an HIV/AIDS training session,” **says Chris Houston, MSF’s logistics manager in Lae, Papua New Guinea.** “My colleague and I are chatting about condoms: ‘Do you think we could give out female condoms in the clinic?’ he asks. I joke about how difficult female condoms are to use. Then he explains: ‘Women on long bus journeys wear them. Just in case they get raped.’ I stop smiling.”

Physical and sexual violence against women and children in Papua New Guinea is extreme. Two out of three women experience domestic violence and 50 percent of women have experienced forced sex, rape or gang rape. Children too suffer enormously from daily abuse.

In December 2007, in response to a lack of specialised care, MSF took over the Women and Children’s Support Centre in Lae, the country’s second biggest city. Working closely with staff from the Ministry of Health hospital, the team provides comprehensive medical and psychosocial care to survivors of gender-based violence.

Violence appears to be an accepted part of the culture in Papua New Guinea. “A lot of the women I saw didn’t know that being beaten by their husband is against the law,” says Karen Stewart, a mental health specialist. “Most thought it was acceptable. We had to let these women know that all they are experiencing after an event like rape is a normal reaction. They have a lot of fear, are anxious or can’t eat, but they don’t know why. We have to show them the link between their reactions and what happened to them.”

The problem permeates throughout society, as Stewart explains: “I truly do see that women and children in Papua New Guinea live in a constant low state of terror. Most families are dealing with domestic violence in some form. Simple errands are dangerous and avoided if possible. There were times when our staff would miss lunch, and I would suggest that they leave early to go and eat, but they refused to go alone. They weren’t travelling through a rural area or the jungle, just to the bus stop in town. But all the same they were afraid of going alone, so they all left as a group at the end of the day.”

“I think that women who live in the area near MSF are fortunate. Hopefully, other centres are going to be opened in other provinces.”

Elvina Yaru

Letting people know about MSF’s free services in a crowded marketplace in Lae

Before MSF came to Lae, the Women and Children’s Support Centre had been run by a Ministry of Health nurse Elvina Yaru and a colleague. They gave basic counselling and legal advice in a room with little privacy next to the hospital’s Accident and Emergency ward. Since MSF took over, the centre has moved to a dedicated nearby site, medical services have been strengthened and a team of counsellors has been trained. “Counselling children affected by sexual violence is a pretty advanced skill,” says Stewart. “Our counsellors have to manage some very difficult cases, be it suicidal, rape, gang rape or kidnapping. There’s just a lot of stuff that happens in Papua New Guinea. I remember one child that was really far removed, pretty much catatonic – non-verbal, not eating, not sleeping – and the fact that no one noticed. I was trying to educate the mother; her response had been to beat the child, because the child was not responding to her. The child would be in the corner and her mother would call her and she wouldn’t come, so she’d go and physically assault her to get her to listen. To educate the mother about why her child is this way and then to have the mother say, ‘Wow, okay,’ is what keeps us motivated.”

You can read Chris Houston’s blog from Lae at **www.msf.org.uk/chrish**

thank you”

Opening up the centre in the morning, ready for another busy day
© Helen Pantenburg/MSF [2009] PNG

MSF’s input is making a tangible difference in this community. “The women say they like the good service,” says Yaru. “At the other hospitals you have to wait four hours just to be seen. They feel frightened very quickly and then leave. But here, with rape cases we explain as soon as they come that they will have to stay almost half a day because of the medical and then they have to be seen by a counsellor. We then see them for medical treatment once a week for a month to prevent HIV infection and we make follow-up dates for them to come back.”

To raise awareness of sexual and gender-based violence in the community, the MSF clinic supports outreach programmes, enlisting the help of influential people such as Adam, captain of the Lae Bombers rugby team, who regularly visits schools and community groups to talk about the effects of violence.

By December 2008, one year after the clinic opened its doors, the team had treated 2,500 patients. This project is intended to be a model of care – the government has a long-term goal of opening 21 centres like the MSF one throughout the country. “MSF is making a big difference,” says Yaru. “Now that MSF is here, more and more women are coming because they know it is a free service. I enjoy seeing women getting treatment and access to services; I get to triage them and give them human feeling, see them smile and say thank you.”

Serah and Elsie, two of the team of counsellors at the Lae clinic
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MSF UK volunteers currently in the field

Bolivia Thomas Ellman *HEAD OF MISSION* Cambodia Maria Doyle *NURSE* Chad Simon Brown *LOGISTICAL ADMINISTRATOR* Sophie Sabatier *COACHING MANAGER* Sarah Maynard *LOGISTICIAN* Tim Tranter *LOGISTICAL ADMINISTRATOR* Claire Grisaffi *WATER & SANITATION EXPERT* Colombia David Cook *LOGISTICAL ADMINISTRATOR* Alison Criado-Perez *NURSE* Ruth Spelman *NURSE* Democratic Republic of Congo Fiona Bass *NURSE* Pavithra Natarajan *DOCTOR* Caroline King *FINANCIAL CONTROLLER* Lucy Reynolds *HEAD OF MISSION* Geraldine Kelly *MIDWIFE* Catriona Carmichael *NURSE* Nicole Hendriksen *NURSE* Megan Craven *NURSE* Renate Raisinger *NURSE* Tom Hutchison *DOCTOR* Anna Halford *PROJECT COORDINATOR* Alyson Froud *PROJECT COORDINATOR* Karl Lellouche *WATER & SANITATION EXPERT* Alexander Nash *WATER & SANITATION EXPERT* Ethiopia Peter Camp *LOGISTICAL ADMINISTRATOR* Sanjay Joshi *LOGISTICAL ADMINISTRATOR* Kolja Stille *DOCTOR* John Hart *DOCTOR* Jonathan Henry *PROJECT COORDINATOR* Guatamala Alison Jones *MEDICAL COORDINATOR* India Joseph Jacob *DOCTOR* Liza Cragg *FINANCIAL CONTROLLER* Yaso Ariaratnam *FINANCIAL CONTROLLER* Jonathan Williams *DOCTOR* Hannah Denton *MENTAL HEALTH SPECIALIST* Joanna Cox *MEDICAL COORDINATOR* Alice Thomas *NURSE* Adam Thomas *PROJECT COORDINATOR* Bruce Russell *PROJECT COORDINATOR* Jordan Laura Smith *LOGISTICAL ADMINISTRATOR* Kenya Danielle Catherine Ferris *LOGISTICAL ADMINISTRATOR* Susan Sandars *REGIONAL INFORMATION OFFICER* Lesotho Helen Bygrave *DOCTOR* Liberia Laura Todd *DOCTOR* Owen Gorves *LOGISTICIAN* Emily Bell *LOGISTICAL ADMINISTRATOR* Malawi Robin Aherne *LOGISTICIAN* Bryn Button *LOGISTICIAN* Mali Mweyna Mewesa *DOCTOR* Malta Philippa Farrugia *DOCTOR* Mozambique Chris Peskett *PROJECT COORDINATOR* Myanmar Luke Arend *ASSISTANT HEAD OF MISSION* Monica Arend-Trujillo *DOCTOR* Nepal Sarah Quinnell *MIDWIFE* Niger Kiran Jobanputra *DOCTOR* Helen Austin *NURSE* Nigeria Miroslav Stavel *DOCTOR* Miriam Bord *NURSE* Pakistan Patrick MacGoey *DOCTOR* Christopher Lockyear *HEAD OF MISSION* Palestinian Territories Kevin Davies *MENTAL HEALTH SPECIALIST* Papua New Guinea Chris Houston *LOGISTICAL ADMINISTRATOR* Edward Crowther *PROJECT COORDINATOR* Sierra Leone Sophie Dunkley *EPIDEMIOLOGIST* Paola Cinotto *PHARMACIST* Somalia Tom Quinn *HEAD OF MISSION* Chris Hall *LOGISTICIAN* South Africa Louise Knight *EPIDEMIOLOGIST* Garrod Cooper *LOGISTICIAN* Sri Lanka Leanne Tracy Sellers *NURSE* Sudan Gina Bark *ASSISTANT HEAD OF MISSION* Simon Jones *DOCTOR* Katie Johnstone *HUMAN RESOURCES OFFICER* Margaret Othigo *LABORATORY TECHNICIAN* Christine Heward-Mills *LOGISTICAL ADMINISTRATOR* Emily Goodwin *LOGISTICAL ADMINISTRATOR* Lydia Stone *LOGISTICAL ADMINISTRATOR* Mark Shephard *LOGISTICAL ADMINISTRATOR* Stella Bowgen *LABORATORY SPECIALIST* Richard Sturge *DOCTOR* Sonia de Alcock *MIDWIFE* Tracy Lavelle *NURSE* Gerard Bowdren *NURSE* lorena Matoes *NURSE* Joanna Knight *PROJECT COORDINATOR* Anthony Kilbride *WATER & SANITATION EXPERT* Thailand Paul Cawthorne *PROJECT COORDINATOR* David Wilson *DOCTOR* Uganda Janet Raymond *NURSE* Zambia Thomas Needham *WATER & SANITATION EXPERT* Zimbabwe Gareth Walker *LOGISTICIAN* Cokie Van Der Velde *LOGISTICAL ADMINISTRATOR* Andrew Mews *LOGISTICAL ADMINISTRATOR* Annas Alamudi *LOGISTICAL ADMINISTRATOR* Simon Woods *LOGISTICAL ADMINISTRATOR* Daniel Mburu *DOCTOR* Melanie Rosenvinge *DOCTOR* Dawn Taylor *WATER & SANITATION EXPERT* John Rowe *WATER & SANITATION EXPERT*

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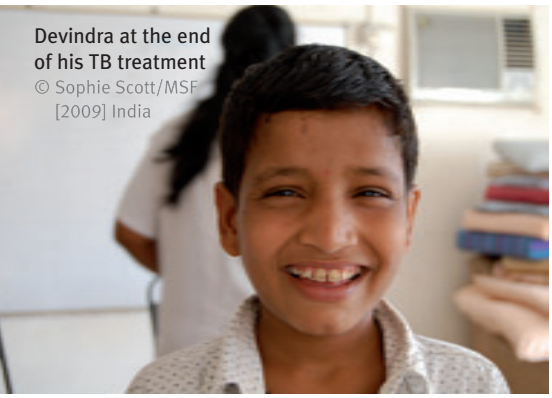
Recovering from drug-resistant TB



Devindra at the end of his TB treatment
© Sophie Scott/MSF [2009] India

Devindra Dercie is an 11-year-old orphan who lives in Mumbai with his uncle. In 2006 he fell ill and his local hospital said he had tuberculosis (TB). They started treating him, but for two years his condition didn't improve. It wasn't until he went to MSF's clinic in Mumbai that he was correctly diagnosed. Like most young children, Devindra found it hard to cough up a good sample of sputum from his lungs for testing, but MSF's TB specialists were able to identify that he had a form of the disease that is resistant to the usual TB drugs. They started treating him with a cocktail of drugs that was formulated to treat his specific form of TB. Now, 18 months later, he has successfully completed his treatment.

"He used to get ill the whole time," says Devindra's uncle. "He was never hungry and he was losing weight. When we finally came to MSF we found out he had drug-resistant TB - it would have been better if we had known earlier.

"He started the treatment as soon as possible. He had to wear a mask over his mouth and the headmaster of his school wanted to know why. We explained that he had TB and the headmaster said that Devindra should not go to school because the other children might be infected. For two years he had to study alone and had no one to play with."

"Throughout the treatment it was difficult to take the medicines," says Devindra. "I used to want to vomit and I suffered a lot of problems. And it was difficult to wear the mask because it smelled bad, but I still wore it because I knew it was important.

"I am happy I have got over TB. Now the treatment is over, I don't want to use the mask anymore and I can play with my friends and go back to school again."

Tuberculosis: spiralling out of control

Tuberculosis is a contagious airborne disease and spreads like a common cold. It is caused by a bacterium called *Mycobacterium tuberculosis,* which usually infects the lungs. In 2007, an estimated nine million people contracted the disease and almost 1.7 million died of it. MSF treats around 26,000 people with TB in 31 countries, including India where MSF runs an HIV/AIDS and drug-resistant TB programme in Mumbai.

Inadequate tools to detect and treat TB are contributing to the spread of this disease. The most commonly used diagnostic test was developed over a century ago, and in real life settings misses about as many patients as it detects, is particularly poor at detecting TB in children, and cannot determine whether a person has a drug-resistant strain of the disease.

Hence Devindra is an exception. He is exceptionally lucky to have been correctly diagnosed, to have been treated with the right drugs, and to have coped with the full 18 months of difficult and unpleasant treatment without defaulting. But hundreds of thousands are not so lucky, and will continue to die of this curable disease if more is not done. That is why MSF is calling for governments and international donors to bring about an immediate revolution in TB care and to galvanise research into new TB treatments and diagnostic tests now.

Find out more about the challenges TB poses to MSF and our patients at **www.msf.org.uk/tbtest**

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