The Work of Medecins Sans Frontieres

by

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The Chairman of the meeting was Ms. Pauline Shiff.

I'd like to talk to you tonight about Medecins sans Frontieres. I have had the good fortune of working directly for it and now I work for it a slightly different way on the Board of Medecins sans Frontieres, Australia.

I thought I would take you through some of the history of Medecins sans Frontieres and also talk a little about some of the personal experiences I have had in various parts of the world. Medecins sans Frontieres started with a number of people like Bernard Kushner who was a Minister of Health in France and now is the UN special representative in Yugoslavia. He and a number of others were working in Biafra in Western Africa during the Biafran famine from 1968 to 1970 and they and Xavier Emmanuelle decided that they wanted to create, in a sense, the first non-governmental, non-military medical assistance group in the world. The reason was because they had previously worked with the Red Cross but the Red Cross was never allowed to really question what was going on. They always had to toe the line at what was happening and they decided to create this group, in a sense, so that they could make sure that they could provide much quicker, more rapid, more effective medical assistance. They created this in France and the first mission of Medecins sans Frontieres France was as a response to the Nicaraguan earthquake. The first conflict mission they ran was in Beirut in 1976 and something like 50 people were working in conditions where they were being bombed.

From 1976 to 1980 they then became very involved in the major population movements in South East Asia and also in Western Africa and this is the first appearance of the word *temoignage*, meaning "witness" which is an important part of what Medecins sans Frontieres does. Not only does, but also it tells other people about what it's doing and challenges the status quo. Cambodia was the first time when they decided to say something about the situation and to get international publicity and international change for what was going on inside Cambodia. In 1980 other groups of Medecins sans Frontieres were established in Belgium and Switzerland.

In 1985 Medecins sans Frontieres was involved in Ethiopia. I happened to be working on the Sudanese side. This was the first time where they became very involved in letting the international press know about the diversion of humanitarian aid within the major camps within Ethiopia - you will remember this is the time of BandAid - "We are the world. We are the people." Within the camps in Ethiopia a lot of the food was being diverted by the Mengeste regime. This was

a major challenge. And this is always a major challenge for every humanitarian organisation - do you stay or do you go? What are the ethics of staying, what are the ethics of going? It doesn't matter how solid the humanitarian law is, you have to deal with the situation as it is. Medecins sans Frontieres was expelled for taking this position and received some criticism for it.

I was involved in working on the border of Ethiopia in Sudan - in 1979/80 with Save the Children Fund Australia. We set up mother/child health clinics for refugees coming across the border and this was where, having learned clinical medicine, I really started to get interested in public health because you see the same problems coming in time and time again and you think "Well, how much can I do as a clinician? Maybe I need to go back into the community a bit more and find out why things are happening and what I might be able to do." We then got very involved in health education, in nutrition, education and in the provision of clean food and water.

We also learned a lot about what traditional medicines. This slide shows a girl who had tuberculosis, you can see some of the scars on her chest from local healers where that was the only thing they had to offer. There is a real clash of culture, the clash of the Western medical culture with the culture of local healers. Still today most of rural Africa has access to African healers. They certainly don't have access to Western medicine.

These camps were often set up in places that were pretty tough to live in. What is interesting about the flow of refugees around the world is that there seems to be sort of an inverse law of responsibility. In other words, the least resources you have the more you are expected to look after a greater number of refugees. If you look at the way that our government currently deals with asylum seekers compared with what the Sudan has to look after, literally hundreds of thousands, maybe millions of refugees who cross their border and no one saying "Sorry, we'll push you back again." They take them. There's this notion of those who have least have to take the most refugees.

This slide shows the refugee camp in Wad Kowli in 1985 which is right on the border of Sudan and Ethiopia. People walked for three weeks out of the bombing in Ethiopia to collapse over the border. Unfortunately, this camp has some of the highest recorded death rates because when they got there people were so sick; there were very high levels of tuberculosis. There was a major measles epidemic because the vaccinations couldn't get there fast enough, and in the time I was there,

there was a meningitis epidemic, there was a hepatitis epidemic, there was a major problem with malaria and we also had a cholera epidemic. I don't know if anybody has ever been in a cholera epidemic but that is very, very frightening.

I was studying tropical medicine at the time and one of our lecturers happened to be from Medecins sans Frontieres and not only did they lecture, they also recruited and they would say, "Anybody here who'd like to work for them? I'll see you after the show." They were after people who'd worked there previously and I'd worked there, so I said yes, I'd go down. I went down for three weeks to see what was happening and to start work. But in that time I unfortunately got quite sick. I got these dreadful, dreadful headaches so much so that I thought I had meningitis. Stupidly, I agreed to have a lumbar puncture in a hut like this. I didn't have meningitis but unfortunately the lumbar puncture leaked and so every time I'd sit up I'd get this dreadful headache and so I'd lie down again and then sit up and lie down again. I remember doing a television interview in French at an angle of 45 degrees and I'd lie down in between questions. It was rather an odd thing to do.

The cholera epidemic was quite frightening because people die very, very quickly. They could die in a very few hours simply from terrible diarrhoea and vomiting. On the other hand, if you work very quickly you can see where the cases are, you can clean up the water supply and you can treat those people who have it quite quickly and it can be dealt with very rapidly. The problem is that not only the refugees get it but the local population gets it as well. Here the problem was that the care for the refugees was in the long run better than the care for the Sudanese simply because there were international teams available to them.

I was the medical co-ordinator of a multi-national team; they were French speakers from a number of countries. It was probably the most uncomfortable job I have ever had because we would have a morning meeting and everybody would be talking and I couldn't quite catch what people were saying. You think you get it but you're not quite sure and you don't want to make an idiot of yourself by admitting that you don't know. This is probably the job where I have really felt as though I have failed the most by virtue of never really being on top of what was going on. The other thing was that everything - this is really Murphy's Law - everything that could go wrong went wrong. We had built our place on the other side of a river and before we got everything over the river the rains started so we couldn't get across until someone had built a bridge and we got some boats. That was pretty difficult. We

weren't actually meant to stay there because it was a reception camp, but because of the cholera we couldn't move. We had this wonderful idea of getting some sheeting to put over the poorly thatched rooves. Then one day this great storm came along - this shows you how bad our planning was – and it filled the plastic sheets with water, the plastic sheets then started to bring everything down, so we had to put holes in the plastic sheets to let the water out. Trying to put a drip in when water is dripping all over you is not a lot of fun. We had such a big storm one night that it blew - you know "I'll puff and I'll puff and I'll blow your house down" - it blew everything down. So we had to move. We only had a couple of these tents and a large food tent, so we had to move about 80 or 90 patients out of the thatched huts that were no longer protecting us and move them into tents. Later there were various epidemics that made it very difficult. The rain played a major part in this whole venture, trying to get anywhere, move anywhere. We had enormous difficulty just getting up to the local town and getting any supplies over that time.

I was enormously impressed with the courage and the resilience of the Eritrean and Ethiopian refugees. I was worried like hell and couldn't organise anything, and night after night it'd be pouring and they'd get out in the morning and hang everything up and it'd dry off and then the next night it'd pour again and you'd still hear music and singing and dancing, despite the high level of illness and the high level of - in many ways - misery. But the resilience and the strength of those people was something really to learn from and admire.

One of our team was a Dutch anaesthetic nurse, extremely skilful, and probably the best in terms of reviving patients, certainly those who were moribund with cholera. I diagnosed a man who had an acute abdomen, he'd obviously had a life-threatening problem inside his stomach. The nearest hospital was three or four hours away on an incredibly difficult road. The previous people I'd admitted to that hospital had all died. What do you do? And I still worry about it, to this day. The notion of whether we'd said "No, we think it's better to help this man die" and yet there was really no hope of sending him anywhere else. The notion that you are playing God is something that medical and legal practitioners come up against so much, but in this particular instance, it was a very, very tough decision. One of the other major abiding memories is that sometimes we assume somehow that people who live in areas of very high mortality somehow get used to it. Watching a father see his six-year-old die of cerebral malaria was one

of the most moving moments I've ever had as a medical practitioner.

All the sectors of Medecins sans Frontieres were very much involved in the Gulf War crisis. I was at that time studying public health at Harvard and with a group of public health students and law students - another rapprochement of the professions - went to Iraq about six weeks after the war to do a study on the effects of the sanctions and the Allied bombing on paediatric mortality, or levels of mortality under five, simply because we didn't really believe the story that this was surgical bombing. You had bombs that go in the top of a roof, go down, whiz around a bit and come out the bottom door and no one else gets hurt. This is the stuff that, certainly, the New York Times was putting out. We decided to go and have a look, simply because we felt that the innocent sufferer was the Iraqi young population and the ordinary mums and dads. On the other hand, no way were we on the side of Saddam. We got the visas to go there, got to Jordan, drove into Baghdad along the road that had been bombed all the way and then we split up into two teams, put Red Cross stickers or Red Crescent stickers on the sides of taxis and then drove around Iraq to look at what was happening.

This slide shows the destruction of a place called Najaf. That is not the result of Allied bombing, that's the impact of Saddam after the bombing had finished when he decided that he would clean up the Shiites and the Kurds up north. You are dealing with an absolute tyrant and the people in the middle of the sandwich were the Iraqi population. In many ways it was a huge pity that the Allies didn't go in and knock him off at that time. This slide shows a hospital where a shell had gone right through. It is absolutely staggering to talk to surgeons who had been operating with a gun to their head or who were trying to cope with not only the bombing but also the post-bombing civil war.

When the bombing happened there was a whole lot of mesh that was dropped on the electrical system so that the whole system in Iraq short-circuited. The power was down, so the sewerage system and the chlorination system could no longer work. Coming into an area when, having been in a previous cholera outbreak, immediately you recognise the smell, you know exactly what it is. This is a form of biological warfare because the whole electrical system got knocked out and the sewerage system was now actually pumping untreated sewage into the Euphrates and into the Tigris - affecting the whole population. We had outbreaks of typhoid, cholera and gastroenteritis and that had a very dramatic effect on all parts of the Iraqi population - the Shiites, the

Kurds. We documented what the effect would be on the population in Iraq and we then went back to the US and to Washington.

We had started out as "The Student Commission on Civilian Casualties", but by the time we got back we'd dropped off the "Student" bit because that wasn't so cool and then we changed our name to "The Harvard Study Team." We had a pro bono PR firm from Washington who really knew their business and our aim was to get this story on the front page of the New York Times and when there are 200 stories a day that isn't very easy. Through their skill - not ours - we actually did. We wanted to do the whole story to get this into the UN so that the sanctions could be reduced and that food and clean water could start to come into the country because that was the major problem for the Iraqi population. As it turns out that started the whole notion of the trade of oil for food.

Medecins sans Frontieres was working up in the north with the Kurdish populations, coming down through Turkey, providing care for Kurdish refugees who'd moved very quickly. Having travelled within Iraq at that stage we could absolutely understand why people feared Saddam, and fear him today,. Whoever puts their hand up gets knocked off very quickly. It's still a major problem today. There are sanctions going on but it is unfortunate that it is the population who are held to ransom by Saddam and also by the sanctions.

In Somalia most of you will remember the civil war and the famine and the notion of humanitarian policing or peacekeeping. At that time Medecins sans Frontieres got very involved in drawing attention to the inappropriate behaviour of many of the UN troops who were behaving in ways that were quite contrary to humanitarian law.

In 1994 virtually all of the sections in Medecins sans Frontieres were involved in the Rwanda/Zaire genocide crisis. Because they had a number of teams already in place, they were the first to call for international assistance around the genocide. This was again a major problem of do you stay or do you go? One of the problems was with the people moving out of Rwanda into Zaire, they were still controlled by some of the Rwanda Patriotic Army who were the ones who committed the genocide in the first place. So by providing care in this situation they were reinforcing the terrible work that had been done, the killing that had been done by the Rwandans. That was a major problem and again it was a terrible decision to leave but, on the other hand, by staying they felt they were propping up the dreadful situation and, in a

sense, you need to be able to make a statement so that, hopefully, the situation changes.

In that year Medecins sans Frontieres Australia was established and from then on, Medecins sans Frontieres has been involved every year in virtually all of the major catastrophes or humanitarian situations that have occurred.

Hurricane Mitch was a major problem in Nicaragua. An Australian doctor, Jane Connor, working for Medecins sans Frontieres unfortunately disappeared in a helicopter going out to save people. As it has been articulated over the last 30 years, the principle of Medecins sans Frontieres is that the reason for being there is medical action. At the same time, the notion of witnessing is an integral part. You can't be silent. You need to be able to say what is happening. If you listen to reports from areas of disaster, often the first person you'll hear is a Medecins sans Frontieres doctor, simply because they happen to be there either before or very quickly after. I bet you in the next six months or a year when you listen to a particular new problem that's occurring then one of the first people you will hear will be a Belgian or a French or now an Australian voice telling you what's happening.

Obviously, respect for medical ethics and a defence of human rights and independence and witnessing can sometimes be seen as political and that's where there are some real tensions about working in the field where you stand in between the refugee population that you may be looking after and, for example, the local police. That happened to us in the Sudan, particularly when there were problems with the Sudanese who were brutalising the Ethiopians or Eritreans. What do you do? How do you act in that way without becoming so embroiled in the situation that you became an active dependent rather than an independent active? That's why we try to keep a notion of impartiality and a spirit of neutrality within the other principles of any good organisation; transparency and accountability. It's still an organisation of volunteers and association of members. That's what's very exciting for me, to work on their Board. I go to Sydney every so often for their Board meetings and there's a real spirit of volunteerism - which has been so, so successful during the Olympics, so much so that I was rung up today saying that there is a new disease - SPODS - Sydney post-Olympics Depressive Syndrome. I was asked whether there was MPODS, a Melbourne equivalent and I said, "We didn't have such a high here so therefore the low won't be as bad." It was the notion of no volunteers around to cheer everybody up, that's why they're feeling

a bit sad up in Sydney. And someone else said "Oh well, if the Sydney people are feeling sad that makes Melbourne people feel happy." But I didn't believe that.

The charter of Medecins sans Frontieres reinforces that it is about offering assistance to populations in distress, to victims of natural man-made disasters and to victims of armed conflict, without discrimination. When I was in the Sudan there were a lot of people who had worked in Afghanistan, probably the most interesting and the coolest, because they used to dress up as the local Mujahadeen and come in through Pakistan and live this incredible existence which was quite dangerous but exciting at the same time. Within Medecins sans Frontieres circles, this was no doubt the mission to have done.

Another part of the charter refers to respecting neutrality and impartiality. This question of the right to humanitarian assistance and demanding full and unhindered freedom in the exercise of its functions is a very hard phrase to make sure to adhere to. On the other hand, if the sense of the charter of the organisation is well known then it's actually easier to push in countries if the reputation goes ahead of the people. Maintaining independence from all political, economic and religious powers can become quite clouded at any time, in that you take a side because the side may be seen to have some political, economic or religious association. There is the issue of people understanding that when they do this work they are undergoing risks and dangers and don't have a right to compensation for themselves or their beneficiaries other than what is available through Medecins sans Frontieres.

In the very early days Medecins sans Frontieres were known as "cowboys" because they'd go in and be pretty gung-ho. I was working with another organisation at that time so we would complain a bit. They have become very, very professional about what they do, they really evaluate what they do very well, and they improve their systems and have been major contributors to improving what is done in these situations. Mike Toole at MacFarlane Burnet Centre is probably one of the three leading people in the world on refugee health care. He's done a lot of work with Medecins sans Frontieres about improving the situation. In many cases there are people that get involved in humanitarian care who in some ways think with their heart rather than their head and provide quite inappropriate assistance, such as used IV needles or used stuff that they think might be nice to send to a poor country. Well, it's not very useful. There was one case of a dentist's caravan that got sent over from the States and it was huge and it got

shipped to Port Sudan and then got driven about 1,500 miles all the way down on the back of a truck to a place called Showak, then got plugged in to the local electric supply and the rest of the town's lights when "bzzzz." In it they had these wonderful tablets: banana-flavoured appetite suppressants. The irony was a bit strong for a place where there was not much food. They were thinking but they weren't thinking too clearly. The notion of making this not a humanitarian exercise that is done with your heart but a humanitarian exercise that is done with your head and is as professional as anything else that we might do in either the law or medicine is very important.

There are five operational sections: France, Holland, Spain, Belgian, and Switzerland. They aren't without disagreements. International organisations aren't easy places to run and for quite a long time the French would fight with the Belgians about different issues. In particular, the French have always been much more interested in the acute issues and the Belgians were much oriented around development. They wanted to work out what do you do after you've been there for six months. Do you stay or do you go? And those questions have been quite difficult to deal with. Because of this rapid growth in a number of sections, they also decided that international support agencies like the one in Australia wouldn't be operational themselves because otherwise you would have, for example, in Indonesia maybe 10 or 15 different sections of Medecins sans Frontieres all trying to operate together. That is why there are only five operational sections. The Australian group is in charge of recruitment, communications, fund-raising and also intelligence gathering about what's happening in the region. It looks at where Medecins sans Frontieres should be responding, particularly in support projects in Papua New Guinea, in Bougainville and many throughout Indonesia. It also recruits a lot of people for other parts of the world. Medecins sans Frontieres is working in about 80 countries. The 1998 data shows 2,600 departures of mainly medical and para-medical staff but also a number of non-medical staff.

If you look at what is the best thing to do in a refugee situation you need food, water, vaccination and commonsense. It is important that the logistics are done very well, because if you have good doctors and nurses with poor logistics then you don't do a very good job. Dealing with a cholera epidemic is more about planning and logistics than it is about acute medical interventions. On the other hand, once things have stabilised then having very good medical systems can be extremely important in lowering mortality rates quite quickly. In many cases

specialists are going to particular situations where that's appropriate. The important thing is to have the right horses for courses. In terms of Australia, in 1999, there were 77 missions - these doctors, nurses and specialists and admin and logistics people are doing some very interesting and very important work in a whole number of countries.

So what does Medecins sans Frontieres do? There is medical and surgical care, hospital rehabilitation, public health programmes, nutrition programmes, developing centres for therapeutic care, nutrition for really sick kids, or centres for supplementary nutrition for kids who aren't quite as sick. There are vaccination programmes because in every situation where you've got mass movement of people, the first thing you have to do is vaccinate against measles. It's the unwritten law. If you don't, then you risk very high death rates. Expanding those vaccination programmes is also important.

Obviously, looking after water, hygiene and sanitation is essential. Often in these situations there are different non-government organisations. Some NGOs have more expertise, such as Oxfam in water hygiene and sanitation. Medecins sans Frontieres does less of that and does more of the vaccination and the medical care. Training is very important in terms of working with local health care workers (a) because you need to by virtue of numbers and (b) in terms of what is left behind.

There are basically two types of projects. The first is the very unstable war situation and the natural catastrophes where there is major man-made or nature-caused displacement of populations where there's a risk of epidemics. There is generally an acute phase and then a chronic phase and often there is the difficulty of how long do you stay? There is also the issue of costs of support but as I mentioned before, often the services that are being provided for the refugee population might be far more than the services that are being provided for the local population. The second type of project is the more stable programme where Medecins sans Frontieres has been really very active. When I was in Uganda they had a very successful HIV programme in the north that contributed to the national response. They have been involved in a whole range of other particular public health programmes and also in supporting health systems and getting to people who can't access health care systems. In Nepal, for example, in Northern India when you have to travel for two or three days to get to health care systems, then helping to provide the extension of health care services is very important.

How does Medecins sans Frontieres get going? I must admit every time I hear of a catastrophe I think people have to be pretty much switched on and responsive to virtually everything that happens. It's like our own SES. Medecins sans Frontieres might find out from media, other NGOs. They develop a crisis cell. A group of, say, three people is then sent out on the next plane to have a look around, see what's going on, get as precise information as possible about what the situation is like, report back, then a decision to open a mission or not, sending a team and materials which are all in a sense pre-packed. The people aren't necessarily pre-packed - but the equipment is. If a field hospital is needed then that's fine and all the equipment for running a nutrition programme for 3,000 kids is there ready to go.

As I mentioned before, there is regular evaluation of programmes and constant thought about modification and closure of programmes. Medecins sans Frontieres now has Fondation Medecins sans Frontieres based in Paris which is looking at overall issues of humanitarian law, of humanitarian practice and, as I said before, the issue of do you stay or do you go? There's a clever Australian woman, Fiona Terry who is working there, who has recently done a PhD in this whole area and is now applying that work to looking at how we improve humanitarian law and how we improve humanitarian practice.

In a typical Medecins sans Frontieres mission, there is a co-ordination team in the capital and then maybe three or four projects in the centre. Life in the field is interesting. You go and live in a group that you may not choose to live with from day to day. When I was running this particular team, one day I was sitting there before breakfast and three or four people came up and said, "We're going. We've had enough. We're off." I felt terrible. This was my responsibility to run this team and try and keep it together. They ended up staying but it was a very stressful time when everybody was under pressure. We were seeing 600 to 800 patients a day and, as I said, the refugees were doing far better than we were. The issue of cultural understanding, of trying to accommodate those differences of how people see their own health - we're introducing a brand of Western medicine - and accommodating differences of culture between those people providing health care services and those receiving them, let alone the differences within the team makes for a very interesting time.

Lastly, when people come back from a mission then they have time to debrief and to evaluate. What we've instituted in Australia is to make sure that they have access to counselling and access to

psychological debriefing because many have been in quite traumatic situations. Unless they do have access to being able to deal with that we don't feel it is a healthy situation. Medecins sans Frontieres in Australia is providing pre-departure courses for doctors and nurses who want to go, both at James Cook University and the MacFarlane Burnet Centre and is very keen on getting people to do two or three missions. Obviously, people can't keep doing them forever and ever because you don't get much money or you get no money. But, on the other hand, from my point of view, I guess I have learned more from that particular job and other similar situations than from anything else I have done.

QUESTION: Where does the money come from?

DR MOODIE. It comes from two places. One is from private donations and the other is from government. Medecins sans Frontieres is committed to never having more than 50 per cent from government and in fact in several instances won't take money from, for example, Australian aid agencies or the US aid agencies, where that might compromise what they are doing. I must admit the Australian population and, particularly, the medical profession is very generous because we now have a "doctors for doctors' Day" and the responses generally are exceptionally good. In France, for example, private funding has been a major drive. In Belgium the European Commission provides a lot of funds to the Belgian group and to the Dutch group. But we don't want the government to ruin our independence. That is why a level of private support and donation is very important.

QUESTION: Working under these conditions must be very emotionally demanding, very stressful. How do you cope with that? How do you handle the human misery and the difficult circumstances?

DR MOODIE. It really depends on the situation. I've been in Sudan twice, one time working for Save the Children Fund for nearly two years and the other time working for only about four or five months with Medecins sans Frontieres. The second one was far more stressful. Again, because of the role I felt I had to play and the changing situation. I didn't cope all that well, to be honest. The best way is to create a good team that is very supportive, where people have an opportunity to talk and discuss and work through it. In the Sudan the second time I used to look at my wedding ring because it's got an inscription that says "All things change." So the notion that this doesn't last forever was actually a relatively reassuring thought.

QUESTION: I'd be interested in knowing how things work out from a clinical perspective when you have a team of people who have

been trained in very different ways: a Dutch nurse working with an American doctor supported by someone trained in Australia in some other field. How do those differences in background sort themselves out?

DR MOODIE. That's a very good question. What Medecins sans Frontieres has done is to produce a number of protocols for public health approaches and clinical approaches and, generally, the simpler the better. The rules say, "This is the minimum set of standards about how things should be approached", and were developed about ten or 15 years ago in response to the issue that you raised. But that doesn't stop that question of intra-team "argy-bargy" about "Our way's better than yours."

QUESTION: You mentioned universal medical ethics. What are they? Are we such a homogeneous profession that we can have these standards, these agreed values which are translatable from one place to another and from one intolerable situation to another?

DR MOODIE. It's a bit like universal human rights. It's a matter of establishing a baseline of medical care that is situation specific because often the ethics of doing one thing in one particular situation is unethical in another situation. There is a very interesting debate going on at the moment about clinical trials of HIV treatments in the developing world with AZT in particular. My view is that not to have done those tests, not to have run those clinical trials was unethical and people say "Well, this is the way we run it in the West and it has to be run this way in developing countries with completely different resource capacities." I think you're right that there is no universal code. I guess there's a universal spirit that somehow you have to try and apply.

QUESTION: How do you meld in with all of the other charitable organisations like Red Cross and Oxfam?

DR. MOODIE. I haven't been to an acute zone for quite a few years and I was discussing this recently. Certainly the level of co-ordination is much greater than it was. In 1985, there was a fair bit of elbowing about who's doing what and "We're good at this" and that took quite a bit of organisation. Generally, the United Nations High Commission of Refugees is there and they have the mandate through the local government to provide the co-ordination. They generally bring in the groups that are there and then say, "Okay, Red Cross you should be doing this. Medecins sans Frontieres this. International Committee of Refugees this. Oxfam this." When there's a man-made disaster you'll have a number of different agencies who will be doing exploratory

missions and there is a negotiation process about do you stay or do you go? On the other hand, there will always be some organisations that come that may not necessarily have the right experience.

QUESTION: Rob, as a lawyer would I be mediator or a medicator if I was to join the group?

DR MOODIE. You'd be a mediator. Half the people who go are non-medical, either because they're exceptionally good at logistics or they're good at running teams because you need good management in any situation. It doesn't have to be medical or nursing and the more I work in public health the more I realise that we're actually not very well trained for management. So people who are good at that have a natural advantage.

QUESTION: What is the difference between Medecins sans Frontieres and the Red Cross? Why did you not join them?

DR MOODIE. The International Red Cross has, by virtue of its charter, less freedom particularly for the witnessing and the overt naming of what's going on, because in most countries Red Cross is within that country and therefore has a more restricted role. But I think that it's not a case of either/or. We do need a plurality of groups. I have great respect for the work that Red Cross does or Oxfam or CAA or Care Australia or World Vision. We will never all get under one roof. I don't think we should

QUESTION: I'm a psychiatrist and I'm responding to your comment about withdrawal of psychological support. There must be several hundred professional staff or thousands now who have been involved with this over the years and I just wonder if there has been any follow-up to assess the general welfare and particularly psychological welfare of the people involved. My guess would be that they're highly motivated, they're not paid, they're relatively exposed but they're doing good work in extremely traumatic circumstances and I wonder if the outcome is essentially negative or largely positive.

DR MOODIE. Certainly, from my experience with the people who have done this and my own experience, the experience is positive. There is no doubt about that. There are some people that get into real trouble because they are the wrong people in the wrong place at the wrong time and where there is a real clash between what they are doing and what the other members of the team are doing or what they're doing and what the organisation is doing. There have been horrific experiences for people who have either injured themselves or been psychologically injured in places like Rwanda and Zaire. I think there has been a

follow-up done by Medecins sans Frontieres in France. We discussed this issue recently for Australian volunteers, simply because we need to set up a system so that people have good access to debriefing and psychological support when they get back, not just for the first week or two weeks but when they need it after three months or six months.

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