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Speech for Florence Nightingale International Achievement Award.
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I'm very honoured to be here today receiving this very prestigious award, named after a woman who accomplished so much in her lifetime; Florence Nightingale. She truly changed and professionalized the work of nurses in wartime as well as in peacetime.

In 1991, one year after my graduation from nursing school in Sweden, a friend and I decided that it was time to travel the world, so we left on a back-packing tour. In India we stayed in Calcutta for a while and I volunteered to work as a nurse in one of Mother Theresa's hospices. It wasn't really a long period, I think only two months, but it was an experience that in a way changed my perception of India, but also of poverty and vulnerability; to have absolutely nothing and to have no-one to rely on if you are ill. I think I only understood or saw a glimpse of people's reality. Even so, that glimpse made me very angry and frustrated. The realisation of the profound inequities between people, regardless of all international talk and work for a more equal world and for the realisation of human rights. That's what I started to understand there at Khaligat in Calcutta and it's still keeping me and driving me to continue my work today.

In 1859, Florence stated that:

"No man, not even a doctor, ever gives any other definition of what a nurse should be than this -- 'devoted and obedient.' This definition would do just as well for a porter. It might even do for a horse". As a representative of a medical humanitarian organisation where nurses play a crucial role, I truly hope that her quote is no longer valid. And that we nurses have gained the recognition we deserve and I guess just being here today is a proof of that.

I want to share the honour with my colleagues. One third of the international volunteers and a big part of the staff employed nationally in Médecins Sans Frontières projects around the world are nurses. Nurses that are working in positions with considerable responsibility, as field nurses with direct patient care, as emergency- or project-coordinators, as mission responsible, as operational directors...

Over the years I worked with some truly remarkable nurses working in the often underfinanced national health care systems. Nurses who choose to fight for the right to care for their patients, be it HIV/AIDS patients in settings where ARV treatment has been too

costly and yet so needed. Nurses who did everything in their power to ensure quality care in very basic settings. Those who had to take on far too big a responsibility, because there were just no doctors available. Others who refused to become part of civil wars but chose to treat patients from all sides in a conflict. This might seem obvious for any of us but it takes some courage and strength when you are treating the people who killed your family members.

I will try to tell you about some of my experiences and thoughts around nursing in crisis and war torn areas. I would as well like to share some thoughts about the humanitarian dimension of this work. Since I just returned from Niger, the situation there will also be of special focus.

Several times, in my work with Médecins Sans Frontières, I have been part of re-opening hospitals and health centres that have been looted and abandoned in the midst of war and fighting. These projects have been important and in many ways obvious. People affected by war and catastrophes have a right to humanitarian aid. We were often able to contribute also in a longer perspective with knowledge, capacity building and rehabilitation of buildings. But even when this failed, when buildings were torn down, people, including the health staff, were fleeing; it didn't mean that our work failed.

Humanitarian work is about saving lives and alleviating suffering, *here and now*. Every life counts. The humanitarian act is carried by a universal conviction that all people have the same value. The humanitarian imperative implies an obligation to assist people in need, to give first aid and to offer protection. In other words, people have a right to humanitarian aid, because they need it, not because they are part of a particular ethnic or religious group, because they are "the enemies of your enemies" or because they are considered as part of a military strategy aimed at "winning hearts and minds". Humanitarian aid is not a tool to end war or to create peace. "It is a citizens' response to political failure. It is an immediate, short-term act that cannot erase the long-term necessity of political responsibility"¹.

I remember a conversation I had once with a Swedish state official who was thoroughly disappointed in a project by Médecins Sans Frontières in Burundi, where I had worked. He claimed that nothing was achieved since he saw no trace of our work. We hadn't achieved any sustainable change with our humanitarian work. I was thinking about Nkurunkie, and Sebastian, two young people who had been attacked during the war and whom we had

¹ MSF's Nobel Peace Prize speech, December 1999.

saved at the hospital. The patients cured from tuberculosis. The children born through caesarean sections and the women who survived the complicated deliveries. Even the women who arrived at the hospital with their uterus ruptured after long and obstructed labour, where we were able to save their lives. But also about the improvements in nursing procedures that Rebecca – the head nurse – and I implemented and that actually meant the difference between life and death for severely ill patients. How we treated Hutus AND Tutsis without distinction, in the midst of a protracted civil war, when this was far from obvious. To me, those are the real achievements of humanitarian work.

When talking about war and catastrophes, the images we often see in front of us are of violent attacks, wounded and displaced people. In most conflicts today this is also the cruel reality. However, after some time you come to realise that health care in a war situation is different but also the same as in any other situation. Most of the patients I have met have not been wounded by bullets or grenades. Even if the situation in Freetown, Sierra Leone was awful when I worked there during the spring of 1999 - we treated so many people who had been brutally mutilated by the rebel army - the need for primary health care still remained a crucial one. During days of intense fighting around us in Chechnya, in 1995, we had to do triage among all the people who had been wounded. Some were in such a bad state that if we would have focused our efforts on saving them, many others would have died meanwhile. All we could do was to ensure that they were not suffering from pain. Still, most of the time our work focused on sustaining basic health care; treatment for the children's respiratory infections and diarrhoea, treatment of skin infections and hypertension. People are often more at risk in various ways. Many have fled or been chased away from home. Lack of food, clean water, soap and space, makes people more vulnerable than usual.

In the last decade it has become more obvious how exposed women are in conflicts and how alarmingly common rape is, as a mean of warfare. This knowledge has to be transformed into action - in our practical nursing work but also in advocacy.

We have learnt that also after natural catastrophes such as the Tsunami or the earthquake that hit Pakistan one and a half years ago, that the immediate lifesaving efforts need to be combined with rebuilding of destroyed health facilities and health infrastructures. In a situation of abnormality we need to work towards normality.

For the sake of the people we aim to assist, we have to combine commitment with professionalism. It's not enough to have a big heart and WANT to "do good". As in any other medical work we need to learn from our and other's experiences. Both on an individual as

well as an organisational level, we need to be prepared, also to deal with the unexpected. We must base our work on needs. We have to be accountable towards those who finance our assistance but, most importantly, towards those we aim to assist.

When I worked in Niger 2005 I recognised the same feeling as in Calcutta nearly 15 years earlier. Again I felt the same frustration over the daily reality that many people are facing. After some years of work in Sweden, it was my first international mission since my children were born. I was working in an emergency nutrition project.

Niger is one of poorest countries in the world, over two thirds of the population is living on less than 1 USD a day. As many as 40% of the children under five years suffer from chronic malnutrition. Nearly half of Niger's population lack access to health care. The child mortality is among the highest in the world, where one in four children will not live to see its fifth birthday. The lifetime risk for a woman to die in complications from pregnancy or delivery is one in seven. This year the "hunger-gap" was worse than usual and among the smallest children we saw an epidemic of acute malnutrition. It was disheartening to realize the feeling of desperation you must feel as a parent when you can't protect your child from malnutrition, when you don't have any food to give or to share. It also made me frustrated and very angry, since I had seen hundreds and hundreds of severely malnourished children in the last weeks, and since I knew how the food aid had been delayed and put on hold with political and economical arguments. I knew that our nutrition clinics wouldn't solve the problem of poverty and other underlying causes to food shortage but I know that for the thousands of children we treated it meant the difference between life and death.

I'm just back from a second mission with Médecins Sans Frontières in Niger. In recognition of the high child and maternal mortality figures, the government of Niger has passed a law that should make health care for children under five as well as for pregnant women free. The system still needs to be set-up and *financed*, though.

In the district of Dakoro, Medecins sans Frontieres were setting up a project where the aim was to provide health care, free of charge for children under five years of age and to pregnant women, in line with the government policy. We were also addressing the ever present problem of malnutrition with a nutritional programme for children suffering from acute malnutrition.

I want to share some of my experiences from this distant district and from a small health centre in a village called Sabon Machi, with you. Together with my colleagues from Niger I

started the activities in this centre, initially focusing on child health care and, in collaboration with World Vision, on nutrition. The small health centre used to have around ten consultations per day. In our first three weeks we saw more than 1 500 sick and/or malnourished children.

One of my most valued moments during these weeks of work was when the government employed nurse, who was responsible for the health centre, came to show me his vaccination register. We had agreed that he would keep vaccinating all children and now he came to show me the big increase in number of children and how he had vaccinated a few that were already almost one year old and hadn't received a single dose of vaccine before. Even if vaccinations had been free before, the attendance at the child clinic brought up the numbers and for Tassiou it meant that he could reach a much bigger number of children. Children who will not fall ill with measles or die of tetanus. He was very content, even happy.

In the whole program, we were treating more than 3 000 children suffering from acute malnutrition only a few weeks after opening the project, still with the "hunger-gap" in front of us. This is the "normal" situation, and yet there is nothing normal about it. How can the death of almost 200 000 children each year, year after year, in Niger be anything but a catastrophe?

How can the grandmother's shudder, as a gesture of resignation seem trivial, when she tells about her four daughters, three of whom have died in complicated pregnancies? She had brought her granddaughter to us, a fifteen day old baby, weighing a little over one kg.

How can a health system force the nurses in a hospital to wait for the relatives of a severely injured woman to buy all material and medicines, before starting any treatment? Such a situation violates general medical ethics. This is what happened in Niger when I brought a woman to the city hospital. Yet, it is happening in so many health facilities in poorest countries but also in the richer world.

In my country, Sweden, one of the most vulnerable groups in society, the undocumented migrants, have great difficulties in accessing health care. Cost and fear of being found and deported are the main obstacles. As undocumented you do not receive any subsidies but are expected to pay the full cost for care. That means 3 400 USD for a normal delivery. Primary health care is almost inaccessible and for a doctors consultation at an emergency room the cost is almost 300 USD. This is as impossible as the 20 USD that was charged for the x-ray of the woman that was injured in the car accident in Niger.

Peoples' right to life and right to health - their right to access to basic health-care, is not only applicable in times of war, but also established in human rights conventions ratified by most of the world's countries. For the rich countries, the donor countries, these conventions also establish a duty to help poor countries to live up to their responsibility.

Despite this responsibility, the same donor countries are requesting that many of the poorest countries are keeping their social costs at a very low level, in order not to create financial imbalance.

Just one week ago in Johannesburg, Medecins Sans Frontières sounded the alarm over the human resources crisis for health care across southern Africa. We stated that, if we want to be serious about providing treatment to much higher numbers of people who live with HIV, we need to give more responsibility to nursing staff. We also stated that governments in the region should do much more to retain their nurses by addressing inadequate salaries and poor working conditions. And we called upon international donors to stop using arguments of "sustainability" for imposing limits on investments in health staff.

When you are working in the everyday reality at a health clinic in Sabon Machi, it's very difficult to understand the discussions about sustainable development and the risks of aid dependence. How can we sacrifice the lives of these children for the sake of sustainability? I'm sure I'm wrong in many ways and indeed financial development of a country is crucial. But I'm also sure that there is not *one* right answer. In a war - peace would be the ultimate goal, in a situation of deep poverty - development and poverty reduction is needed. As a nurse working for a humanitarian medical organisation my responsibility is neither of those. I am working to save lives and alleviate suffering and I'm not doing it to solve the overall situation. I'm doing it because it has to be done - because it's the decent thing to do.

Do we have a responsibility as nurses, as health professionals? A responsibility to treat? To act? To raise our voice? I think so. That is one of the main reasons why I choose to work for MSF who sees the responsibility to speak out as a very important part of the identity. One of the reasons that I'm so proud to be the recipient of this award is also this aspect of Florence Nightingale's work. She saw it as a responsibility to raise her voice and to advocate for what she believed was important. She fought for health care for people regardless of faith or economic background, especially for the most vulnerable.

Thank you once again for this prominent award and also for this chance to speak to you today. Thank you for taking the time to listen.