SERVING THE HELPLESS AN 'UNEXPECTED TONIC'

Putting herself in the face of suffering in places where nobody else wanted to go had the surprising effect of 'rejuvenating' her when she got home, says Wits-trained Médecins sans Frontières (MSF) recruit Prinitha Pillay.

She was interviewed by *Izindaba* fresh from her latest adventure in the Sudan and just before heading off to Paris for an MSF course on co-ordinating and managing emergency situations.

She spoke about her MSF work in Lesotho, India and South Sudan.

Already well-versed in HIV clinical work, including dealing with second-line drug resistance and HIV2, the dapper Lenasia-born former ANC youth league member has strong experience-based views on local adherence and delivery needs. Describing the current local medico-political climate, she said she could 'feel the disillusionment creeping in' among old activists who nevertheless somehow managed to maintain 'an unrelenting optimism', which she shared about South Africa.

New adherence models vital

'We have to work on our adherence models and find creative ways of supporting patients, especially those who've been on ARVs for a long time and are tired of standing in long queues at central clinics – we've got to look at community support.'

She believes that having created a national multiple drug-resistant TB pandemic, preventing a second-line HIV drug resistance crisis will prove a formidable challenge for the health care system.

Producing knowledgeable clinicians 'able to play around with different drug permutations', and using 'novel' first-line regimens containing Tenofovir, were urgent to avoid alienating patients via current treatment side-effects. This also means advocating for access to newer medicines, and new models of delivery.

Prinitha Pillay with Lefa Khoele, 12, her first ART patient in Lesotho in March 2006, who bounced back from a CD 4 count of 2.

Picture: Wayne Conradie

'We have to keep campaigning for price reductions, quicker registration and inclusion in the tender process, but the main thing is to get far more creative to prevent second-line resistance in the first place.'

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The two most effective measures she could think of to loosen current delivery log jams would be to train up and let nurses prescribe ARV drugs and to allow lay counsellors to conduct HIV tests.

'We simply have to move beyond the existing situation,' she said.

Pillay graduated from Wits with honours in medical biochemistry, took a year-long working holiday in the UK, and then returned to her Alma Mater to study her first love, medicine, graduating in 2003.

With an internship at the 'Bara of Cape Town' (GF Jooste Hospital on the Cape Flats), she did community service at Tintswalo Hospital near the Kruger Park before contacting MSF's Dr Eric Goemaere in Khayelitsha in January 2006. 'He quizzed me and I told him I basically wanted to do Africa and the world, so he said what about Lesotho?' MSF was about to begin an HIV project in the Mountain Kingdom which badly needed doctors (there are only 89 in the entire country). Pillay relented.

Seven-hour donkey ride to get ARVs

'It was good to lay my hands on patients who had no access and were in desperate need – some people travel

7 hours on a donkey to get their ARVs and the HIV prevalence was around 25 - 30%.'

The start-up ARV programme based in a rural health district outside Maseru put her on a steep year-long learning curve after her initial but limited experience at GF Jooste, which she described as 'an inspiring playground for the most amazing minds'.

Her next stop was Mumbai, India where she saw a 'completely different face of the (HIV) epidemic'.

Health-seeking behaviour patterns differed from local ones and there were specialists 'on every corner, and pharmacies everywhere'. Patients went from mono- to dual therapy and often defaulted for a month or more when cash strapped.

Co-infections (HIV1 and 2) and drug resistance were common, creating treatment challenges and requiring a range of drugs, some of which were 10 times more expensive than the standard treatment. MSF pioneered second-line roll-out in Mumbai as numbers burgeoned, with government dragging its feet.

After 3 invaluable months, Pillay moved on to the bleak and blisteringly hot South Sudan, a country recently emerging from a 20-year conflict, where the spectrum of tropical diseases had similarities but also some stark differences to South Africa. There was little water, no electricity, few roads and a dearth of basic health care.

MSF workers were converting an earthquake-struck building into the only secondary-level hospital in a state larger than England and training local staff to deal with outbreaks such as meningitis and cholera.

Ebola scare

Her first day proved 'scary' when an Ebola suspect who reported mild malaria-like symptoms suddenly went into massive haemorrhage upon admission and died. She helped with ensuing surveillance in neighbouring villages.

Pillay led an MSF team at a hospital in Bor that drained a vast semi-desert area populated mainly by nomadic Dinka cattle herders. While HIV, TB and malaria were common, so too was kala azar (visceral leishmaniasis, a parasitic disease), and she encountered a greater incidence of cerebral malaria, often in pregnant women who duly lost their babies.

She says working in different countries helped her feel 'part of the world – I realised that the middle of nowhere is somewhere for someone'. She saw MSF work as 'going where nobody else goes, bearing witness and speaking out for somebody who cannot – I always feel more invigorated and rejuvenated when I come back'.

Pillay successfully conducted her first solo emergency surgery at Bor in a tent, sweltering at 43°C. 'The guy doing all the surgeries fell ill and was evacuated to Nairobi. I was on call during the weekend when a 24-year-old came in with an abdominal gunshot wound. I opened her up and found 6 perforations, which I did my best to repair.'

Pillay describes this as 'one of my stronger moments – I'd never have had that opportunity were it not for MSF. You feel worthy, and in one moment I knew I was there for something good and worthwhile.'

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Focus on patient, not political mud-slinging

She said that she believed it vital to 'develop the skills to sift through the political mud-slinging we see in South Africa, get down to work and make it about the patient – it's always about the patient, it's out of that that we're able to make changes'.

Lesotho had shown her what a difference a government with political will could make. 'Half their population was disappearing and their leaders were incredibly willing and unafraid to take bold steps.' MSF had enabled her to 'posture myself between public health, human rights and clinical work'.

At 33 her world was 'just opening up – I want to be exposed to as many things as possible before deciding where I want to plant my feet, clinically speaking'.

South African-trained doctors had the 'immense luxury' of moving between resource-constrained settings and state-of-the-art health care, often doing what most could only do as consultants.

'South African doctors are so well placed to serve populations in need. With MSF I realised it was less and less about me. When I was giving more than I was taking, I was so much happier,' she added.

To find out about work opportunities with MSF visit: www.msf.org.za

Chris Bateman