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MAY 2015

MEDICAL CARE UNDER SIEGE

EMERGENCY HEALTHCARE IN THE SYRIAN CIVIL WAR

Preventive care

VACCINATING REFUGEES IN SOUTH SUDAN
EDITORIAL

Syria’s background noise is deafening

As we enter the fifth year of war in Syria, we are constantly reminded of how frustrating it can be to get the world’s attention.

It’s all too easy when reflecting on humanitarian issues today to portray everything as being more complex, more compounding and disastrous than in the past. And there is a risk, with mobile phones in the hands of every victim and a 24-hour news cycle, that disastrous events are sensationalised and truths sorted and stretched in the telling of the story. It is little wonder there can be ‘disaster fatigue’ when reporting on people in crisis.

As an organisation founded by doctors and journalists, we are frustratingly aware of how difficult it can be to get the attention of the outside world. Now, as we enter the fifth year of war in Syria, we are tragically reminded of that frustration. The Syrian people’s cries for help fill social media, yet they have become little more than background noise. Yet those cries come from so many, and we in Australia should grasp the numbers. Syria’s population is similar to ours. 22 million, compared to our 24 million. The recent Failing Syria report—a report authored by 21 NGOs—states that 12 million, or half our population, are in need of humanitarian assistance. Furthermore, the number of Syrian people living in areas difficult or impossible for aid agencies to reach has almost doubled from the 2013 figure of 2.5 million and now stands at 4.8 million – the equivalent of the entire population of Sydney.

Never have we faced a more complex, bloody and catastrophic situation. Never have we confronted such a combination of operational constraints in the delivery of life-saving medical care. Rarely have we witnessed such brutal violence with no distinction between civilians and combatants, where Government and opposition alike act with complete impunity committing war crimes laid bare for the world to witness. We have watched towns besieged, barrel bombed, and even bombed with chemicals like Sarin gas and chlorine. Our underground operating theatres piece together men, women and children. The Syrian Government continues to deny aid to those in most need, and the opposition in turn targets civilian populations, isolating and cutting off essential supply chains. Some of the most powerful, like Islamic State, threaten, abduct and kill. Aid workers including those from Médecins Sans Frontières, have been directly targeted by Islamic State, threatening the little cross-border aid that remains. As international aid is locked out, medical staff, hospitals and suppliers are attacked for the very life-saving help they represent.

As this perfect storm stalls over Syria, the international community charged with restoring global peace and security stands by largely unable or unwilling to act. Again, drawing from the Failing Syria report, we know that in the past three years, those needing humanitarian assistance inside Syria have increased two and a half fold, from 1 million to 12 million. We also know that the 2015 humanitarian funding appeal for Syria, launched as part of the Syria Response Plan in December 2014 that called for $2.9 billion, will fail tragically short. The sum required is much closer to $8.4 billion.

So when Médecins Sans Frontières called on recently that Syria should be the aid sector’s largest-scale humanitarian mission, we meant exactly that. It is an unacceptable political and humanitarian failure that has led to hundreds of thousands – if not millions – of deaths, unimaginable suffering and the largest-scale internal and external displacement of people today. In the absence of a political solution – something that seems a long way off yet – we have to do more.

It should be stated that some political progress has been made among UN member States. Australia can claim some credit in pushing for this. Security Council resolution 2159 in February 2014 demanded that all parties, in particular the Syrian authorities, allow humanitarian access in Syria across conflict lines, in besieged areas and across borders, and expressed the intent to take further steps in the case of non-compliance. Later in July 2014 this was followed by another Security Council resolution 2165 authorising cross-border and cross-line access for the UN and its partners to deliver humanitarian aid in Syria without State consent. However, we see little real impact from this. In fact neighbouring countries such as Turkey, Jordan and Lebanon have reduced the number of access points where aid can go directly into Syria. UN cross-border activities have only reached hundreds of thousands, not the millions of peoples intended. The two most insurmountable blockages – Islamic State targeting of humanitarian workers, and the Government’s siege tactics – still have to be overcome.

And yet assistance is not altogether impossible. Médecins Sans Frontières continues to manage six hospitals in opposition-held territories, and through these support a network of 100 more facilities around Syria. There are a large number of Syrians actively trying to set up and manage emergency relief in the absence of international responders. This edition of The Pulse highlights the experience of some of those we work directly with. In the absence of any other means to access Syria, they must be supported in whatever way possible. However, to address the needs in Syria on anything like a proportionate scale will clearly require a political solution. I imagine this will be a bitter one. At the very least some level of workable guarantee is needed now, from the top, that the parties to the conflict are willing to take practical steps to allow humanitarian access into Syria on all sides of the conflict. Only through re-establishing respect for the basic provisions of humanitarian law can the politics of war continue to be waged while at least life-saving assistance starts. This is the responsibility of all those backing directly or indirectly those currently at war. And yes, the consequences of not achieving this are more complex, more compounding and more disastrous than in the past.

Paul McPhun
Executive Director
Médecins Sans Frontières Australia
Surgical care for the wounded

BACKGROUND
Political tensions have been high in Yemen since late 2013, and insecurity has cut off many Yemenis from basic healthcare. Regular outbreaks of violence have caused dramatic upsurges in wounded patients needing emergency surgery, with hundreds of people injured during clashes in Aden in March.

ACTION
Médecins Sans Frontières provides emergency medical care in several facilities across Yemen, and also supports a number of health structures with training and supplies. Teams carried out more than 100,000 consultations across the country in 2014, and conducted 4,100 surgical interventions. In March, the emergency surgical unit in Aden admitted approximately 500 wounded patients as violence erupted in the city. However, insecurity continues to compromise Médecins Sans Frontières’ operations in Yemen, with teams having to pull out of the country a number of times over the past twelve months.

A young boy receives emergency skin graft surgery at Médecins Sans Frontières’ specialist unit in Aden.

Medical care for those displaced by Boko Haram

BACKGROUND
As many as 1.2 million people have become internally displaced, and others have fled into neighbouring countries as Boko Haram continues its offensive throughout Nigeria. Many are experiencing psychological trauma and are living in precarious conditions without access to health and hygiene facilities. Health centres in the communities hosting internally displaced people (IDP) and refugees are struggling to cope with the influx of thousands of new patients.

ACTION
Médecins Sans Frontières teams are working in several IDP and refugee camps to ensure access to basic health care, running vaccination campaigns, mobile clinics, and supplying hygiene and medical kits. Médecins Sans Frontières psychologists have also been running individual and group mental health sessions in various camps. Teams have worked with local health facilities throughout the country to ensure that they have adequate supplies and training to cope with further inflows of patients during emergencies.

A camp for internally displaced people in Nigeria.

Dire medical and humanitarian needs in eastern Ukraine

BACKGROUND
More than one million people have been displaced by the ongoing conflict in eastern Ukraine, and thousands more have been injured. The medical and humanitarian needs in this context are vast, but medical facilities in the country have repeatedly come under fire, forcing staff to flee and depriving thousands of people of healthcare. The conflict is also disrupting medical supply lines into the country.

ACTION
Médecins Sans Frontières has started running mobile health clinics in 19 locations in eastern Ukraine to provide basic healthcare to thousands of those displaced or affected by the conflict. Médecins Sans Frontières psychologists are also providing mental health support throughout the region, running more than 700 individual and 1,760 group counselling sessions. Teams have been responding to critical national shortages in medical supplies by donating enough medicines and materials to treat more than 15,000 patients.

A Médecins Sans Frontières doctor examines a young patient to determine if she has tuberculosis in a temporary clinic in Donetsk, Ukraine, on the frontline of the ongoing conflict.

New clinic to fight tuberculosis on Australia’s doorstep

BACKGROUND
Papua New Guinea (PNG) has the second-highest tuberculosis (TB) rates in the Western Pacific region. With 85 per cent of the population living in rural areas, lack of access to treatment and limited resources have contributed to a growing TB crisis in the country. Of particular concern is the emerging threat of drug-resistant strains of the disease, for which the treatment is lengthy, complex and arduous.

ACTION
Médecins Sans Frontières is expanding its tuberculosis program in PNG by opening a new project in the district surrounding Port MoreSBey in May 2015. The project will provide better access to TB diagnosis and care facilities and ensure that patients in rural areas are not lost to treatment. Médecins Sans Frontières has been running a TB project in Kowora, PNG since May 2014.

A Médecins Sans Frontières doctor examines a young patient to determine if she has tuberculosis in a temporary clinic in Papua New Guinea.

Largest Ebola management centre set for handover

BACKGROUND
With no Ebola patients currently confirmed in Liberia, Médecins Sans Frontières is beginning preparations to hand over its largest Ebola management centre to the Liberian Ministry of Health. The centre has admitted a total of 1,917 patients since opening in August 2014. The handover comprises part of Médecins Sans Frontières’ evolving response to the ongoing Ebola outbreak in the country.

ACTION
Médecins Sans Frontières is currently supporting 23 health facilities in Liberia, and is training staff on infection prevention and control. Teams will continue health promotion and outreach activities in Liberia and will maintain a rapid response team in case of a resurgence of the virus. Since the beginning of the outbreak, Médecins Sans Frontières has admitted more than 8,000 patients to its Ebola management centres in the region.

A Médecins Sans Frontières rapid response team works to contain an outbreak of Ebola in Qweim, Liberia.
Tackling Ebola in the villages and slums of Sierra Leone

As Ebola cases decline, Médecins Sans Frontières has adapted its response. From running large Ebola Management Centres, Médecins Sans Frontières is now focusing on activities in the community, where most of the needs exist today.

The residents of Moa Bay Wharf slum in central Freetown have ocean views from almost every corner, but the cramped and chaotic living conditions make the environment anything but idyllic. As pigs laze nearby, epidemiologist Dr Kieran O’Connor and his outreach team talk to a family which has recently lost two members to Ebola. As primary contacts of Ebola patients, the remaining members of the household are at risk of infection themselves. The team asks if anyone is experiencing any symptoms, and checks for fever using an infrared thermometer.

“We are feeling well but we are tired of this,” says Ibrahim, whose mother was one of the people who passed away. “We are praying to God for this epidemic to come to an end.”

Detective work
Health promoter Shekhu Jabbie says contact tracing is not as easy as simply asking for the names of family members. Instead the team has to become detectives, tracking down everyone they may have had close contact with.

“We ask about their occupation, whether they’re a farmer, trader, or a traditional healer. We interview them about their travel history, funeral attendance or visits to a healer. We interview them about their marriage background, their children, the people they live with, the people they share a latrine with.”

Following a suspected Ebola case or death it is critical that the home is disinfected to remove any trace of the virus. In Freetown, a Médecins Sans Frontières water and sanitation team disinfects the home and latrine by spraying with chlorine, removes the mattress used by the person and destroys it safely, and provides a new mattress.

“We try to link up new cases to existing chains of transmission. Most of the time we are able to do that now, which is a good sign.”

Despite the high mobility of people across the border between Sierra Leone and Guinea, the Ebola response has too often stopped at country boundaries, with little regional cooperation. Médecins Sans Frontières’ outreach team in Kambia, Sierra Leone, has just completed a project focusing on case investigation of Ebola patients with a cross-border component. The team collaborates with Médecins Sans Frontières colleagues and other organisations in Forecariah, on the Guinean side, to allow follow up across the border. The team has also worked to raise awareness about the importance of cross-border issues with other organisations, which has contributed towards ensuring that cross-border activities are now integrated into case investigation in the area.

Contact tracing in Freetown.

Health promotion activities are a key part of Médecins Sans Frontières’ community approach. In Magburaka, a small town in central Sierra Leone, Médecins Sans Frontières’ outreach team uses innovative techniques such as drama to engage the community. A crowd gathers round to watch the entertainment as health promotion staff act out scenes that encourage sick people to seek care early, avoid unsafe burials, and support their neighbours whose loved ones have Ebola. “We learnt that there is no shame in being sick, no judgement,” says one local man. “The play has given us a lot of ideas of how to protect ourselves.”

Cross-border outreach

© Sophie McNamara/MSF
Protecting against measles and polio in Yida

 Médecins Sans Frontières launched a vaccination campaign to stem a measles outbreak and to increase immunisation coverage in the population to protect them from future outbreaks.

There are approximately 35,000 children aged between 0 and 15 years in Yida. The aim is to vaccinate 90 per cent of them against measles and polio, in an effort to stem the ongoing measles epidemic and protect the population from future outbreaks.

Local staff inform the community about measles and polio, and let them know about the upcoming vaccination campaign.

Most vaccines need to be kept cold, within a small temperature range, to be effective. This creates a significant challenge for our logisticians as they transport vaccines in a “cold-chain” from Europe to remote refugee camps like Yida in South Sudan.

Crowd controllers keep the vaccination line moving and organised.

All vaccinations are recorded to ensure that the required coverage is achieved.

Parents seek shade as they wait patiently for their children to be vaccinated.

All children up to 15 years get the oral polio vaccine.
"Laughter erupts from our survivor... Somehow, the thaw has begun."

BY KAREN CHUNG

A young girl sits silently, eyes downcast. Her jersey is tied tight around her waist. Her clothes are torn. Her skin bruised and scraped. She is so slender a slight breeze might blow her over. She is so quiet and still that she seems an extension of the chair on which she sits. Three hours ago, this was a normal day. She and her classmate were walking to school when a man jumped out from the bushes. He had a knife. The day then became a nightmare. He caught her friend first and threatened to hurt her if either of them ran. He made her lie on the ground underneath and made them swap positions. She is a survivor.

You want to protect, to undo, to smite. We want to do everything, that movement, that desire to protect, to undo, to smite. We are reminds sharply of our limits and vulnerabilities. We want to do everything but we can only do so much.

Resilience and hope

Providing SGBV care is both a devastating and a beautiful thing. In the deepest darkness, there can be rays of light. Our frozen girl sitting silently; at some stage, she has to get up from that chair. When her tightly tied jersey falls away, we see her skirt is caked with dried brown blood. She looks so bewildered, so ashamed. I get her some new underwear from the children’s drawer. As they unfold themselves I must look genuinely dismayed to find they are roughly the size of the girl’s nurse. A short burst of laughter erupts from our survivor which turns into a stream of merriment when I look into her eyes. Somehow, the thaw has begun. A week later, she is seen by our psychosocial team. She draws a picture of a beautiful smiling lady with gorgeous long hair and stunning high heels, labelled with the word ‘love’. When asked who this person is, she says it’s our counsellor. This little girl is nothing like the frozen creature of a week before. She radiates warmth. What a beautiful thing the human spirit can be, filled with resilience and hope and love.

Like HIV and tuberculosis, which comprise our core work in Swaziland, SGBV is fraught with issues like ignorance, fear and stigma. These are huge barriers to access. According to a UNICEF survey in 2007 of 1,244 females aged 13–24, only 2.3 per cent of survivors sought medical help. SGBV work cannot be done in the clinic alone. As such, we have embarked on ‘sensitisation’, or community engagement. SGBV was the focus of our activities at Umhlanga, the annual Swazi reed dance ceremony.

In partnership with One Stop Centre, a new care facility providing integrated SGBV services, we shared our message of getting medical care for SGBV within 72 hours. More than 100 girls with bright young faces danced, chanting ‘72 hours’, laughing and giggling, full of life. More than 100 girls raised eager hands to answer questions about SGBV. When an opportunity came to speak, over a dozen girls were seen to move forwards then step hastily back, eyes downcast, shy, afraid. One brave girl came forward and shared her story. It was unexpected, that movement, that desire to share them and there. They were too many. Too much. It безе your heart.

The support, love and care for survivors, is nothing like the frozen creature of a week before. She is a survivor. They have medical needs certainly; and/or management of pregnancy, sexually transmitted infections, HIV, hepatitis B and tetanus. But they also have psychosocial and medical-legal needs. We interact with other organisations to address these multi-faceted needs. Their stories are so sad, so terrible, so infuriating that, as health professionals, we may find we have our own needs to be met. A staff nurse said in a training session, “you go home from this so upset, so angry, especially when you think of your own children, that you just cannot function.”

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Strengthening relationships

With the community engagement activities, more and more survivors are presenting to us. But we cannot do our work in isolation. We are forming and strengthening our relationships with the police, public prosecutors and other clinics and NGOs. This year we have also embarked on multiple onsite training sessions for all our medical and psychosocial staff. We have been fortunate to have had staff complete international SGBV training. They have taken leading roles in training other staff and in improving the services we offer.

Sometimes it is the most unmeasurable things that reflect the highest-quality, the softest smile, the gentlest touch, the knowledge that good and kind people were there when they were needed. In our training sessions, people were asked what the needs of survivors were. Every person wrote something about support, love and care. As SGBV care evolves, we will continue to strive for quality in providing care and contact to people who flee their own countries.

I used to donate to lots of different organisations speculatively then decided it was better to donate to one organisation regularly. I chose Médecins Sans Frontières as I wanted to work for the organisation one day, and because I strongly feel that Médecins Sans Frontières does good work.

Médecins Sans Frontières works in places where other organisations do not and if the country’s health system has collapsed and there is no support from other organisations, how can these people access the help they need?

Médecins Sans Frontières seems to just get in there and do it. They tackle regions and diseases that other organisations don’t. When you hear about a crisis or conflict, Médecins Sans Frontières often seems to be one of the first organisations to respond.

I hope I get a posting soon!

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

NAME: Harriet Barker

HOME: Brisbane

OCCUPATION: Registered Nurse

Harriet Barker has been a supporter of Médecins Sans Frontières since 2010 and signed up to be a Field Partner last year. She is also one of our newest Field Workers.

I have wanted to work for Médecins Sans Frontières ever since I was a nursing student. My mother (a regular donor for the past ten years) used to put the magazines in my room, so I would look at them instead of reading my textbooks! I always imagined that as a nurse one day I would have the opportunity to work with Médecins Sans Frontières – although I imagine working on a Médecins Sans Frontières project will be vastly different from Australian hospitals.

I have worked previously on Christmas Island with asylum seekers and their families and I feel strongly about providing care and support to people who flee their own countries.

Auckland general practitioner Dr Karen Chung recently spent a year in Swaziland, where she was Médecins Sans Frontières’ focus person for survivors of sexual violence.

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"You want to protect, to undo, to smite... We want to do everything but we can only do so much.

BY KAREN CHUNG

Somehow, the thaw has begun.”
When the Syrian civil war erupted in the spring of 2011, Dr S had just finished training to become a surgeon. Within a short time, he had operated in some of the most difficult medical conditions in the world – in one of the most dangerous locations.

Dr S recalls performing his first ever C-section. As shells hammered the surrounding area, he says, “I had never done the operation before, but I could stop time, because whatever reaches us is covered in the blood of the people who have risked their lives to get it here.”

When the woman was brought into the operating theatre, and Dr S successfully delivered a healthy baby girl. “It was a magical moment,” he says.

Yet despite the desperate medical needs, Médecins Sans Frontières has largely been prevented from providing health care to the Syrian people. The government has not given permission for the organisation to work in the country, and humanitarian workers have been a target of violence and abductions from all parties in the conflict. In 2014, five Médecins Sans Frontières staff members were kidnapped for five months by Islamic State militants.

Dr S says that, after just three years in the profession, he is already waiting for the day he will no longer need to work as a surgeon. “I was on the phone recently with my surgery professor and he said, ‘your work these three years matches my whole thirty years. You have reached retirement in just three years.’”

“Every moment of every day I feel I have had more than half of our needs. But when we can only get hold of one box at a time, how much medicine can we stock for 90,000 people?”

Medical work targeted

With the constant risk of abduction, and the targeting of health workers and facilities by both government and opposition forces, medical staff work in a constant state of fear. Many have fled the country and, of an estimated 2,500 doctors working in Aleppo at the beginning of the conflict, fewer than one hundred remain.

“We work underground, literally. There are entire hospitals below the earth,” says another Médecins Sans Frontières-supported doctor. He says that he and his staff are afraid that their hospital will be a bombing target, and that working in basements is the only way to ensure their patients’ safety.

Dr S speaks of the day his own hospital was hit by a rocket, remembering it as “apocalyptic.”

“The explosion turned the place upside down and tore out the wooden walls. Medical tools and people were thrown in all directions,” he says.

“From them, we were under siege. I often operated on two people at once. We worked around the clock. Sleeping and resting were an impossible luxury. The numbers of injured people were way beyond what we could handle,” he says.

“With Médecins Sans Frontières’ support we can at least count on some medicine; it covers more than half of our needs. But when we can only get hold of one box at a time, how much medicine can we stock for 90,000 people?”

Health care under siege

Access to medical supplies has become one of the most significant obstacles to providing care in Syria. In order to weaken resistance to the regime, government forces block medical supplies from reaching areas controlled by opposition groups.

“We only have one path for supplies, but we call it the ‘death path’ because there are snipers; whatever reaches us is covered in the blood of the people who have risked their lives to get it here,” says Dr A, who directs a Médecins Sans Frontières-supported hospital in a large area under government siege.

“Our top priority is to try to secure the medicine and material we need for surgery and emergency care. Often we struggle even to get basics like gauze.”

With Médecins Sans Frontières’ support we can at least count on some medicine; it covers more than half of our needs. But when we can only get hold of one box at a time, how much medicine can we stock for 90,000 people?”

For many, life in Syria has become untenable. The conflict has driven more than three million Syrians across the country’s borders into Lebanon, Jordan and Iraq, where Médecins Sans Frontières is working to meet the refugee population’s vast health needs.

Médecins Sans Frontières is the main healthcare provider in a number of refugee camps in these countries, including Domiz refugee camp in Northern Iraq, which houses more than 60,000 Syrian refugees. Since the beginning of 2014, Médecins Sans Frontières has treated over 60,500 patients in the camp, with services ranging from vaccinations to mental health care to a specialist maternity unit.

In neighbouring Lebanon, Médecins Sans Frontières has provided more than 410,000 health care consultations to Syrian refugees. In particular, Médecins Sans Frontières psychologists work with refugees struggling to come to terms with the violence, abuses, and loss that they have suffered as a result of the war.

“People here need us.”

Dr S says that, after just three years in the profession, he is already waiting for the day he will no longer need to work as a surgeon. “I was on the phone recently with my surgery professor and he said, ‘your work these three years matches my whole thirty years. You have reached retirement in just three years.’”

“Every moment of every day I feel I have had enough, but we have no other choice,” Dr S says.

“People here need us.”

Note: the names of doctors working inside Syria have been abbreviated for security reasons.

Supplies are transported by donkey along the dangerous road to a Médecins Sans Frontières-supported hospital in northern Syria.
**FIELD WORKER**

**NAME:** Paul Yarnall  
**HOME:** Hobart, Tasmania

“I had always dreamed of doing humanitarian work but I thought it wouldn’t be an option.”

What were you doing before you applied for Médecins Sans Frontières?

After leaving school I studied stage management and lighting for three years at NIDA (National Institute of Dramatic Art) in Sydney. Stage management is effectively all the logistics of putting on a theatrical show or an event. After finishing NIDA the bulk of my work was big outdoor cultural events in Australia and overseas, like the Arab Games in Qatar and the Rugby World Cup in New Zealand. All these events had a major logistics component but after a while I started to feel a little less satisfied. I had always dreamed about doing humanitarian work but I thought it wouldn’t be an option because I didn’t have an academic background. But I explored Médecins Sans Frontières, and saw that there was this ability to become a logistician. I looked through the required skills and thought, “this is me. I am flexible. I do have the interpersonal skills, I have a lot of travel experience and I do regard myself as a kind of jack-of-all-trades”. It became apparent quite quickly that the skill set I had developed in production management translates really well to humanitarian logistics.

What did your role in Middiwa, Kenya involve?

The prevalence of HIV in Middiwa in 2012 was 24.1 per cent, which is astronomically high. That’s a fraction less than one in four people who are HIV positive. Médecins Sans Frontières is working closely with the Ministry of Health, with the overall aim of reducing the rate of new infections and increasing the diagnostic capabilities and quality of care.

I was there at the start of the project, so a lot of my work involved identifying the need. For instance we identified a space to create isolation wards at an inpatient department. Another time we identified where we could put a bore hole so we could get running water to a maternity ward. We started the construction to convert an old mortuary into a pharmacy, which was urgently needed. From my theatrical work, I had a lot of experience with drawing and computer aided design so I took measurements and drew up the construction designs. Along with my team we selected and secured suppliers, and monitored the construction.

A massive part of my role was training local staff. The team I had in Kenya was incredibly competent. I was still across everything but the more I could delegate to the local staff so they could develop their skills, the better off we were. Because one day Médecins Sans Frontières will leave, and it will be the local staff who will be there to maintain the work. I also looked after the maintenance and management of the car fleet, I maintained all the generators along with a mechanic who was a local staff member; I did all the IT support. Generally speaking, the medical and paramedical staff are responsible for all patient care, administrators handle all the finance and HR, and logisticians cover everything else. A logistician’s remit from placement to placement, and in some cases from day to day, is rarely the same.

What advice would you have for other people considering this work?

You’ve got to be able to roll with the punches, because there will be hundreds of them and it won’t be limited to any easier. In terms of skills, your ability to adapt is the most critical aspect. You can get training in whatever technical skills you need. If you’re the type of person who can pick things up quickly and is willing to accept new ideas, accept criticism, accept your failings and work on them, then that makes you a fantastic logistician.

What are the most challenging aspects of working with Médecins Sans Frontières?

You won’t get to pick the country you’re going to, you’ll be assigned a room in a share house with potentially 20 other people, all different nationalities, all with completely different upbringings and value systems, and then you have to work with them everyday, and live with them every night. People are like mushrooms. They come and go. To some people that would sound like hell – and it is challenging. But I think it’s one of the reasons I love it. It’s that you can’t help but get to know everyone.

What have been some of the unexpected aspects of the work?

What surprised me is the diversity of people’s backgrounds. That continues to amaze me. Among the Leds, I’ve met a guy who used to be an instrumentation engineer on superyachts, an Aussie girl who ran a large cattle ranch, a motorbike tour guide, a guy who was a carpenter and had also worked on super yacht farms. That diversity was a real surprise, because I thought everyone but me would have some degree in supply chain management or be a trained civil engineer, but in fact I haven’t met anyone like that.

To learn more about becoming a logistician with Médecins Sans Frontières, visit: www.msf.org.au/logistician
A Médecins Sans Frontières psychologist runs a group mental health session with high school students in Donetsk, Ukraine. Their school had been hit by shelling in a battle for the city.