THE PULSE

BRINGING MEDICAL HUMANITARIAN ACTION TO YOU

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

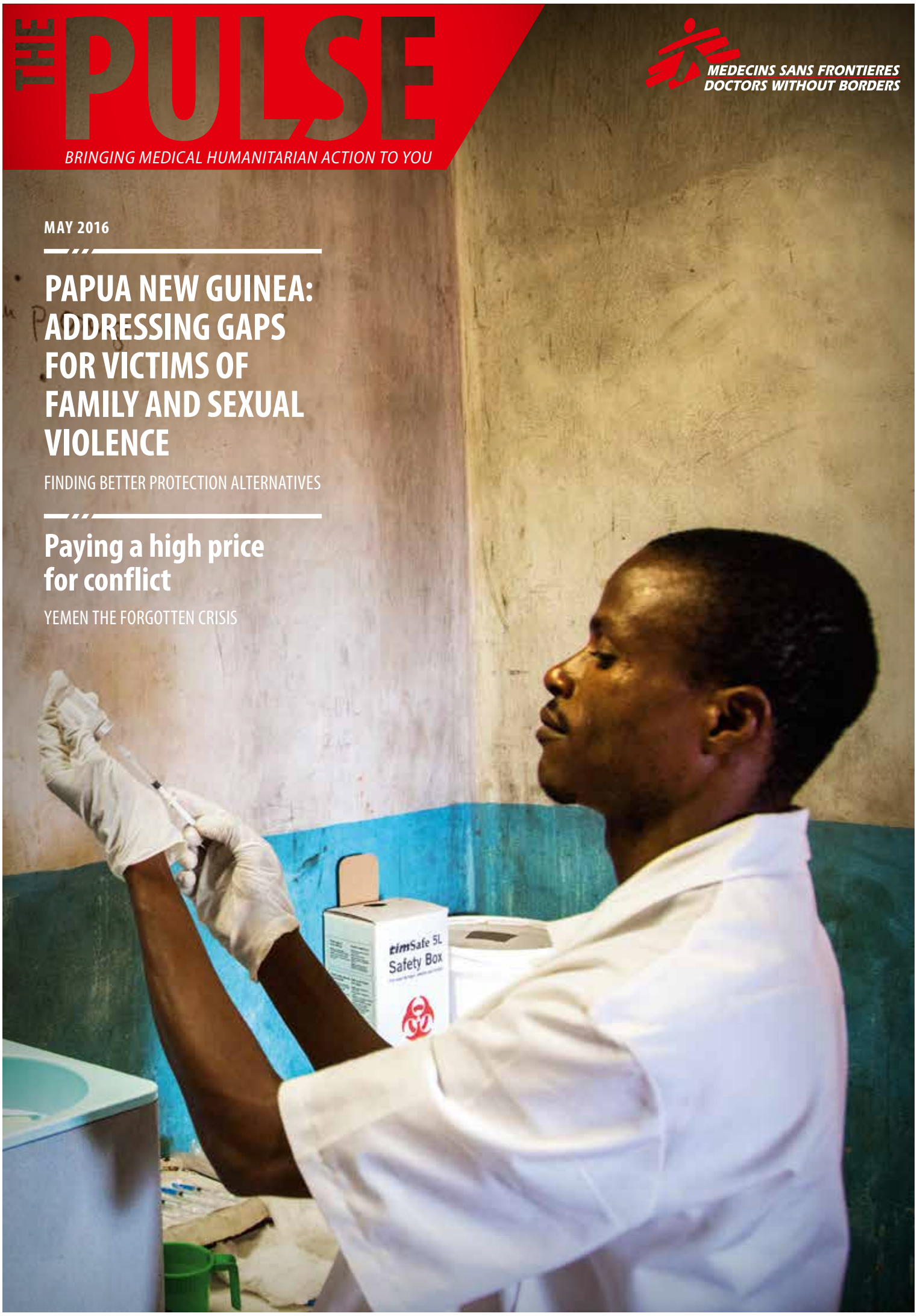
MAY 2016

PAPUA NEW GUINEA: ADDRESSING GAPS FOR VICTIMS OF FAMILY AND SEXUAL VIOLENCE

FINDING BETTER PROTECTION ALTERNATIVES

Paying a high price for conflict

YEMEN THE FORGOTTEN CRISIS



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BY PAUL MCPHUN

© Jodi Bieber

Four women await treatment outside the Surgical Ward at Tari Hospital in Papua New Guinea's Hela Province. Since 2009 MSF has treated 27,993 survivors of family and sexual violence care in Papua New Guinea.

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 2014, 190 field positions were filled by Australians and New Zealanders.

Front cover: A doctor prepares a vaccine in the Central African Republic. An unprecedented vaccination campaign is underway, with the objective to vaccinate as many children as possible against some of the most common preventable diseases. © Pierre-Yves Bernard/MSF

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EDITORIAL

When condemnation is not enough...

Changes in the tactics of warfare have seen an increase in the targeting of Médecins Sans Frontières run and supported hospital facilities, often resulting in their complete or partial destruction, mass casualties among patients and staff and thousands of people deprived of life saving medical care.

Already in the first quarter of 2016 seven Médecins Sans Frontières (MSF) run and supported hospitals were attacked in Syria and Yemen. This follows on from 2015, where a staggering 106 aerial shelling and bombing attacks hit 75 hospitals - 63 in Syria, five in Yemen, five in Ukraine, one in Afghanistan and one in Sudan.

As an organisation experienced in providing medical and humanitarian response in conflict settings, we are witnessing changes in the conduct of warfare that seemingly re-write the rules of war. Densely populated urban areas are indiscriminately targeted in aerial attacks, repeat attacks are carried out when emergency responders are on the scene, known and demarcated hospitals are singled out and destroyed, and civilian populations are besieged and literally starved to death.

Admittedly, today's wars in the Middle East are predominantly fought in towns and cities, where some argue it is harder to make a distinction between civilian and militarised neighbourhoods. However while 'collateral damage' has come to be expected today, 40% of the patients MSF treated for war trauma in Syria in 2015 were women and children. This is not an inevitable cost of war. This is an abhorrently disproportional use of force.

Our experience points to a real increase in the number of attacks on medical facilities – most notably in Syria, Yemen and Afghanistan. These are not internal wars waged by local parties. Four of Five permanent UN Security Council members are now directly involved militarily in these conflicts. The very same UNSC Member States that have voted on numerous resolutions to limit the impact of conflict on civilians are also in part responsible for military strategies causing such indiscriminate suffering in the first place.

Whether medical facilities are being targeted within a context of counter-terrorist operations, as a way to deprive enemy controlled territories of key infrastructures, or as a strategy to make life unbearable for civilians, one outcome is constant; medical providers, patients and care takers are killed or injured; health facilities stop functioning; and civilians are deprived of life-saving medical care, making life even more unbearable in conflict-stricken areas.

Much has now been documented about the Médecins Sans Frontières trauma hospital in Kunduz, Afghanistan, being destroyed by precise and repeated US airstrikes on 3 October 2015. The incident which killed 42 people and wounded dozens more, including 14 MSF staff members is amongst the worst in our 45 year history. Six months later what is left of the hospital remains closed until further notice. Beyond the limited information released to the media, MSF has yet to see a direct account from the US for what happened.

> This is not an inevitable cost of war. This is an abhorrently disproportional use of force.

In the aftermath of the Kunduz bombing President Obama stated that the US 'does not bomb hospitals'. Their Afghan coalition counterparts were not so quick to make the same assertions. They indicated that if MSF was treating injured Taliban in its hospital that this meant the hospital could be considered militarised. It is far from clear at what point a hospital could be attacked to achieve what might be considered a worthwhile military objective. Perhaps a greater leeway and autonomy can at times be granted, if the stakes are high enough. The destruction and loss of lives emerging from this cannot therefore be qualified only in military terms. There has to be accountability for actions by warring parties, and independent fact finding into what has taken place when things go wrong.

Currently however there is no independent accountability when the conduct of war is in question. Instead (and as the United States did in Afghanistan) militaries hold themselves accountable.

What more can MSF and others do under the current realties to secure the safeguards necessary to ensure patients, staff and facilities are respected during conflicts? There are four key areas of action we must demand that I want to stress in this editorial.

Firstly we have to keep calling upon all warring parties—state and non-state actors—to respect our patients' rights to seek and receive care in conflict-stricken areas. Secondly, State and non-state actors must publicly and unambiguously recommit to the protection of health care delivery in times of conflict, and actively enable health care workers to treat all sick and wounded without discrimination or interference, including wounded combatants and those designated as 'enemies' or 'terrorists'.

Thirdly, whenever an attack occurs, an impartial and independent fact-finding mechanism should establish the facts. States should commit to upholding these standards of independence when it comes to fact-finding efforts. And fourthly, there must be a regular and formal reporting of attacks against health care at the highest levels: incidents & attacks against medical facilities and medical personnel should be reported regularly by the UN Secretary General, and in other relevant fora including the World Health Organisation.

I think everybody who supports Médecins Sans Frontières will want to champion the notion that loss of life and suffering from war has to be limited to a minimum. We have then to use all means to ensure State and non state actors reaffirm the protected nature of the medical mission regardless of the complexities of the setting or the military and political ambitions of the warring parties. We look forward to your support in making this a reality.

Paul McPhun
Executive Director,
Médecins Sans Frontières Australia

NEWS IN BRIEF

FOR THE LATEST MSF NEWS
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2.7 million
PEOPLE DISPLACED AS A RESULT OF THE LAKE CHAD CRISIS

12,526 consultations
carried out in Moria, Greece, in less than a year

80,000 PEOPLE VACCINATED AGAINST CHOLERA IN CHILWA, MALAWI

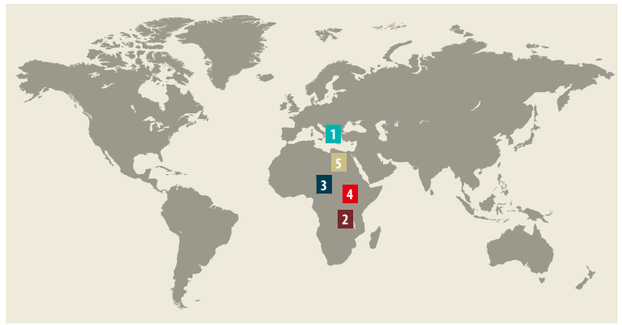
JOIN OUR TEAM

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

INFORMATION EVENINGS

Tues 18 April	*Auckland*
Wed 18 May	*Perth*
Tues 07 June	*Live Webinar*

PAST WEBINARS ARE ALSO AVAILABLE ONLINE TO WATCH ON DEMAND.
Visit **msf.org.au** for details on all our recruitment events.



MESSAGE OF SUPPORT

"We want to say thank-you. We appreciate all you do to help people living in the most distressing situations in the world."

– **DONOR, MESSAGE OF SUPPORT TO OUR DEDICATED FIELD WORKERS.**
READ MORE ABOUT THE WORK OF FIELD WORKERS ON PAGE 14.

1 GREECE

Médecins Sans Frontières suspends activities inside the Lesvos "hotspot"


© Alessandro Penso/MSF

Kim Clausen, a logistician with Médecins Sans Frontières helps a handicapped boy from Syria disembark a Greek coast guard ship, onto the island of Lesvos.

BACKGROUND:

Since July 2015, Médecins Sans Frontières has provided medical consultations, mental health support, distributed relief items and conducted water and sanitation activities in Moria camp in Lesvos, Greece. Médecins Sans Frontières has carried out 24,314 consultations on the island, including 12,526 in Moria, and has supported 3,532 people with psychological sessions. Teams also provided temporary shelter and transportation between the North and the registration centres of Moria and Kara Tepe.

ACTION:

Following the EU Turkey deal which will lead to the forced return of migrants and asylum seekers from Lesvos – a deal which Médecins Sans Frontières deems unfair and inhumane – the organisation has decided to immediately suspend its activities in the Moria "hotspot". This includes the transportation of refugees to the centre, the water and sanitation activities and the medical clinic. Médecins Sans Frontières will continue to run its first assistance transit centre in Mantamados, its sea rescue activities on the northern beaches of Lesvos and mobile clinics in other areas of the island.

2 MALAWI

Cholera response at Lake Chilwa


© Aurelie Baumel/MSF

Médecins Sans Frontières logistician Labana, briefing the team that are about to sail on the Chilwa Lake to vaccinate the 6,000 people who live in floating houses.

BACKGROUND:

Lake Chilwa is the second largest lake in Malawi and straddles the Malawi-Mozambique border. With an annual catch of some 20,000 tonnes, it is an important fish distribution and market point in the region. Nearly 6,000 fishermen and women live on the lake in floating houses called 'zimboweras'. In recent months an outbreak of cholera, a highly contagious acute intestinal infection transmitted by the ingestion of water or food contaminated with the cholera bacillus, has impacted the Machinga, Phalombe and Zomba districts. Since December 2015 there have been 920 reported cases and 25 deaths from cholera in the region.

ACTION:

Médecins Sans Frontières responded to the outbreak in Machinga, Phalombe and Zomba through case management, water and sanitation activities and a vaccination campaign. The organisation ran two rounds of vaccinations, targeting 80,000 people aged over one year, including 6,000 to 10,000 people living in zimboweras. For some hard-to-reach populations, teams administered the first dose and left the second one to be self-administered two weeks later; the first time this strategy has been implemented.

3 LAKE CHAD


© Sylvain Cherkaoui/MSF

Médecins Sans Frontières works with the Chadian Ministry of Health to support the primary health centre in Koulkimé.

Trapped in deadly violence

BACKGROUND:

With more than 2.7 million people uprooted from their homes, the Lake Chad basin is currently home to one of the African continent's biggest humanitarian crises. The region is reaching breaking point due to attacks by Boko Haram and the strong military response that has been launched to curb the violence. From its origins in Nigeria, the conflict has expanded across borders to Cameroon, Chad and Niger, causing widespread displacement and suffering. People are in need of basic amenities such as food, water, shelter and healthcare.

ACTION:

Médecins Sans Frontières is significantly scaling up its medical activities and assistance to people in the Lake Chad region. The organisation employs 1,223 staff throughout locations in Nigeria, Cameroon, Niger and Chad. In 2015, Médecins Sans Frontières carried out 340,000 outpatient consultations, 32,000 antenatal consultations and 3,800 deliveries, 1,175 surgeries, assisted 13,000 malnourished children, vaccinated 58,500 people against cholera, provided 12,000 displaced people with living essential kits containing blankets and cooking items and distributed 127,400,000 litres of water.

4 SOUTH SUDAN

Chaos and destruction as compound is looted

BACKGROUND:

On 23 February, Médecins Sans Frontières was forced to evacuate to the UN base after heavy fighting in Pibor, South Sudan. Amid the peak of the fighting, the teams quickly established a medical clinic and temporary hospitalisation ward. There they treated 36 wounded patients, including one six-year-old child who later died from a gunshot wound. The team also provided medical care to a population of more than 2,000 people also seeking shelter at the UN base. When the staff were permitted to leave the base four days later, they found the original Médecins Sans Frontières medical centre completely looted, depriving 170,000 people in the area access to specialised healthcare.

ACTION:

Médecins Sans Frontières condemns this violence and calls upon all armed actors to respect the provision of medical care. The organisation has also asked for any looted equipment to be returned. Despite their diminished capacity, the team is working urgently to provide care to those who need it most – providing more than 100 medical consultations per day to patients mostly suffering from malaria, diarrhoea and respiratory tract infections.

© Jacob Kuehn/MSF

Médecins Sans Frontières teams unloading cargo flown in to deal with a short-term, emergency medical response in the wake of heavy fighting and displacement of civilians in Pibor, South Sudan.

5 LIBYA

© Benoit Finck/MSF

Médecins Sans Frontières staff with a patient post surgery in Kasr Ahmed Hospital in Misrata, Libya.

Health system in a state of hidden crisis

BACKGROUND:

Libya's once-efficient health system is in a state of crisis. Hospitals are closed, or struggling to function due to lack of experienced medical staff and shortages of essential medicines and equipment, in particular insulin and dialysis equipment. Many Libyan hospitals were previously staffed by nurses from overseas, but most fled the country after the war against Muammar Al Gaddhafi in 2011 and subsequent armed conflicts. Libya is also dealing with a displacement crisis as people flee the violence; Benghazi alone is sheltering more than 100,000 displaced people.

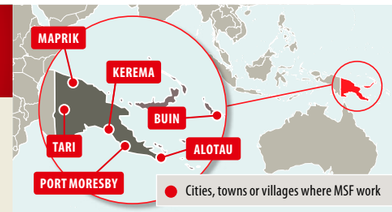
ACTION:

Médecins Sans Frontières is supplying those hospitals that still function with essential medicines and donated antibiotics and analgesics. The team also provides training to medical staff, in inpatient wards, emergency rooms and surgical units. Their aim is to train head nurses in each department, who in turn will be able to instruct nurses who have only a few months' experience caring for patients. In Benghazi, Médecins Sans Frontières distributes food and provides medical consultations to displaced people, with a focus on paediatrics, obstetrics and gynaecology, in close partnership with a local NGO.

PAPUA NEW GUINEA

OVER 7.6 MILLION POPULATION

219 MSF STAFF



In PNG, Médecins Sans Frontières treats:

- endemic/epidemic disease(such as Tuberculosis)
- sexual and family violence and improves access to healthcare

Of child victims,

ONE IN SIX WAS YOUNGER THAN FIVE YEARS

Since 2007 MSF has treated

27,993

sexual and family violence victims in Papua New Guinea

NINE OUT OF 10 SEXUAL VIOLENCE VICTIMS WERE FEMALE

THERE ARE ONLY SIX SAFE HOUSES IN PAPUA NEW GUINEA

When home is where the hurt is...

25 year-old *Rossa and her eight month old daughter in a safe house in Papua New Guinea.

While recent changes to the Lukautim Pikinini (Child Welfare) Act by the Papua New Guinean Government are encouraging, Médecins Sans Frontières calls on the nation to address the large gaps in the provision of medical and psychosocial care for victims of family and sexual violence, and provide better protection alternatives for those with no choice but to return to an abusive environment.

Twenty five year-old Papua New Guinean woman Rossa* knows all too well what it is like to live in a cycle of abuse.

"I was beaten up by my husband with an empty bottle. He has often beaten me. I am always with black eyes. I hardly ever get money for food from him. Sometimes we have been without food for two days at a time. He uses the money for drink and gambling. He comes home drunk and belts me even if I am holding our child. Once he threw our baby in a bush. One day I got the space to run away."

Sadly Rossa's story is not unique.

In Papua New Guinea, women and children endure shockingly high levels of family and sexual violence, with rates of abuse estimated to be some of the highest in the world outside a conflict zone. All too often this unacceptable and unnecessary suffering is inflicted by perpetrators who are known to the victims, in their local communities, in their families and often by intimate partners.

The overwhelming majority – 94 per cent – of these patients are female, and in a quarter of incidents involving intimate partners, the women have been threatened with death. Two in three have been attacked with weapons, including sticks, knives, machetes and blunt instruments.

Children are particularly vulnerable to serious violence from a family member at home, or a known perpetrator in the community. They make up more than half of all Médecins Sans Frontières' consultations in Papua New Guinea. Around one in six are younger than five years old.

** Names have been changed.*

Gaps in the system

These disturbing statistics are amplified by the fact that there is simply not enough comprehensive medical and psychosocial care for victims of family and sexual violence. Very often patients face multiple obstacles in obtaining essential medical and psychological care, and severe limitations in being able to access the legal, social and protection assistance, they require.

Only seven of the 16 Family Support Centres across the country are deemed to be fully functional by national authorities, with services in the remaining centres varying greatly. A lack of referral pathways to connect survivors to assistance beyond immediate medical care is further complicated in rural areas without hospitals, safe houses or an effective police presence.

Despite having some of the highest rates of violence against women and girls in the world, there are only six safe houses in the country, four of which have four beds or fewer. For many women and children, this means that after medical treatment, they have no choice but to return to their abuser. This is alarming, considering that partner and family violence tends to be repetitive and often escalates over time.

In addition an inadequate response from the country's hybrid system of formal and traditional justice and the failure of the protection system also continues to put survivor's lives and health at risk. A continual reliance on traditional forms of justice such as using 'compensation', whereby either money or pigs are paid to victims' families, means that perpetrators often remain in the communities, further exposing women and children to repeated situations of violence.

Medical and psychological consequences of violence

The trauma derived from abusive and sexually violent incidence can have a devastating and long-lasting effect on both an adult and a child's ability to function and carry on with their lives. The health consequences of family and sexual violence are many. In addition to broken bones and serious injury; unwanted pregnancy, unsafe abortion, sexually transmitted infection, HIV, urinary tract infections, miscarriage, sexual dysfunction, infertility, mental trauma and even death can occur.

Our work in Papua New Guinea

A patient receives treatment at the Hospital in Tari, Papua New Guinea, after her husband attacked her with a bush knife.

Médecins Sans Frontières has worked in Papua New Guinea since 1992. Since 2007, we have worked to support victims of sexual and family violence, providing free, confidential and integrated medical and psychological care to 27,993 people around the country. Médecins Sans Frontières teams have run training in 50 health centres, and to police units and community leaders, to reinforce the importance of providing survivors with timely medical and psychological care. In 2016 Médecins Sans Frontières is handing over the management of the last of the Family Support Centres it has run to local health authorities but will continue to monitor the state of care and protection of victims of family violence in Papua New Guinea.

Treatment with dignity

Adequate and timely medical and psychological care is crucial to help minimise the consequences of family and sexual violence. Médecins Sans Frontières-run Family Support Centres have developed a model of care based on a 'one-stop-shop' approach where victims receive integrated medical and psychosocial assistance. This ensures victims do not have to travel between different service providers, which can lead to disengagement and retraumatisation. This essential assistance encompasses:

- Medical first aid to treat injuries
- Psychological first aid
- Medicine and post-exposure prophylaxis (PEP) to prevent HIV infection and treat other sexually transmitted infections (STIs)
- Vaccinations to prevent hepatitis B and tetanus
- Emergency contraception to prevent unwanted pregnancies as a result of rape
- Provision of a medical certificate to patients, with copies kept as proof of medical care provided and the clinical findings. A medical certificate signed by an authorised medical person is required as proof to press charges against the perpetrator.

Médecins Sans Frontières advocates for this free one-stop approach to be adopted in every Papua New Guinean province as a minimum level of care. All victims, including children, should have better access to alternative short and long-term safe housing, should they wish to flee an abusive environment. Safe housing should be provided in all provinces, with adequate human and financial resources. This combined with the improvement of referral pathways between service providers in the protective, legal and social welfare system, coupled with greater community awareness, will go a long way towards meeting a victim's needs. Without an escalated response, women will remain trapped in violent relationships, unable to remove their children from harm.

Yemen, the forgotten crisis

One year on and the civilian population of Yemen is paying an extremely high price for the conflict. The needs generated by this emergency is adding yet more pressure to a healthcare system that was already weak before the conflict started.

A man clears debris revealing the Médecins Sans Frontières logo painted on the roof of the hospital in Haydan, Yemen after an airstrike on the facility.

© Rawan Shaif/MSF

© Rawan Shaif/MSF

A 12 year-old boy recovers at the ICU in Khamer hospital. He was severely injured when he received gun shot wounds to the abdomen after being caught in the middle of a land dispute.

© Rawan Shaif/MSF

Crowds gather in "Change Square", Sana'a to celebrate the fifth anniversary of the start of the Arab Spring revolution.

© Guillaume Binet/MSF

MSF staff members talking to a group of women in Khamer.

© Guillaume Binet/MYOP

Médecins Sans Frontières field worker, Suzel Wiegert at work in Yemen.

© Suzel Wiegert/MSF

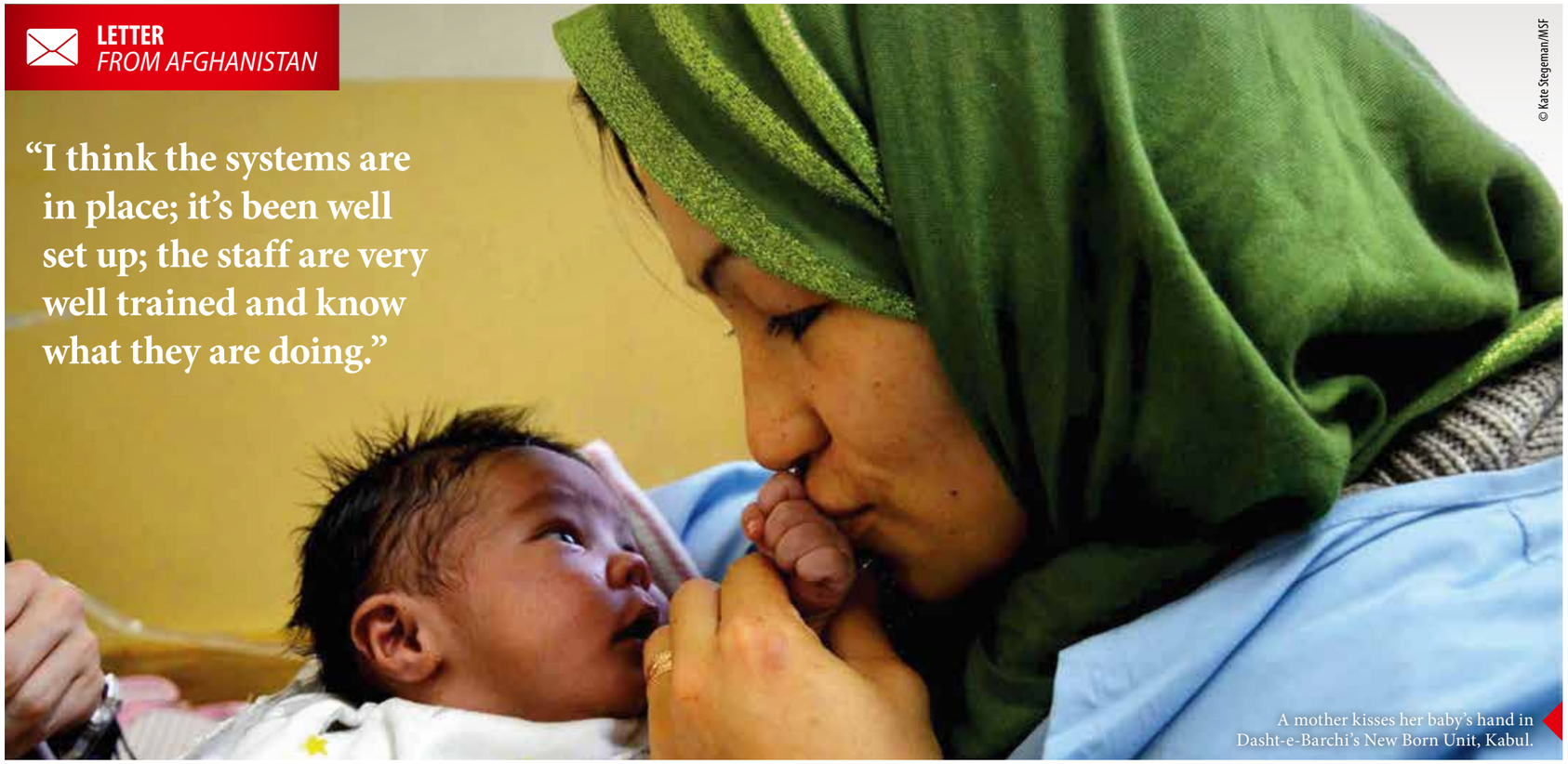
© Malak Shaher

A mobile clinic in Khamer, in northern Yemen.

A young patient lies in the intensive care ward at the malnutrition centre in Khamer hospital, Amran.

© Rawan Shaif/ MSF

LETTER
FROM AFGHANISTAN



© Kate Stegeman/MSF

A mother kisses her baby's hand in Dasht-e-Barchi's New Born Unit, Kabul.

"I think the systems are in place; it's been well set up; the staff are very well trained and know what they are doing."

BY KARA BLACKBURN

Médecins Sans Frontières' Women's Health Advisor and Midwife, Kara Blackburn, recently completed an assessment of Médecins Sans Frontières' fastest growing emergency obstetrics and neonatal care project – Dasht-e-Barchi Hospital in the Afghan capital of Kabul.

© Ruth Molloy/MSF

Kara Blackburn,Médecins Sans Frontières Women's Health Advisor and Midwife

The predominantly Hazara community that we are looking after in the west of Kabul is a very poor population, displaced from their mountainous homes in the provinces of Afghanistan. They have moved into what was originally a smaller Hazara community in Kabul. The population has grown exponentially, from 200,000 in 2001 to 2.1 million people today.

I was asked to visit the Dasht-e-Barchi project because the number of deliveries has doubled each month since the project opened just over a year ago! In round figures, the total for 2015 was 11,000. It will be more this year. We wanted to review the challenges of upholding quality of care under the sheer pressure of more and more women coming to deliver with us.

In the last 24 hours of my visit the team managed 60 deliveries—in any hospital this is a huge volume, and yet everyone kept up the pace working and striving to provide a good quality of care. I was really impressed. My hospital in Australia would have struggled with that, and the staff would have been pretty vocal about the workload.

The increase in deliveries in Dasht-e-Barchi hospital is related to a number of things, including the hospital offering free care, and that there simply aren't enough maternity beds in Kabul. My visit confirmed that our staff continue to adjust and scale up service provision, all the while ensuring good outcomes for the mothers and their babies.

Currently our remit is safe delivery care. That means we run a labour and delivery room, operating theatre, post-delivery services and a newborn unit for sick and at risk babies. The Ministry of Public Health looks after the antenatal clinic and postnatal clinic and there is another NGO, Marie Stopes International, providing family planning twice per week.

> In the last 24 hours of my visit the team managed 60 deliveries—in any hospital this is a huge volume, and yet everyone kept up the pace working and striving to provide a good quality of care.

As a referral centre we see low-risk women and high-risk women, and we're managing a significant number of complications. That's why it's important to have emergency obstetric care. Thankfully we don't see the complications like in some of our other big maternity services, because the majority of women and their families know to come to the hospital if the mother goes into labour or if there's a complication. We do see postpartum haemorrhage, pre-eclampsia (high blood pressure in pregnancy), and placental abruption (when the placenta partially or fully detaches from the uterine wall), but we don't see the severe complications that might develop from these; we usually see them in time to manage them.

While I was visiting, there was a 28 year-old woman who haemorrhaged postpartum when she was under observation in the high dependency unit (HDU). Zainab* had just given birth to her fourth child, but she had come to hospital because she had a heart condition, and had been advised to present early for any pregnancy. A woman with that type of history is really susceptible after delivery. But our midwives can quickly recognise when a complication is developing and act appropriately; starting measures to deal with the complication and bringing in an obstetrician promptly.

Postpartum care is one of the areas of service we've been strengthening. It is not only part of safe delivery care; it can also contribute to prevention of future complications. Our staff know that it is important to educate new mothers to return to the hospital if they are bleeding, if their baby becomes quiet and is not feeding, they need to return. In our hospital, for a number of reasons, women are staying for six hours post-delivery unless there are complications. But we know that the first 24 hours are really crucial; when you have women and babies leaving so early you need to make sure that all the necessary messages are being passed on.

It's very busy, no doubt about it, but we do have the capacity to manage a high level of activity. Our triage pre- and post-delivery, in complement to high quality obstetric care, needs to be very efficient. I think the systems are in place; it's been well set up; the staff are very well trained and know what they are doing. There will come a point when we are really at capacity, and all our efforts now are confidently focused on how we're going to manage that.

Since November 2014, Médecins Sans Frontières has supported the Ministry of Public Health District Hospital in Dasht-e-Barchi. The 25-bed maternity and 20-bed newborn unit offer services free of charge, with a focus on complicated cases. The high quality care for patients is provided by a team of 191 Afghan and international qualified professionals.

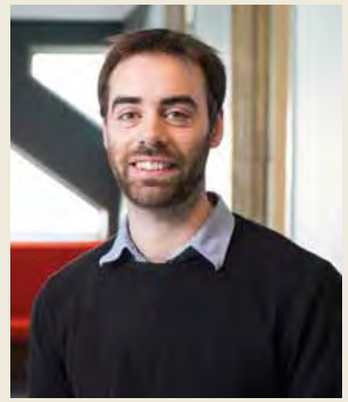
* *Patient name has been changed*

© Ruth Molloy

A patient having an emergency C-section at Dasht-e-Barchi Hospital.

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

SUPPORTER PROFILE



NAME: Martin Schultz

HOME: Hobart

OCCUPATION: Medical Research Fellow

Martin first began supporting Médecins Sans Frontières as a Field Partner in 2012.

It is the independent and impartial nature of Médecins Sans Frontières and the work they undertake that first inspired me to become a supporter. Médecins Sans Frontières has a simple mission: directing medical care to where it's needed most, without prejudice. This is exactly why I feel immensely proud to continue to support such an organisation.

I was particularly interested in the emergency medical response to Nepal in the wake of the 2015 earthquakes. My wife and I were heartbroken for the wonderful people of Nepal, but it was very pleasing to see the response of Médecins Sans Frontières, setting up temporary hospitals in very remote mountain regions, where people had no other access to medical care.

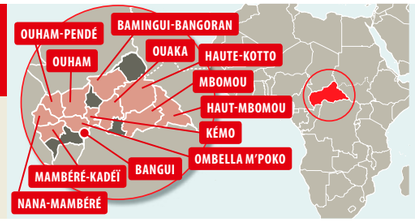
In addition, the work of Médecins Sans Frontières in times of conflict and crisis, when health and medical systems may have completely collapsed is extremely important. Being a medical researcher, I have a particular interest in the response to disease outbreaks/epidemics, such as the recent work of Médecins Sans Frontières that aided in the treatment of the Ebola virus outbreak, as well as the trials and implementation of the preventing vaccine.

Supporting an organisation such as Médecins Sans Frontières puts things into perspective, something that many in a modern society require. It is clearly evident that your support is directed to places where it is needed most, which is very satisfying.

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

CENTRAL AFRICAN REPUBLIC

SUB-SAHARAN AFRICA HAS THE HIGHEST CHILD MORTALITY RATES IN THE WORLD

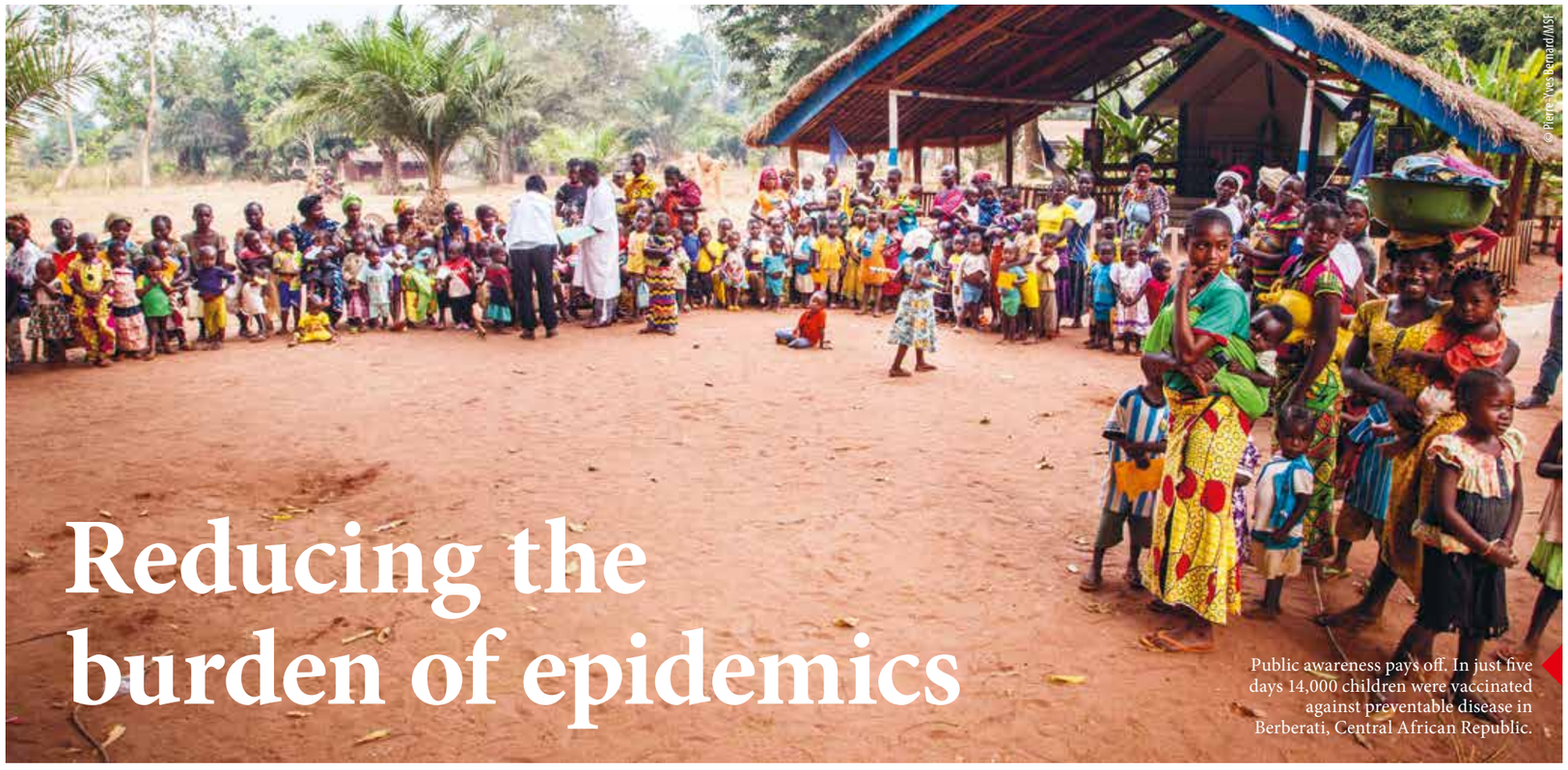


MSF currently has 230 international staff and more than 2,400 national staff working in Central African Republic. Since 2013, MSF has doubled its level of medical support in response to the crisis. Our medical teams offer free healthcare, including paediatrics, routine vaccination, maternal healthcare and surgery, as well as treatment for diseases such as HIV and tuberculosis.

IN 2013, **ONLY 13% OF CHILDREN** IN CENTRAL AFRICAN REPUBLIC WERE FULLY IMMUNISED

SINCE JANUARY 2015, AROUND **73,000** CHILDREN UNDER-FIVE HAVE BEEN VACCINATED AGAINST UP TO EIGHT DISEASES IN CENTRAL AFRICAN REPUBLIC

Médecins Sans Frontières has been operating in Central African Republic since **1996**



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Public awareness pays off. In just five days 14,000 children were vaccinated against preventable disease in Berberati, Central African Republic.

Reducing the burden of epidemics

The Ebola outbreak in West Africa in 2014 dominated the headlines for months. It was an unprecedented crisis that highlighted what worked and what remained to be done to better respond to large-scale epidemics. But by focusing too intently on a single disease, we risk overlooking less spectacular but far more common outbreaks of measles, malaria, cholera, and meningitis that occur every year with profound consequence and loss of life.

Even though epidemics affect all countries, people in low-income countries suffer the most. The root causes of epidemics are diverse: environmental factors, natural disasters, weak or poorly functioning health systems, overcrowding, social unrest and population displacement, all favour transmission.

Compounded with fragile health systems, insufficient investment in surveillance, early detection and response – along with weak international support for emergency response – the identification and control of outbreaks often results in excess mortality.

Communicable diseases with epidemic potential continue to be the main cause of mortality in children aged from one month to 59 months worldwide. Sub-Saharan Africa has child mortality rates higher than any region on the continent, and this is predominantly related to vaccine-preventable and infectious diseases.

Five epidemics to watch in 2016

Sadly the vast majority of vaccine-preventable disease outbreaks will never capture public attention, nor will they be labelled large enough catastrophes for the aid system to fully intervene. Médecins Sans Frontières recently highlighted to the World Health Organization that the lack of proper investment in prevention and response to outbreaks of cholera, malaria, measles, and meningitis – and a group of often overlooked viral and parasitic diseases – will likely pose an ever increasing threat to people's health in the year ahead.

Current strategies to prevent major outbreaks of disease show only limited success. Epidemics continue to occur, opening up cracks in national health systems, exhausting available resources and, in many cases, killing large numbers of people.

"Epidemics of cholera, malaria, measles and meningitis take place every year, incapacitating and killing many – and this needs to stop. At the same time, the threat posed by emerging and re-emerging virus and parasite-spread diseases – such as dengue fever, Zika, Ebola and kala azar – needs to be faced," said Dr Monica Rull, Operational Health Advisor for Médecins Sans Frontières.

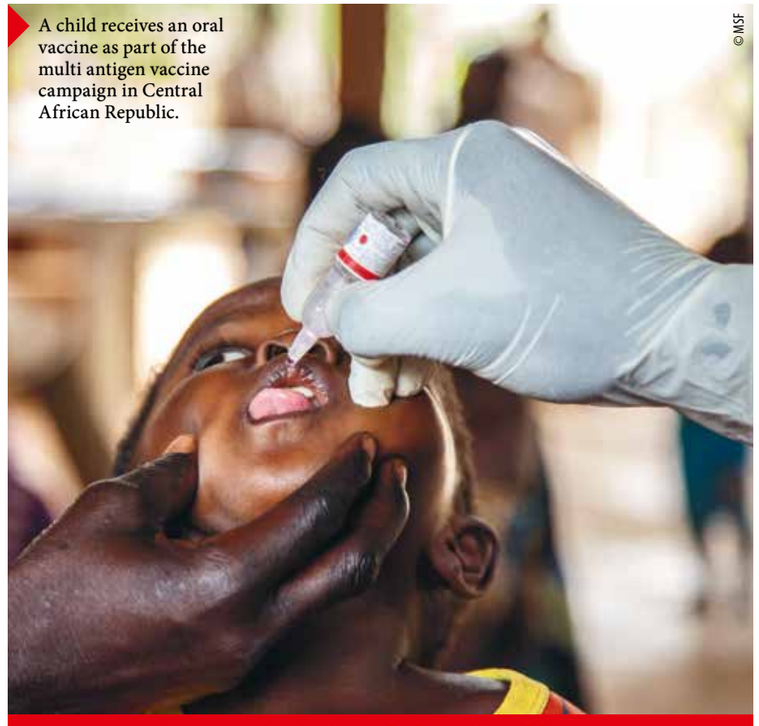
"Current outbreak response strategies are failing the very people they are designed to help. If we don't make significant changes, we will be doomed to repeat past mistakes. We must take responsibility for the consequences," she said.

Increasing preparedness and response

Médecins Sans Frontières emphasises that the first step to global health security is individual health, including for the sickest and most vulnerable people. This can only be achieved if, along with preventative measures, resources are provided to build effective emergency response systems. This must be part of a broader effort to help countries strengthen their health infrastructure and capabilities, and provide health education to local communities.

Additionally, health systems must be bolstered through training, encouragement, and other support so they are ready to evaluate, treat and share information when it becomes clear something is out of the ordinary.

Vaccination needs should be identified and addressed pre-emptively. Surveillance should be reinforced. Rapid alert mechanisms must be accompanied by rapid response activities once a disease breaks out, with free and quality medical care provided to all those affected and responses adapted. Lastly the research and development agenda must be reoriented towards the greater public good. Reform is needed to reduce the burden of epidemics on developing communities and the unnecessary loss of life.



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A child receives an oral vaccine as part of the multi antigen vaccine campaign in Central African Republic.

Mass vaccination campaign in Central African Republic

Although effective vaccines exist, polio, tetanus, diphtheria, whooping cough, hepatitis B, measles and certain forms of pneumonia and meningitis continue to kill children in Central African Republic (CAR). Official health statistics showed that by the end of 2013 only 13 per cent of one-year-olds had fully been immunised. This percentage had fallen sharply as a result of the 2013 crisis which saw extensive internal displacement and significant disruption to people's normal livelihoods.

Since January 2015, Médecins Sans Frontières has engaged in a massive vaccination campaign in CAR targeting children under five. The main aim is to vaccinate as many children as possible in the country, as the risk of epidemics or deaths from vaccine-preventable diseases in CAR is extremely high.

The vaccination campaign organised by Médecins Sans Frontières is a catch-up campaign, whereby children only receive vaccines they should have already received beforehand. To date, around 73,000 children under-five have been vaccinated against up to eight diseases.

The mass vaccination campaign has been a challenging logistical undertaking for Médecins Sans Frontières, as many parts of the country are remote and difficult to access. Transporting vaccines in 40 degree Celsius heat in the summer months requires a cold chain to maintain the required temperature range of vaccines, while the arrival of the rainy season makes the roads impassable.

Another significant obstacle is security. While some areas remain calm, there are still sporadic clashes and bandits on the roads in other regions, restricting access to the major towns. But strengthening ties with local community leaders and promoting the importance routine vaccination operations has helped ease some issues. It is crucial that solutions are found so that vaccines are fully effective and as many children are protected against preventable disease as possible.

FIELD WORKER

NAME: Amy Neilson

HOME: Tasmania

Field Role: Medical Doctor

As a doctor working for Médecins Sans Frontières you may respond to measles or meningitis epidemics, assess medical needs after a natural disaster, treat HIV/AIDS or TB patients or treat survivors of armed conflict.

Médecins Sans Frontières Field Experience

- June 2015 to December 2015
  Tripoli, Lebanon (first mission)

"Take Vegemite. You really miss the little things from home!"

© Amy Neilson

Medical Doctor Amy Neilson and Statistician Rita Loubani at Aabade Clinic on International Diabetes Day in Tripoli, Lebanon.

What led you to become a humanitarian doctor with Médecins Sans Frontières?

Humanitarian work was long an interest of mine, even before beginning medicine. When the opportunity arose to study medicine, I very nearly didn't take it as I was impatient to work overseas in areas of need in whatever capacity I could. A friend's father said to me, matter-of-factly, "No one just turns down an offer of medical school. At least start it. See what you think".

I trained as an Australian 'specialist generalist' essentially, with emphasis on rural and remote emergency medicine and primary care. The goal was to develop a broad, flexible skill set for use in disaster and humanitarian settings. In medical school I also commenced a Master of Public Health and Tropical Medicine with the goal of better understanding perspectives on health across populations.

The particular interest in Médecins Sans Frontières is that they work on the frontline, creating access to resource-poor, vulnerable patients in complex security settings. My interest is in delivering excellent, evidence-based medical care in settings of great need.

What did a typical day look like for you on mission in Tripoli, Lebanon?

I was employed as the chronic, non-communicable disease doctor in Tripoli in a position that spanned clinical and organisational aspects. I was based between the project office and two clinics, attending roughly 2000 recurring chronic disease patients.

Most mornings started in the field office with thick, strong Turkish coffee, welcomes and jokes with the permanent, national team members before piling into cars to brave the endlessly entertaining Lebanese driving.

My time was divided between working with the multidisciplinary team to develop structural aspects of the program where I worked in a more clinical role of supervising doctors and assisting with clinical decision making. I also worked on clinical guidelines and directions for where the team believed the program needed to develop.

What types of medical conditions were you seeing on a regular basis?

The non-communicable disease program was set up to address coronary artery disease, hypertension, diabetes, epilepsy, chronic obstructive airways disease, and asthma.

Chronic, non-communicable disease is a significant contributor to premature death in low and middle income countries. Our goal was, patient by patient, guideline by guideline, to create sustainable structures where patients could receive the care they needed to reduce their risk of premature death, or disability from illness.

We started to see an increasing amount of heart disease and kidney problems, as complications of uncontrolled diabetes in the population of people displaced now for so many years from consistent health care in Syria.

What was the most challenging aspect of your work? How did you overcome this?

Chronic disease programs require long-term investment and at times it can be hard to see the 'wins' for the challenges. One of the most challenging aspects for the team as a whole was that many patients with diabetes for example were quite uncontrolled. There were a lot of things about their environment that the patients could not control in order to help themselves. In that setting, frustration gets magnified, both for the team and the patients.

I think what we did really well as a team was break each challenge down into aspects we could alter or reinforce. I was enormously fortunate to work with a Lebanese Health Promotion supervisor and a Lebanese Head of Nursing, both of whom had been part of the project for a long time and understood both its history and potential. They were invaluable in finding solutions that I could then help to release.

What was the most rewarding aspect of your time away?

Without a shadow of a doubt it was the patients. I particularly enjoyed working with some of our elderly patients. Some of my most rewarding moments were spent sitting at the feet of elderly Syrian women and men, gently debriding and cleaning diabetic ulcerative wounds, and watching them heal over successive consults, thus preventing amputation and the immense ramifications that would have.

For someone travelling on their first mission, what would you recommend?

Keep an open mind; take the time to really absorb the context and the history of the project, people's cultural bias and the nuances of communication within your team. Keep communication straightforward.

Listen to the national staff. They hold the history of the project in their memories. Your exciting new idea may well have been tried before. Take Vegemite. You really miss the little things from home!

CURRENTLY IN THE FIELD

MEDITERRANEAN RESCUE BOAT
- **Madeleine Habib** *Ship Captain* South Hobart, TAS

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- **Jacqueline Boyd** *medical doctor* Mooroobool, QLD
- **Natasha Davies** *nurse* Fernmount, NSW
- **Katherine Franklin** *medical doctor* Melbourne, VIC

ARMENIA
- **Kerrie-Lee Robertson** *admin-fincoordinator* Marsfield, NSW

CONGO, DEMOCRATIC REPUBLIC
- **Raque Kunz** *log-general* Cornubia, QLD
- **Sam Templeman** *nurse* Eastwood, NSW

GEORGIA
- **Virginia Lee** *health promotion* Lindfield, NSW

GREECE
- **Elspeth Kendall-Carpenter** *nurse* Carterton, NZ

HAITI
- **Eugen Salahoru** *medical doctor* Fremantle, WA

INDIA
- **Cindy Gibb** *nurse* Christchurch, NZ
- **Tambri Housen** *epidemiologist* Ascot, WA
- **Simon Janes** *medical coordinator* Ascot, WA

IRAQ
- **Michael Hering** *log coordinator* Kingsbury, VIC
- **Robert Onus** *project coordinator* Chittaway Bay, NSW
- **Elisha Swift** *midwife* Nundah, QLD
- **Sally Thomas** *field coordinator* Rozelle, NSW

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- **Loraine Anderson** *psychologist* Woy Woy, NSW
- **Joseph Pickett** *log-general* Middleton, TAS
- **Jessica Ramsay** *medical scientist* Perth, WA
- **Johanna van Grinsven** *mental health coordinator* Bangor, NSW
- **Anita Williams** *epidemiologist* Narre Warren Sth, VIC

KENYA
- **Rachel Lister** *medical doctor* Dunedin, NZ
- **Zen Patel** *admin-fincoordinator* Bondi, NSW
- **Janthimala Price** *field coordinator* Penrith, NSW

KYRGYZSTAN
- **Marie Reyes** *nurse* Yagoona, NSW

LEBANON
- **Kezia Mansfield** *medical doctor* Hurstville Grove, NSW

LIBERIA
- **Kaye Bentley** *admin-fincoordinator* Wellington, NZ
- **Christopher Lee** *log-construction* Mosman, NSW
- **Helle Poulsen-Dobbyns** *medical coordinator* Birchgrove, NSW

LIBYA
- **Kimberley Hikaka** *log-general* Auckland, NZ
- **Kriya Saraswati** *log-general* Prahran East, VIC
- **Colin Watson** *nurse* Alice Springs, NT

MALAWI
- **Monica Burns** *nurse* East Doncaster, VIC
- **Nicolette Jackson** *head of mission assistant* Mullumbimby, NSW

MYANMAR
- **Roslyn Brooks** *medical doctor* Cooma, NSW
- **Linda Pearson** *field coordinator* Auckland, NZ

NIGERIA
- **Stephanie Davies** *admin-fincoordinator* Pacific Pines, QLD
- **Siry Ibrahim** *field coordinator* Wellington,
- **Kiera Sargeant** *nurse* Beachport, SA

PAKISTAN
- **Prue Coakley** *field coordinator* Enmore, NSW
- **Catherine Moody** *head of mission* Wollongong, Mt Pleasant, NSW
- **Shelagh Woods** *head of mission* Rose Park, SA

PAPUA NEW GUINEA
- **Hugo De Vries** *log-construction* Berowra, NSW

SIERRA LEONE
- **Sue Harrop** *admin-fincoordinator* Wadestown, NZ

SOUTH AFRICA
- **Ellen Kamara** *field coordinator* Beerwah, QLD

SUDAN SOUTH
- **Jordan Amor-Robertson** *medical doctor* Morley, WA
- **Brigid Buick** *health promotion* Carnegie, VIC
- **Jocelyn Chan** *epidemiologist* Strathfield, NSW
- **Nadim Cody** *medical doctor* Gracemere, QLD

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- **Louisa Cormack** *field coordinator* Apsley, VIC
- **Nicole Ganderton** *nurse* Gold Coast, QLD
- **Skye Giannino** *nurse* Sunbury, VIC
- **Roisin Gormley** *midwife* Cranbourne West, VIC
- **Kay Hodgetts** *medical doctor* Blenheim, NZ
- **Amy Neilson** *medical doctor* Sandy Bay, TAS
- **Jessica Paterson** *admin-fincoordinator* Ararat, VIC
- **Alexandra Stewart** *medical doctor* Forrest, ACT
- **Kyla Ulmer** *nurse* Karratha, WA
- **Helen Wolsey** *nurse* Brisbane, QLD
- **Sarah Dina** *mental health coordinator* Beeliar, WA

TAJIKISTAN
- **Frances MacDonald** *nurse* Waikuku Beach, NZ

TANZANIA
- **Emily McGrath** *nurse* Rapid Creek, NT

UGANDA
- **Chinelo Adogu** *pharmacist* Torrensville, SA
- **Rob Baker** *log-general* Darwin, NT
- **Brian Moller** *head of mission* Miami, QLD

UKRAINE
- **Aiesha Ali** *pharmacist* Muogeeraba, QLD
- **Sita Cacioppe** *field coordinator* Naremburn, NSW

UZBEKISTAN
- **David Lister** *medical doctor* Ashwood, VIC
- **Susanne Schmitt** *medical doctor* Rutherford, NSW

VARIOUS
- **Jennifer Duncombe** *medical coordinator* Coal Point, NSW

YEMEN
- **Melissa Hozjan** *medical doctor* Herston, QLD
- **Emma Parker** *nurse* Aranda, ACT
- **Jessa Pontevedra** *nurse* Auckland, NZ
- **Helmut Schoengen** *anaesthetist* Teneriffe, QLD
- **Jonathan Stacey** *anaesthetist* Casuarina, NT
- **Jeanne Vidal** *log-watsan* Caroline Springs, VIC

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.

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Victims of conflict. Three children outside their tent in the internally displaced people's camp in Khamer, Yemen.