Quarterly news from Médecins Sans Frontières UK Issue nº 45 Summer 2007

DISPATCHES

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Médecins Sans Frontières is a leading independent organisation for emergency medical aid. In over 70 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.

Dr Fernando Perreno in November 2006 at MSF's clinic in Bulawayo, where more than 500 children are receiving ARV treatment for HIV/AIDS.

"a matter of life or death"

Zimbabwe is a country characterised by jaw-dropping statistics. Inflation is currently running at over 3,500%. The average life expectancy for women has fallen from 62 in 1990 to just 34 today. 80% of the population are thought to be unemployed. A quarter of all children are orphans.

But most staggering of all are the figures relating to HIV/AIDS. In a population of 12 million, more than one in five adults are HIV positive. Every week, 3,200 people die from HIV-related illnesses, and up to 600,000 people are now estimated to need life-prolonging anti-retroviral (ARV) treatment.

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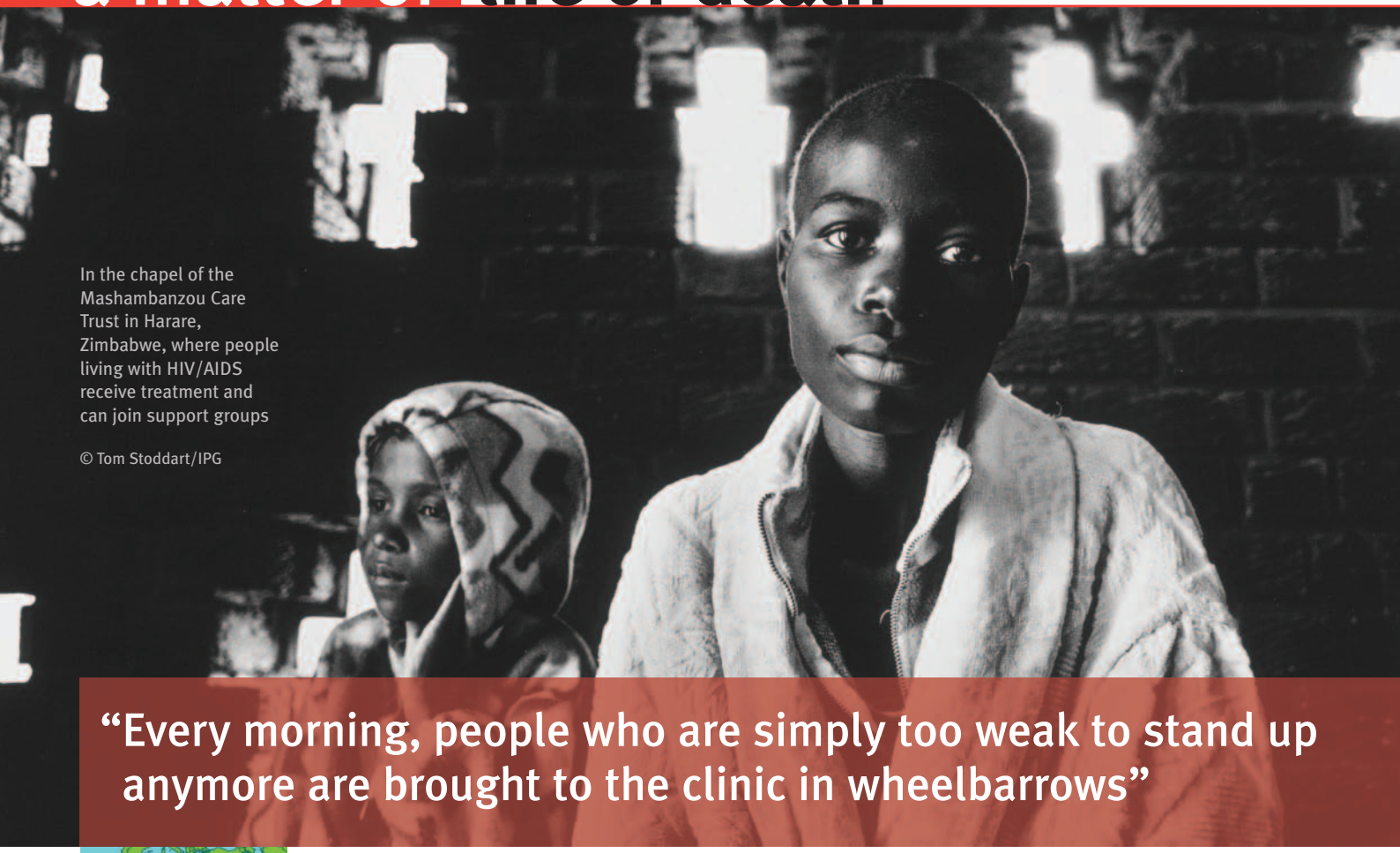
“a matter of life or death”



In the chapel of the Mashambanzou Care Trust in Harare, Zimbabwe, where people living with HIV/AIDS receive treatment and can join support groups

“Every morning, people who are simply too weak to stand up anymore are brought to the clinic in wheelbarrows”

Given the severity of Zimbabwe’s HIV/AIDS situation, it is perhaps surprising to learn that the country was at the forefront of public education on HIV/AIDS during the 1990s and was the first country to make HIV education obligatory in school. A study two years ago showed that almost all Zimbaweans now understand how the disease is transmitted and how to protect themselves against becoming infected.

Despite this, coping with a crisis on this scale is a colossal task.

“Everyday we face an avalanche of needs – it’s like holding back the flood,” says Steve Hide, who has recently set up a new MSF clinic in Epworth, a poor township on the outskirts of Harare. “We knew when we started that it would be an uphill struggle, but we also knew that we had to start somehow, somewhere.”

One of the biggest problems facing Zimbabwe is the lack of doctors. Three-quarters of trained medical staff are thought to have fled the country, mostly to South Africa, Australia and the UK. In addition, many health staff have died or suffered chronic illness due to HIV/AIDS, further contributing to the decimation of the workforce.*

This lack of staff causes a massive bottleneck in terms of getting people onto treatment. According to current Ministry of Health rules, although a patient can be tested for HIV by nurses, only doctors and clinical officers are allowed to make the decision to prescribe anti-retroviral drugs.

“We are lobbying for the protocol to change so that trained nurses also have the authority to start people on treatment,” says Steve. “MSF piloted this model of ‘nurse-based’ care in South Africa with significant success and we think it could work in Zimbabwe too. The levels of education and literacy here are actually very high – Mugabe spent the highest proportion of GNP of any country in the world on education during the 1980s. Unlike many other African countries, Zimbabwean nurses already have a high standard of training. If they were trained to prescribe ARV treatment, it would free up the doctors to deal with the more complicated cases, such as HIV-positive children and people co-infected with both HIV and tuberculosis.”

There is no doubt that Zimbabwe’s dismal reputation on the international stage has contributed to the country’s inability to cope with the crisis. Many international donors have refused to support programmes in Zimbabwe – in 2004, it received just US$10 in international aid per HIV-positive citizen, compared to US$187 per person in neighbouring Zambia.

“Unfortunately, the real victims of these decisions are the poor people,” says Michael Nielsen who recently worked on MSF’s HIV project in Bulawayo. “Zimbabwe has the lowest spending on HIV per capita in the world, yet some of the money that has been committed by donors is just sitting there. One of the main reasons for the hold up is the crazy level of inflation and the fact that the government wants to use the official exchange rate, which means you get very little for your dollar. Donors simply can’t accept that. It also makes it extremely hard for organisations like MSF to operate.”

For health staff currently at the coalface of HIV care, coping with the swelling tide of people in need can be both physically and psychologically overwhelming.

"Every morning, people who are simply too weak to stand up anymore are brought to the Epworth clinic in wheelbarrows," says Steve. "It's an extremely upsetting sight. Sometimes they are motionless under a blanket, and you have to go and check to see if anyone is still alive under there. Most of them have extremely wasted bodies and many are quite young – in their twenties and thirties. These cases are a priority for us, but we are not always able to save them because the disease has often progressed too far."

MSF aims to take on 40 new patients a week in Epworth, which is a relatively fast scaling-up process. But given that there are about 6,000 people in the area who need treatment immediately, it's still just a drop in the ocean.

"Deciding which people to take on is an impossible task for our staff. It's really a matter of life or death and so is incredibly stressful. What makes it even harder to deal with is the fact that many of the big cities in Zimbabwe are relatively developed and living conditions are high for some. Harare and Bulawayo are both beautiful cities with wide leafy boulevards and lovely old houses. Yet when you scratch beneath the surface you find human devastation on a huge scale. I think when you see people dying in the middle of plenty, it makes it even more difficult to cope with psychologically."

A major concern for the future is preventing the transmission of the virus from mother to child. Health care used to be almost free in Zimbabwe, which meant that

A grandmother who looks after 11 children orphaned by AIDS at an orphanage in Highfields, Harare Zimbabwe © Tom Stoddart/IPG

WHAT IS ARV TREATMENT?

HIV/AIDS is treatable with antiretroviral (ARV) drugs. The disease weakens the immune system, and when a patient's white blood cell count is reduced beyond a certain point, ARV drugs are needed to stop the HIV virus replicating and delay immune deterioration.

ARV drugs must be taken every day for life. ARV treatment is not a cure for HIV/AIDS, but it can turn a fatal disease to a manageable chronic illness. Even though ARV treatment is not a cure, it prolongs and enhances the quality of life of people living with HIV/AIDS.

Given the difficulty photographing in Zimbabwe, we have had to resort on this page to photographs taken at MSF projects in 2001. The images are still representative of the situation today.

"Deciding which people to take on is an impossible task for our staff. It's really a matter of life or death"

almost all pregnant women came to antenatal clinics. However, the economic situation is now so bad that people have to pay high fees for health services. In some places antenatal care now costs the equivalent of three months' salary, so women simply don't come to the clinics anymore.

"It's a tragic cycle, because it is women from the poorer areas, where HIV prevalence is probably highest, that just can't afford to attend the antenatal clinics. If you know a pregnant woman is HIV-positive you can give both her and the newborn baby specific drugs to reduce the risk of the child contracting the disease. But if women don't come forward, they cannot be tested for HIV and nothing can be done to prevent the virus being passed onto the child. The government are keen to address the problem, but unfortunately they just don't have the cash to fix it. MSF runs programmes to prevent mother-to-child transmission, but we cannot be everywhere in the country."

Good nutrition is vital to the success of HIV-treatment, yet a short rainy season in many parts of Zimbabwe in early 2007 has again raised the spectre of food shortages and malnutrition. This year's harvest is expected to be poor and in one region farmers have projected a yield of 5,580 tonnes of grain against a requirement of 115,000 tonnes. Unfortunately even in places where food is available, some people can't afford to buy it.

"HIV and opportunistic infections suppress appetite, but when you start treating a patient their appetite returns and they get very hungry," says Steve. "A patient will only do well on ARV treatment if they have enough good quality food to eat."

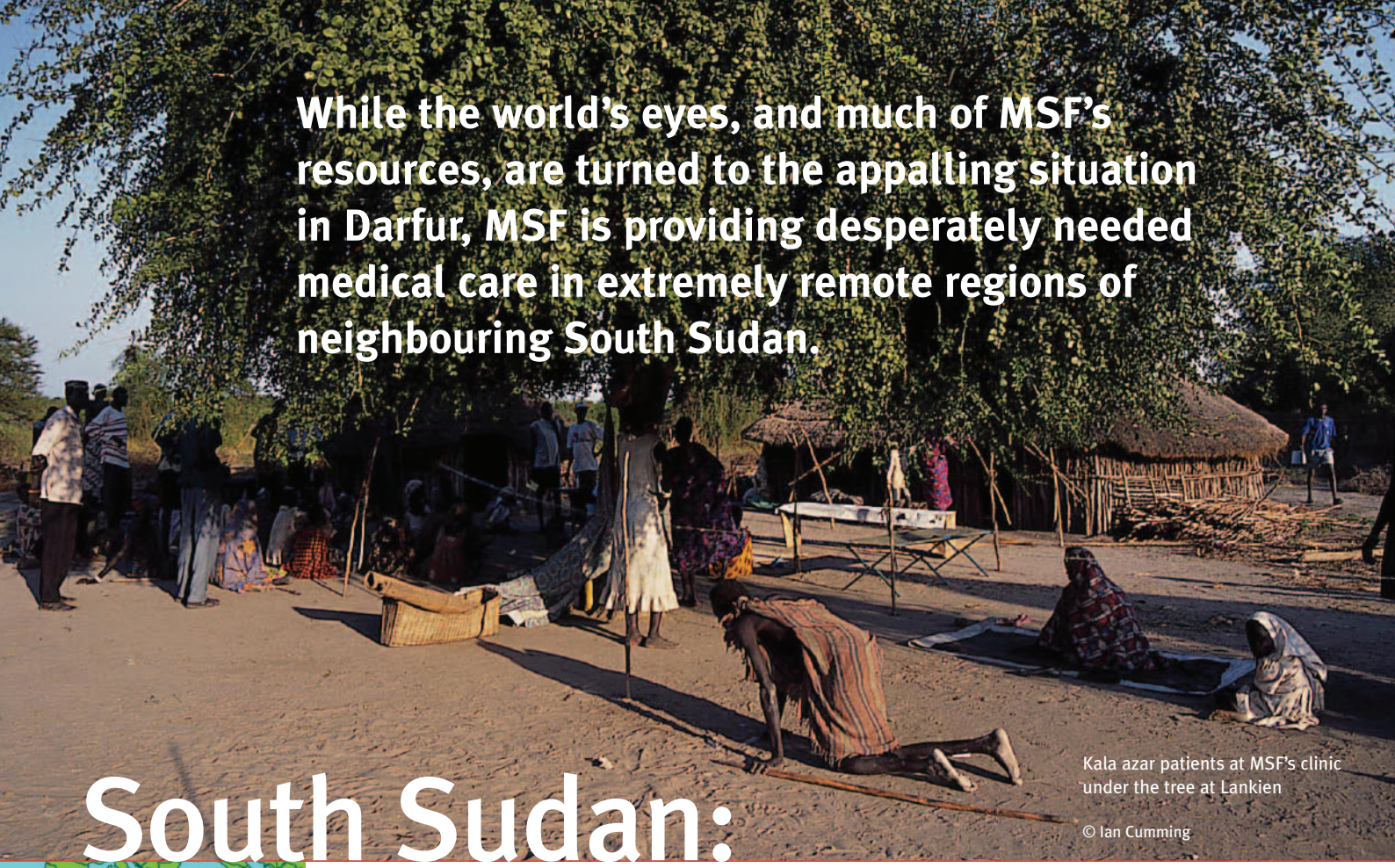
"Epworth is full of people who have come here to die – particularly woman who have lost their husbands to HIV/AIDS. They struggle to make a living, gradually selling their belongings to pay for shelter and food. The last item that most people keep hold of is their wardrobe, so that they can be buried in it if their family can't afford a coffin. It's extremely depressing. MSF's focus now is to get people onto ARV drugs as fast as possible and to show that treatment is possible even in these very difficult circumstances."

MSF is providing free medical care to 33,000 HIV-positive patients in Zimbabwe. We currently work in Bulawayo, Tshlotshlo, Gweru, Epworth and Manicaland, supporting the Zimbabwean Ministry of Health.

11,000 patients are receiving anti-retroviral therapy from MSF. This accounts for over a fifth of all ARV provision in the country. The Zimbabwean government's target is to have 100,000 people on treatment by the end of 2007.

To find out more about MSF in Zimbabwe, please visit www.uk2.msf.org/dispatches/

*Read more about the shortage of health care workers on pages 6 & 7



While the world's eyes, and much of MSF's resources, are turned to the appalling situation in Darfur, MSF is providing desperately needed medical care in extremely remote regions of neighbouring South Sudan.

Kala azar patients at MSF's clinic under the tree at Lankien

© Ian Cumming

South Sudan: a health care desert

In thirty years of brutal warfare between Sudan's southern states and the government in Khartoum, an estimated two million people died. Ground and aerial attacks on towns and villages killed people directly, while others perished from exposure, thirst, malnutrition, epidemics and a host of preventable diseases. Since a 2005 peace agreement, tens of thousands of Southern Sudanese people are returning to their homes after decades in exile, hoping that their suffering can finally draw to a close.

But this is one of the least developed places on Earth; South Sudan is more than twice the size of Great Britain and has virtually no roads – and those that exist are mostly rutted tracks that become impassable in the rainy season. There is virtually no health care and in most of the region walking for days is the only way to get to the precious few health posts that actually exist. As Dr. Jean-Paul Delain explains, "This is the first time I have been in a country with such an absence of health facilities. In Congo, even Ethiopia, there are small health posts all throughout the country, but here it is a health care desert".

Treating kala azar in Upper Nile state

In the middle of a piece of fenced off ground stands a large tree. Its trunk is gnarled and ancient. The sand around its trunk has been neatly swept; there is no litter on the ground. But this is not just a tree: it is the only hospital for miles around. In the shadow of its branches patients lie on food-aid sacks stitched together and six new huts stand in a semicircle around the tree, where the patients sleep and can shelter from the rain.

Many of the patients are suffering from kala azar, a tropical disease that occurs frequently along the upper reaches of the Nile in South Sudan. "You catch it almost as easily as malaria from the bites of sandflies and you waste away as if you had HIV/AIDS," says Dr Erwin De Vries. "In a few months time you will look like a skeleton and you will be dead."

"However," De Vries continues, "for a doctor it is very satisfying to treat this disease. It can usually be cured within three weeks." Seriously ill patients are put on a drip. The plastic bags of fluid can be hung from the branches of the hospital tree. And all patients get two injections a day in a mud hut next to the tree.

Lankien is still one of the few places in the Upper Nile region where people with kala azar and other diseases can get medical help. It often takes days to walk to the health post, which means that people hesitate for a long time before embarking on the journey and sometimes arrive too late to be saved. In the face of overwhelming difficulties, MSF teams try to reach as many communities as possible - but in the rainy season it can take a full day to travel just a few kilometres and the Upper Nile region is larger than Wales. Standing under the tree, Erwin De Vries says "We can only guess how many people die because they live too far away from here."

What is Meningitis?

Meningococcal meningitis is an infection of the membrane that surrounds the brain and spinal cord. It is caused by bacteria that are carried in the nasal passage. Highly contagious, it is transmitted through the air by sneezing or coughing. The most common symptoms are headaches, vomiting, high fever, a stiff neck, sensitivity to light and a typical rash.

It is possible to treat meningococcal meningitis, but the single injection of antibiotics must be administered fast. In most cases treatment leads to a full recovery.

Without treatment, 50 to 80 percent of those who develop active meningitis will die. Even with early diagnosis and treatment 5 to 10 percent of patients can die, typically within 24 to 48 hours of the onset of symptoms.

Even in the sub-Saharan heat, the vaccines must be kept between two and eight degrees Celsius

© Vanessa Vick

In the rainy season large areas flanking the Nile are reduced to swamp making travel extremely difficult

© MSF

"it is like going back in time. [...] All your medical supplies have to be in before the rainy season or you might have to do without for six months"

Half a million vaccinations

South Sudan is frequently hit by epidemics that claim thousands of lives and meningitis is always a particular concern. The 'meningitis belt' is a swathe of Africa running from Senegal in the West to Ethiopia in the East, and it cuts right across South Sudan. Every few years there is a meningococcal meningitis epidemic of huge proportions, and all the signs were there in late 2006. In a country with so little infrastructure this could quickly become a crisis.

Vaccination can prevent the disease, but there are four strains of meningococcal meningitis and it is essential to know which strain is causing the outbreak before vaccinations can start. A doctor performs 'lumber punctures' to extract a small amount of spinal fluid from the first patients presenting with meningitis symptoms. If the fluid is cloudy, meningitis is likely but laboratory tests are needed to identify the strain.

In 2006 in South Sudan two strains were detected in different areas, resulting in a logistical nightmare to get enough vaccines of appropriate types to the right places. To make matters harder, the vaccines need to be transported in a 'cold chain' to ensure they remain strictly between two and eight degrees Celsius from production right through to injection.

David Curtis, head of mission in Jonglei state during the vaccination campaign, explains some of the difficulties: "In many respects it is like going back in time. There are almost no roads or communication systems. In the rainy season the swamps overflow and the land floods. Supplies have to be flown in and it can be hit-and-miss whether the plane is able to land. All your drugs, food stocks, medical supplies and technical equipment have to be in before the rainy season or you might have to do without for six months."

And in the dry season there are other difficulties. "It's a nomadic pastoral existence where people's wealth is in their livestock. There is a seasonal migration during the dry season and the men and boys go with their cattle to cattle camps where herds tens of thousands strong are gathered. So you have to find these cattle camps and vaccinate people there as well as in the villages."

In Jonglei state David's team vaccinated 100,000 people and across the whole of South Sudan, in a series of campaigns, MSF vaccinated over half a million people.

But the ongoing lack of health care requires an enormous aid effort. David Curtis continues, "Every year there are the same emergencies, and as things stand there's no way anyone can stop them. The problem is the isolation – the logistics difficulty and the environment – it's a nightmare and it's very hard to work here. We have the emergency capacity that allows us to respond in South Sudan, which many other organisations don't have. But the needs are immense and it's just incredibly tough work".

To find out more about MSF in Sudan, please visit www.uk2.msf.org/dispatches/

MSF also works in the Darfur region of Sudan. More about our work there is available at www.uk.msf.org

MSF has published a major new report about how the shortage of health care workers in southern Africa has reached crisis levels. Taking four countries – Malawi, Mozambique, South Africa and Lesotho – as case studies, the report examines the situation from the point of view of health workers and patients

Help wanted

Thousands of people are dying because there are not enough health workers in southern Africa. This statement is true across the spectrum of health care, but is thrown into stark relief when you look at the HIV/AIDS pandemic. International pressure has brought down antiretroviral (ARV) drug prices dramatically and jump-started HIV/AIDS treatment programmes in many regions throughout southern Africa. But hundreds of thousands are dying without treatment because health care is coming up against a wall – there are simply not enough health workers to treat the snowballing numbers of patients.

Patients waiting to be seen at the Thyolo District Hospital, Malawi
© Julie Remy

In rural districts in Malawi, a single medical assistant can see up to 200 patients per day. In Mavalane district in Mozambique, patients are forced to wait for up to two months to start treatment because of the lack of doctors and nurse clinicians; many have died during the wait. In Lusikisiki district of South Africa, use of clinic services almost doubled in two years while the number of professional nurses remained constant. Throughout all of southern Africa, there is a grave situation.

Lesotho is a small, poor country with the third highest HIV prevalence in the world. There are only 89 doctors in the whole country and there are 270,000 people living with HIV/AIDS, of whom 57,000 are currently in need of ARV treatment. Nearly 18,000 of these people are receiving ARV drugs, which are provided free by the Ministry of Health, but that leaves nearly 40,000 people who are not receiving any treatment.

MSF is providing HIV/AIDS care and treatment in support of the Scott Hospital, a major district hospital with responsibility for 14 rural health clinics. There are an estimated 35,000 people living with HIV/AIDS in Scott Hospital's catchment area but the hospital has only four doctors. Much of the burden of diagnosis and treatment fell to the 50 nurses employed by the hospital, as MSF's Dr Pheello Lethola explains: "Providing HIV care in rural clinics depends on nurses, and many lives have been saved because they are taking over most of the responsibilities for ARV treatment. But they are overwhelmed by the number of patients."

In 2006, however, more than 25 nurses left Scott Hospital's area for other jobs, and currently more than half of professional nursing posts at the health clinics are vacant. Emily Makha, a 70-year-old nursing Sister at one of the 14 clinics, has remained: "As the only nurse here, I have to do the work of at least four nurses. If I have to go somewhere, the clinic remains closed. Most nurses have left for the UK or South Africa. As a matter of fact, if I were younger, I would also have gone by now!" This exodus has left nursing assistants, who receive just two years of training, to do much of the clinical work.

The situation is echoed elsewhere in southern Africa. The numbers of people who need ARV treatment but are not receiving it are shocking: 85,000 in Malawi; 235,000 in Mozambique; and 735,000 in South Africa. In all three cases, just as in Lesotho, a chronic lack of health workers is seriously limiting access to care for millions of people.

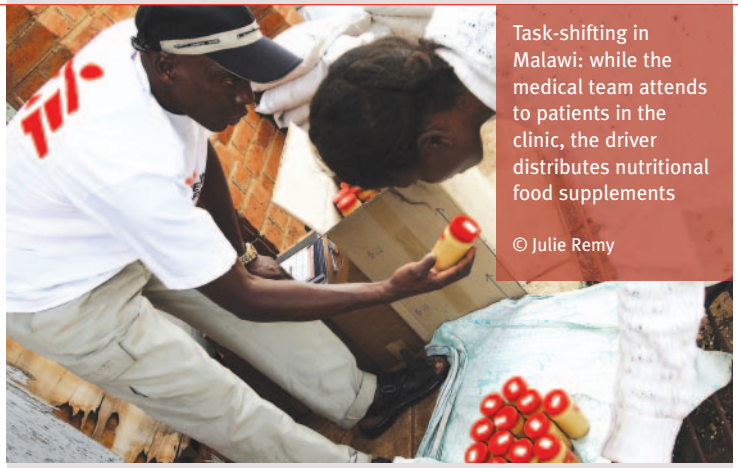
Low salary, lack of benefits, poor working and living conditions (particularly in rural areas) and poor health have all been cited as contributing to the southern African health care drain. Christina Chinji, MSF nurse and health education coordinator, explains the situation in a rural district of Malawi: "I have been working as a nurse since 1971 and in my opinion what we are seeing now is a chronic emergency. There are too many patients for too few nurses and the pressure is too much. So the nurses are leaving for greener pastures. They go where they can find better conditions. I have worked in numerous hospitals and they are all suffering. If you want to solve the problem you need to increase salaries. You need more nurses. And you need more appropriate training and incentives. Otherwise nothing will change."

Western governments are providing funds for life-long ARV treatment and the building of new clinics, but many refuse support for health care worker salaries on grounds that it is 'unsustainable'. "This position is incomprehensible," says MSF's Sharonann Lynch in Lesotho, "when people living with HIV/AIDS do not only need drugs

Task-shifting embraced in Malawi

In Malawi there is a desperate shortage of health workers in rural areas. Absences owing to illness, family commitments or training put a heavy strain on remaining staff. Fatigue and burn-out are common, as staff often work double shifts or forego holidays to replace colleagues.

Aiming to alleviate these problems, MSF teams have relied on "task-shifting" from doctors to nurses and nurses to community workers as a coping mechanism. For example, doctors focus on providing care at hospitals, treating complicated cases and supervising mobile teams rather than



Task-shifting in Malawi: while the medical team attends to patients in the clinic, the driver distributes nutritional food supplements

© Julie Remy

handling all clinical management of patients; nurses assess patients to diagnose and treat opportunistic infections (such as tuberculosis or malaria) and initiate and monitor ARV treatment rather than exclusively supporting doctors; and lay workers provide testing and counselling, support patients in adhering to their treatment, and assist with general clinic support.

While task-shifting is hard in places like Mozambique, where the government does not allow nurses to prescribe ARV treatment, many governments in southern Africa are prepared to embrace the flexibilities necessary to allow task-shifting to work. Where is has been possible, such as in Malawi, task-shifting has brought appreciable benefits for patients. But it is not a panacea. People living with HIV/AIDS can be susceptible to complicated medical conditions that require skilled nurses or doctors and task-shifting should not become an alibi for accepting shortages of skilled staff.

and clinics; they need trained, motivated health care workers to diagnose, monitor, and treat them."

Five years ago, providing ARV treatment to people in sub-Saharan Africa was a contentious issue, with many believing it was too complicated and costly. The refusal to accept that people with HIV/AIDS in the developing world would die because the drugs were too expensive forced a sea change in attitude and policy. The human resource crisis calls for a similar refusal to accept the status quo.

"We are absolutely saturated, and even with all of MSF's means it feels like we are losing the battle," says Eric Goemaere, MSF Head of Mission in South Africa. "For those guys sitting in offices far away from the epidemic our message is that you will be held responsible if you are not reactive or flexible enough to find solutions to the staff shortages."

For a more in-depth look at the situation in Malawi, Mozambique, South Africa and Lesotho, you can read the report at www.uk2.msf.org/dispatches/

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DISPATCHES is a quarterly publication designed to keep our supporters updated on the work of Médecins Sans Frontières.

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A woman walks to work in Baghdad past a wall peppered with bullet holes © Geert Van Kesteren

Supporting victims of violence in Iraq

MSF is making its first attempt to return to work in Iraq since the organisation left in October 2004 because of insecurity and the direct targeting of aid workers.

From August 2006 to January 2007 more than 100 people were killed each and every day on average in Iraq and many more were severely wounded. It is a situation of violence, neglect and deliberate abuse.

In one region of Iraq, where MSF considers the security situation manageable, MSF will start working in two emergency hospitals, strengthening the referral system, providing training and medical supplies and developing emergency plans.

But in most of the country, the security situation means that MSF cannot do hands-on work. When MSF asked Iraqi doctors what the organisation could do to help, they were told that it would be far too dangerous for Iraqi medics to invite MSF into their hospitals.

Instead, they asked for surgical materials, equipment and supplies. Former general hospitals, previously used to referring all but simple emergency cases, were now performing complex emergency surgery with only the most basic equipment and drugs. Doctors had to ask the relatives of injured patients to search local pharmacies for blood bags, sutures and infusions before they could start emergency surgery.

"By being in regular contact, we want to express our solidarity with the Iraqi medical staff who are continuing to work under very difficult conditions," explains MSF's Erwin Van Der Borght. "Obviously we try as much as possible to take the necessary precautions to reduce the risks for our contacts and counterparts. Being in contact with an international organisation such as MSF may increase their security risks. But as long as there are dedicated and courageous medical staff present in the hospitals providing life saving medical and surgical assistance, MSF can certainly be of use by ensuring that they have the necessary medical supplies to be able to work in acceptable conditions."

Another suggestion by Iraqi doctors was for MSF to provide reconstructive surgery in Amman, Jordan. Although obtaining a passport and travelling out of Iraq can be fraught with difficulty, since August 2006 MSF has treated more than 200 badly injured people in Amman.

The full text of an interview with Erwin Van Der Borght is available at www.uk2.msf.org/dispatches/

How to make a donation

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Please quote your supporter number (located on the top right hand side of the letter) and name and address when making a donation.

Why *Dispatches*?

Dispatches is written by people in MSF and sent every three months to our supporters and volunteers in the field. It costs 8 pence per copy to produce and 22.5p to send, using Mailsort Three, the cheapest form of post. We send it to keep you, our donors, informed on how your money is spent and what our latest activities are.

Dispatches also gives our patients, staff and volunteers a voice to speak out about the conflicts, emergencies, and epidemics in which MSF works, and about the plight of those we strive to help.

Living in Darfur – an email diary

The cover letter for the last issue of *Dispatches* was written by Joe Jacob, an MSF doctor in Darfur.

Joe has allowed us to publish a series of his emails home. They offer a fascinating insight into the day-to-day life of MSF staff working in a tough situation.

Read his emails at:
www.uk2.msf.org/dispatches/
(please note that you'll need to copy the address exactly as this web address contains the number 2 unlike most other web sites).

MEDECINS SANS FRONTIERES

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