# THE PULSE

BRINGING MEDICAL HUMANITARIAN ACTION TO YOU

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

SPRING 2025

**MENTAL HEALTH:**
Providing care
in emergencies

**GLOBAL AID CUTS:**
The fallout of defunding

**ROHINGYA:**
Keeping a culture alive

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*Content warning: This issue contains references to suicide. Support is available: Lifeline 13 11 14; Suicide Call Back Service 1300 659 467.*

Cover: Noor Azizah, a Rohingya refugee who came to Australia as a child, visited Rohingya patients and MSF facilities in June to hear about the health situation in the refugee camps in Bangladesh. Noor works with MSF Australia as well as other organisations on Rohingya advocacy projects.
© Victor Caringal/MSF


**MEDECINS SANS FRONTIERES**

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.

Today Médecins Sans Frontières is a worldwide movement of 24 associations, including one in Australia. In 2024, 125 Australians and New Zealanders filled roles in our medical humanitarian projects.


*Médecins Sans Frontières Australia acknowledges the Gadigal of the Eora nation, the traditional owners of the land on which our office is located. We recognise their ongoing custodianship of land, waters and culture. We pay our respects to Elders past and present.*


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# A simple, effective humanitarian act

## Mental healthcare is a low-cost and effective way to enable people who have been dehumanised to regain dignity.

I was 17 when I sat in Psych 101 and studied the infamous 1971 Stanford prison experiment, in which a mere toss of a coin designated the student volunteers to the role of 'prisoner' or 'guard'. Intended to last two weeks, the experiment was shut down after less than a week because of what unfolded. Within a few days, the 'guards' became consumed by their roles of power and turned abusive, and the 'prisoners' became psychologically distressed and traumatised, despite having the choice to withdraw from the experiment at any time.

I didn't anticipate that 20 years later I would be working as a psychologist in a real-life Stanford prison experiment, but without the option to withdraw – Palestine.

My first assignment with MSF was in the West Bank. I left 10 months later with everything I knew about mental health in doubt.

In my time in the West Bank, we saw patients diagnosed as chronically 'depressed', 'anxious' and with 'panic disorder'. But the typical treatments that worked for my patients in Sydney, such as cognitive behavioural therapy, did not work. In Sydney, to disengage from unrealistic catastrophising, I would gently ask my patients, "What is the worst thing that can happen?"

> We are human beings reaching out to our fellow human beings who find themselves in the most difficult circumstances.

In the West Bank, I made the mistake of asking that same question.

"My other son could be killed by the soldiers… like my first one," answered a grief-stricken mother.

I never made that mistake again.

My time in the West Bank has haunted me in my dreams ever since: a child shepherd cowering behind rocks as Israeli settlers slaughter their flock; the blank look of dissociation on children's faces in our clinic, after witnessing their family members suffer unspeakable violence by settlers.

And from my recent time in Gaza, my dreams have new images. Everyone is in extreme distress and terrorised all night and day by drones, quadcopters and bombings. In my dreams I am torn with guilt as I leave the confines of Gaza for safety, leaving behind my colleagues, the doctors, nurses and counsellors, who show up to work without fail every day, despite immense grief, fear and pain.

MSF mental health activity manager Katrin Glatz Brubakk (left) and psychologist Samar Ismail Abu Mezyed plan a workshop for caregivers, Deir al-Balah, Gaza, February 2025. © MSF

These words from former MSF president James Orbinski's Nobel Peace Prize speech ground me:

"Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is profoundly abnormal… The act of humanitarianism comes down to one thing: individual human beings reaching out to those others who find themselves in the most difficult circumstances."

Back home, people often ask me, "What can a psychologist possibly do in the midst of crisis? Aren't you best there after the conflict? It's not the time for mental health."

Mental health in conflict is not complex therapy like it is in high-income contexts like Australia or New Zealand. Delivering mental health activities is one of the simplest, low-cost, yet most effective humanitarian acts: we are creating spaces of normalcy in very abnormal situations. Enabling people who have been dehumanised to regain dignity, simply by hearing their stories. Showing compassion and care by validating their distress.

We are human beings reaching out to our fellow human beings who find themselves in the most difficult circumstances. That is what caring for mental health is at its core, and that's what my team did in Gaza.

We created breastfeeding spaces for women who hadn't had privacy in eight months and were unable to lactate due to the incredible stress and pressure of having a newborn in these circumstances.

We helped new mums cope with their starving babies and supported the mother–child bond necessary for the baby's survival.

We created a day school program for kids who hadn't been to school in months, in a population with a 97 per cent literacy rate.

We conducted play therapy with traumatised children who had no words to describe the horrors around them.

We trained counsellors to calm distressed and desperate crowds of people, parents carrying their sick, injured children in their arms, waiting in the sun without food or water, who needed urgent medical assistance.

We taught children, using a few pencils and paper, what unexploded ordnance looks like and what to do if they saw something dangerous.

At MSF our mental health projects adapt to the needs of that community, guided by what they tell us mental health looks like. Sometimes yes, that means treating acute psychosis and severe depression, which we do in several projects elsewhere in the world.

Other times, it means showing solidarity and care for another human being, who by a mere flip of a coin found themselves on the 'wrong' side of the fence.

**Scarlett Wong**
MSF international mobile staff member
MSF Australia Board member

## MSF response in Palestine

As of September 2025, MSF has more than 900 staff working in Gaza's hospitals, clinics and other facilities, and 250 staff in the West Bank. Our teams provide surgical care, wound and burn care, malnutrition screening and treatment, maternal and paediatric care, physiotherapy, vaccination, mental health support, water and sanitation support, and care for non-communicable diseases, among other services.

Janet Kilea, MSF community engagement supervisor, with Judith, a community health worker, and Cathy, a village health volunteer, in Mondumil village aid post in Jiwaka province, PNG. © Sophie McNamara/MSF

PAPUA NEW GUINEA

## Supporting victim-survivors

Sexual and gender-based violence (SGBV) persists at alarming levels across PNG, particularly in the Highlands. With the few medical facilities scattered across rugged terrain, it is difficult for rural communities in Jiwaka province to access care, leaving many without the treatment they need.

MSF, in collaboration with PNG health authorities, began setting up a project in Jiwaka last year, aiming to improve access to care for victims and survivors of violence.

The team will engage communities to understand values and attitudes towards sexual health and family planning and offer education through health talks and training for caregivers and volunteers on sexually transmitted illnesses, gender-based violence care and survivor care.

"Information is power to change people's mindsets," said Janet Kilea, MSF community engagement supervisor. "Together we have to reach out to the women who are silent out there. We can be a voice for change."

**60% of women**

in PNG have experienced physical or sexual violence from an intimate partner.

SUDAN

## War fuels a cholera outbreak

During a war that has made 8 million people internally displaced and forced a further 3 million people to seek safety in neighbouring countries, Sudan is experiencing the worst cholera outbreak it has had in years. First declared by the Ministry of Health (MoH) a year ago, there have since been 99,700 suspected cases and more than 2,470 related deaths, as of 11 August.

As people continue to flee violence, the outbreak is spreading further in Sudan and into neighbouring Chad and South Sudan.

In collaboration with the MoH, MSF teams have treated more than 2,300 cholera patients in Tawila in North Darfur state, where the situation is the most extreme. In Central Darfur, MSF opened a 73-bed cholera treatment centre in Golo hospital, and in South Darfur, in coordination with the MoH, MSF has expanded the cholera treatment centre in Nyala to 80 beds. MSF is urging others to join an international response that will provide healthcare, improve water and sanitation, and launch mass vaccination campaigns across the Darfur region.

**24.6 million people**

– half of Sudan's population – face high levels of acute food insecurity.

Cholera patients inside the MSF-supported cholera treatment centre in Al-Nahda Hospital in Nyala, South Darfur, Sudan. © Rehab Adam Adam Abaker/MSF

SOUTH SUDAN

## Thousands escape violence to DRC

South Sudan is currently experiencing its highest rates of violence since the country's civil war ended in 2018. An estimated 300,000 people were displaced in the first half of 2025, and more than 33,000 refugees have now fled to northern Democratic Republic of Congo (DRC) to escape the surging violence. Many arrive with few or no possessions.

MSF has deployed two mobile clinics and set up six community care centres. The weekly average has reached 370 consultations and continues to rise. More than half the people seeking care have malaria, and MSF is also providing care to survivors of sexual violence, including to girls as young as 12.

Measles has been reported within the refugee community, and MSF is responding with a mass vaccination campaign targeting 62,000 children.

MSF has also undertaken critical infrastructure projects, installing six water distribution points and 200 latrines and showers.

South Sudanese register with DRC's National Committee of Refugees. Once registration is complete, they become eligible to receive non-food item (NFI) kits from MSF. The kits contain mosquito nets, buckets, soap and other essential items. © Sam Bradpiece/MSF

**"Six per cent of children aged six to 59 months seen by MSF teams near the border are suffering from severe [acute] malnutrition, which represents a major public health problem."**
Dr Léonard Wabingwa,
MSF medical activity manager in Adi

PALESTINE

## The deliberate denial of water

Two years on from the escalation of war, the availability of water in Gaza has become a critical issue. Israel's deliberate restriction of water to the people of Gaza is part of its genocidal campaign, another denial of life's necessities, alongside food, fuel and healthcare.

A lack of adequate clean water in Gaza has resulted in an increase of disease, with MSF medical teams conducting more than 1,000 consultations for acute watery diarrhoea per week throughout July and August. Without sufficient water for hygiene, people have been suffering from skin conditions such as scabies.

MSF is seeking to increase its water treatment capacity by adding another nine treatment units to its existing seven. However, since June 2024, for every 10 requests to bring in water treatment supplies, MSF has had only one approved. In August, an MSF water truck came under fire at a water distribution point in Khan Younis, despite being clearly marked with an MSF logo and identifiable as a humanitarian vehicle.

Displaced Palestinians in Gaza line up their empty jerrycans for water, 15 July 2025.© Nour Alsaqqa/MSF

**Seven MSF water treatment units**

produce enough water for 65,000 people to receive 7.5 litres per day, but it is a fraction of what is needed.


# Navigating global pressures on humanitarian aid

**The rapid decrease in global foreign aid budgets is already impacting the delivery of humanitarian aid. With crises becoming increasingly protracted, and with states increasingly linking aid to national interests, the future has become even more uncertain for the world's most vulnerable.**

Humanitarian crises are lasting longer. UN-coordinated emergency appeals, which lay out global humanitarian funding needs every year, are a good indicator of this trend. In 2014, 29 per cent of emergency appeals were for protracted crises – where humanitarian response went on for five or more consecutive years. A decade later, that figure reached 91 per cent.

In the Democratic Republic of Congo, South Sudan, Syria, Yemen and elsewhere, crises have lasted many years, even decades, with intertwined factors of conflict, ethnic disputes, political instability, mass displacement and climate-related disasters. Funding and delivering aid in these conditions has grown more challenging, leaving responders overstretched and vulnerable communities yet more vulnerable.

At a time when countries should be urgently increasing their aid budgets to meet the scale of need, the opposite is happening. In 2025, the US closed its aid agency USAID and slashed its foreign aid budget by 80 per cent; Germany is cutting its foreign aid budget in half, the UK is reducing its budget by 40 per cent, and France by 37 per cent. Meanwhile, Australia's aid budget sits at a historic low of 0.2 per cent of gross national income, well below the UN target of 0.7 per cent for developed countries.

A healthy foreign aid budget can achieve significant advances in public health. "If we take some examples from southern Africa, where we started 25 years ago when HIV was a death sentence, the advances that have been made with the support of the international community are incredible, such that [HIV] is now a chronic disease like any other," said Dr Tom Ellman, director of MSF's Southern Africa Medical Unit.

Historically, much of that support came from USAID.

"Currently, there are almost 20 million people reliant on US funding for HIV globally," he said. "The US provided over 70 per cent of global international support for HIV, and around 40 per cent for tuberculosis."

What that means for patients can be seen in the overnight collapse of a program for adolescent girls in Harare, Zimbabwe. It was a flagship program of PEPFAR, the US President's Emergency Plan for AIDS Relief, and supported 10 million girls in the region with sexual violence prevention, family planning, and HIV support. With no other support mechanism in the area, MSF programs have seen a surge in patients.

It's just one example of how a radical decrease in international funding will place enormous pressure on organisations like MSF. In settings where supply chains have collapsed, Dr Ellman stated that, although MSF is independent (i.e. MSF is funded by private donations and does not take government funding, so is not tied to any government's agenda), we still work within an aid ecosystem and are therefore dependent on the Global Fund for the development, production and supply of medicines.

The disappearance of funding – possible by year's end – will reverse the clock on HIV treatment and acceptance.

> We are now seeing policies that are centring on national interest only… And then reframing humanitarian aid as a tool and a transaction.

"We will move back to where we were 10, 20 years ago," he said.

That concern is shared by Louise Roland-Gosselin Muamba, MSF's global humanitarian affairs coordinator, based in Nairobi. "There have been a few months of shock for the humanitarian sector and the populations we assist, but not just because of the funding cuts, but because of the rhetoric that goes around it," she said.

"We are now seeing policies that are centring on national interest only. There's a defunding and a deprioritisation of solidarity, of helping people based on need. And then reframing humanitarian aid as a tool and a transaction," she said.

As Dr Ellman explains, the most vulnerable populations and groups – people living with HIV, people identifying as LGBTQI+, and those seen to pose a threat to political and economic priorities – will bear the brunt of drastic change.

"Communities, and especially vulnerable communities, have been targeted because it is part of the narrative behind some of the cuts – a deliberate targeting of certain groups," he said.

"And those groups were historically abandoned by their own governments. They were particularly dependent on foreign support – on US government, on EU support, and on organisations like ours to provide for their needs. The disappearance of that support has pulled the rug from under them. They were always resilient, always working in tension with their own governments, and now they've lost the last support they had."

"As we speak out – and we must continue – we will be ever more reliant on people whose trust we need, both to provide our services and exist," Dr Ellman said. "I am hopeful that the model we have developed over the last 50 years, one that relies on communities and on independence, is one that will serve us ever more strongly in the future."

◂ Opposite: MSF's Mbare adolescent sexual and reproductive health clinic in Harare, Zimbabwe, provides medical care, HIV testing, STI care and treatment, contraceptive services, health promotion, psychosocial care, and individual and family support sessions. © Frances Cheung/MSF

▴ Above: A mother and father sit beside their child receiving treatment at MSF's inpatient therapeutic feeding centre in Kule refugee camp, Ethiopia. © Ehab Zawati/MSF

# Malnutrition crisis persists in Nigeria

**More than 50 years after outrage over war and famine in Nigeria sparked the creation of MSF, another malnutrition crisis is gripping the country's north. But it's a crisis largely unnoticed by the global community. MSF Australia's Simon Eccleshall, recent head of mission in Nigeria, shares what he saw.**

### How would you describe the scale and urgency of the current malnutrition crisis in Nigeria?

It's hard to emphasise just how large and how urgent the malnutrition crisis is. In 2024, more than 250,000 people were treated for severe malnutrition in our facilities. That was a 38 per cent increase on 2023. And then already this year we've had a 13 per cent increase on top of those numbers, and we haven't reached the peak.

### What's driving such a huge increase in malnutrition?

It's really a complex mix of factors, particularly in the northwest. This is an area that's been neglected by other organisations. It's a hard area to work in, because you've got insecurity – banditry, criminal action, risk of kidnapping – which means people aren't confident to go to the field and plant their crops.

And then you compound on top of that changing patterns of weather [that] impacts agricultural productivity. But because of other structural problems in the economy, for example, Nigeria had inflation running at 35 per cent last year, 55 per cent this year, which has just taken the purchasing power away from people. People have reduced the number of meals they have. They've gone from three to two or two to one. They're eating the seed stock that they would have used for planting. They're engaging in risky behaviour to get food. So, there's all sorts of anecdotal indicators which show that we're not only seeing an acute malnutrition crisis for kids, but we're also seeing pregnant and lactating women presenting with severe acute malnutrition.

### How is MSF responding, and what more do we need?

MSF is currently managing 11 inpatient therapeutic feeding centres and about 30 outpatient therapeutic feeding centres in seven states across the northeast and the northwest.

> The world is largely going to forget this humanitarian disaster. A lot of people are going to die.

It is really heartbreaking to see so many of the kids we treat become critical again. We get them back over that [malnutrition] level and then they go back to the village with Plumpy'Nut [a therapeutic food enriched with vitamins and minerals for treating malnutrition], and then they come back in a month's time, or in two months' time. And that's because of a range of factors. The kids get sick. Maybe they're not taking all the nutritional supplement that they should – it's being shared with other kids, or some of it's being sold to be able to maintain the household's income and survivability.

People are in a desperate state where they're doing whatever they can to survive, because so little aid is getting through.

### What will the outcome be if enough aid doesn't get through?

It's death. These kids, who are between three months and five years old, they die. They're unable to be strong enough to survive disease or they die from malnutrition.

We look on the boards every day at the hospital. We [see] the number of children who have died and that number creeps up. It was at 652 kids in the first six months of the year.

And the first six months is the regular season. It's not the lean season, which is why we're getting the whistle blowing, getting this on people's radars now. We're saying children, thousands of children potentially, are going to die from malnutrition if there isn't an increase in access to therapeutic feeding and to food more broadly for the whole community.

### What message you would like to share with donors?

[There is] a weed called Tafasa. It's normally fed to animals. It's a last resort for people. When we see people are just eating weeds, we know it's close to their last resort.

The world is largely going to forget this humanitarian disaster. A lot of people are going to die. With everything else going on in the world, it's easy for a massive malnutrition crisis in Nigeria or Sudan or elsewhere to go on without getting headlines

We need to scale up. This isn't business as usual here – there is a major crisis unfolding in northern Nigeria. Every, *every* dollar here will save lives.

Musiaba Gidado holds her baby Fatima, who is recovering in the MSF inpatient feeding centre in Katsina city, in northern Nigeria. Fatima is suffering from severe malnutrition and complications like oedema, which has caused painful swelling in her face and legs. © Zoe Bennell/MSF

# Far from home, keeping a culture alive

**Cox's Bazar, Bangladesh, has become host to the world's largest refugee camp. For the Rohingya people living there for years or only just arrived, the struggle to survive threatens to erase connections to culture, tradition and home.**

*Photos by MSF's Victor Caringal and Sahat Zia Hero, a Rohingya photographer living in the camp.*

Violence in Myanmar's Rakhine State has led to the arrival this year of around 150,000 Rohingya seeking safety in Bangladesh. With little remaining space in the densely populated camps, the Rohingya pictured built their shelter on land prone to landslides, and far smaller than the home they left behind. © Sahat Zia Hero

A bridge crossing separates camp districts in Kutupalong refugee camp. Photographer Sahat Zia Hero notes that previously there had been a sturdier bridge in place, but it was eroded and swept away over time from monsoonal flooding. People of all ages traverse the bamboo structure, sometimes carrying heavy loads of materials and rations as they move between camps. © Victor Caringal/MSF

▲ Australian Rohingya advocate Noor Azizah visits the mental health wards of MSF's Kutupalong Hospital. MSF has seen an increasing number of Rohingya patients with severe conditions leading to attempted suicide, including in children under 15 years of age. MSF works with patients to improve emotional resilience and community engagement. © Victor Caringal/MSF

▸ Top right: The taro leaf is being used by Rohingya to symbolise the feeling of protracted displacement. Nurul Islam, the weaver who created this artwork, notes, "Unless we return to our homeland, our culture will fade. Without art, we are not fully Rohingya. When water falls on a taro leaf, we hope it leaves a mark. This is our mark – especially for when we return." © Victor Caringal/MSF

▸ Right: A young Rohingya girl studying in her shelter. With recent aid cuts in the camps, learning centres have closed with contracts terminated for 1,179 local teachers. Education is seen as one of the few opportunities for Rohingya youth to improve their situation, but now there are no schools. © Sahat Zia Hero

▲ Rohingya carpenter Mohamed Kolim (right) with Australian social designer Tasman Munro, working on a taro leaf artwork. "Our life is like water on a taro leaf, we have no ground beneath us, no place to stand. But by showing this publicly, across the world, we leave a mark that cannot be thrown away." MSF is working with Rohingya artists and communities to assist them in sharing about their situation and advocating for durable solutions. © Victor Caringal/MSF

# Displacement orders drive a cycle of grief

**More than 30 displacement orders have been issued since Israel broke the ceasefire on 18 March this year. The constant state of alert brought on by these orders has devastating consequences on people's mental health. MSF mental health supervisor *Iman Abu Shawish* explains.**

People in Gaza who have gone through displacement orders are forced to relive the experience again and again. Even if their current living conditions are bad, living in tents, barely making ends meet, evacuation means restarting from zero. Humans crave stability, but evacuation means chaos, change, loss. Displacement in itself is a loss. It's a loss of people who are important in your life, just like when you lose a job, a place, or a life routine.

The cruelty is not only in the evacuation orders themselves, but also in how they are phrased. These aren't straightforward military orders – they are psychological traps. The Israeli army doesn't just tell people to leave. They twist the very symbols that once gave Palestinians comfort. Quranic verses about 'divine punishment' are printed on evacuation flyers. Classical Arabic poetry about exile is used in social media warnings. Even their spokesperson's tweets become sudden death notices, with no clear timeframe, just a vague threat broadcast to millions already traumatised.

## A range of reactions

The psychological impact of this situation mirrors the five stages of grief: denial, anger, bargaining, depression and acceptance. There are a lot of individual differences, depending on someone's personality, past experiences, support system and ability to cope. Denial, for example, can last an hour for one person, or years for another.

> A child once looked at me and said, "I think I am dead, but if you can hear me, maybe I am alive."

Suppose you are in one of these stages. Even if you are in the bargaining or denial stage, it may seem to others that you are stable. But deep inside, it can be chaos as you process what happened. We find different reactions – some people can get very aggressive, verbally or physically, and some go to the other extreme, becoming isolated, withdrawing from everything, feeling depressed. And here's the cruel reality: just when someone has reached acceptance, another evacuation order comes.

Anxiety can take the form of panic attacks or panic disorder. And there are traumatic reactions, which we call post-traumatic stress disorder (PTSD) or acute stress disorder, which include many things, such as dissociation.

MSF mental health supervisor Iman Abu Shawish. © MSF


A displacement order leaflet seen in Gaza on 1 May 2025 quotes a verse from the Qur'an: "Then We revealed to Moses, (commanding him): 'Strike the sea with your rod.' Thereupon the sea split up, and then each became like the mass of a huge mount." It warns: "Residents of Gaza – the Israeli Army is coming." © Nour Alsaqqa/MSF

One nurse described that when she goes to work and comes back, she keeps looking at her hands asking herself if she is real or not. A child once looked at me and said, "I think I am dead, but if you can hear me, maybe I am alive."

Acute stress reactions include images or detailed memories from previous evacuation orders and become intrusive. The resulting stress and anxiety can provoke physical reactions – muscular and abdominal pain, shaking or fatigue. In children, if affects their emotions and the way they play. We see children building tents as a game and re-creating evacuations – flashbacks revealed through their only form of expression.

Anxiety, depression, negative emotional state, inability to live positive emotions – we don't have time to cope in the right way, because our brains are not free to think or to assess situations in the right way. We think about other things, how to get food, water, bread. The support system is falling because the people who support you live in the same conditions.

## A different way of thinking

There is a term in psychology called 'post-traumatic growth', and I have seen this a lot. I have seen colleagues adopt a positive change in their way of thinking and in their behaviour after trauma.

As people, we learn to deal with trauma, meaning, "Okay, there was displacement, then ceasefire. Okay, the house got bombed, and we got out of it." We adopt new personality traits, a different way of thinking, different behaviour.

How does a nurse who lost all her family keep coming to work? How does she do not give up? Of course there are triggers, but the growth of this nurse made her able to deal with it, because she came up with a new meaning. Every time memories come up, a new meaning comes up as well. And this is an important component of our resilience.



## James Richardson

**Location:** Black Rock, Victoria (Bunurong Land)

**James 'Jim' Richardson first came across MSF in the news many years ago and immediately connected to the organisation's core mission: to provide medical assistance to people in distress, in the wake of disasters and as the result of armed conflict.**

He strongly supports MSF's approach of working where we're needed, irrespective of gender, race, religion, creed or political convictions, and of employing local staff in these roles. As a retired engineer, Jim feels immensely grateful to have grown up in a peaceful country like Australia where he had access to education and employment. It is this gratitude that has prompted him to want to improve the lives and outcomes of people around the globe, who haven't had the same opportunities.

Jim is a long-term supporter of MSF's, making his first donation in 2007. He is particularly passionate about supporting MSF's work in conflict-afflicted areas of the world including Gaza and Sudan and is very conscious of the long-term need for our care, which is why he also decided to leave a gift in his Will to MSF. "We need to try and limit the bad in the world and to promote the good," he said.

Our wonderful supporters like Jim, ensure MSF is always independent and always ready to respond, delivering medical humanitarian aid – today, tomorrow and always. Our supporters' contributions, whatever the size, are what makes our work possible, and we are so grateful.

If you would like to learn more about this special way of giving, please reach out to our friendly gifts in Wills team, they would love to chat and can be reached on **02 8570 2611** and **giftsinwills@sydney.msf.org**.

## TRUDY ROSENWALD

**Home:** Mt Helena, WA (Whadjuk Noongar Land)

**MSF experience:**
Bangladesh, Ethiopia, Greece, Libya, Tajikistan

Trudy Rosenwald in Hitsats refugee camp in Ethiopia in June 2019, where MSF started a mental health project for Eritrean refugees in 2015. (Photo supplied)

**You were in your sixties when you started working with MSF. How did that come about?**

I first heard about MSF after the Biafra famine, just after MSF started. It was 1972, and it was big news even in Australia. It really lodged in my brain. I felt that was something I really wanted to do.

**Were you a psychologist at the time?**

No, not at all. I was a new migrant and 21-year-old mother of two baby boys, but I always kept it in the back of my mind to become a doctor and work for MSF.

**And you did. Can you tell us about that journey?**

Well, by the time I was 36, we had 10 children. I started correspondence courses in psychology and Aboriginal and intercultural studies at a university in Western Australia. Once I was a registered psychologist, I went back for my PhD. Once I had a PhD in psychology, I felt I was one step closer to working with MSF, but still needed some relevant experience. So I started working in torture and trauma services for asylum seekers and refugees. After three years, I began working in Australia's offshore detention centres in Manus and Nauru, because I wanted to see what was really going on there. It was worse than expected. MSF came to Perth to recruit just as I returned from Nauru. I was about 66, 67 and found out they didn't have an age restriction. I applied and they accepted me!

**What was your first assignment?**

Surprisingly, it was in northern Greece. I never expected to be sent to Europe. I thought it would be Asia or Africa. But Greece was a very interesting assignment – just at the point when Europe closed its borders. People were piling up at the northern borders, and conditions were very rough for them. In winter it was bitterly cold in the refugee camps. It was physically and mentally challenging to work there.

How did the reality of working with MSF compare with what you'd imagined for so long?

It pretty well matched – it was just the location that was a surprise – but the need was huge. I mean the location was like a fairy tale – northern Greece is beautiful, so I felt really lucky. I made some good friends with whom I remain in close contact.

The project was very mental health focused, but back then, there was still a culture of mental health being the second cousin to physical health. This was very confronting. Many of the refugees and asylum seekers didn't know about mental health, so the work included a lot of education about looking after their own and their family's mental health.

Is that something that you've seen elsewhere?

I've seen it in every assignment. But there has been a big improvement, and I feel that the 'There is no health without mental health' message is getting through.

More recently, you were in Bangladesh working in the camps for Rohingya refugees from Myanmar. Can you tell us about that experience?

It was my first assignment where I committed to 12 months. My role was mental health activity manager, a flying one, which means I was covering three different locations. You can become overwhelmed if you just look at the numbers. There are around a million refugees there, and the vast majority are very traumatised. The sense of hopelessness and helplessness is very strong and pervasive, with many questioning the point of living. Many people have suicidal thoughts despite their faith being against it.

I took a community psychology approach to work on this. Firstly, helping people accept that talking about your feelings is okay, talking about suicide is okay. We followed up with teaching ways of prevention and early intervention such as how to observe, listen to and talk with people who show signs of being at risk.

I did that training first among my MSF colleagues, including the refugee community workers. We then extended it to other parts and departments of the projects and also engaged with leaders and teachers in the refugee community.

When you come to the end of an assignment, do you feel you've left something that will be carried on?

Absolutely. Bangladesh is a good example. The mental health activity manager has always been an international staff member. I advocated strongly that the role should be held by a local staff member, because the necessary skills, knowledge and capabilities already existed there. I managed to convince the management about doing a high-level national recruitment drive, and one of the local mental health supervisors was successful. Everybody was happy about that outcome, so yeah, I feel pretty good about that.


## ON ASSIGNMENT

▲ A view of Bamyan province in the central highlands of Afghanistan, where eight MSF-built health facilities provide access to healthcare for people living in remote areas. © Logan Turner/MSF

**During the last quarter, 46 staff from Australia and eight from New Zealand covered 58 assignments with MSF.**

This list of project staff comprises only those recruited by MSF Australia who have given permission for their names to be used. We also wish to recognise other Australians and New Zealanders who have contributed to MSF programs worldwide but are not listed because they joined the organisation overseas or prefer not to be named.

### Afghanistan
Katie Dabbs, nursing activity manager
Rachel Lister, ICU doctor
Khairil Musa, ICU doctor

### Democratic Republic of Congo
Alec Kelly, operational deputy head of mission

### Haiti
Gregory Le Pape, project finance/HR manager
Anne Lickliter, infection prevention and control manager

### India
Prem Chopra, mental health activity manager
Emily Young, project medical referent

### Kenya
Naomi Thomson, logistics manager

### Kiribati
Leanne Baldwin, midwife activity manager
Peter Clausen, head of mission
Benjamin Meates, deputy head of mission
Bradley Ogden, logistics manager
Kiera Sargeant, medical coordinator
Adriana Talotta, midwife activity manager

### Lebanon
Patrick Baffoun, project finance/HR manager
Justine Cain, medical doctor
Louisa Cormack, head of mission

### Libya
Steven Purbrick, head of mission

### Malawi
Shanti Hegde, obstetrician-gynaecologist

### Myanmar
Kathrine Charlton, medical coordinator
Samuel Templeman, medical coordinator

### Nigeria
Shelley Cook, nursing activity manager
Rodney Miller, project coordinator

### Palestine
Paul Blackery, medical activity manager and ER doctor
Thienminh Dinh, medical activity manager
Rhianon Hutcheson, nursing activity manager
Claire Manera, project coordinator
Narelle Raiss, nursing activity manager
Caterina Schneider-King, mission finance/HR manager
Ben Shearman, logistics team leader
Aidan Yuen, epidemiology activity manager

### Pakistan
Pearl Bailey, logistics manager
Matthew Calissi, logistics manager

### South Sudan
Natasha Allan, nursing activity manager
James Aridas, obstetrician-gynaecologist
Lucy Butler, HR coordinator
Louise Clarke, surgeon
Indu Kapoor, anaesthetist
Annie Lee, nursing activity manager
Ralien Palmer, project finance manager
Kristi Young, intersectional legal advisor

### Sudan
Susan Bucknell, operational deputy head of mission
Esther Choi, midwife activity manager
Malaika El Amrani, nursing activity manager
Josephine Goodyer, paediatrician
Alec Kelly, operational deputy head of mission
Tara Pollock, project coordinator
David Rawson, anaesthetist
Kaylene Tomkins, project medical referent

### Syria
Catherine Flanigan, sexual violence program activity manager
Brian Moller, head of mission
Christian Seufert, nursing activity manager
Aidan Yuen, epidemiology activity manager

### Yemen
Pippa Lukin, midwife activity manager
Adam Mangal, logistics manager