Doctors Without Borders (MSF) Southern Africa
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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Living in emergency

MSF helps people survive disasters, conflict, epidemics and neglect

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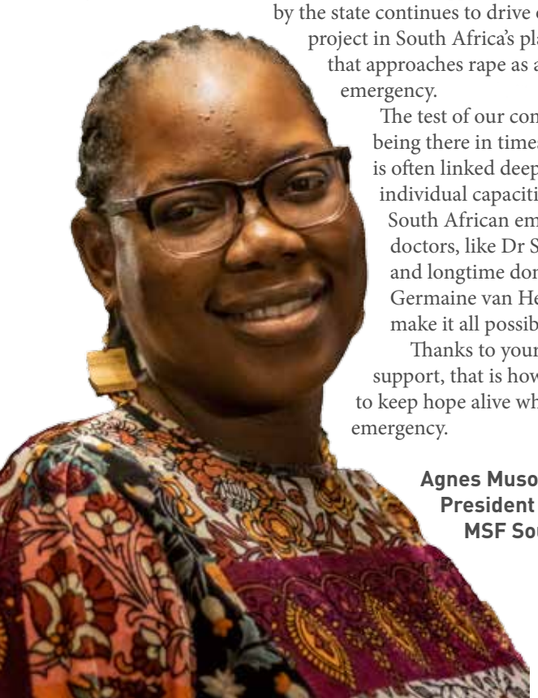
EDITORIAL

Emergencies, seen and unseen

As a medical organisation that's been around for 48 years, we provide people living in emergency with the care they need when they're trying to survive in times of crisis. In the eyes of the world, these emergencies are sometimes difficult to ignore because they're so visible – think about natural disasters, epidemics such as Ebola, or conflicts such as the war in Yemen that grab international headlines. But other emergencies are almost invisible – as much as the people who suffer through them.

Close to home, the massive destruction of Cyclone Idai and the floods in Southern Africa caught the world's attention and prompted quick action. But beyond the immediate disaster requiring a swift response to possible large-scale cholera outbreaks, another emergency was emerging. Hundreds of thousands of people living with HIV in our region are alive and healthy because they're on antiretroviral treatment. When disaster strikes, it is their access to this lifeline that is disrupted, especially the most vulnerable and marginalised: sex workers and men who have sex with men in the Mozambican port city of Beira. During such a massive emergency, it's also our staff who have to overcome deep personal loss to stand strong and bring care to their communities, like nurse Armanda*, whose story you can read on page 4.

Our work as Doctors Without Borders (MSF) means we look closer, take action and bear witness to ignored emergencies, such as those caused by unsafe abortions. This preventable cause of death and suffering for tens of thousands of women contributes to up to 30% of obstetric emergencies in some of our hospitals. Similarly, the invisibility of the deep psychological wounds suffered by survivors of sexual violence and the struggling national response by the state continues to drive our ongoing project in South Africa's platinum belt that approaches rape as a medical emergency.



The test of our commitment to being there in times of emergency is often linked deeply to the individual capacities of talented South African emergency doctors, like Dr Sian Geraty, and longtime donors, like Germaine van Heerden, who make it all possible.

Thanks to your continued support, that is how we manage to keep hope alive when living in emergency.

Agnes Musonda
President
MSF Southern Africa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Hope rising from the flood


© Pablo Garrigos, Mozambique

Armanda*, 26, is a nurse working with MSF in Mozambique. She and her children survived Cyclone Idai, but her husband was killed. Despite the tragedy, she cares for patients in remote communities devastated by the effects of the cyclone. This is her story


© Mohammad Ghannam, Mozambique


© Mohammad Ghannam, Mozambique

I was born in a small town, but moved to Nhamatanda to study to become a nurse. I met my husband at a football match – right here on this field where we land the helicopter to run our mobile clinics. He was studying to become a teacher. We used to organise matches between nursing and education students. At one of these games, we met and fell in love.

In 2015, we graduated and married soon after. We moved to his house to raise our family close to his parents. We had our son, who is now two years old, and my husband helped me raise my two older daughters from my first marriage. My husband moved away from home to teach primary school. He used to come every month to see us, and he was so proud of his work teaching children to become better citizens. I took care of the house, and worked to make ends meet. We were happy.

On 14 March, everything changed. We already knew bad weather was coming – the cyclone – but nothing could have prepared us for what happened. My husband called us just before it hit to ask how we were and to tell us to be safe. He was so concerned, but we told him we would take care. He said he would do the same and said he loved us. That was the last time we spoke. At 10pm, it started raining. The water started to rise in our house. Furniture floated. I put my children on our kitchen table so they wouldn't get wet and prayed. I was so afraid. I thought of my husband.

Everything I know about his fate comes from his colleagues and friends who were with him that night. They say the water started to rise in the school until it reached their necks. They had to swim to the roof. Soon the roof was also covered in water, and the current was strong. People had to swim to the closest trees and pray that the tree they reached would resist the winds and the water.

My husband and many others climbed the wrong tree. It fell into the water and he was carried away in the currents. After two days of no news from him, his brothers went to the beach to search among those bodies, but they never found him.

I spent two days in bed after what happened, unable to move or to do anything. My house was destroyed, my husband was gone, my life had changed entirely in one night. One morning, it hit me – I was unemployed, alone, with three children. I had to fight.

A lot of my strength to move on comes from being a nurse. A nurse has to be strong. We see sadness and pain every day, and it is our role in the world to support and treat. How can I cry when it is my job to comfort those who suffer? This tragedy has not only hit me or my home; so many around us have suffered and lost so much. I will never forget, but I will move on, not only for myself but for others.

My job in MSF takes me to places where people have lost much more than me, and makes me realise how this has affected my people. From a helicopter, you see the flooded areas and the torn trees, but there is a lot you can't see. Beneath the waters, below the broken branches, you will find us – our stories and our sadness and our resolve to live.

**Not her real name. The nurse requested not be identified or photographed.*

R100
provides 100 000 litres of clean water – enough for 5 000 people a day. Clean water is essential for people facing natural disasters

R300
provides a survival hygiene kit for a family of six. Kits contain toothbrushes with toothpaste, toilet paper, feminine hygiene, wet-wipes, tissues

R1 100
provides MSF medics with emergency care kits for up to 40 people. Kits contain basic supplies like oral and topical medicines, bandages, and essential surgical tools

READY TO RESPOND: BETWEEN STORMS

High winds and waters killed 600 people and damaged or destroyed thousands of buildings in the port city of Beira – homes, schools, health centres and hospitals.

In the hours and days after Cyclone Idai hit, MSF's HIV project team in Beira responded to urgent needs before emergency team members arrived. The response included setting up cholera treatment centres, rebuilding and restocking health facilities, providing technical support in oral cholera vaccination campaigns, and providing water and sanitation services and psychological support to cyclone survivors. The teams also worked on restarting HIV programmes for groups most at risk, such as sex workers. Although fears around extensive cholera outbreaks did not materialise, MSF teams treated about 4 000 people in total.

900
MSF STAFF WERE INVOLVED IN THE RESPONSE

100
PATIENTS WERE TREATED FOR CHOLERA EACH DAY

A few weeks later, before Cyclone Kenneth struck in Cabo Delgado province, MSF teams were ready – offering water, sanitation and hygiene services in Pemba town. Supplies were sent direct to Pemba ahead of the cyclone to build temporary 15-bed cholera treatment units in Pemba, Mecufi and Metuge.


© Pablo Garrigos, Mozambique


© Pablo Garrigos, Mozambique


© Pablo Garrigos, Mozambique

When the rains came, we were *ready*

Working with communities in Malawi's flood-prone Makhanga district, MSF teams saw the big impact of small changes when heavy rains hit the region in the run-up to Cyclone Idai

Logistician and community health worker Labana Steven has worked with MSF for 20 years in Malawi. In the past 10 years, he has seen devastation of floodwaters in the south of the country three times: in 2008, 2015 and 2018.

His historical understanding and deep engagement with local partners and communities in southern Malawi were essential to enable MSF teams to support thousands of people affected by severe flooding with health and sanitation supplies.

"The Makhanga area is low and flat, and surrounded by the Shire River and its largest tributary, the Ruo, so it basically looks like an island. This makes it very prone to flooding. Heavy rains starting in early March affected all the southern districts, so the entire area was largely submerged for weeks."

The fertile district is home to about 18 000 people who rear cattle and grow crops such as maize and rice.

The lessons Labana learned while responding to the previous severe flooding in Makhanga in 2008 and 2015 were a significant boon to MSF's emergency response efforts in 2019. "In 2015, we mapped the most risky, flood-prone areas in order to focus our response and identified people to work with closely in the community."

These relationships enabled MSF to come in quickly as the heavy rains set in. MSF was able to assess the situation and plan an immediate response with the community, who already had some experience of how to distribute relief items.

"In our previous flooding responses, we shared information on how to find and prioritise people who needed medical care. In 2015, a lot of people died in this area, but this year fewer lives have been lost to the flooding, partly because people now know where to find higher ground."

In the most recent floods, Makhanga health centre was severely flooded, but MSF's experience from responding to previous floods again proved helpful. "In 2015, a lot of drugs were soaked in floodwater, ruining them," says Labana. "Afterwards the MSF team raised the height of the shelves so that the drugs would be safe from the water, so this time the stocks were spared."

The floodwaters also submerged boreholes and destroyed toilets. With thousands of people having to defecate in the open, the risk of waterborne diseases such as diarrhoea and cholera breaking out was high. In addition, Labana says the area's many swamps are breeding grounds for mosquitos, putting people at risk of contracting malaria.

The borehole at Makhanga health centre was contaminated by the floodwaters, but MSF teams managed to clean it and ensure the water was safer to use. Elsewhere, MSF's water and sanitation teams distributed chlorine, cleaned water points, and constructed toilets and showers.

Working with the Malawian district health office, the MSF medical team conducted an outreach clinic to ensure access to primary health care services and drugs for patients with chronic diseases, including HIV and tuberculosis, who lost their medication in the floods.

© MSF, Malawi

© MSF, Malawi

© MSF, Zimbabwe

Quick response in the aftermath of the storm

MSF medical team leader **Dr Marthe Frieden** shares her account of how MSF teams provided relief in the first four days after Cyclone Idai hit Zimbabwe

DAY 1
I'm at an urgent meeting called by a civic body. A sense of desperation and helplessness grows as the extent of the damage becomes clear, along with the realisation that the devastated areas are now cut off from the world. We have to work in emergency mode now.

DAY 2
The MSF team leaves Mutare to drop off medical supplies at a hospital in Chimanimani district. After a day of muddling through a labyrinth of collapsed bridges and roads blocked by land and rockslides, we realise that neither the two roads, nor the secondary dirt roads into the district are accessible. The district is completely cut off. We need to change our approach.

463 012
PEOPLE VACCINATED AGAINST CHOLERA THROUGH MSF TECHNICAL LOGISTICS SUPPORT

597
PEOPLE HELPED THROUGH GROUP MENTAL HEALTH SESSIONS

DAY 3
We set up three tents as part of a stabilisation centre for survivors at a strategic point overlooking the affected area, known as 'Skyline'. The army helps to deliver much-needed supplies to cut-off hospitals. Local community members gather and discuss strategies to save the lives of friends and family members trapped in the Chimanimani valley. They're frustrated at the pace of relief efforts. The rains continue to pour down. Mist turns into fog, keeping the helicopters grounded. The clock is ticking.

DAY 4
As an increasing number of emergency aid organisations arrive, collaboration happens in ad hoc but synergistic ways. A coordination mechanism is set up and much of the communication happens in WhatsApp groups. The first patients arrive before any beds can be organised. Some have infected wounds, but there is no water for handwashing yet. Lying on plastic sheeting on the floor, patients are examined and stabilised by doctors and nurses. As the sky clears up, more and more patients with broken bones or deep cuts are evacuated by helicopter.

On hostile land and at sea:
Human emergency

Since February 2016, MSF's *Aquarius* sea rescue vessel helped almost 30 000 at-risk people in the central Mediterranean Sea. But obstructionist European policies have forced it to cease its operations

Across the world, states are pushing back refugees and migrants. European governments attempted to cover up the human cost of their harmful policies by demonising, threatening and blocking MSF's attempts to provide assistance and our ability to bear witness.

In early December 2018, we were forced to end our search and rescue operations in the central Mediterranean after increasingly obstructive actions by Italy, which shut its ports to MSF's *Aquarius* and other rescue boats – even though thousands of people drown while attempting to leave Libya after fleeing war and unliveable conditions at home.

Since February 2016, the *Aquarius* helped nearly 30 000 people in international waters between Libya, Italy and Malta. With the sabotage of the *Aquarius*, gone is the most basic humanitarian and legal commitment: saving lives at sea.

This is illustration by Hong Kong artist Ah Leung pays tribute to the human solidarity demonstrated on the *Aquarius*.

Meanwhile, thousands of vulnerable refugees and migrants remain trapped in Libyan detention centres after fighting escalated in and around Tripoli since April 2019. Scores of detainees held in unliveable conditions were shot and injured, according to evidence reviewed by MSF.

"The international community can only be blamed for its complete and utter inaction. MSF again pleads for the refugees' urgent and immediate evacuation out of that country. Until then, they remain at risk of another attack or crossfire," says Karline Kleijer, MSF's Head of Emergencies.

5 REASONS NOT TO BLOCK MIGRANTS AND REFUGEES IN LIBYA

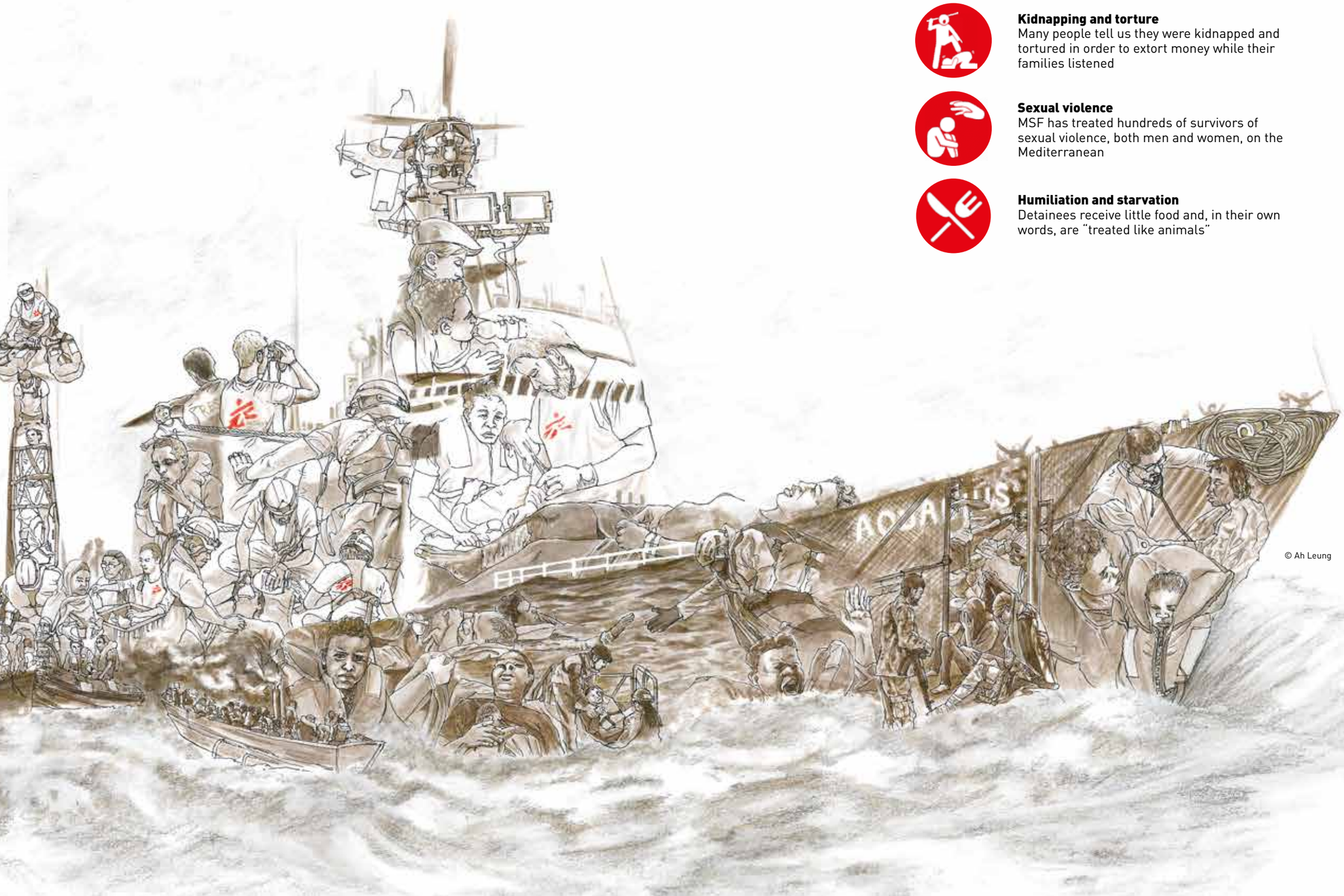
Arbitrary detention and violence
People are detained in overcrowded detention centres where they are subjected to violence

Forced labour
Both men and women are bought and sold by criminals and forced to work without pay

Kidnapping and torture
Many people tell us they were kidnapped and tortured in order to extort money while their families listened

Sexual violence
MSF has treated hundreds of survivors of sexual violence, both men and women, on the Mediterranean

Humiliation and starvation
Detainees receive little food and, in their own words, are "treated like animals"



© Ah Leung

Shupikai Bondamakora, 39, a survivor of domestic and sexual violence helped by MSF clinic in Bapong, Rustenburg

Treating rape's invisible wounds

Yolanda Hanning, a psychologist working at MSF's sexual and gender-based violence (SGBV) project in Rustenburg, highlights the unseen and often ignored medical and psychological emergency rape survivors face

© Melanie Wenger, South Africa

Candice* was gang raped. She sought help at a public hospital, where she explained to an assistant that she was thinking about taking her own life. Assessing the risk of suicide for survivors of SGBV should be included in screening questionnaires at health facilities, and patients presenting symptoms should be admitted for care and linked to a psychologist or psychiatrist without delay.

But candice was not assessed. Nor was she appropriately cared for. Instead, she was made to wait all night to see a health provider, sitting in a metal chair surrounded by the sick and injured. Candice eventually received the care she needed in a private facility, but incidents of this nature are common. Most survivors don't get the care they need.

MSF investigated the issue in 2018. Our report, "Untreated Violence 3: Critical Gaps in Mental Health Care for Survivors of Sexual Violence in South Africa", confirmed the poor overall response to the physical consequences of sexual violence, and that the "invisible" psychological consequences – including post-traumatic stress disorder, depression, anxiety and suicidal inclinations – are often overlooked.

Of the 265 facilities in South Africa designated by the government to provide comprehensive care to survivors of sexual violence, MSF's survey data shows that one in five offers no mental health services; 45% say they offer no counselling services for children; and nearly 40% provide no risk assessment of suicidality.

Access to mental health services after rape should not be a lottery for survivors. We know that rape can have severe psychological consequences, and that these can be prevented or reduced with access to the right care. But a huge barrier to progress is the low number of health facilities equipped to provide services to survivors, and the fact that most of them are based in hospitals in urban areas, making them difficult for many survivors to get to.

MSF's response to this situation has been to support the set-up of dedicated SGBV clinics at the primary health care level in the North West province's Bojanala district. Most of these facilities are integrated into existing community health centres called Kgomotso Care Centres (KCCs) – Kgomotso being Setswana for "place of comfort". MSF currently supports four government KCCs, in which more than 1 800 survivors of SGBV have received mental health consultations since 2016.

45%

OF STATE FACILITIES DESIGNATED TO PROVIDE CARE TO SURVIVORS OF SEXUAL VIOLENCE OFFER NO COUNSELLING SERVICES FOR CHILDREN

20%

OF STATE FACILITIES DESIGNATED TO PROVIDE CARE TO SURVIVORS OF SEXUAL VIOLENCE OFFER NO MENTAL HEALTH SERVICES AT ALL

Developing an adequate mental health response has not been easy. In Rustenburg, MSF ensures, at the minimum, that every survivor entering a KCC gets a mental health assessment from a registered counsellor. All staff working in KCCs are trained as first responders to SGBV cases, including MSF drivers, who frequently pick up survivors and transport them to KCCs. Our patients are asked to return for a follow-up assessment one week later if needed, and are referred to a psychologist or psychiatrist if symptoms of severe psychological conditions persist.

We are using our operational experience and findings from the 2018 survey to call on the South African government to reduce the psychological illness and suffering caused by sexual violence. Yes, improving mental health care for rape survivors is a major challenge, but government should not baulk at its complexity. The true cost of this failure to respond is counted in smashed ambitions, broken families, sickness, dysfunctional relationships and ruined lives. Survivors like Candice deserve better."

** Name changed to protect her identity.*

© Gazelle Galgnaire/MSF

Safe abortions to save women

Every day, MSF sees the consequences of unsafe abortions – an ignored medical emergency. In some of our hospitals, it is the cause of up to 30% of obstetric emergencies. Yet this devastating cost to the health and lives of women and girls is completely preventable, writes **Dr Claire Fotheringham**

It was September 2011 and I was on my first assignment with MSF. Setting foot in a busy maternity hospital in West Africa, I was completely unprepared for what I found: women arriving on death's door, with complications like heavy bleeding and septic shock. In the operating theatre, examining many of these women, I found trauma marks on the cervix, caused by objects such as sticks that had been inserted to terminate their pregnancies. These were scars from unsafe abortions that had resulted in horrific injury.

I realised the sheer desperation that must have driven these women to do this, and how limited their options must have been. They were willing to resort to any means to terminate their pregnancies, even while knowing the huge risk to their own lives.

Some of these women needed antibiotics or tetanus injections for infection. Others required blood transfusions for life-threatening bleeding, or major surgery to repair perforations to their bladders, bowels or abdomens, or to remove infected tissue caused by peritonitis or abdominal abscesses. Even if these initial complications could be rectified, I knew these women faced the danger of long-term effects, including chronic pain, anaemia and infertility. Even if a woman simply didn't want one pregnancy, she might never be able to have children again.

Encountering this sort of medical emergency was shocking. But I shouldn't have been surprised; I now know that unsafe abortions represent a major public health issue worldwide. At least 22 000 women and girls die from unsafe abortions each year, making it one of the top-five direct causes of maternal mortality. In addition, a conservatively estimated 7 million women and girls suffer long-term consequences from unsafe abortions. Sadly, these numbers are likely much higher as many unsafe abortions, just like the pregnancies, are not disclosed.

Safe abortion care is recognised as a medical necessity, established as part of the package of sexual and reproductive health that is considered worldwide to be beneficial to preventing mortality in women. The termination of pregnancy is a safe, effective procedure that can be accomplished by minor surgery or tablets. These tablets, a two-stage, five-pill therapy known as medication abortion, are increasingly used in MSF projects and can be dispensed as part of our outpatient care. Every safe abortion provided is an unsafe abortion averted.

Barriers to safe abortion care do not stop at shame and stigma in many societies. They include legal restrictions, economic and social obstacles, and administrative hurdles. Institutional decision-makers and medical providers might also lack knowledge, fear repercussions, or object on personal grounds.

Since the baseline set by the Millennium Development Goals in 1990, we have seen reductions in maternal mortality in many countries, but there has been little change in deaths from unsafe abortions.

This is simply unacceptable. We must continue to push for more progress on safe abortion care worldwide. The lives of women and girls depend on it.

The relentless fight for *survival*

War and conflict pushes civilian life to extremes, especially when health care systems the perfect storm for epidemic outbreaks, and increase the difficulties and complexities Democratic Republic of the Congo, where an Ebola outbreak still rages, and in Yemen, are destroyed access to urgent care becomes near impossible. These conditions create MSF teams face in responding during these emergencies. This reality is most acute in the where cholera is taking its toll

FENDING OFF EBOLA IN THE DRC

© John Wessels, DRC

The DRC is still battling an ever growing Ebola outbreak – the most serious in 30 years and the second-largest in world history. By June 2019, more than 2 000 people had been infected, and 1 400 people had died in North Kivu as the death rate of almost year-long outbreak soared to 67%.

MSF has been part of the outbreak response, led by the country's ministry of health and World Health Organization, but the struggles of working in an active conflict zone are real, and progress has been slow despite significant funding, access to a promising new vaccine and several new drugs

So far, the response isn't adapting to people's priorities and fears. Because of the violence, communities are fearful of authorities and people delay or avoid seeking treatment. In the first four months of 2019, two MSF Ebola treatment centres were attacked, prompting MSF to withdraw teams from Butembo and Katwa.

Elsewhere, MSF continues to provide patient care in transit centres and isolation units, supporting the local health care system with Ebola preparedness in hospitals – especially with infection prevention and control measures to screen patients, disinfection, the short-term isolation of suspect patients and decontamination when confirmed Ebola patients are admitted. MSF teams also provide essential activities that promote health among communities at risk, and reinforces the disease surveillance system, while training medical staff.

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TOLL OF WAR ON HEALTH IN YEMEN

© Agnes Varraine-Leca, Yemen

© Agnes Varraine-Leca, Yemen

© Agnes Varraine-Leca, Yemen

The Yemeni people are living a nightmare. Four years of war in Yemen have left the country and its health care system in ruins. Outbreaks of cholera and other vaccine-preventable diseases, such as diphtheria and measles in 2018, demonstrate the country's collapse. From January to October 2018, MSF teams treated nearly 6 700 suspected cholera cases and nearly 5 000 cases of malnutrition. In the first three months of 2019, a new surge in cholera saw MSF admitting nearly 8 000 suspected cholera patients to our health facilities.

Airstrikes and bombings by the Emirati and Saudi military coalitions continued to hit civilian areas. Last year, an MSF cholera treatment centre in Abs was destroyed in a bombing and our teams were forced to withdraw from Ad Dhale after multiple security incidents that directly affected patients, staff and MSF-supported medical facilities.

Due to increased fighting and despite challenges, we opened a surgical field hospital in Mocha, to provide emergency medical care to people coming from the Hodeidah and Taiz frontlines. It is the only surgical facility outside of Aden, and before patients would need to travel up to eight hours by ambulance to reach help – at huge risk and cost in a country at war. Among the patients are war-wounded and pregnant women with complicated deliveries that require urgent surgery. Since opening, nearly 2 000 patients were seen in the busy emergency room, and more than 1 000 surgeries were performed.


© Elisa Fourt, Iraq

From chaos to order in the ER

In her six months at a busy ER in Baghdad, South African emergency medicine specialist **Dr Sian Geraty** helped set up a system to ease the load of doctors treating 700 patients a day

When people think of MSF, they often picture dealing with extreme emergencies, doctors treating people whose lives are in danger. Too little is known about MSF's work behind the headlines, dealing with everyday emergencies. When I first set foot in Baghdad's Sadr City in mid-2018, I understood immediately how that dimension of our work is just as important as the rest of the things we do.

Sadr City, home to about 3.5 million people, is overcrowded. There are just four hospitals in the city. MSF started supporting one of them in late-2017, a 240-bed facility called the Imam Ali hospital. Last year, the hospital's ER received an average of 20 000 patients a month, meaning that doctors treat up to 700 people per day!

Various factors, including the limited availability of services in the city and high rates of accidents and diseases, are responsible for the high numbers of patients. The environment people live in also plays a big role.

The ER of Imam Ali is staffed by Iraqi doctors in their first years of practice, under the supervision of a single emergency specialist. They deal with hundreds of patients daily who need urgent treatment. In an environment where threats to doctors are relatively frequent, and where things can quickly become chaotic, these doctors struggle to work to the best of their abilities, and prioritising cases quickly becomes a challenge.

When MSF first visited the hospital in 2017, and immediately proposed improving the way the ER worked. We started by donating equipment to the hospital, and went on to renovate the whole ER. We also suggested implementing a triage system, which meant adapting the layout.

Triage – prioritising patients' treatments based on the severity of their condition – is not yet implemented in most medical facilities in Iraq. Triage means that patients are sorted as soon as they arrive at the ER. People who are critically ill do not need to wait in line to be seen.

We trained more than 80 ER doctors and nurses in how to classify patients correctly using a simple colour code.

By the time the hospital's new ER opened in December 2018, doctors and nurses were ready to work with the new system. Since then, the chaos has become much more manageable. Doctors feel less stressed, and nurses have said they like going to work more since this new system was implemented.

COLOUR-CODED TRIAGE

Red is for patients in need of immediate medical attention

Yellow is for patients who are seriously injured or sick, but in a condition that is not immediately life-threatening

Green is for patients with non-serious injuries or medical conditions

Bridging the gap between compassion and action

Germaine van Heerden has been a committed monthly MSF donor since 2011. After seeing how badly people in Mozambique needed help in the wake of Cyclone Idai, he made a special, extra donation to MSF's emergency response


© Tadeu Andre, South Africa

What motivates you to support MSF as a donor?
I feel a deep sense of compassion for people who suffer. Seeing my fellow human beings getting access to health care motivates me. If I can make a difference by helping one more person to live a better quality life through access to basic medical treatment, I feel good. The selfless efforts of MSF medical staff and fieldworkers warms my heart, along with the gratitude of people whose lives are changed.

Why did you decide to make an extra donation towards the emergency response after Cyclone Idai?
Last year I was on an outreach project with our church in Mozambique to help build a basic church structure and jungle gym. For many people in Mozambique having access to some of the very basic facilities like running water, toilets and electricity is not common. I remember the catastrophic floods in the early 2000's and how many people suffered. When I heard of the latest emergency with Cyclone Idai and the cholera outbreak, I had to do something to help reduce suffering and contribute to MSF.

What does 'living in emergency' mean to you?
It has almost become the norm for humanity today. We are living in a time when disaster and change have become a way of life. We cannot simply stick our heads in the sand to ignore it. We can see weather-related disasters in Southeast Asia and the Americas, and we cannot somehow believe Southern Africa is immune. We need to face up to reality without wallowing in negativity – you can reduce the impact of an emergency and be part of the solution. Whether it is working on a rescue boat at sea, treating malaria and cholera, or providing medical care in warzones – in all these emergencies, MSF is there.

OUR DONORS MAKE IT POSSIBLE

MSF Southern Africa's emergency appeal linked to Cyclone Idai attracted huge support from corporate and business donors. We're particularly grateful for the generous donations from the following companies towards our emergency medical humanitarian work:

- CBD Biotechnologies
- Datatech
- Enza Construction
- Horizon Global
- Flight Centre Foundation
- Illovo Sugar Africa
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- Samsung
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CONTACT MSF SOUTHERN AFRICA
Telephone: +27 (0) 11 403 4440/1/2
Email: office-joburg@joburg.msf.org
Website: www.msf.org.za

MSFsouthafrica
MSF_southafrica
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