
THE URGENT NEED FOR LONG-TERM HEALTHCARE

MEDECINS SANS FRONTIERES
GLOBAL UPDATE SPRING 2022





The Médecins Sans Frontières outreach team discusses tuberculosis symptoms and prevention measures with the community at Morata Stage 1, in Port Moresby, National Capital District, Papua New Guinea. © MSF/ Leanne JORARI, 2022



MEDICAL AND HUMANITARIAN CARE WITHOUT LIMITS

Emergency medical response is at the heart of what we do. However, in the conflict and crisis zones where our medical teams work, treating patients with chronic or long-term non-communicable diseases is just as vital.

Long-term care requires long-term commitment. That is why we are so grateful for the compassion and generosity of supporters like you. In this report, you will meet resilient patients who are learning to thrive despite a devastating diagnosis, people who are rebuilding their lives following reconstructive surgery, and children surviving neglected diseases against the odds. You will also see the many ways our teams are able to adapt and innovate to shorten treatment times, deliver rapid diagnostics, and deliver quality patient-centred care for people who need it most.

NONE OF THIS WOULD BE POSSIBLE WITHOUT YOU.

As you read this report, please take a moment to reflect on the part you play in ensuring the independent, impartial medical care we provide is always there. Your support is integral. Thank you from us all.

Jennifer Tierney
Executive Director
Médecins Sans Frontières Australia



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TACKLING TUBERCULOSIS ONE PATIENT AT A TIME

Médecins Sans Frontières is one of the largest non-governmental providers of tuberculosis (TB) treatment worldwide. However, obsolete treatments, the lack of an effective vaccine and suitable diagnostic tools have made it difficult to control the TB pandemic. With your support, we are participating in two clinical trials which are providing new hope.



TB, one of the oldest known diseases in the world, is preventable and curable. Yet it is the second leading infectious killer disease after COVID-19. Around 10 million people fell sick with TB in 2020, and an estimated one in three people globally with the disease are not diagnosed.

Patients with TB experience serious symptoms that greatly affect their lives, including severe coughing, chest pain, weakness, sudden loss of weight and fever. Uncomplicated TB is curable, but many of the drugs used to treat it are decades old, while some were not originally developed for TB use, or have toxic side effects. Patients have traditionally had to endure long months or even up to two years of treatment with these harsh drugs. TB can also become resistant to these medications and evolve into drug-resistant tuberculosis (DR-TB) or multidrug-resistant tuberculosis (MDR-TB).

Clinical trials bring new hope

With the urgent need to find shorter, more effective drug regimens, Médecins Sans Frontières is now participating in two clinical trials, EndTB and PRACTECAL. The EndTB trial enrolled its final patients in October 2021. In the same month, preliminary results from the PRACTECAL trial showed that its six-month, all-oral regimen cured nine in 10 patients.

OVERCOMING DRUG-RESISTANT TUBERCULOSIS IN PAPUA NEW GUINEA

TB is a major public health concern in PNG. Around 30,000 new cases each year are causing a high disease burden and death rate. Limited awareness of the disease, long distances to health facilities and misinformation are key challenges for our teams.

In Port Moresby, Médecins Sans Frontières is working with patients to strengthen prevention, diagnosis, and treatment in the National Capital District, at a clinic in Gerehu General Hospital and at the newly opened Six Mile Clinic. We also run an education outreach program to prevent the spread of the disease.

Executive director Jennifer Tierney recently returned from Port Moresby. In this Q & A, she explains how we are addressing TB in PNG, and the emphasis we are placing on patient-centred care.

“Papua New Guinea is a slow-rolling emergency which does not always get the headlines”

– Jennifer Tierney, executive director

Why is Médecins Sans Frontières in PNG?

There are huge challenges in the country: everything from non-communicable diseases to sexual violence to communicable diseases like TB. In addition, there are low vaccination rates, lack of access to primary healthcare, and lack of appropriate medical staff and resources.

We have been working there on and off since 1993, and right now, the focus of the project is on TB and its drug-resistant and multidrug-resistant forms.

Two in three people with drug-resistant TB aren't getting the treatment they need. We are trying to make sure that people finish their treatment because it is tough and long, and it is important that they do – so that we do not have more people with drug resistant TB in the community.

What are some of the impacts of the project?

At Gerehu we saw dozens and dozens of patients waiting outside the TB clinic to be triaged and tested. Each test then went to our sophisticated lab, which determined whether or not this was a standard case of TB that could be treated in about six months, or whether it was DR-TB that would mean a much more complicated and longer course of treatment.

The new Six Mile Clinic is an expansion of our services for MDR-TB. That is going to be fantastic for the community, because we will be able to do better testing, and patients in that area will have access to treatment.

Can you talk more about patient-centred care in the project?

This was what struck me about our team there: the fact that they were really focused on patient comfort. For patients and families waiting outside the clinic, sitting out in the elements, it can get very hot, and also rainy. This is what we talk about in terms of patient-centred care – really thinking about the experience of the patient from start to finish. So now we are going to start construction of some basic covering, possibly with fans for cooling, so that people feel comfortable when they are there.

As I was touring the clinic, there was an elderly gentleman who was there to take his medications, his 11 pills, through what is referred to as ‘directly observed treatment’. Looking at him that day, sitting there, it was clear that the trip to get there had exhausted him. One of the really important things that we are doing is trying to ensure that patients like this can receive treatment at home, so that they do not have to travel to the clinic or have additional stress on them when they are feeling unwell. We are doubling down on community health, making sure that our health workers can go out and support patients, instead of them having to come to us.

Did this process unearth other findings?

Now that we have started to do mobile ultrasound to detect TB in the lungs, we are also finding a lot of patients with tumours. Cancer in PNG is a neglected disease. The question now is how to help these patients who have cancer, where we do not actually have a cancer program.

Because cancer presents so much like a neglected disease in PNG, we are looking at potentially supporting a cancer project in Lae and in the surrounding areas. A team will be evaluating how we might execute that project in the coming months.

What will help drive that decision?

If we do get involved with this cancer program, it will be a matter of partnering with organisations that are already working on the ground with the National Department of Health. It is such a massive challenge that we could not handle it on our own.

The continued support and generosity of our donors is what really helps us to make decisions about where to invest based on the disease burden, as opposed to how much it costs to treat a patient. Our whole project in PNG is really a study in how important it is for donors to stick with us and stay by our side.

Reflecting on your visit to PNG, what is it about this program that you most grateful for?

I am grateful for the amazing capacity of the PNG and international team to be able to respond as they do. They are driven, ambitious, hardworking, compassionate people who are coming together from around the world with only one thing in common, which is that they want to make the world a little bit better by supporting our patients – just like our donors.

I walked away being reminded of what this movement, and this big project, are all about.

PATIENT STORIES

“I had already written my Will”

Nhlanhla Mshengu from KwaZulu-Natal, South Africa felt like he would never recover from TB until he enrolled in the PRACTECAL clinical trial. From that moment his life changed:

“I had been diagnosed and put on a pulmonary TB treatment for over a year before it was discovered that I had MDR-TB.

During the time when I was still using the ordinary TB treatment, I used to suffer a lot because my condition would stay the same for months.

At this stage I had given up hope and had written my own Will. I thought I would never survive this ordeal, until I was referred for MDR-TB treatment.

My condition improved drastically to such an extent that it took me only one month to get out of bed and return to my workplace.

It is through the good work and patience of the trial staff that I bear testimony that even MDR-TB can be cured, and it is my plea to all those, like me in the past, who have lost hope in the health system to believe once again and give it a try.”

CONFRONTING THE HIV/AIDS PANDEMIC

Nearly 38 million people were living with the human immunodeficiency virus (HIV) at the end of 2020, most of them in sub-Saharan Africa.

HIV lowers the body's immune response, and without effective treatment, leaves people much more vulnerable to deadly opportunistic infections like tuberculosis (TB).

While there is no cure for HIV, a combination of drugs, known as antiretrovirals (ARVs), enable people to live longer, healthier lives if taken regularly. The cost of first-line drugs is now cheaper than ever, but efforts are still needed to ensure people living with HIV receive lifesaving treatment.

The impact of COVID-19

The COVID-19 pandemic has had an additional impact, causing a reduction in the number of people able to start ARV treatment, and to remain in care. That situation is expected to worsen, as we see an increase in people living with HIV, and co-morbidities like TB and severe bacterial and fungal infections. As Leena Menghaney from Médecins Sans Frontières' Access Campaign said:

“The COVID-19 pandemic must not be an excuse to divert attention from HIV. HIV is not an easy virus to defeat, and we cannot be complacent in our response to the epidemic.”

Our response

One-fifth of all AIDS-related deaths, and for children, four out of every 10 deaths, in the world occur in countries in West and Central Africa. We continue to reach out to people living with HIV, with immediate and intensified action for early detection and treatment.

PATIENT STORIES HIV AND SELF-CARE IN ESWATINI



Nombulelo Ndlovu, a counsellor in Médecins Sans Frontières' HIV and tuberculosis prevention and treatment program in Shiselweni district, Eswatini. © MSF, 2021

“Self-testing gives you the freedom to know your HIV status”

Every year in Eswatini 1 in 100 adults becomes HIV positive.

HIV testing can now be done in two ways – the conventional finger prick and self-testing. The convenience has given women in particular the motivation to take their health into their own hands, explained Nombulelo Ndlovu, Médecins Sans Frontières HIV counsellor in Eswatini. In our program there, people can be tested for HIV at our container clinic, and if they are negative, are provided with self-testing kits to use at home.

“They are able to take charge of their own health,” Nombulelo said. “Women get empowered and encourage other people to get tested as well.

“We really encourage women to continue testing for HIV so that they always know their status. This will ensure that even if they still are HIV negative, they are able to continue to protect themselves and remain negative. Likewise, if they happen to receive a positive result, we assure them that life goes on. All they need to do is go to the nearest clinic where they will get all the necessary assistance and be able to start ARV treatment.”

Patient Thoko* added: “When HIV first came there was a lot of stigma around it, and we were all scared. If you have it you are not really accepted into the community. So generally, we have always been terrified by the idea of going to hospital to test for HIV.

“After some time, it emerged that the relatives that I was assisting were HIV positive. So, I then went to get tested. I locked myself in my bedroom, took the test and waited. One line appeared next to the letter C, which meant that I was negative. I was then able to tell my siblings about it. What I like about self-testing is that it gives you the freedom to know your HIV status without anyone else knowing. With self-testing you always know what your status is.”

PATIENT STORIES

Offering care and hope relentlessly

South Sudan is one country where we provide a comprehensive package of care. With the right medications and enough to eat, people with HIV can live long, healthy lives. But what happens when you live in a place where access to these basics is a challenge? Dr Ebenezer Ngwakwe, who worked in our project in Old Fangak, recalls a young mother named Nya-Cece*:

“She walked into my clinic quietly, with her five-month-old baby wrapped up in her arms. I could easily see the overwhelming emotions she was trying so hard to conceal, as tears started streaming down her face. This was one of numerous similar encounters that would characterise my 11-month assignment with Médecins Sans Frontières.

Old Fangak is a region in the north of the country, transacted by the river Phow. There are no telecommunication networks, no tarred roads, and no cars, only boats. Every evening, as we ride the boat back to our compound, the breath-taking sunset, the chirping birds, the lush green bushes by the riverside, the sound of water splashing on the boat and children swimming by the riverbank, temporarily relieves you of all the memories of the suffering sick people in the hospital.

Nya-Cece is in her early 20s, had her first child at 14 and now has a new baby with a soldier husband who lives far away in another community and hardly ever visits.

The tears rolled down her face as she spoke. ‘I feel all alone, I have no one. My father does not care about me because I had my first child outside marriage. He says I brought shame to his family. My mother remarried and left with her new husband. Now, here I am, HIV positive, with no money, no job and almost no food for my boys.’

Listening to her, I knew this was the exact reason I joined Médecins Sans Frontières, to help people like her.

With the help of our HIV counsellor, we offered Nya-Cece medical care, psychosocial support and linked her to another organisation that provides food. Through this kind of work, we now have 120 patients enrolled in HIV treatment in Old Fangak, up from zero three years ago.

Still, the HIV situation in Old Fangak is very challenging. According to UNAIDS reports, about 190,000 people are living with HIV in South Sudan. Being the major healthcare organisation in Old Fangak, we provide a comprehensive HIV care package via a six-days-per-week HIV clinic that provides counselling and testing services, consultations, in-patient management of opportunistic infections, viral load assays, prevention of mother-to-child transmission, and community HIV awareness campaigns.

Perhaps the most heart-wrenching thing I have noticed during my time in Old Fangak is the glaring gender inequality in a traditional culture. Like Nya-Cece, most young ladies are already married and have at least one child by the time they turn 18. They mostly do not have any formal education; therefore, they have no jobs and it is hard for them to earn money.

I near the end of this assignment with a deep appreciation for our relevance in Old Fangak. Nya-Cece is just one example. I saw her again later and she was doing much better, taking her medications regularly and taking care of her boys.

Looking back, it has been an impactful 11 months of offering care and hope relentlessly.”

PATIENT STORIES

Our decision to remain in Myanmar

For over 20 years, we have been at the forefront of Myanmar’s HIV response pioneering antiretroviral treatment and at one point becoming the largest provider of antiretrovirals in the country. During recent years, we have been strengthening the government’s capacity to care for people living with HIV, with the aim of transferring our patients to its National AIDS Programme (NAP) and closing our HIV operations.

However, after the military takeover of February 2021, national doctors and nurses were among the first to lead the protests – walking out of their jobs days after. This had an overwhelming impact on the public healthcare system, including the NAP, which looks after more than 150,000 people living with HIV.

Delivering treatment for patients on the edge

Delayed diagnosis or interrupted treatment is devastating for people. It leads to increased levels of the virus in their blood, weakening their immune system and leaving their body struggling to fight off potentially deadly opportunistic infections. If HIV is not diagnosed until it is in an advanced stage, it becomes less responsive to treatment. The risk is not only for the patients themselves. Higher virus levels also increase the likelihood of transmission to others.

Although slowly recovering, the NAP is not yet able to return to accepting our patients. We have therefore reversed our strategy to downscale HIV activities in Myanmar. We are now diagnosing and initiating treatment for large numbers of new patients for the first time since 2019. And with nowhere else to receive support, NAP patients have also visited our facilities in Shan, Kachin and Tanintharyi over 7,200 times to continue their care.

Our clinics are working hard, but the level of the care they can offer varies. In Kachin state we provide drug refills, diagnosis, and check-ups, but the volume of NAP patients coming to our facilities in Shan state is so large it limits the support we can give and threatens our medical supplies. If these stocks dry up, it could cause patients to die.

Many people must travel long distances to reach our clinics, their journeys increasingly fraught with danger and insecurity. Brang Seng*, 30, who was recently diagnosed with HIV, has to make frequent visits to our clinic as he begins treatment. He said:

“The road between Chipwe and Myitkyina has been officially closed for months, so there are many checkpoints, and few drivers dare to come. I am worried about conflict escalating, which would stop me from being able to travel, and then missing my appointment, so I came earlier. I can only come when there is a taxi. They are not every day.”

* Names have been changed to protect patient identities.

THE SILENT EPIDEMIC

Hepatitis C is a blood-borne virus that attacks the liver. It is called a “silent killer” because people are often unaware of their infection, going untreated for years. They show no symptoms of the disease and therefore do not seek treatment.

Worldwide, an estimated 58 million people are infected with the hepatitis C virus (HCV). Almost 400,000 people die each year, mostly from resulting complications, usually cirrhosis or liver cancer.

Direct-acting antiviral medicines (DAAs) can cure patients in two to six months, but millions of people are not able to access treatment due to prohibitive costs.

Médecins Sans Frontières treats people with hepatitis C in several countries, and has dedicated projects in Iran, Myanmar, Ukraine, Pakistan and India.

We are also part of the Hepatitis C Partnership for Control and Treatment, or Hepatitis C PACT, set up to address the barriers to testing and treatment.



An HIV/hepatitis C patient receives a consultation at Médecins Sans Frontières office Yangon, Myanmar. © MSF/Ben Small, 2021

CAMBODIA: A BREAKTHROUGH MODEL OF CARE

“The cure rate for thousands of patients was over 97 per cent”

– Mickaël Le Paih, former head of mission

In Cambodia, three quarters of people live in rural areas with limited access to medical care. Our two hepatitis C projects – in Phnom Penh and in Battambang province – aimed to expand access to care. Working with the Ministry of Health, we have introduced innovative ways of diagnosing and treating patients.

First, all patients now receive the same treatment regardless of the type and stage of their liver disease, which means they no longer need most of the pre-treatment analysis required by earlier treatments. Second, DAAs are very safe, so additional tests and monitoring, which used to take place before and during

treatment, are no longer necessary. Patients now need only five medical consultations instead of 16, which means it is easier and more affordable to adhere to or to complete the treatment. Mickaël Le Paih, head of mission in Cambodia, said:

“We have been working with Cambodia's Ministry of Health since 2016 to enable access to treatment, simplify hepatitis C care, and integrate this model in routine health services. Once the model was integrated, the cure rate for thousands of patients remained over 97 per cent in tertiary level clinics or primary health care centres.

“This model is based on the use of rapid diagnostic tests, fewer follow-up visits and biological tests, and the transfer of many clinical tasks from physicians to nurses and pharmacists.

“We are confident that this model can be replicated in other resource-limited settings to improve access to care for people with HCV. The model should help reduce the barriers to care for the estimated 58 million people living with HCV, and thus contribute to reducing the impact of hepatitis C.”

THE CHALLENGES OF TREATING NON-COMMUNICABLE DISEASES

The prevalence of non-communicable diseases (NCDs) including diabetes, hypertension (high blood pressure) and heart disease, is increasing around the world. They make the largest contribution to mortality both globally and in the majority of low- and middle- income countries. These diseases are costly to treat because of the need for long-term medication and monitoring. But early diagnosis leads to better outcomes than treating the complicated conditions that can develop without care, such as kidney failure.

Dr Anjali Anand is a non-communicable diseases advisor providing field support and developing guidelines for their treatment. She describes the impact of these diseases on the people we support.

Why is Médecins Sans Frontières focusing on this topic now?

Of the poorest billion people, a third of them suffer from NCDs, but almost no Ministry of Health budget goes toward managing them in any of our low middle income countries. And we do not have a Global Fund for diabetes or hypertension. These are therefore people who experience lifelong disability as a result of their conditions. They have lifespans that are often 20 years shorter.

The causes of NCDs in these populations might be different, and so we often do not think of them because we are primed to focus on malaria or other infectious diseases. But NCDs are a significant burden of morbidity and mortality in these places that are just severely underfunded.

What are the main challenges in providing care?

The broadest challenge with all these diseases is that they require continuity of care. That is incredibly difficult in our contexts, partly technologically – we do not have access to detailed electronic medical records, where staff are able to pull up a patient's medical record very quickly.

In our projects, you do not have integrated care very commonly. So, you might have a file for their HIV care, a separate file for their hypertension care, and never the two shall meet, even though you know there

are treatment implications that are significant to both. There might be medication interactions, and there is not necessarily one person who is following all of that for a patient. That becomes very important with chronic diseases in general, but certainly with NCDs because, with some exceptions, these are lifelong conditions.

They travel together as well – so if you have diabetes, your chances of having hypertension are higher – and these comorbidities need to be treated together. In our projects that see a lot of patients with NCDs, we are thinking of how we can reorient clinics in a way that is more friendly towards continuity of care, where we are able to integrate the different conditions together.

Can you give us a specific example of that patient-centred care from our programs?

The project in Cox's Bazar, Bangladesh has our largest cohort of patients with diabetes – over 2,000. Around 14 per cent are on insulin, which is quite significant. A large proportion also have high blood pressure, so we have set up an NCD outpatient department where all of that care is managed at the same time, by the same clinicians.

What is nice with the Bangladesh project is that this is a pilot that is showing us the ways in which those things travel together in the same population, and how we can respond.

What latest developments are you excited about?

Epilepsy, diabetes and hypertension, because they're the ones where we're innovating.

In terms of diabetes, a lot of what we are working on is identifying models of care that enable patients to both access the medications they need, but also the devices and other accoutrements they need to manage their condition.

With hypertension, there are some very interesting things happening right now. Different types of medication formulations have been newly included on the WHO Essential Medicines List and have the potential to really simplify treatment algorithms. You will hopefully start to see hypertension following the HIV model of care, where they were able to decentralise care and get people started on therapy at lower levels of the health system.

With epilepsy, likewise, we are working on bringing newer generation medications, that have an improved

safety profile, to our patients. We are also working on community education that combats stigma. People think it is something that they can catch, for example, so a lot of what we do is reassure communities that these patients can safely be in the community. This is to ensure that our children are able to access school and that people are able to work with their condition.

Why do we need more support for these programs?

These diseases really impact our patients across the whole course of their lives. The donations we receive can, for example, support the ability of patients with

diabetes to monitor their blood sugars at home, so they have control over their condition. They can go about their lives knowing that they are not going to have a hypoglycaemic episode, where they are not able to work or go to school.

I would really encourage people to remember that their support is critical to ensuring economic output, gender parity – all of the things that we look for in ensuring equity in these populations.

Without controlling non-communicable diseases, you will never get there.



Médecins Sans Frontières nurse is examining and recording the vital signs of a patient suffering from a chronic disease at the Médecins Sans Frontières run clinic for chronic diseases in the Hawija primary healthcare centre, northern Iraq. © MSF/Hassan Kamal Al-Deen, 2022

DYING BEFORE DIAGNOSIS

Diabetes is one of the most common non-communicable diseases among the people we care for in over 70 countries. This chronic, progressive disease can be controlled; however, many people are not getting the treatment they need. Many are simply dying before being diagnosed.

Insulin, discovered almost 100 years ago, is still not readily available to people who need it. This is due to a combination of factors, including high prices, challenging storage requirements and complex treatment protocols. With your continued support, we are working to change this.

DIABETES: A SNAPSHOT OF OUR PROGRAMS

We run 20 diabetes projects across 11 countries where insulin is often not available in public health facilities or private pharmacies.

In Jordan, we treat approximately 3,600 Syrian refugees and Jordanians with diabetes, including around 600 using insulin. The package of care includes counselling and education about diet and lifestyle, as well as prescribing and monitoring insulin.

Ahmad, a 32-year-old Syrian refugee, refused to take insulin after he was diagnosed. “Dr Noor Al-Khazali, who works in the program, said: “He had very high blood pressure and oedema and no response to oral medications, so I counselled him to take insulin.” However, Ahmad was worried about the trouble of taking insulin every day: “He said it would ruin his life even more.”

With the help of our health educator, Dr Al-Khazali persuaded Ahmad to take insulin under their

monitoring. She added: “Three months later, he was so happy and said his life was completely changed. This is why I love this work.”

- **In Lebanon**, we run a continuous glucose monitoring (CGM) program for children with type 1 diabetes who are refugees. The children wear a sensor on their arm to measure blood glucose concentrations. Around 100 children have insulin pens, which are fast-acting and easier to use than syringes.

Houssam, 12, is one of our patients on CGM in north Bekaa, Lebanon. He has learned to live with the disease with the help of his parents and medical team. “I dream of travelling to Sweden to study to become a doctor,” he said.

- **In Zimbabwe**, 23-year-old Viola Makore struggled to afford the insulin she needed, and to properly manage her type-1 diabetes:

“When I was diagnosed with diabetes in 2014 I was told that I was supposed to administer and inject myself with insulin twice a day.

“My mother used to buy the medication for me from pharmacies. When she did not have money, my uncle would assist us to buy insulin and syringes. I would re-use two syringes and needles per month, yet we are supposed to use at most one needle twice a day.

“At one point, I spent the whole week without medication because I could not afford to buy it. I would only inject a little bit of the prescription so that I could reserve it for another day until we got some money.”

Viola’s health deteriorated, and she was admitted to hospital: “I remembered my mother’s friend who passed on because she was not taking insulin for two weeks. I was scared that if I could not get the medication, I was also going to die.”

In hospital Viola heard about our Manicaland NCD project, and registered. “There were so many things that I did not know that I learnt. A nurse from Médecins Sans Frontières prescribed a diet for me and advised on the food that I was supposed to eat.

“Now I can manage to control my blood sugar. Now I want to enrol in a teacher training program.”

DIABETES: STUDY CHANGES THE GAME

A study published by Médecins Sans Frontières and the University of Geneva last year showed that a range of insulins could be kept at temperatures of 25–37°C for up to four weeks. This could be a game-changer in many countries where we work, and where there is little access to refrigeration. This is especially important for self-management in diabetes care, freeing patients from clinic visits and allowing home injections. Philippa Boule, non-communicable diseases advisor, explained:

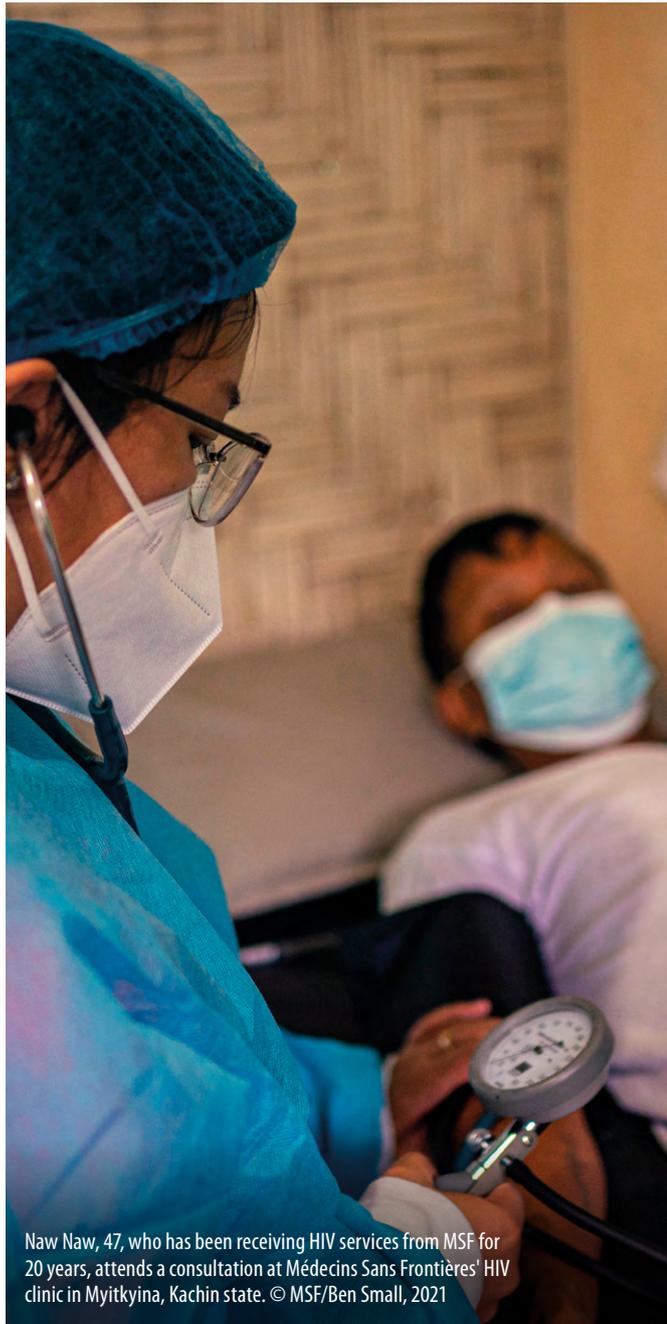
“For far too long, we were unable to send people with diabetes back to their homes with insulin due to its cold storage requirements. Some of these people were travelling long distances daily, and some even relocated to get their insulin injections at the clinic.

“The ability to self-inject insulin is a fundamental aspect of diabetes self-management and the ability of people with diabetes to be empowered.

“Additionally, we hope that pharmaceutical corporations will urgently submit to regulatory authorities for use of insulin under expanded temperature ranges. It is time to ensure that everyone who needs insulin, regardless of where they live, can access it. For too many people living with diabetes, life is difficult enough without this burden.”



Home insulin programme, Abyei, South Sudan © MSF/Musa Mahad 2022



Naw Naw, 47, who has been receiving HIV services from MSF for 20 years, attends a consultation at Médecins Sans Frontières' HIV clinic in Myitkyina, Kachin state. © MSF/Ben Small, 2021

TREATING ONE OF THE WORLD'S BIGGEST KILLERS

Increasing access to affordable, safe and essential hypertension medicines can save millions of lives.

High blood pressure, known as hypertension, kills more than 10 million people every year. 75 per cent of people with high blood pressure live in low- and middle-income countries, but despite the availability of medication, less than one in 10 is effectively treated.

In a new report issued in conjunction with Resolve to Save Lives this year, we found that blood pressure drugs can cost up to 40 times more in regions where people suffer the most strokes and heart attacks.

The report also revealed that:

- Pills combining two or more medicines are recommended as the standard, but combination pills are often unavailable or unaffordable to patients
- Current prices put treatment of hypertension out of reach of many people living in low- and middle-income countries

Helen Bygrave, chronic diseases advisor for our Access Campaign explained: “With less than 10 per cent of people living with hypertension having their blood pressure controlled in these countries, we need to reimagine and simplify how we deliver hypertension treatment. Access to single-pill hypertension combinations is an important part of this change.”

“Our lives can be extended”

Médecins Sans Frontières calls on leaders from governments, civil society and the pharmaceutical industry to make these medicines more affordable and accessible to the millions of people living with high blood pressure – patients like Olabisi Obelawo from Osogbo, Nigeria:

“Both of my parents had high blood pressure when they were young. They passed away and the same thing is happening to people in my community now. I do not want this to happen to me. Paying for my high blood pressure medicine is difficult on top of my household expenses. If we can get high-quality drugs more affordably, our lives can be extended.”



Médecins Sans Frontières doctor Dr Sara examines Shafiee Abdullah, 45, at the MSF clinic in Butterworth, Penang for treatment of hypertension and diabetes. © MSF/Kit Chan, 2022



The medical team inside the intensive care unit (ICU) of the Médecins Sans Frontières medical train monitor and stabilise a seriously war-wounded patient during the journey from Pokrovsk, eastern Ukraine to Lviv, in western Ukraine. © MSF/Andrii Ovod, 2022

NO MERCY FOR CIVILIANS IN UKRAINE

Accounts from the medical referral train

Christopher Stokes, Médecins Sans Frontières emergency coordinator reports on the toll the war is taking on civilians.

“Our patients’ wounds and the stories they tell show unquestionably the shocking level of suffering the indiscriminate violence of this war is inflicting on civilians.

Many patients on the Médecins Sans Frontières train were wounded by military strikes that hit civilian residential areas. Although we cannot specifically point to an intention to target civilians, the decision to use heavy weaponry en masse on densely populated areas means that civilians are inescapably, and are therefore knowingly, being killed and wounded.”

Over 40 percent of the war-wounded on the train have been elderly people and children with blast wounds, traumatic amputations, shrapnel and gunshot wounds. This lack of respect for civilian protection is a serious violation of international humanitarian law.

Patients and their caretakers tell unimaginable stories of civilians trapped in conflict, bombed in shelters, attacked during evacuations, and injured in explosions, by bombs, by gunshots, or by mines and shrapnel.

Some were injured in their homes. Others came under heavy weapons fire as they tried to travel to safer areas.

A 92-year-old woman from Lyman, Donetsk region, shares her harrowing experience: “I was on my way to the toilet when an explosion happened. I lost consciousness and fell. Once I came around, my face was covered in dry blood. I had an open arm fracture and a broken nose. I was alone and in pain screaming for help. Later, a volunteer found me and spent two days trying to call an ambulance.”

Médecins Sans Frontières president Dr Bertrand Draguez has issued an urgent call to armed groups to respect international humanitarian law and abide by their obligations to protect civilians:

“Allow people to flee to safety, and for the safe evacuation of the sick and wounded. Grant humanitarian access, so that we can provide aid in Ukraine, where we see indiscriminate attacks on civilians.”

EPILEPSY: A NEGLECTED CRISIS

UNDIAGNOSED, UNTREATED, MISUNDERSTOOD

Epilepsy affects an estimated 50 million people and is the world's most common chronic neurological disorder. People with epilepsy face many challenges in low-resource countries, where the disease often remains undiagnosed, untreated and misunderstood.

The disease is not curable, but 70 per cent of people living with epilepsy could live seizure-free if properly diagnosed and treated. Neurologist Léonard Nfor, who worked in our program in Liberia, explained:

“Around 80 per cent of people with epilepsy live in low- and middle-income countries, and almost three-quarters of them do not receive the treatment they need. In Africa the prevalence of this disease is very high and qualified personnel are lacking. We must therefore find a system where epilepsy can be treated despite the absence of specialists in the disease.”

In Liberia, we work with the Ministry of Health in Montserrado County to train and supervise mental health clinicians at five health centres. The clinicians diagnose and treat epilepsy and psychiatric disorders, with guidance from specialists like Dr Nfor. Medications play a key role in controlling symptoms such as epileptic seizures, while counselling also helps patients understand how to manage their condition.

PATIENT STORIES

CAST OUT BY HIS CLASSMATES

Amuchin Nango was nine years old when he suffered a head injury in a bicycle accident. He began experiencing seizures, falling to the ground, jerking uncontrollably, biting his tongue. Abraham Kollie, a psychosocial worker in our Liberia program, explained:

“His family got so confused and did not know what to do. At some point the family believed it was spiritual, like witchcraft. He was taken to many traditional healers in Liberia and Sierra Leone.”

At school, Nango suffered repeated seizures, and was shunned by some of his classmates. A common misperception is that epilepsy is contagious, and Nango soon dropped out of school. He said:

“Even the principal had problems with it. I told my mother, no need for me to attend there.”

Eight years after his accident, Nango finally found the help he needed at Médecins Sans Frontières' program in Monrovia. He was screened by a mental health clinician and eventually diagnosed with epilepsy.

A third of our epilepsy patients are school-age children, yet the majority are not attending school, often due to social stigma. Abraham Kollie added:

“After an intensive awareness raising on epilepsy with students and administrative staff, Nango was finally accepted back in school.”

Nango's symptoms are now well controlled by medication. He has graduated from high school and is working as a junior high school teacher. He is also a strong advocate in his community for the importance of seeking treatment and care for this debilitating disease.



Blessing Jelleh, shown at home with her mother Solange Jelleh, is receiving treatment for epilepsy through health a facility we support in Montserrado County, Liberia.
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INVISIBLE DISABILITIES

A TREATMENT CHALLENGE

Invisible disabilities are conditions that interfere with people's day-to-day functioning but are not immediately apparent to others. Some examples include:

- Chronic illnesses with disabling conditions (such as HIV, asthma, diabetes)
- Consequences of severe reproductive health complications (obstetric fistula)
- Certain cardiovascular diseases
- Neurological conditions (such as epilepsy)
- Blindness and vision impairment
- Mental illnesses with disabling conditions (anxiety, depression, bipolar disorder)
- Learning disabilities (dyslexia)
- Attention Deficit-Hyperactivity Disorder (ADHD)

With training and sensitisation of medical staff, collaboration with community-led organisations,

tailored services and a rights-based approach, we continue to work towards more inclusive interventions, so that people living with invisible disabilities are able to participate in society on an equal basis.

WOMEN AND GIRLS AT GREATER RISK

Women are overrepresented among persons with disabilities. Reproductive health is one of the key factors putting women at greater risk of acquiring a disability in their lifetime, explains women's health advisor Dr Séverine Caluwaerts:

“In most settings where we work, the risks of reproductive health complications are high. One reason for this is difficult access to family planning. Another is distance to health facilities. In Sierra Leone, I met women who had travelled for days to get a lifesaving caesarean section for obstructed labour; some of the women would end up with an obstetric fistula or with a drop foot due to nerve injury.”

PATIENT STORIES

WOMEN SHOULD BE SEEN

Tens of thousands of women in South Sudan suffer from obstetric fistula due to a birth injury. Midwife Sonja Kalsvik recalls a memorable patient from the 'fistula village', one of our projects there:

“There is this amazing sisterhood here, a family like no other. The women celebrate every night until the small hours the fact that they have finally met someone like themselves and found hope for a cure. They savour the new found sense of belonging and acceptance. I cannot explain this sisterhood with words, but it is one of the most beautiful things I have ever seen.

Obstetric fistula is a condition that can be prevented but continues to affect millions of vulnerable women. While it is possible to repair a fistula, the procedure is complicated and few surgeons master it. Since the condition is virtually absent in Europe, doctors are not taught how to treat it. Some hospitals in African countries do train surgeons to perform the operation, but treatment remains very costly and demands long hospital stays. Most importantly, it requires the conscious and considerable effort of identifying women affected by fistula and letting them be seen.

A smiling 17-year-old

I first met Agok when she was getting ready for her second operation. A smiling 17-year-old, Agok is cheeky and likes to dance. One and a half years earlier, she was pregnant with her first baby, excited and ready for life's new wonder. Nothing went as planned. She was in labour for days, but the baby did not come out. Its movements got fewer and weaker – until they stopped. Fearing for Agok's life, her

family called for a “spear doctor”, a traditional healer believed to have unnatural power. He removed the dead child's body, saving the mother. But the damage to her pelvic floor was tremendous. Agok was left with three fistulas. She was constantly leaking urine and faeces. Still, she was among the fortunate few: when her husband divorced her and the community rejected her out of fear that she might have a demon, the family greeted her back. They have cared for her since.

Six months earlier, she had undergone her first surgery, which had closed one of the fistulas. With two more fistulas left, the heavy leaking continued. It was so bad that we sent Agok home with a special bed – the one used in treating cholera cases, with a hole in the middle – to ensure that she would not sleep in her own urine and faeces. I still remember Agok's smile when she returned to the fistula village, carrying the bed she hoped she would no longer need. In the second surgery, we closed the fistula between rectum and vagina. This is a simpler procedure, and Agok could travel home one week after the surgery. I would not meet her until six months later, when she came back for her final operation.

Agok knew that she would have to use a urinary catheter for five weeks post-surgery, but after such a long time in the fistula village, she also knew very well how to remove it. The night before the scheduled date, the girl secretly took the necessary medical tool and performed the procedure herself. I have never seen anyone dance and smile so much leaving a toilet. For the first time in two years, Agok actually needed one.”

HEALING DEEP WOUNDS IN GAZA

UNDIAGNOSED, UNTREATED, MISUNDERSTOOD

In Gaza the local healthcare system is overstretched, underfunded, and deeply impacted by over a decade of blockade. In 2018, Médecins Sans Frontières began offering reconstructive and orthopaedic surgery, dressing changes, physiotherapy, health education and psychosocial support to thousands of Gazans injured in the Great March of Return protests. Many patients have complex wounds that to this day need intense levels of follow-up and rehabilitation.

That patient cohort has grown substantially following an 11-day offensive in Gaza in 2021, which killed more than 250 people and left almost 2,000 injured. These patients have already faced months of surgery and are looking at the prospect of lifelong disability.

“This is a model for how to do reconstructive plastic surgery in a context like this.”

– Orthopaedic surgeon Dr Herwig Drobetz

RECONSTRUCTIVE SURGERY PROJECT COMES OF AGE

Having first worked in the program in 2019, Australian orthopaedic surgeon Dr Herwig Drobetz returned to Gaza in 2022. Despite the continued blockade and hardship, he was amazed at the transformation.

How did you find the project this time around?

“It was incredibly impressive – 5,000 times better. In 2019, I was continually emphasising that this was a unique patient collective. They have hugely complex and difficult problems, and need a surgeon who can do plastic surgery, orthopaedic surgery, who is experienced in lower limb reconstruction surgery – and that is basically like searching for a unicorn, because these surgeons do not really exist.

However, when I was there this time, the team had basically managed to make themselves a unicorn, because they have a Palestinian plastic surgeon, they have a Palestinian orthopaedic surgeon. They have managed to get the special external fixators and to get special implants. They are hands down two of the best surgeons



I have ever worked with. What is more, they are working perfectly together as an orthoplastic reconstructive unit. Worldwide there are only a few who do it to that degree. It is amazing what they are doing.

The project has gone all the way from having just the basic stuff to be nearly world leaders in this field. That is because Médecins Sans Frontières believed in it, and our supporters believed in it, and it paid off big time.”

Can you describe the patient cohort – how many are currently being treated in the program?

“It is still managing the chronic cases from the Great March of Return, and now the bombings in May last year. We also take acute cases now, like traffic accidents. We also had a case where a child played with an explosive device that he found and had a severe hand injury. We do some paediatric cases where they have congenital malformations of their limbs which is not acute surgery, but it is the same kind of reconstructive surgery.

Currently more than 200 patients have and are still receiving orthoplastic treatment, which may not sound a lot. However, every one of these patients needs at least five operations, and some of them need more than 20. These are really big reconstructive plastic surgeries, they sometimes take three, four, five hours.”



An Médecins Sans Frontières supported surgical team at Al-Shifa's burn unit, in Gaza city cleans the wound of a child after a burn injury at home. Al-Shifa's burn unit – the main referral unit for all hospitals in Gaza – where on average 270 patients are treated annually. © MSF/Tetiana Gaviuk, 2021

Can you describe what challenges you faced in treating these patients?

"They have explosive blast injuries, chronic open wounds, chronic fractures, chronic infections that were often not treated. Sometimes the fractures were treated with external fixators by another hospital. Some of the patients went to Egypt or Syria to get treatment, and then came back with an infection.

To treat them you need to make a plan, you need to see if you can save the limb. If not, you need to amputate. That is also new in the project: in 2019, it was extremely difficult to do an amputation – it was not accepted. But now, thankfully, it is becoming more and more accepted because Médecins Sans Frontières has been working hard to make it less stigmatised.

This is important because sometimes the infection is too far gone, the soft tissues are too bad. Yes, as the patient you could go around with a chronic infection, spending six months or one year battling that infection. But it is extremely draining on your immune system; you have no energy, your body constantly works overtime. Patients who were 40 years old looked 70. After we did the amputation, the very next day they became different people. They looked years younger, they had energy. It was amazing to see the transformation."

VOICES FROM GAZA

GAZANS LEFT WITH LIFE-CHANGING DISABILITIES

Hani, 26, was severely injured in the bombings in 2021: "I was about to open the door of my house when a missile hit a building nearby." With the bones in his lower leg shattered by a piece of debris, Hani was unable to move, so he waited for the bombing to end. The life-changing nature of his injuries is hard to accept. Hani will require multiple rounds of reconstructive and plastic surgery before he can walk again.

Mohammed, 31, was shot in the leg during the Great March of Return protests in 2018. He underwent more than 30 rounds of surgery over three years. He finished treatment for a bone infection and was discharged from hospital just before the 2021 offensive started:

"The pharmacy increased its prices when the bombing began, so I could no longer afford dressings or medication." Now his wounds are severely infected again and he is back in hospital.

Ahmad, 41: "I was at home when the house was hit. Two of my cousins died, and another relative was left disabled. I finally reached Al Shifa hospital and after a week I was referred to Médecins Sans Frontières in Al Awda hospital. In both hospitals, they feared the bombs were going to hit us. I had eight different surgeries and my hand was amputated. What hurts the most is that I cannot provide for my family. I was a driver, and I cannot drive without my hand. I was responsible not only for my wife and kids but also for my elderly parents."

What else inspires you about a long-term program like this?

"What is positive about this program is what it can provide. These patients need plastic surgery, antibiotics for infectious disease, physician input. They need nursing care and rehab – the whole package because it is this whole journey. That is what they are getting, and Médecins Sans Frontières is committed to stay there and to see it through. This has become a model hospital and we are thinking about having people come from overseas to learn there, to train young surgeons in this type of reconstructive surgery.

It was a huge privilege to be part of this team, to see how the surgeons put everything into the program there, and how much they care. What I also learned is that these people are resilient. They get bombed. They come back; they rebuild. They do not give up. It was inspirational."

What is important about supporting a project like this?

"This is the future of orthopaedic and plastic surgery in a conflict setting. However, all these patients need a lot of care. The operations are extremely complex, and we just need to hang in there to support them."



TRANSFORMING CANCER CARE IN LOW-RESOURCE SETTINGS

“Our mission is not just to save lives but also to alleviate suffering.”

– Alice Authier, oncology project coordinator, Mali

Around three quarters of all cancer deaths occur in low-income and middle-income countries, where people come very late to hospital, and there is a critical lack of access to diagnosis and treatment.

Beyond Médecins Sans Frontières, very few non-governmental organisations provide cancer care in regions with developing medical systems. Our strategy encompasses a three-pronged approach: cancer management projects, access to quality care, and research.

“I COULD NOT STOP THINKING ABOUT OUR PATIENTS”

Dr Ebenezer Ngwakwe was working in Old Fangak, South Sudan, when violence suddenly escalated. People fled with nothing, and our medical teams were forced to evacuate our hospital there:

“We could see women and children fleeing Old Fangak in droves, in anticipation of war. On that morning of evacuation, we discharged stable patients, and suspended all activities. The unstable patients needed continued care, so they came with us to New Fangak. Some of the South Sudanese staff evacuated with us to help care for them, while others fled Old Fangak to seek safety elsewhere.

“In New Fangak, news of our arrival spread so fast, that in no time, people started coming for medical care. We even resuscitated some war-wounded people and referred them on to other medical facilities for surgical care.

“But I could not stop thinking about all the patients in Old Fangak who would now be denied access to health care for one week. What about the patients with type 1 diabetes who depend on us for their daily insulin? What about the people living with HIV who would

need their drugs? What about the women in labour who would need obstetric care? The list goes on and on.”

ALWAYS THERE

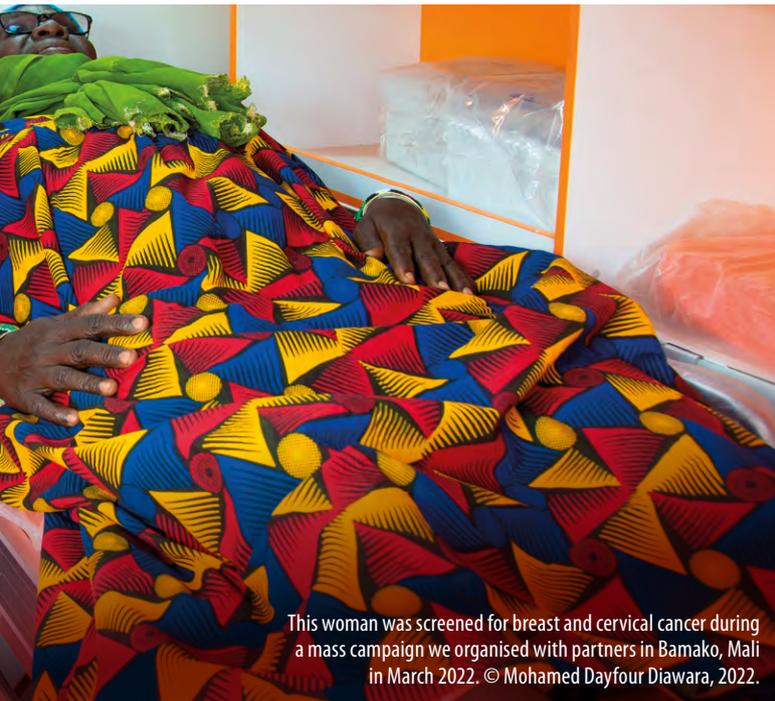
Eyewitness testimonies like these epitomise the medical humanitarian care you support in over 400 projects worldwide, where you help us adapt and innovate to maintain treatment.

While these emergencies will always require our rapid response, so too will the chronic diseases which cause millions of unnecessary deaths each year, such as diabetes, HIV/AIDS, hypertension, and epilepsy. Many of these conditions are preventable, manageable, even curable – but all need long-term treatment.

That is why we are so grateful for your support.

Long after the headlines have faded, we will be there to care for people with chronic and non-communicable diseases, to ensure they are not forgotten or neglected.

Thank you for helping us continue to care beyond borders.



This woman was screened for breast and cervical cancer during a mass campaign we organised with partners in Bamako, Mali in March 2022. © Mohamed Dayfour Diawara, 2022.

VOICES FROM MALI

During last year's Pink October campaign in Bamako, more than 5,000 women in Bamako were screened for breast and cervical cancer.

Sokono Diallo, midwife: "Women are advised to perform monthly breast screenings at home. This requires doing a home self-examination after menstruation. But annual screening in a health centre is also recommended."

Diawara, patient: "When I heard there was a free screening campaign, I decided to come. I have been screened and I am pleased to have found out I have no health issues, thank goodness."

Faye Kadiatou, cancer survivor: "I decided to get together with other cancer patients to establish an association because I had a breast removed due to cancer. Cancer that is diagnosed in time can be treated successfully. I have witnessed several cases of complete remission."

CASE STUDY

TREATING CANCER IN MALI

"Beating the disease is a race against time"

Since 2018, our teams have joined forces with Mali's Ministry of Health to assist patients diagnosed with breast or cervical cancer, explains Alice Authier, oncology project coordinator:

What support do you provide?

"Our aim has been to ensure all women with suspected breast or cervical cancer have access to screening, diagnosis, and treatment. Early diagnosis, particularly in the case of breast cancer, is essential to improving chances of survival and ensuring speedy access to treatment.

We organise information campaigns, donate equipment and provide technical assistance to midwives and nurses in Bamako's health centres. We also cover the cost of mammograms, additional examinations, medical imaging, and follow-up of patients while they are on treatment."

What packages of care are there for patients?

"There are three therapies which, depending on the stage of the cancer, can be either used together or separately. These are surgery, chemotherapy, and radiotherapy. The medical team provide chemotherapy sessions in Point G Hospital's oncology and haematology departments.

In 2020, we provided a total of 3,000 sessions. We have also refurbished a room for preparing chemotherapy to improve safety standards. When the government runs short of drugs, we supply them so that patients have access to free treatment. We also pay for patients to have surgery in Point G and in Gabriel Touré hospitals, as it is essential they can initiate treatment as quickly as possible. Beating the disease is a race against time.

Radiotherapy, which is often used to treat breast and cervical cancers, is available in Mali Hospital. The hospital has Mali's only radiotherapy machine, but as the country has a population of over 20 million, it is not enough to treat all patients. Waiting times can be long and breakdowns are common.

It should also be pointed out that radiotherapy cannot be interrupted because the effects can be more harmful than if the patient had never started it."

What are the next steps for the project?

"Palliative care, pain management, psychological and social support, care of malignant wounds – including in the home – will continue to be an important part of our work with patients.

We plan to do even more to inform women and their families of the importance of getting screened and the different treatment options available to them. We also need to increase systematic breast and cervical cancer screening in routine medical consultations. We now want to go farther afield than Bamako and set up similar activities in the country's other regions."

This project can significantly contribute to reducing cancer mortality in low-income countries. Médecins Sans Frontières could become one of the first international medical organisations to develop a global approach to patient-centred cancer care, and contribute to better access to prevention, diagnosis and treatment for cancer patients beyond our projects. It is important to remember that our mission is not just to save lives but also to alleviate suffering.



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Patients waiting for consultations with medical oncologists prior to their chemotherapy session at Point G University Hospital, Mali. © MSF/Fatoumata Tioye COULIBALY, 2021

