THE PULSE

BRINGING MEDICAL HUMANITARIAN ACTION TO YOU

MAY 2017

MOSUL, IRAQ

URGENT CARE FOR THE SICK AND WOUNDED

Saving mothers and newborns

MATERNAL HEALTHCARE IN COTE D'IVOIRE

THE PULSE

MAY 2017
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URGENT CARE FOR MOSUL'S WAR WOUNDED

© Siegfried Modola

People queue at Médecins Sans Frontières' outdoor support clinic in Leer County, South Sudan, March 2017. Protracted conflict in Leer County is leading to extremely high levels of malnutrition.

ABOUT MÉDECINS SANS FRONTIÈRES

Médecins Sans Frontières is an international, independent, medical humanitarian organisation that was founded in France in 1971. The organisation delivers emergency medical aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. Assistance is provided based on need and irrespective of race, religion, gender or political affiliation.

When Médecins Sans Frontières witnesses serious acts of violence, neglected crises, or obstructions to its activities, the organisation may speak out about this.

Today, Médecins Sans Frontières is a worldwide movement of 24 associations, including one in Australia. In 2016, 203 field positions were filled by Australians and New Zealanders.

Front cover: Médecins Sans Frontières staff care for an infant suffering from pneumonia at Qayyarah hospital near Mosul, Iraq. © MSF/Javier Rius Trigueros

The Pulse is the quarterly magazine of Médecins Sans Frontières Australia.

Médecins Sans Frontières Australia
PO Box 847, Broadway NSW 2007, Australia
1300 136 061 or (61) (2) 8570 2600

office@sydney.msf.org
msf.org.au

facebook.com/msf.english
@MSFAustralia

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Design, artwork and production: Marlin Communications • marlincommunications.com

SURVIVING TUBERCULOSIS AND ITS GRUELLING TREATMENT

LETTER FROM CENTRAL AFRICAN REPUBLIC

BY PAUL MCPHUN

EDITORIAL

Struggling to deliver

From Nigeria to Yemen, the international aid system needs to address serious limitations in responding to acute emergencies.

In March this year, the United Nations declared that the world was facing the largest humanitarian crisis since the UN was founded – more than 20 million people in four countries were on the brink of starvation. Famine was officially declared in South Sudan, while Yemen, Somalia and Nigeria were at risk of the same fate.

While it is difficult to generalise across these four countries, what unites them is that they are all affected by brutal, complex conflicts. The nutritional crises in these four countries are not only the result of natural phenomena like drought or late rains. Rather protracted conflicts are the root cause, as displacement makes it impossible for people to cultivate or harvest foods, while food stocks are destroyed or stolen and supply routes are cut.

This is a clear emergency, caused by prolonged conflict, that requires a political solution and, until then, demands a direct and immediate humanitarian response. The main challenge however will be access for aid organisations to affected populations in volatile and insecure areas. In north Nigeria, South Sudan and Yemen, Médecins Sans Frontières teams are treating thousands of children suffering moderate and severe acute malnutrition. Our teams also treat other illnesses like malaria, pneumonia and diarrhoea that both exacerbate, and are exacerbated by, malnutrition.

But how has the situation reached this dire point? In Nigeria, for example, the conflict in Borno state that started in 2009 escalated into a major humanitarian emergency in 2015 and remains so today. There has been no political progress to arrest the conflict, only a scale up in military investment. Yet in the absence of any foreseeable resolution the aid system has been slow to recognise the crisis, and even slower to react to the nutritional catastrophe that followed in 2016.

This is just one of many such examples. In many of the places we work, the inadequate humanitarian response in the acute phase of an emergency is a stark reality. Currently there is a lack of assistance for people affected by conflict in Central African Republic and South Sudan, and for Burundian refugees in Tanzania. The traditional humanitarian system is struggling to deliver in acute crises, and particularly in conflicts.

In the international aid system, there is ongoing debate and analysis on the role of emergency, humanitarian aid that is the core business of Médecins Sans Frontières, compared with the role of long-term development approaches of many other actors. Both approaches are crucially important, in different situations, and have very different objectives.

In May 2016, the UN brought together world leaders and non-governmental organisations to try and address some of the limitations in the international aid system at the first ever World Humanitarian Summit. While the ambition was admirable, it soon became obvious there were serious shortcomings.

There was a priority focus on prevention, on long-term sustainable development strategies, but little appetite to address the serious limitations in today's humanitarian and emergency response capacity. Ultimately Médecins Sans Frontières boycotted the Summit when it was clear that addressing this crucial failure was not on the agenda.

Médecins Sans Frontières' concerns were and frankly still are, that the vision pushed at the Summit was not one of building bridges between humanitarianism and other sectors, but one where humanitarian action should be assimilated by them. As saving lives does little to address the underlying causes of crisis it is considered an area to be divested from. As a result we now risk having a well-meaning aid and development sector that is slow, inflexible, politicised and progressively less able to meet acute emergency needs today. The international *humanitarian* system falls well short of its good intentions.

To be clear Médecins Sans Frontières is not anti-development nor anti-'localisation', another theme championed at the Summit. Most of our staff are local to the countries where we work, and we invest substantially in their training and local infrastructure. Empowering, supporting and partnering with local organisations is essential and perfectly feasible in many situations, but can be hugely challenging during acute emergencies and conflict. Timeliness seems to have been dropped as an ambition of effective humanitarian response. Relying on local organisations is presented as one way to overcome this, but these organisations often lack capacity, and can be inherently compromised in their neutrality in conflict settings.

Médecins Sans Frontières has been directly witnessing significant structural deficits in the emergency aid system in terms of logistics, security management and negotiated access. We see organisations (specifically UN agencies) refusing to even temporarily adapt fee-based approaches in hospitals despite influxes of thousands of displaced people who are destitute and unable to pay for care. We see organisations rejecting offers of support and defending emergency program coverage they have yet to implement as they wait for concept approval and funding. We see organisations simply unable to shift into an emergency gear when required, something even Médecins Sans Frontières is not immune from.

Working in conflicts is difficult, dangerous, messy and expensive. We often see a sector that is becoming conservative, risk-averse and cost-obsessed, rather than needs-oriented. We see programs established where it is most accessible and convenient, over where the needs may be greatest. There is a growing emphasis on protection of staff and assets over the humanitarian imperative to "stay and deliver".

As the nutrition crisis becomes more acute, and the appeal for assistance in the face of famine ever louder, we must answer the call from our patients in places like Yemen, Nigeria and South Sudan who demand firstly an end to conflict, and secondly a more responsive humanitarian system that can step up and meet their needs, however challenging that is. Our issue is not with the existence of a global agenda for sustainable development aimed at ending need. It is with the absence of an agenda to address the current failings of the emergency humanitarian system.

Paul McPhun
Executive Director
Médecins Sans Frontières Australia

NEWS IN BRIEF

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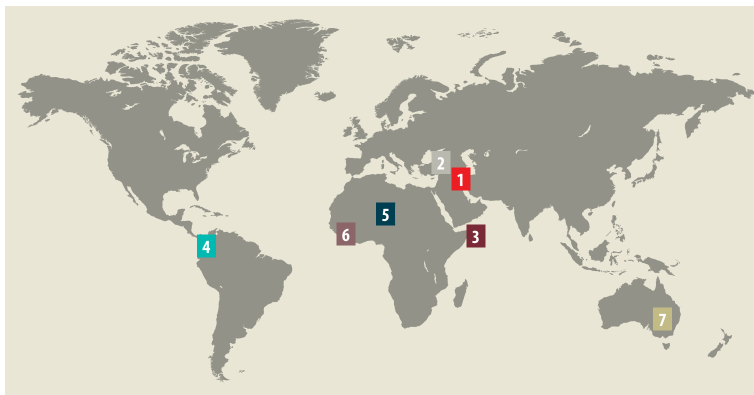
300,000 consultations carried out in 2013 by Médecins Sans Frontières in Somalia

MEDECINS SANS FRONTIERES DIRECTLY OPERATES **4 health facilities** in northern Syria and supports more than **150 health facilities countrywide**

MEDECINS SANS FRONTIERES HAS WORKED IN COLOMBIA FOR 15 YEARS, PROVIDING PRIMARY, MENTAL, SEXUAL AND REPRODUCTIVE HEALTHCARE



1 IRAQ

"That was the most dramatic thing about this field placement: kids being shot, even toddlers being shot. That was an emotional experience for the team, and there were plenty of tears shed, including my own."

– ANAESTHETIST DR KEVIN BAKER DESCRIBES SOME OF HIS PATIENTS IN MOSUL, IRAQ.
READ MORE ABOUT DR BAKER'S WORK ON PAGE 6.

2 SYRIA

Symptoms consistent with chemical weapons attack

BACKGROUND:
More than 70 people died in an airstrike on the town of Khan Sheikhoun in Idlib governorate, northern Syria, in early April according to widespread media reports. Several victims of the attack were brought to Bab Al Hawa hospital, 100km north of the town, where a Médecins Sans Frontières medical team supports the emergency department. Eight patients showed symptoms consistent with exposure to a neurotoxic agent such as sarin gas. The symptoms included constricted pupils, muscle spasms and involuntary defecation.

ACTION:
The Médecins Sans Frontières team provided drugs and antidotes to treat patients, and protective clothing for medical staff in the hospital's emergency room. Our teams also visited other hospitals where victims of the attack were being treated, and reported that victims smelt of bleach, suggesting they had been exposed to chlorine. These reports strongly suggest that victims of the attack on Khan Sheikhoun were exposed to at least two different chemical agents.

3 SOMALIA

Return to Somalia

© Sven Torfinn/PANOS
Women outside therapeutic feeding centre, Somalia, 2011.

BACKGROUND:
After 22 years of continuous operations, Médecins Sans Frontières withdrew from Somalia in August 2013 following a series of extreme attacks on staff with the tacit acceptance – or active complicity – of armed groups and civilian authorities. Since withdrawing, Médecins Sans Frontières has continuously monitored the situation to assess whether conditions allow our staff to operate safely, and patients and health facilities to be protected from violent attacks.

ACTION:
Médecins Sans Frontières plans to resume work in Somalia in the first half of 2017, taking a limited approach for now. Somali and international staff intend to provide support to the emergency department, inpatient department, paediatric ward and therapeutic feeding program at Mudug regional hospital, Galkayo North, in Somalia's Puntland region.

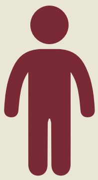
4 COLOMBIA

Medical and psychosocial care for landslide survivors

© Angel Cabello
Médecins Sans Frontières provides assistance to survivors of the landslides in Mocoa region, Colombia.

BACKGROUND:
In the early hours of 1 April, heavy rains triggered landslides in several parts of Mocoa, southern Colombia. The avalanche of mud and stones is reported to have killed and injured hundreds of people, affecting more than 3,000 families.

ACTION:
Within hours of the disaster Médecins Sans Frontières dispatched an emergency team from different parts of Colombia, where we were already working on different projects. After assessing the humanitarian needs, the team began providing mental healthcare and primary health consultations both within the community and at a shelter for those affected by the disaster. Psychologists aim to help people cope with the loss of their loved ones and their homes, and to restore normality after the disaster that destroyed more than 17 neighbourhoods in the area.



EVERY DAY, **1,300 children** die from rotavirus worldwide

JOIN OUR TEAM

Find out more about becoming a Médecins Sans Frontières field worker at one of our upcoming webinars and recruitment information evenings. Additional information evenings are scheduled in Australian and New Zealand cities throughout the year.

INFORMATION EVENINGS

Tues 4 July ***Webinar***
Tues 11 July ***Darwin***
Tues 8 Aug ***Melbourne***

PAST WEBINARS ARE ALSO AVAILABLE ONLINE TO WATCH ON DEMAND.

Visit **msf.org.au/recruitment-events** for more details.

5 NIGER

A child is examined as part of the rotavirus clinical trial in Niger.

© Séverine Bonnet / MSF

New vaccine a 'game changer' against rotavirus

BACKGROUND:

Rotavirus infection is the leading cause of severe diarrhoea and kills an estimated 1,300 children each day, primarily in sub-Saharan Africa. Diarrhoea is the second biggest cause of death in children under five worldwide. Most of these deaths occur in low-income countries where access to water, sanitation and medical care is limited. Currently, two vaccines exist against rotavirus, but they must be kept refrigerated at all times.

ACTION:

Médecins Sans Frontiéres, along with several partner organisations, has conducted a trial of a new vaccine against rotavirus involving more than 4,000 children under two in Niger's Maradi region. The vaccine was found to be safe and effective against rotavirus, with the results of the trial published in the *New England Journal of Medicine*. The new vaccine—known as BRV-PV—is cheaper than existing vaccines, specifically adapted to the rotavirus strains found in sub-Saharan Africa, and does not need to be refrigerated. This will make it much easier to reach communities in remote areas that have limited access to health services. Ultimately it could prevent large numbers of children from dying of diarrhoea in sub-Saharan Africa.

6 GUINEA

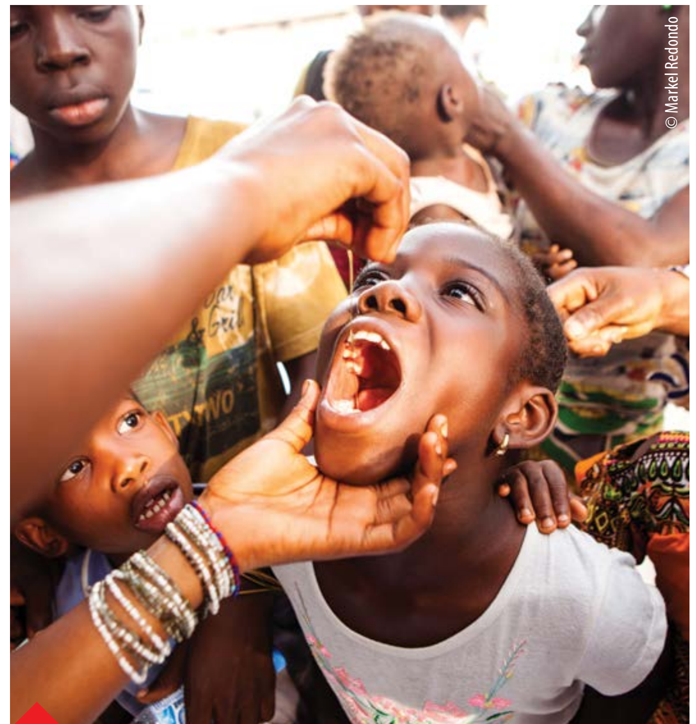
Up to 1 million children protected against measles

BACKGROUND:

A large measles epidemic has been declared in Guinea, including in the capital Conakry, with almost 3,500 confirmed cases since the start of the year. Routine vaccination was drastically reduced during the 2014-15 Ebola epidemic, because resources were instead directed towards Ebola management and as people avoided health facilities due to fear. Vaccination activities were also suspended because of infection risks, leaving thousands of young children unprotected against preventable diseases.

ACTION:

Médecins Sans Frontières along with the Guinean Ministry of Health has launched a large-scale measles vaccination campaign in Conakry, targeting all children aged six months to 10 years – an estimated population of 1 million. The campaign involves 126 teams of 13 people, spread out across 164 vaccination sites. Médecins Sans Frontières also supports 30 health centres in Conakry for children with mild cases of measles, as well as a hospital referral centre for severe cases.



© Markel Redondo

A child is vaccinated during the first day of the measles vaccination campaign in Guinea.

7 AUSTRALIA

Médecins Sans Frontières wins public health award

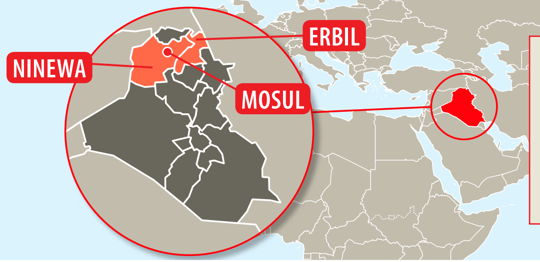
Médecins Sans Frontières is honoured to receive the World Federation of Public Health Associations (WFPHA) 2017 Organizational Excellence Award. The award recognises outstanding contributions to public health by a non-governmental organisation or institution working to promote health and to prevent disease and injury.

The award was presented at the World Congress on Public Health on 5 April in Melbourne. President of the WFPHA, Dr Michael Moore, says it is appropriate "to acknowledge the outstanding contribution of Médecins Sans Frontières to world health. Not only is their contribution made by ensuring treatment of those in need, but Médecins Sans Frontières has committed serious resources to preventive activities."

IRAQ

38 MILLION POPULATION (APPROX)

1,600 FIELD STAFF



MOSUL IS IRAQ'S SECOND BIGGEST CITY

IN 2017 TO DATE, AUSTRALIANS AND NEW ZEALANDERS HAVE FULFILLED **28 FIELD PLACEMENTS IN IRAQ**

Urgent care for Mosul's war wounded

As fighting rages in Mosul, Iraq, civilians are caught in the middle with limited access to lifesaving medical care.

Since the offensive to retake the city of Mosul from the so-called Islamic State started last October, hundreds of thousands of people have been displaced and those who remain face extreme difficulty reaching healthcare.

Many have been wounded or killed, often as the frontline moves through their neighbourhood.

A high-intensity urban war

"We are seeing every kind of war injury you can imagine – multiple gunshot wounds, blast injuries and severe burns. We are trying our best to deal with the medical effects of a high-intensity urban war unleashed on a trapped population," says Jonathan Whittall, who recently worked as Field Coordinator in Médecins Sans Frontières' field trauma hospital to the south of Mosul.

"There is a near constant flow of patients and every single one comes with horrific stories. An entire family killed, with only one survivor. A baby arrived with a bullet wound. A severely malnourished 21-year-old man with a blunt trauma to the head from a rifle butt was stretchered in."

As well as the countless directly wounded, the severe disruption to the healthcare system has left many others unable to access desperately needed medical care, including people with life-threatening conditions such as heart disease, or pregnant women in need of emergency caesareans.

Boosting activities

Since the start of the offensive Médecins Sans Frontières has boosted its activities, offering lifesaving stabilisation, emergency medical care and surgery in several locations both within Mosul city and surrounding areas. Teams are also providing long-term post-operative care with rehabilitation and psychosocial support for wounded who have been treated in field hospitals in Mosul.

In a hospital in East Mosul, Médecins Sans Frontières runs the emergency room, operating theatre, maternity and inpatient department. An average of 35 to 40 babies are born every week.

Médecins Sans Frontières' field trauma hospital to the south of Mosul city has been flooded with patients (see testimony from Dr Kevin Baker, right). Most are war-wounded civilians and around half of all patients are women and children.

Médecins Sans Frontières is also providing primary healthcare and psychological support in camps for people fleeing war and instability across Iraq. More than 4,800 medical consultations plus 4,300 mental health consultations were provided in January and February.

Difficulty reaching healthcare

It is extremely challenging for people to reach healthcare facilities in the middle of this intense conflict, with reports of many people trapped in their neighbourhoods.

"They often arrive barefoot and covered in mud after having walked in the rain, across front lines in darkness, with literally nothing but the clothes on their back," says Jonathan Whittall.

In 2016, throughout Iraq, our teams carried out over

195,000 outpatient consultations

23,766 mental health consultations

MORE THAN **430,000 PEOPLE HAVE BEEN DISPLACED** IN MOSUL SINCE OCTOBER

FEB 19 - - - - - > APRIL 2

THE TRAUMA HOSPITAL IN THE SOUTH OF MOSUL (BELOW) SAW **1,135 WAR WOUNDED PATIENTS**

© Alice Martins

Dr Kevin Baker, far right, and colleagues attend to a patient in Mosul, Iraq, March 2017.

> "Many have been living under siege and trapped for months, they have not eaten in days and are afraid and bewildered."

"Beyond the extent of their injuries, the state in which our patients arrive is also extremely disconcerting. Many have been living under siege and trapped for months, they have not eaten in days and are afraid and bewildered."

Mental healthcare is also a key part of Médecins Sans Frontières response in several locations. Our multidisciplinary teams treat moderate and severe mental health conditions, including post-traumatic stress disorder, depression, anxiety and schizophrenia.

Most of our staff are Iraqi, and for those from Mosul, many have themselves been directly affected by the war.

"Our hospital is surrounded by destroyed homes. Everyone has lost someone in this war."

"There were plenty of tears shed, including my own"

Médecins Sans Frontières' field trauma hospital to the south of Mosul.

© MSF

Dr Kevin Baker, pictured left, an anaesthetist from Sydney, recently spent a month working in Médecins Sans Frontières' trauma hospital to the south of Mosul.

"We were almost overrun by the numbers initially. After an initial triage process we received the code-red patients, such as those with gunshot wounds to the chest or abdomen. People who had typically lost a lot of blood. Near-death experiences basically. One day we received 100 patients, but 40 to 60 patients was a fairly typical day.

Because of the sheer numbers and the time constraints, we were only able to do damage control surgery. If the surgery was expected to take more than 1.5 hours then the next person waiting wouldn't make it, so we were working on the principle of 'doing the best for the most'. We aimed to stabilise patients before transferring them to another MSF facility in safer grounds where they could have more surgery.

The facilities are remarkable, with all the required surgical and anaesthetic equipment. There's one operating theatre in a shipping container on the back of a truck, which is claustrophobic at first, but just brilliant once you get used to it. Then there's a second operating theatre in a tent and a recovery room with an intensive care unit, where we would maintain patients before transferring them.

The injuries we were seeing were predominantly gunshot wounds. There was a remarkable number of children under 15. Many of these kids weren't hit by a stray piece of shrapnel – but appeared to suffer sniper wounds. It seemed they had been intentionally hit. That was the most dramatic thing about this field placement: kids being shot, even toddlers being shot. That was an emotional experience for the team, and there were plenty of tears shed, including my own.

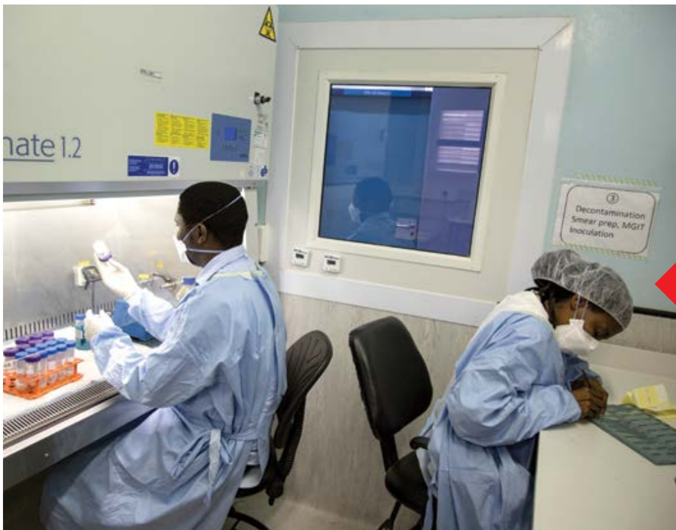
There was one little boy who had a gunshot wound in the neck and had apparently been lying in a gutter for several days. It initially appeared that the bullet hadn't gone too deep, but we soon realised that it was no wonder he hadn't moved, because the bullet had transected his spine at about the T2 [upper chest] level. He was still breathing, but had become paralysed below chest level. It was remarkable that he had survived; hard to believe actually. We sent him to Erbil to see what surgery they could do, and there can be some healing with the spinal cord. But it's hard not to think about what's ahead for a little boy like him, how difficult his life is going to be.

Some of the things I saw were like a scene out of World War Two. Two of our patients were husband and wife who had been separated as they fled. And there they were, reunited in our medical tent, clutching each other, just weeping and laughing, with their baby suspended between them. It was incredible to witness.

It was a difficult mission, and everyone worked incredibly hard. Most of our staff were local Iraqis, who were brilliant. The whole experience for people working there is exhausting, overwhelming, but humbling somehow… an experience that probably all of us will be a bit damaged by initially. I think it's the sheer numbers of patients – and particularly the number of children."

Surviving TB – and its gruelling

A Médecins Sans Frontières doctor examines a man suspected of being infected with TB in Manzini region, Swaziland.



Lab technologists prepare sputum samples at the National TB Reference Laboratory in Mbabane, Swaziland. Médecins Sans Frontières supports drug-resistance diagnostics at the lab.

A man with multidrug-resistant TB undergoes an audiological evaluation to assess whether the treatment is affecting his hearing.

treatment

Swaziland has one of the highest rates of drug-resistant tuberculosis (TB) in the world. Treatment can last years and have severe side effects including debilitating nausea and permanent deafness.

Norma* lost her hearing as a side effect of the drug-resistant TB treatment. Médecins Sans Frontières is providing sign language training for patients who have lost their hearing due to TB treatment.

A Médecins Sans Frontières team pays a home visit to a patient who has been diagnosed with extensively drug-resistant TB. Where possible, Médecins Sans Frontières provides home-based treatment and support to minimise disruption to patients' lives.

Norma's young neighbour has also begun learning sign language so they can continue to communicate.

* Patient names have been changed to protect privacy

LETTER *FROM*
CENTRAL AFRICAN REPUBLIC

Swimming against the tide of childhood illness

Dr Katie Treble is a British critical care doctor who has worked in Australia since 2012. She is currently working in a paediatric hospital in Bria, a rural town in the Central African Republic. This is her first assignment with Médecins Sans Frontières.

Dr Katie Treble with a young patient in Bria, Central African Republic.

I arrived in Bria in early February and when the tiny propeller plane touched down on the red dirt airstrip, I felt like I had landed on Mars. The landscape, language, culture, climate and way of life were all utterly alien to me, and as we skidded to a halt, I goggled out the window at the incredible moonscape that was to be my home for the next six months. To say that it's hot and bustling here would be an understatement. I got off the plane, and instantly my eyelids started sweating to the point where I almost blinded myself. Mosquitoes mauled all my exposed skin. Everyone was yelling at me in French, but suddenly the only French I could remember was how to order a croque-monsieur, which was unfortunately absolutely out of the question. I was as far from cheese on toast as I'd been in my life.

Bria is home to about 45,000 people, plus a few extra thousand in refugee camps, displaced by nearby rebel fighting. The roads are ochre dirt tracks lined with mud-brick huts. People cook on open fires, rubbish is piled up and burnt on the roadside, water is pumped from wells and the electricity comes from generators run on fuel driven overland by trucks, which get periodically stopped by bandits, leaving Bria in the dark. Huge mango trees shade the town from the fierce sunshine, and people in fabulously brightly coloured outfits balance enormous cargoes on their heads.

A hungry country

There is a distinct lack of anything resembling a functioning infrastructure here. Healthcare in rural towns like Bria is almost non-existent, other than what is provided by Médecins Sans Frontières and a couple of other NGOs. There is one hospital, and Médecins Sans Frontières controls all the paediatric services. My job is to be part of a team of five paediatric doctors: together we run an emergency department, an Intensive Care Unit (a tent), a neonatal unit and an inpatient ward (another tent) – about 40 beds in total. Our nurse-run outpatient clinic sees between 100 and 150 children a day, the emergency department sees 20 to 40 urgent cases a day, and any sick neonates born in the maternity ward come into our neonatal department.

Even though I have been a doctor for nearly eight years and I thought I'd seen my fair share of sick kids, it turns out I hadn't seen anything 'til I got here. The Central African Republic is one of the poorest, hungriest countries in the world, with one of the highest infant mortality rates. The majority of kids who come through my emergency department are so much sicker than any child I've ever seen in the west, and have diseases I've only read about in textbooks. Everything is severely, severely severe: meningitis,

To read more letters from the field, please visit: **www.msf.org.au/stories-news**

A girl who is receiving treatment for malaria in Médecins Sans Frontières' paediatric hospital in Bria.

© William Daniels/Panos Pictures

BY KATIE TREBLE

pneumonia, malaria, necrotising fasciitis [a flesh-eating disease], whooping cough, burns, dehydration, anaemia. Haemoglobins of 2-3 are nothing out of the ordinary here (normal is >13). A lot of the children are malnourished and weak before they even get sick, and many live far away in camps for displaced people where they are visited occasionally by our mobile outreach clinics, so they're usually desperately unwell by the time they reach us. A 19-year-old mother cycled 100km with her 3-week-old baby to get to us the other day.

Back to basics

And when they do actually get here, the tools we have to treat them are rudimentary compared to the enormous arsenal of treatments in the west – resources are stretched thinly in this country of enormous need and precious little funds. Diagnosis is based on a thorough examination and clinical suspicion, then starting treatment and waiting to see whether it works. It's surprisingly effective, and has me wondering if in the west I was suffering a withering in my clinical examination skills from relying so heavily on CT scans and elaborate laboratory tests.

It's a beautiful country but a brutal place to be a child, with tetanus, pneumonia, TB, starvation, diarrhoea and malaria all on the cards. The children survive through a pervasive resilience and cheerfulness, and for every death there are dozens who pull through who I'd never have imagined could recover.

I treated a two-year-old girl last week for severe cerebral malaria and meningitis. She arrived unconscious, bundled in rags and looking completely awful; in shock, dehydrated with a fever of 40 degrees, and had been convulsing all morning. After starting treatment, I admitted her to the ICU, and was gently encouraged by one of the other doctors to stop hovering over her and to go and eat some lunch. That afternoon, I returned to peer anxiously at her, but no change. In the west this little girl would be on a ventilator, but we'd already given all the treatment we could offer. The following day I was braced to see her empty bed, but nope: there she was, sitting up in bed holding a plastic whistle. When she saw me, she cracked a huge grin and blew the whistle at me. It was just what I needed to see – this unbelievably tough kid showed me that being here and trying to swim against the overwhelming tide of childhood disease isn't always a completely pointless, thankless task after all.

A child is screened for malnutrition outside Bria paediatric hospital.

© Christophe Da Silva/Hans Lucas

SUPPORTER PROFILE

NAME: Sean McCarthy

HOME: Coogee, NSW

OCCUPATION: Project Manager (Construction)

Sean became a Médecins Sans Frontières Field Partner in 2006.

I have been a proud supporter of Médecins Sans Frontières for 10 years now. It's very clichéd, but it was a TV ad that first inspired me. I just felt that the work Médecins Sans Frontières was doing was so important, and I thought "that's something that I must support". I called and signed up right then and there.

I was adopted from Fiji when I was a baby and have grown up here in Australia since. I feel extremely privileged and fortunate to live in this country and to have access to clean drinking water, nutrition, healthcare and education. I'm grateful for organisations like Médecins Sans Frontières that help people in these tragic circumstances who are in such great need.

Working as a Project Manager in the construction industry, I also appreciate the significant challenges that would have to be overcome to provide medical care in regions experiencing political unrest, epidemics, war, famine or natural disaster.

I recently found out that Médecins Sans Frontières Australia is independent and impartial – with no government funding. This means they make their decisions based on where people in the world need them the most. That's really important to me.

To anyone who is thinking of supporting Médecins Sans Frontières I would simply say that it is a great cause and they should get as much support as possible.

For more information on becoming a Field Partner, please visit www.msf.org.au

CÔTE D'IVOIRE

23 MILLION POPULATION

134 FIELD STAFF

MORE THAN 3,000 BIRTHS, 20 per cent of them caesarean section, were assisted in Katiola hospital in 2016

AROUND 50 PER CENT of women give birth at home in Hambol region

Saving the lives of mothers and

Dr Rasha Khoury, centre, and the the surgical team perform a caesarean to deliver Albertine's baby.

© Jean-Christophe Nougaret

In Côte D'Ivoire's central Hambol region, Médecins Sans Frontières is partnering with the Ministry of Health and Public Hygiene to reduce maternal and child mortality. In 2017, their joint program is extending its support to the region's most far-flung communities.

He doesn't yet have a name, but after just 48 hours of life the baby boy is already a survivor. His mother, Fatoumata*, barely 20 years old, had already given birth to twins two and a half years ago at home. This time in March, bearing twins again, she gave birth once more at home on the edge of the town of Katiola.

But the delivery was troubled, and when Fatoumata arrived at hospital the first twin was already born but suffering from severe respiratory distress. His brother meanwhile was stuck, awkwardly positioned, in utero. The first twin was rushed to the neonatal intensive care unit; his mother, to the operating theatre where her second baby was delivered by caesarean section. But despite all their efforts the medical team was unable to save the mother, and the first baby too passed away.

The odds were stacked against the mother: she had had no antenatal care, and when she arrived at the hospital she was too late, too sick, and had lost too much blood. Her second twin, the survivor, has been admitted to the newborn intensive care unit, regularly attended by the neonatal team and visited each day by his widowed father.

Too many women like Fatoumata

"Fatoumata's story is emblematic of the reasons why Médecins Sans Frontières is in Katiola," says Dr Gabriel Kabilwa, medical referent for the program.

"Here in the region of Hambol there are too many women every year just like Fatoumata, and newborns, who die during childbirth or soon after. The principal causes in the women are severe haemorrhage and eclampsia [a hypertensive disorder during pregnancy]. For the babies, the key cause is sepsis [severe general infection]."

"Many maternal and newborn deaths are also the result of poor access to the level of care which would handle complications such as these. This type of care is too expensive, too far away, or just simply unavailable. That is why it is important to strengthen access to care in the most under-served areas of Hambol."

A continuum of care

To achieve this, Médecins Sans Frontières has partnered with the national Ministry of Health and Public Hygiene to support access to quality care for women in the region. Romain Jacquier, program coordinator in Katiola, explains that this includes support in Katiola hospital as well as three local-level primary healthcare centres.

"These are the physical links in our continuum of care, that starts with monitoring of the pregnancy before delivery, and progresses

* Patient names have been changed to protect privacy

MORE THAN
1,200
DELIVERIES WERE RECORDED
in the three primary health care centres supported by the MSF-Ministry of Health partnership

Estimated maternal deaths per 100,000 live births
Côte D'Ivoire = 645
Australia = 6

60 NEWBORNS EACH MONTH ARE TREATED FOR COMPLICATIONS AT BIRTH

BY JEAN-CHRISTOPHE NOUGARET

their newborns

Two days after her caesarean in Katiola hospital, Albertine enjoys a quiet moment with her newborn baby.

© Jean-Christophe Nougaret

Médecins Sans Frontières paediatrician Dr Katherine Horan checks on the surviving baby of Fatoumata.

© Jean-Christophe Nougaret

through maternity care at the time of childbirth, the management of obstetric emergencies, and neonatal care when the baby has been born too small or too early or suffers complications."

> "Many maternal and newborn deaths are also the result of poor access to the level of care which would handle complications."

"Since we began supporting the primary healthcare centres, our joint Médecins Sans Frontières and Ministry team of midwives has assisted with direct care in the centres, telephone consultations when staff have emergency patients, and organising referral to the hospital if the women or newborns require it. Médecins Sans Frontières also supplies essential medicines, equipment and regular access to clean water in the primary healthcare centres and the hospital," says Estelle Thomas, Médecins Sans Frontières' outreach activities manager for Hambol.

In 2017 the objective is to double the number of primary healthcare centres supported by the partnership, and to help renovate Katiola's long-standing mother-and-child health centre.

A serious complication

Early in the morning, in the same week that Fatoumata arrived, Albertine has been referred to Katiola hospital from Dabakala, more than 80km away. Obstetrician-gynaecologist Dr Rasha Khoury explains Albertine's case before getting ready to operate. "She needs to have her baby delivered by caesarean section because her baby is bigger than her pelvis. This is a potentially life-saving intervention, because if her labour prolongs she risks a uterine rupture or dystocia [obstructed labour], and both could cause serious, future complications for her. She has already had a caesarean for her first baby, and she took traditional medicine to accelerate the birth this time. In fact, this combination has already caused a partial uterine rupture."

One hour after surgery began, Albertine is out of trouble. Her newborn survived but had to be resuscitated by a paediatrician and midwife, because his small lungs are filled with meconium [a baby's first faeces]. He is under care in the neonatal intensive care unit.

Dr Khoury says that the network of care that Médecins Sans Frontières has established in the region has led to this good outcome for mother and baby.

"Without the quick referral from Dabakala, the emergency obstetric services here in Katiola hospital, the trained staff, the blood bank and the newborn unit, mother and baby would probably have not survived."

Jean-Christophe Nougaret is Médecins Sans Frontières Australia's Operational Communications and Media Manager who conducted a field visit to Côte D'Ivoire in March 2017.

FIELD WORKER

NAME: Jennifer Duncombe

HOME: Sydney, NSW

Field Role: Epidemiologist

Epidemiologists with Médecins Sans Frontières typically work in three areas: outbreak response/control, surveys and research. Responsibilities could include establishing a surveillance system for a cholera or meningitis outbreak or conducting a mortality survey.

Médecins Sans Frontières Field Experience

10 placements including:

- 2013 Nigeria
- 2014 Sierra Leone
- 2015 South Sudan
- 2016 Various including Ethiopia, Kenya, South Sudan, Turkey, Zimbabwe
- 2017 Myanmar

"The work of an epidemiologist is extremely varied and we often have to be creative."

Why did you decide to become an epidemiologist with Médecins Sans Frontières?

I remember seeing Médecins Sans Frontières on the news when I was in primary school – I think it was for the Ethiopian famine response – and thinking, "wow, those people are amazing!" I ended up studying public health and worked at NSW Health as an epidemiologist. It was interesting, especially when we had outbreaks like H1N1 (swine flu) and cryptosporidiosis (an intestinal infection), but outbreaks were few and far between! So I moved to Queensland and started a PhD in infectious disease epidemiology: essentially, modelling dengue fever outbreaks in Asia. I also did a bit of lecturing and tutoring when I wasn't overseas collecting mosquitoes. It was a great learning curve but I quickly became very disillusioned with the competitiveness of academia. I saw a Médecins Sans Frontières ad online saying that they were looking for epidemiologists and I jumped on it and haven't looked back.

After 10 field placements, what keeps you coming back?

Articulating an answer to this question is a bit like trying to describe why you love someone. I could say that I relish travelling to crazy places where no one else gets to go, that I meet incredible people who regularly blow me away with their resilience and beauty despite their circumstances, or that I get immense satisfaction from making a little difference in a few people's lives. But, really, I can't describe why I love this job – I just do.

What do you find the most challenging aspect of the work?

There are many challenging aspects of working for Médecins Sans Frontières, from constantly expecting the unexpected, to trying to live and work with up to 50 other international staff, to trying to negotiate access to a population that needs help, and the weather (usually very, very hot or very, very cold). But, for me, the most challenging part is also the most rewarding: meeting and talking to the people we're helping. Hearing stories of pain, loss and immense suffering is incredibly heartbreaking. I always feel so privileged and humbled when

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An epidemiologist meets with villagers near Kailahun, Sierra Leone, October 2014.

people share their stories with me. When an old man shares his last kettle of tea and tells me, with tears streaming down his face, how he and his wife fled Syria but how the rest of his family died as they were all running down the street with bombs going off around them. Words can't ever do those conversations justice.

Could you describe a national staff colleague who made an impact on you?

Our national staff in South Sudan are incredible. Our Data Encoder, John, was born in the Médecins Sans Frontières hospital where we were both working. He is extremely dedicated to the organisation and does far more than we put in his job description!

For example, there was a security incident in 2015 and the international staff were evacuated. John and his colleagues kept the hospital functioning for as long as they could, and hid all our valuables in the bush. They drove the cars to villages where they knew they would be safe, and swam across crocodile-infested water with drugs and satellite phones on their heads (to keep them dry) and buried them on islands kilometres away from the front line of the war. When the situation improved they let us know, and when we arrived back they were waiting for us, surrounded by our valuables, ready to work. Unbelievable!

I'll never forget John and his sage advice. He and I were doing a survey one day – walking for tens of kilometres in 50°C. I was struggling to keep up and hollered "wait for me!" As I approached, he turned serious and gazed towards the horizon and said, "Don't look down, Jenn, always look ahead".

I am still struck by his profound words and whenever I find myself looking at my feet, I remember and laugh in wonder.

What are the responsibilities of an epidemiologist with Médecins Sans Frontières?

The work of an epidemiologist is extremely varied and we often have to be creative in our solutions to problems. Surveillance is, of course, a key task. One of my bosses used to call me her 'crystal ball' because I would dissect the surveillance data and make predictions about how the situation would evolve – invaluable when we are planning our activities. The best part of surveillance is getting out in the community to see what is going on and to figure out how best to collect information. I have also done loads of surveys, looking at everything from vaccination coverage, to assessing the impact of war (deaths, sickness), and the nutritional status of children. We also investigate outbreaks and, as a result, help set up interventions such as cholera treatment centres or measles vaccination campaigns. This is my favourite part of the job – I love getting my hands dirty!

What advice do you have for other epidemiologists considering this work?

Keep an open mind: every day brings different challenges. In each project, I have ended up doing tasks that aren't in my job description, like distributing blankets, counting drugs or packing ice for vaccination campaigns. We need people who are willing to do whatever needs to be done, for the sake of our patients.

CURRENTLY IN THE FIELD

Note: This list of field workers comprises only those recruited by Médecins Sans Frontières Australia. We also wish to recognise other Australians and New Zealanders who have contributed to Médecins Sans Frontières programs worldwide but are not listed here because they joined the organisation directly overseas.

AFGHANISTAN
Nicole Campbell
Nurse
Maroubra, NSW

Jeff Fischer
General Logistician
Healesville, VIC

Siry Ibrahim
Head of Mission
Wellington, NZ

Heather Loane
Anaesthetist
Hawthorn, VIC

BANGLADESH
Arunn Jegatheeswaran
Field Coordinator
Greenacre, NSW

CAMBODIA
Helen Tindall
Nurse
Alice Springs, NT

CENTRAL AFRICAN REPUBLIC
Jordan Amor-Robertson
Medical Doctor
Morley, WA

Hugo De Vries
General Logistician
Berowra, NSW

Katie Treble
Medical Doctor
Byron Bay, NSW

Brian Willett
Head of Mission
Gisborne, VIC

DEMOCRATIC REPUBLIC OF CONGO
Johanna White
Midwife
Porirua, NZ

Kaheba Clement Honda
Medical Doctor
Northmead, NSW

ETHIOPIA
Cindy Gibb
Medical Team Leader
Christchurch, NZ

INDIA
Stobdan Kalon
Medical Coordinator
Leeton, NSW

Virginia Lee
Mental Health Coordinator
Lindfield, NSW

Susan Mundt
Nurse
Auckland, NZ

IRAQ
Sita Cacioppe
Nurse
Naremburn, NSW

Emma Clark
Medical Doctor
New Town, TAS

Philippa Collins
Nurse
Kununurra, WA

Emer McCarthy
Nurse
Sunbury, VIC

Jessa Pontevedra
Nurse
Hamilton, NZ

Vino Ramasamy
Administration Finance Coordinator
West Perth, WA

Stephanie Sarta
Logistics Team Leader
Middle Park, QLD

Rose Stephens
Nurse
Fitzroy, VIC

Neil Thompson
Logistician-Electrician
Port Macquarie, NSW

Louise Timbs
Nurse
Milton, QLD

Rachel Tullet
Medical Doctor
Christchurch, NZ

ITALY
Shaun Cornelius
General Logistician
Wellington, NZ

Erica Spry
Psychologist
Kensington, SA

JORDAN
Gregory Keane
Mental Health Referent
North Balgowlah, NSW

KYRGYZSTAN
Graham Baker
General Logistician
Woodroffe, NT

LEBANON
Prue Coakley
Field Coordinator
Enmore, NSW

Louisa Cormack
Field Coordinator
Apsley, VIC

Mohamad-Ali Trad
Medical Doctor
Endeavour Hills, VIC

Shelagh Woods
Head of Mission
Rose Park, SA

LIBERIA
Jim Cutts
Logisitician- Electrician
Somerville, VIC

MALAWI
Rose Burns
Field Administration
North Melbourne, VIC

Nicolette Jackson
Head of Mission Assistant
Mullumbimby, NSW

MYANMAR
Jennifer Duncombe
Field Coordinator
Coal Point, NSW

Adelene Hilbig
Medical Doctor
Halls Gap, VIC

Linda Pearson
Field Coordinator
Auckland, NZ

NIGERIA
Shanti Hegde
Obstetrician-Gynaecologist
Montmorency, VIC

Jacqui Jones
Midwife
Wyoming, NSW

Kriya Saraswati
General Logistician
Prahran East, VIC

Maurice Scott
General Logistician
Bairnsdale, VIC

Sarah Scott
Medical Doctor
Bairnsdale, VIC

PAKISTAN
Kate Edmonds
Midwife
Auburn, SA

Catherine Moody
Head of Mission
Wollongong, NSW

PHILIPPINES
Kaye Bentley
Administration-Finance Coordinator
Wellington, NZ

PAPUA NEW GUINEA
Florence Bascombe
Nurse
Wilston, QLD

SIERRA LEONE
Debra Fincham
Midwife
Levin, NZ

Anita Williams
Epidemiologist
Narre Warren South, VIC

SOUTH AFRICA
Ellen Kamara
Field Coordinator
Beerwah, QLD

SOUTH SUDAN
Rob Baker
Logisitician-Construction
Darwin, NT

Brigid Buick
Health Promotion Manager
Carnegie, VIC

Ben Collard
Logistics Coordinator
Corrimal, NSW

Tien Dinh
Pharmacist
St Albans, VIC

Neville Kelly
General Logistician
Broadford, VIC

Brian Moller
Field Coordinator
Miami, QLD

Allen Murphy
Field Coordinator
Morningside, QLD

Emma Parker
Nurse
Aranda, ACT

Edith Torricke-Barton
Nurse
Railway Estate, QLD

Petra van Beek
HR officer - Regional
Burnett Heads, QLD

Jessie Watson
Administration Finance Coordinator
Gold Coast, QLD

SWAZILAND
Nick O'Halloran
Administration Finance Coordinator
Randwick, NSW

TAJIKISTAN
Prudence Wheelwright
Midwife
Crookwell, NSW

TANZANIA
Jennifer Craig
Logistics Team Leader
Tapping, WA

David Nash
Head of Mission
Cremorne, NSW

Elisha Swift
Midwife
Nundah, QLD

TURKEY
Declan Overton
Logisitician Coordinator
Wynn Vale, SA

UGANDA
Anna Haskovec
General Logistician
Murrumbateman, NSW

Amy Le Compte
Midwife
Gisborne, NZ

Janthimala Price
Field Coordinator
Penrith, NSW

Adelle Springer
Epidemiologist
Darwin, NT

UKRAINE
Zen Patel
Administration-Finance Coordinator
Baulkham Hills, NSW

UZBEKISTAN
Elspeth Kendall-Carpenter
Nurse
Carterton, NZ

Jemma Taylor
Medical Doctor
Carnegie, VIC

YEMEN
Lisa Altmann
Nurse
Mount Barker, SA

Natasha Davies
Nurse
Alice Springs, NT

Liam Hannon
Medical Doctor
Richmond, VIC

Richard Lees
Anaesthetist
Dee Why, NSW

Claire Manera
Field Coordinator
Fremantle, WA

Melissa McRae
Medical Coordinator
North Carlton, VIC

VARIOUS/ OTHER
Robert Gardner
Administration-Finance Coordinator
Masterton, NZ

Melissa Hozjan
Medical Doctor
Herston, QLD

Robert Onus
Field Coordinator
Chittaway Bay, NSW

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WE ARE RECRUITING EPIDEMIOLOGISTS

Interested? 'MSF yes'

msf.org.au/yes

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Patients queue to receive medication at a Médecins Sans Frontières outdoor support clinic in Leer County, South Sudan, March 2017.