Experience as an emergency physician in Sudan

It is already more than a year since I returned from South Sudan—a place where I worked for *Médecins Sans Frontières* (MSF) for 5 months. I knew of MSF through a display I had encountered as a medical student. I had been particularly impressed by one poster, which showed two surgeons—one black, one white—absorbed in surgery. The picture was so inspiring that I had decided to join MSF at some stage after my graduation.

Before heading off to Africa, I spent the first 4 months of 2002 at the London School of Tropical Medicine and Hygiene to prepare myself for the coming challenges. After the MSF pre-departure preparatory course, I set off for Lokichokio, Kenya, a town near the border with Sudan, where the headquarters of MSF for the Southern Sudan and many other non-government organisations, including the International Committee of the Red Cross (ICRC) are based. South Sudan has been blighted by over 30 years of civil war. *Médecins Sans Frontières* started humanitarian work in South Sudan in 1978. The Charter and Code of Conduct for the MSF is based on temoignage (witnessing and advocacy). Besides providing primary health care in South Sudan, MSF plays an important role in emergency preparedness, assessment, and response for:

(1) war wounded;
(2) displacement;
(3) epidemics; and
(4) famine.

I worked as a 'mobile' doctor. There was one primary health care centre (PHCC) and a few primary health care units (PHCU). The PHCC, which included in-patient and out-patient units, was quite well-organised. The in-patient unit included a 10-bed paediatric ward, a 10-bed adult ward, and a four-bed obstetric ward. The out-patient unit included the out-patient clinic, and the maternal child health care unit. As a mobile doctor, I moved around these units, supporting local staff running the clinics.

Sudanese women are required to be strong and tough. They do all the household tasks, as well as agricultural work. It is not uncommon to see pregnant Sudanese women walking barefoot to the farm carrying enormous loads of wood, and a child supported by goatskin. The environment is harsh. Infant mortality is believed to be as high as 20%. Women are considered blessed if they give birth. If they do not, they may be divorced by their husband, and even asked to return the marriage presents (often cows) given to the bride's family. As a result, the women are under pressure to have as many children as possible. Most deliveries in the villages are attended by traditional birth attendants (TBAs) and only some of the TBAs are trained.

Obstetric practice proved a major challenge. There were a lot of obstetrics complications seen, such as obstructed labour, postpartum haemorrhage, wound infection, neonatal tetanus, vesicovaginal fistula, and anaemia. I saw one patient who gave birth in the village where the TBA had cut the umbilical cord before the placenta had been delivered. By the time the woman reached the PHCC, it was already evening. There was no electricity and the solar lamp could hardly provide enough lighting for me to work. I tried syntocinon in vain. The over-sized 7.5 glove made things more difficult, as I could hardly differentiate the folded-up glove from the placenta. Fortunately, I was able to accomplish my first manual removal of retained placenta. At the end of the procedure, I noticed that the whole village had climbed over the roof of the PHCC to watch the scene, nearly causing the roof to collapse. The next morning, the woman's pulse was noted to be 120 beats per minute because of anaemia. Only then did I observe that the local nurses did not know how to take the pulse accurately and that the previous monitoring had been erroneous. Refresher courses were promptly organised for the local staff.

Surgical cases were handled differently. All surgical and war-wounded patients were transferred by air from Sudan to the ICRC in Lokichokio for treatment. Although MSF has worked in South Sudan for many years, it has no plans to upgrade the PHCU to a surgical unit. If a patient misses a flight, he/she has to survive a further 10 days until the next one. This can create a lot of frustration for doctors, as they are without the means of providing appropriate care. One evening, I attended a woman with term pregnancy who was brought in by the local ambulance (a blanket tied to a pole) 2 days after the onset of labour. No foetal heartbeat was detected and she was running a fever. The next flight would not be for 3 days. In an attempt to save the woman's life, I undertook a cruciate craniotomy of the foetus to drain the brain—a surgical procedure described in the textbook of *Primary Surgery: Volume 2: Trauma*. The dead foetus was already foul-smelling. I gave the woman antibiotics and hoped for the best. Despite initial improvement, she died the next evening.

I visited the ICRC once when I passed through Lokichokio. A Sudanese woman came over and spoke to me in her tribal language with great excitement. I did not recognise her and although she made gestures at her abdomen, I remained puzzled. Then she held my hands gratefully and brought me through the ward to her baby. Now, I remembered. This was an unfortunate woman of small stature who had lost three babies because of obstructed labour in the bush, and her husband's family had been about to send her back to her family. After seeing her at the PHCU

during her fourth pregnancy, I had referred her to the ICRC for elective caesarean section. She could finally smile in satisfaction at having a healthy infant and it was very gratifying to see this positive outcome.

In a large organisation, such as the MSF, planning is critical but may be negated by local events. We had organised a vaccination campaign following an outbreak of tetanus and had been to the villages to mobilise people, ordered the vaccine from UNICEF, and organised all the logistics and necessary manpower. Suddenly, the civil war became tense and the Government of Sudan announced a ban commencing in 24 hours on all flights over South Sudan, even United Nations ones. We had to go back to the village to announce cancellation of the vaccination programme, and to organise flights to decrease the number of expatriates on the ground within 24 hours for safety reasons.

Although I only spent a short time in Sudan, the experience with MSF has had a considerable impact on me. I am confident that it will remain a particularly memorable part of my professional career.

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I. Clinical profile and genetic basis of Brugada syndrome in the Chinese population

A	1. True	2. False	3. True	4. False	5. False
B	1. False	2. False	3. True	4. False	5. True

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II. Obstructive sleep apnoea syndrome and obesity in children

A	1. True	2. True	3. False	4. True	5. True
B	1. False	2. True	3. True	4. False	5. True