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Winter 2024

Dispatches

SITUATION REPORT

Photograph © Finbarr O'Reilly/VII Photo

1. CHAD

MSF doctors Faiza Hamed Hangata (centre) and Lara Rivero Ali (right) work to resuscitate ten-year-old Haidara, who has tracheal bronchitis and septic shock, watched by the boy's father Zaharia (left), in the intensive care unit of MSF's hospital in Metche, eastern Chad. Metche camp hosts some 40,000 Sudanese refugees who fled violence in Darfur. More than half a million refugees have settled in eastern Chad since war broke out in Sudan in April 2023.

Photograph © Eugene Osidiana/MSF

2. KENYA

Dahabo Qole Abdi has lived in Dagahaley refugee camp – one of the three camps that make up Dadaab – for 30 years. MSF first began working in Dadaab, located in Kenya's eastern desert, in 1992, providing medical care to the mostly Somali refugees who had sought shelter there. In recent months, a combination of drought, flooding and a new influx of refugees from across the Somali border has resulted in significant strains on the residents of Dadaab, as well as on MSF's hospital and health centres in Dagahaley camp, which currently hosts more than twice the number of people for which it was intended.

6,030

Number of surgeries conducted by MSF in Sudan between January and September 2024.

Photograph © Abba Adamu Musa/MSF

3. NIGERIA

MSF nurse Yakellu takes a blood sample from a patient to test for malaria at Teacher's Village camp near Maiduguri, after severe flooding in September forced some half a million people from their homes. As well as providing outpatient consultations in the camps, and medical referrals to specialised health facilities elsewhere, MSF teams are providing clean water, installing and repairing latrines and distributing mosquito nets.

Photograph © Olexandr Glyadyelov

4. UKRAINE

Pavlo, aged 25, is stretchered into an MSF ambulance to be taken to Dnipro for treatment for leg injuries. The war in Ukraine has caused large numbers of casualties and resulted in significant damage to health facilities, making access to medical care increasingly difficult for people living near the frontlines. MSF operates 15 ambulances dedicated to medical evacuations of wounded patients, more than 60 per cent of whom have serious war-related injuries, including shrapnel wounds, amputations, burns and blast injuries.

60%

of patients transported by MSF in eastern Ukraine have suffered serious war-related injuries.

6. ABYEI SPECIAL ADMINISTRATIVE AREA

An MSF Land Cruiser gets stuck in the mud on the road between Abyei town and Agok, in a region contested by Sudan and South Sudan. Due to the poor roads, the 38-km trip can take six hours, and water trucks are frequently delayed or prevented from reaching Abyei, which is currently experiencing an outbreak of hepatitis E – a disease spread through contaminated drinking water. Since the outbreak was declared in July, more than 30 cases of hepatitis E have been reported, with four deaths, including three of pregnant women. Poor sanitation, severe water shortages and inadequate infrastructure have exacerbated the spread of the virus, as has the arrival of more than 22,000 people fleeing conflict in Sudan. MSF teams are scaling up their water and sanitation activities in the area to help tackle the crisis.


Photograph © Godfrida Jolia/MSF

5. TANZANIA

MSF laboratory technician Safia Chale uses a microscope to analyse test results in MSF's hospital in Nduta refugee camp. Since 2015, MSF has provided free medical care to Burundian and Congolese refugees in Nduta camp as well as to people from the local community.

Photograph © Aurelie Lecrivain/MSF

GAZA/LEBANON
PHOTOGRAPHY
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'Humanity is under siege'

▲ An MSF doctor attends to Suad and her newborn baby at Nasser hospital, southern Gaza, 23 June 2024. Photograph © Mariam Abu Dagga/MSF

DR JAVID ABDELMONEIM REPORTS FROM THE FRONTLINE OF MSF'S WORK IN GAZA.

"At Nasser hospital, we provide trauma surgery and burns care to patients. One Saturday early in my time there, we received hundreds of injured, as well as people who had been killed, following a missile strike. We first understood that something bad had happened from the enormous explosions, which were closer to the hospital than ever before. Almost immediately, we heard the ambulances.

It was chaos. Our team went to the emergency room. One of the injured was a three-year-old girl. She was breathing and looking at me – so she must be okay, I thought. But as I rolled down her dressing, I found that her entire left thigh was open to the bone.

Seconds later, the doors crashed open. Four to five injured people were brought in, most of them first-aid responders. Among them was a boy who wasn't breathing, so we tried to revive him, but the nurse looked at us and asked: 'Why are we responding to him if he can't breathe? We have to save other lives.' No one had the heart to call it and move on to the next person. He was someone's child. But we had to move on to the next, and then the next, and this continued for another four and a half hours.

In the emergency room, there was blood all over the floor. I had to kneel to see the patients, who were sprawled everywhere because there were no beds left. I could feel my knees getting wet from the blood. At the same time, more and more patients were coming in.

I've responded to mass casualty incidents around the world and the smell of blood is the same wherever you are. But, here in Gaza, the horror really hits home. In the middle of our work, we saw our colleague, an MSF anaesthetist, in the emergency room. I asked him what he was doing there and why he wasn't in the operating theatre. 'I've just heard my house has been destroyed and my daughter and nephews are in here somewhere,' he said. Later, we found out that his nephew had been killed. Our colleagues are all directly affected by the violence and displacement.

'The hospital is a sanctuary'

▶ Staff at an MSF mobile clinic set up on Beirut's seafront provide healthcare and medicines to people displaced by the conflict. Photograph © Salam Daoud/MSF

Four days later, we faced another mass casualty incident at the hospital. It seemed to never end. Our Palestinian medical staff are some of the bravest people I've ever met. Despite being shaken to their core by serial evacuation orders and nearby airstrikes, they show up to work, day after day. Despite their grief, they are there, treating patients, their professionalism shining through even as the world around them is reduced to rubble.

Because of their dedication, the hospital is a sanctuary. Together with surgical and burns care, we've got mental health counsellors working with people, physiotherapy & occupational therapy going on, and you see people improve and leave with a smile on their face. There is real physical healing happening there and it's important not to forget that.

The scale of destruction in Gaza is unprecedented. The sheer amount of bombs dropped in such a small area is staggering. When the guns eventually fall silent – and I pray that they do –what will be left? The people of Gaza will need extensive rehabilitation, not just physically but mentally and emotionally. It will take years, but they need to regain a sense of safety, something that has been stripped away from them, day by day, strike by strike.

I've worked in many wars, but Gaza has changed me. It's not just another conflict zone; it's a place where the very essence of humanity is under siege. And while I've now returned home to the UK, part of me will always remain there, with the people who have lost so much, and with my MSF colleagues who continue to risk their lives to provide care in the most harrowing of circumstances."

CRISIS IN LEBANON

In the early hours of 23 September 2024, the Israeli army launched a large-scale military operation targeting dozens of towns across Lebanon. Further bombardments in the following days led to residents fleeing these areas to seek safety elsewhere.

"Families are fleeing their homes in search of safety, many of them are seeking refuge in underprepared and overcrowded shelters," says MSF medical coordinator Dr Luna Hammad. "The people who have been displaced are very vulnerable, especially children, women, elderly people and people with physical disabilities. They are living in terrible conditions, with poor sanitation and with limited access to clean water and basic healthcare services. The needs are huge."

In response to the escalating conflict, MSF has scaled up its emergency response and deployed mobile medical teams to schools and other shelters. These teams have provided more than 8,281 general medical consultations since 25 September.

FIND OUT MORE AT **MSF.ORG.UK/LEBANON**

HAITI
PHOTOGRAPHY
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THE MYSTERY PATIENT

WHEN A YOUNG MAN MYSTERIOUSLY SLIPS INTO A COMA AFTER BREAKING HIS LEGS, **DR SOPHIE POOLEY** AND HER TEAM IN TABARRE, HAITI, MUST FIND A DIAGNOSIS BEFORE IT'S TOO LATE…

The victim of a road traffic accident arrives at the emergency room of MSF's Tabarre hospital in Port-au-Prince. Photograph © Pierre Fromentin/MSF

“Manny*’s oxygen levels are 70 per cent. He’s wearing an oxygen mask, getting the maximum we can give him. His levels should be 100 per cent, but we can’t get them anywhere near that. He’s confused, barely awake. He came into the hospital last night with two broken legs but otherwise okay. Now he’s barely conscious.

It doesn’t make sense.

Manny is being treated by our trauma team in Tabarre, Port-au-Prince. Haiti’s capital has been in a state of emergency since March, when armed groups took control of government-controlled areas. Alongside the violence, the city’s infrastructure has been damaged and traffic accidents are not uncommon.

I am one of the intensive care doctors at the hospital in Tabarre, here for a short stint to support our Haitian colleagues, who do incredible work despite the near-impossible living conditions.

We do another chest X-ray on Manny, looking for an injury that might explain his gasping breaths, for something we’ve missed. But nothing.

We go through his chart again. Manny is 28, a minibus driver who was transferred here less than 24 hours ago after a high-impact collision.

Both of his legs were badly broken in the crash. The first hospital he was taken to sent him to us for external fixators – a kind of metal framework with pins that go through the skin and into the bone to keep the fracture stable.

This is a specialist procedure in that it requires an operating theatre, trained staff and access to supplies like the fixator itself. But it is also routine, the kind of thing the trauma team at Tabarre do every day. There was no indication that Manny was a patient we would be admitting to our intensive care unit (ICU), a patient whose life was on the line.

THE PATIENT DETERIORATES

It was the anaesthetist who first spotted something was wrong.

Manny arrived at the hospital on Monday night. On the Tuesday morning, the anaesthetist came to do a pre-assessment ahead of his surgery for the fixators.

She noticed that Manny wasn’t quite right. Nothing too alarming, so she made some changes to his treatment and kept an eye on him, planning to fit him into the schedule that afternoon, once he’d stabilised.

But Manny didn’t stabilise. His breathing got worse; he became confused, scarcely awake. Having done everything they could, I was called to review him as he was deteriorating fast.

Now we have to decide whether to intubate this man and put him on a ventilator. This is the only way we might be able to improve his oxygen levels. Might. Because Manny’s symptoms are unexplained, we don’t know if it will work or whether he’ll get stuck on the ventilator, or even die despite it. And we only have two ventilators for the entire ICU, for the entire city. One is already in use.

As we’re making the decision, Manny has a seizure. He’s getting worse.

We put him on the ventilator.

▲ An MSF ambulance makes its way to Tabarre hospital in Port-au-Prince. Photograph © Pierre Fromentin/MSF

‘His gaze is totally vacant. He doesn’t blink...’

‘WILL HE EVER WAKE UP?’

We speak to his family. They understand the dilemma. He has a twin brother who’s a bit tearful and a young wife who hugs me and cries on my shoulder when I tell her that it’s possible that Manny won’t make it.

But after a few days, his oxygen levels start to improve. Gradually we’re able to reduce the oxygen he’s on to 21 per cent – the same as air. We turn off the sedation, expecting that he will wake up.

He doesn't.

We turn down the sedation but it's clear he is in a coma. He lies there for days.

We do everything we can. The physios are there with him every day. The nurses are rolling him every four hours and doing meticulous tube care. It's really high intensity to keep this man alive, intubated. But we do everything we can to optimise his condition.

His breathing improves. He's coughing spontaneously, he's swallowing spontaneously, and he doesn't really need the ventilator machine anymore.

So then we have to have discussions with the family about his future, whether he'll ever wake up. And you can never say never.

We decide that, as he can breathe by himself, we will extubate him [remove the breathing tube]. And as we're having this discussion, he opens his eyes.

His gaze is totally vacant. He doesn't blink, doesn't make eye contact, doesn't follow our movements. He just opens his eyes and I start to be scared that we might have saved his life, but not his quality of life.

We extubate him. His condition doesn't change: he still coughs and swallows and stares vacantly. And the nurses continue to give him excellent care.

A HOPEFUL DAY

The day that someone first says he is following them with his eyes, I almost don't believe it. He can already move his eyes a bit but, as I remind the team, that doesn't mean he's really looking. And then we check and he is looking, and then he's trying to mouth words, and then he's moving his arms and then his legs.

Unsurprisingly, he's very weak. Nothing like the strong young man who first arrived with the two fractured tibia. After two weeks completely motionless in an intensive care bed, he's lost a lot of weight. But he's not malnourished because the nasal gastric feeding was started early. He hasn't got pressure sores because the nurses looked after him so diligently. And although he can't walk yet, his external fixators are already in place – the procedure done on day three by the orthopaedic surgeon who was certain that this young, healthy patient would recover, and who, it turns out, was right.

Manny still needs a lot of care, even with basic things like sitting up and feeding himself. But there's his family who do one-to-one care with him, so soon he can be transferred from the ICU to a regular ward.

A MYSTERY SOLVED

It takes a lot to make me cry, but I cry quietly and happily when he goes to the ward. In fact, I'd cried before that, when he first understood what we were saying, when he first squeezed a nurse's finger.

In medicine we sometimes talk about 'moral injury': the feeling of hopelessness that comes when you work so hard to try to save a patient but they don't survive. Manny's case – of a patient making an unexpected recovery – was the opposite of that. In a hospital that sees the consequences of a lot of violence, everyone, even staff who didn't work in intensive care, would ask how he was doing and share the excitement as he improved.

We did eventually figure out what had happened to Manny. It's called a fat embolus. It's a common complication of certain kinds of fractures, where a bit of bone marrow gets into your bloodstream and gets stuck in the small blood vessels. This causes problems in your lungs, where the blood has to get through small vessels to get oxygen, and in your brain. I've seen it many times in the UK: usually, it makes people have slightly low blood pressure for a couple of hours.

I've never seen a fat embolus with an effect like this, and neither have any of the colleagues I've asked, either in MSF or the NHS. But as a diagnosis, it fits. It's the only thing that fits.

Without the specialist care provided by the ICU team in Tabarre, I think it's very likely that Manny would not have survived that Tuesday afternoon. He would most probably have died before the end of the shift.

Once I was back in the UK after my assignment, I reached out to the team, asking for an update. They sent me the good news: Manny is home with his family."

**All names have been changed.*

SIERRA LEONE
PHOTOGRAPHY
MSF

I LOVE MY PATIENTS

IN SIERRA LEONE, HEALTH COUNSELLOR AND EDUCATOR **ANGELA KAMARAH** HELPS PATIENTS FIND HOPE AND HEALING IN TOUGH TIMES.

"Mary* is a three-year-old girl who comes into the MSF hospital with severe burns. Her grandmother, who is her caretaker, tells us that Mary fell into a bucket of hot water while she was alone in the room. The burns cover her arms, chest and part of her head. The first time I see her, she is crying in pain as her dressings are changed, her small body tense with fear.

As a health counsellor and educator, I know that this moment is where my work begins. My role is to support patients through some of their most difficult times, and I can see that Mary will need both medical and emotional care to recover. My focus is not only on her physical pain, but also on her fear and the trauma this experience has caused. I decide to introduce play therapy to her, a method we often use to help children cope and heal during their stay with us.

'WHY I LOVE MY JOB'

In the beginning, Mary is scared of moving. She is too afraid to use the parts of her body that are burned. I sit with her, encouraging her and gently guiding her through small exercises. First, I help her lift her hands and stretch her arms. We toss a small ball back and forth, slowly building her confidence. I bring in some of the other children from the ward, hoping that their laughter and activity will draw her out. I teach Mary simple songs and get her to engage in group play. The joy on her face when she starts moving without fear is overwhelming. Her grandmother begins to participate too, singing along and playing with Mary, forming a stronger bond with her.

These moments remind me of why I love my job. I've been working with MSF for five years now, starting as a security guard in 2019. Since I had a diploma in community health, after six months I became a health promoter, and soon I realised that I wanted to do more. My empathy for the patients I met pushed me to become a counsellor and educator. Now, every day is filled with moments like this, where I see patients and their families slowly finding hope in situations that seem impossible. I really love my patients. I work hard to build a rapport with them and then they become used to me and we flow together.

PATIENCE AND UNDERSTANDING

Kenema, in the eastern province of Sierra Leone, where I work, is a place with high rates of maternal and child mortality. But we have been able to make a real impact here, reducing maternal mortality through healthcare initiatives, including the maternity and paediatric services we offer. Our paediatric hospital, especially the intensive therapeutic feeding centre, focuses on children under five, providing them with both medical treatment and

◀ An MSF nurse fashions a balloon from an inflated glove for a child in the intensive care unit of MSF's Hangha hospital in Kenema, Sierra Leone. Photograph © MSF

therapeutic programmes. We deal with malnourished children, those suffering from pneumonia and diarrhoea, and other diseases.

But it's not just the medical side that's important. My team and I provide psychosocial support to patients daily. One of the biggest challenges we face is what's called non-compliance. Because some patients have traditional beliefs about medicine and health, they sometimes don't want to follow medical advice. It takes a lot of patience and understanding to help them see the importance of the treatments we offer.

FINDING HOPE AND HEALING

As Mary's stay with us stretches into weeks, I see her transform. The play therapy strengthens her muscles, and her confidence grows with every game and activity. After 11 weeks, she is healed and ready to go home. It's an emotional day for all of us. We call her our little heroine, and we give her a school bag and some supplies to help her when she returns to school. Her grandmother calls us often, telling us how well Mary is doing, and how she misses the friends she made at the hospital.

These success stories are what keep me going, even when the work is hard and the days are long. After a challenging day, I find my own ways to cope. I exercise, meditate and listen to music. We also started a small project within the hospital where people can donate clothes for us to provide to patients who come in unprepared for long stays. At the end of the day, I feel fortunate to be part of this work. The smiles on the faces of the patients, the relief in their eyes – these are the moments that drive me. So many broken-hearted people have been able to endure because of the work here. I know that the support we provide makes a real difference, and I am proud to be part of MSF, helping people like Mary and her grandmother find hope and healing."

** Names have been changed.*

Doctors without maps

MANY PEOPLE IN THE REMOTE DISTRICT OF LABARAB PAYAM, SOUTH SUDAN, HAVE NO ACCESS TO MEDICAL CARE. HEALTH PROMOTER AND SOCIAL ANTHROPOLOGIST **ELIZABETH WAIT** TAKES US ALONG AS AN MSF TEAM PREPARES FOR A VITAL VACCINATION CAMPAIGN…

"Labarab Payam is one of the most remote districts in South Sudan's Eastern Greater Pibor Administrator Area, along the border with Ethiopia. There are few roads or even marked paths. While I was there, I almost never saw another vehicle or permanent structure.

South Sudan's national vaccination services haven't reached Labarab, so communities there are at risk of measles, polio, whooping cough, hepatitis B, tuberculosis and other deadly diseases.

Earlier this year, our team started work on a plan to change this through a preventative vaccination campaign.

TAKING THE FIRST STEP

Our goal was to inoculate 95 per cent of children under the age of five. But immediately we hit a problem: how many eligible children were there? In Lararab Payam, almost all children are born at home

▲ MSF team members give the Land Cruiser a push-start. Photograph © Elisabeth Wait

and births aren't registered. Existing population estimates were wildly varied and out of date. But this information is essential: without it we ran the risk of running out of vaccines during the campaign, with no easy way to restock. Alternatively, we could find ourselves with too many doses, wasting valuable resources that could be used to provide much-needed medical care elsewhere.

After considering several options, we concluded there was only one way to find the information we needed: we would have to travel household to household to get the most accurate count. If we started early in the morning and camped overnight, it would take seven days.

Although I am generally obsessive about detail, I would soon learn that there was only so much I could plan…

THE JOURNEY BEGINS

There are no maps of Labarab Payam and no mobile phone coverage. As we scoured Google Earth, the screen showed no major buildings, roads or electricity pylons, just a hazy image of very dry land.

After a bumpy five-hour drive to the entry point, local leaders helped to map out the area on a large piece of flipchart paper. A long line, a squiggle, a mark for the river and for the location of each village: this would be almost all we had to steer us over the next week.

We spent the next seven days driving through untamed woodland, forcing our way through low-hanging branches. Sometimes it took us five hours to travel 30km.

We were hit with a flat tyre, a windscreen crack, and a non-starting car engine that required us all to get out and push in the 43-degree heat.

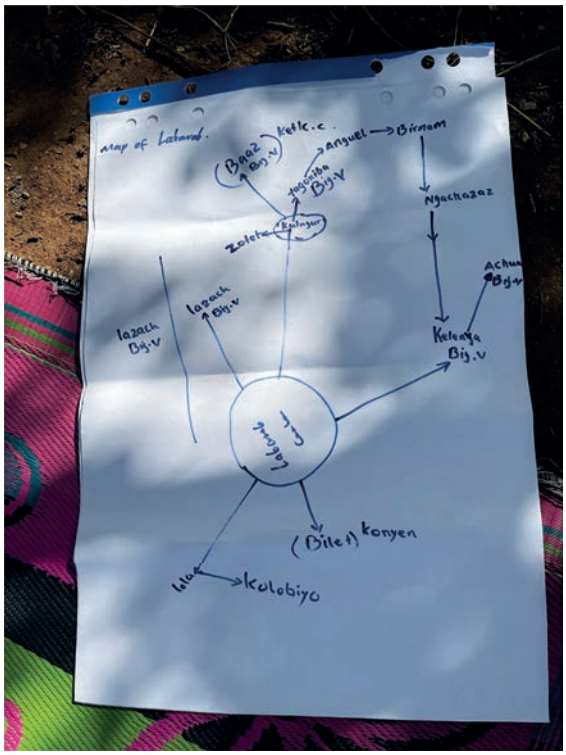
When we got to a village, the team would fan out to survey the households, while a few of us would meet with the local leaders. The vaccination campaign would only be a success with their support, so it was vital to hear the needs of the community from their perspective.

In the evenings we would camp out and tussle over tomorrow's plan: deciding which set of villages we would travel to next, deciphering feasible routes, and debating where we would collect river water for our short evening showers.

A CHANGING ENVIRONMENT

It was hot. We were there in the dry season, but local leaders told us that weather patterns were becoming inconsistent. They described rapidly depleting water sources, soaring temperatures and irregular rains. These environmental changes were deteriorating the maize crop and changing the migration patterns of the antelope, forcing families to scatter in different directions in search of water and animals to hunt.

As well as making living conditions tough for the community, all this would make finding and vaccinating 95 per cent of eligible children hugely challenging. Some vaccines would require three doses, timed to strict guidelines, which meant that the vaccination team would need to reach the same population across different seasons and locations. It felt like an almost impossible endeavour.



▶ The hand-drawn map. Photograph © Elisabeth Wait

NO ACCESS TO CARE

Despite the challenges, we continued driving, stopping, talking, building up the data that would be needed.

'We are in the bush, our children are suffering,' one woman told me. 'We really appreciate that you are here. We hope MSF will help us.'

In each village we invited parents to talk about their previous experience of healthcare and what they knew about vaccines.

I'd never seen parents struggle so much in a conversation like this, simply because they had so little experience of healthcare to draw on.

As one mother from Tagoniba village told me: 'If our child is sick, we cannot do anything. We just give leaves and roots of the tree. If the child is not improving, we are just waiting for God. There is nothing else we can do.'

FROM ESTIMATE TO IMPACT

Over the course of the week, we visited 31 settlements in Labarab Payam, finding a population of 8,394 people, with 3,116 children under the age of five.

I've now finished my assignment in South Sudan, but another MSF team has already conducted the first round of the vaccination campaign. Over 1,400 doses are now helping to protect vulnerable children, which is great news. But there is more to be done.

Thanks to the survey, the team know how many children they need to reach and they are planning to return to do a second round of vaccinations before the end of the year."

MSF water and sanitation engineers arrive at Kaljack village, near Bentiu, South Sudan, to repair a water-well hand pump following devastating floods. Photograph © Sean Sutton

MEET THE FIXER

EPIDEMICS, WAR ZONES, NATURAL DISASTERS: MSF TEAMS ARE USED TO WORKING IN HIGH-RISK ENVIRONMENTS. BUT HOW DO WE PROTECT OUR TEAMS AND PROJECTS IF THINGS GO WRONG? **BERTIL POTSEMA** IS MSF'S INTERNATIONAL INSURANCE ADVISOR AND EXPLAINS HIS ROLE…

Why is insurance important for an organisation like MSF?

"There are two key reasons: the work and the staff. MSF is a huge organisation. We work in crises in over 70 countries around the world. The supplies, the equipment, the transport – all of that costs money, which comes only from the generosity of our supporters.

Let's say a fire or a flood hits one of our big supply warehouses. If it causes €5,000 worth of damage, that might cause problems in the short term, but long term it won't impact our ability to function, to provide medical care to people in crises.

However, if €3,000,000 worth of supplies and equipment are destroyed, then you have a much bigger issue.

We call that a catastrophic risk. Obviously, we have a lot of safeguards in place to prevent it, but if for any reason the worst does happen, insurance is one of the key factors that will allow us to continue to reach our patients."

What's the second reason…?

"The second reason insurance is vital is our staff. They are the ones working in really challenging circumstances, doing the best they can, trying to save lives. I'm just sitting behind the desk.

So if something happens and a staff member becomes ill or injured, I want to make sure they can access medical care. Even if it's 2 am, even if they need to be medically evacuated. Knowing that the insurance is there, and that payment is guaranteed, means that there's no need to hesitate.

I'm often the person who answers the phone when something has happened and a claim needs to be made. So, for me, this work is personal. Being the international insurance advisor means I've helped to support staff members and their families through incredibly stressful situations, through tragedy, but I've also been able to ensure that a local staff member's little baby can be found a bed in the intensive care unit.

MSF staff often work in places that are isolated or unstable, so I believe that making sure they are covered by insurance is the very least we can do."

What are the challenges you face to achieve this?

"MSF staff often work in places that most insurance policies don't cover. We have enhanced coverage, but even so there can be issues.

One example is epidemics. All of our projects have strict protocols around infection prevention and control, especially in outbreak contexts. However, insurance companies can withdraw health and life insurance if they think the risk is too great.

I explain to them the strict measures we take, the personal protective equipment the teams use. During the West Africa Ebola outbreak in 2014, I was ready to beg on my knees to keep our existing coverage for staff members being sent to work in affected areas. Thankfully the insurers behaved excellently and the staff remained covered. Our insurers really are big supporters of our work."

What other risks does MSF have to plan for?

"So many! But some of the most interesting for me are when we start working in completely new ways. For example, the MSF Foundation recently created an app to help lab teams identify which antibiotics a patient's infection will respond to. In high-income countries, a microbiologist would do this, but when that level of expertise isn't available, the app can help, which is better for the patient and reduces the risk of antibiotic resistance.

This app didn't exist in the world before. It's been rigorously tested, it's secure, it works really well. But even something like that needs insurance. I work with the team, I write down all the possible risks, and then I go to insurers and ask if they are willing to cover these risks. In this case, we found a really good insurer who gave us a very reasonable premium, and the app is out in the world and being used both by MSF and other organisations."

It sounds like you always have to be thinking about the worst-case scenario. Does it have an emotional impact on you?

"No. In the same way that it's a doctor's job to think about disease and sickness, it's my job to think about potential risks. I'm passionate about what I do. When you are helping a staff member or their family through difficult times, you can feel responsible, but I don't find it depressing.

Before I joined MSF I was a self-employed insurance broker. I sold my company, but I was only 48 – too young to retire. I saw the job advertised, and it was only 20 hours a week, so I thought it would still give me time to do other things. It didn't, but I'm still here 11 years later. My favourite thing about being part of the MSF team is the *saamhorigheid* – that's a Dutch word which translates to something like 'togetherness'.

It is 24/7 though. I've been doing this for 11 years and I haven't had a full day off in that time. Even when I'm on holiday, I'm contactable, I check emails. Not because I'm a workaholic, but because you just don't know when someone will need urgent support.

Some people consider insurance a purely financial instrument, but for me that's too abstract. There is always a person behind the policy."

What's your proudest achievement at MSF?

"My proudest achievement is arriving at 31 December every year knowing that everyone is still insured. Sometimes insurers require the policies to be renegotiated every year, and sometimes you need to change from one insurer to another because the old one doesn't want to take that risk anymore, and it's all a bit of a rush to the deadline. So getting to that point on New Year's Eve and knowing, before the champagne is opened, that we're all covered, that's a proud moment and it makes me happy. I can relax for a few hours before it all starts again on 1 January…"

MSF'S UK VOLUNTEERS

Afghanistan: Clare Atterton, *Doctor*; Jemma Berwick, *Nurse*

Bangladesh: Orla Murphy, *Head of mission*; Melissa Buxton, *Nurse*

Central African Republic: Jenna Darler, *Humanitarian affairs manager*; Melody Cuba Babasasa, *Nurse*

Democratic Republic of Congo: Samuel Arnold, *Logistician*; Jeremie Postel, *Health promoter*

Ethiopia: Cara Brooks, *Head of mission*; Ana Moral Garcia, *Midwife*

France: Lucia Alvarez Marron, *Head nurse*

Haiti: Charles Hardstone, *Water and sanitation team leader*; Sarah Mitchell, *Water and sanitation manager*

India: Nicole Hart, *Deputy medical coordinator*

Kenya: Paul Banks, *Procurement manager*; Samuel Moody, *Doctor*

Lebanon: Amel al Fulaij, Doctor; Fabian Erwig, *HR coordinator*

Myanmar: Betsie Lewis, *Humanitarian affairs officer*

Nigeria: Zoe Bennell, *Field communications manager*

Palestinian Territories: Anna Halford, *Head of mission*; Laura Gardiola, *Nurse*; Iyalla Peterside, *Psychologist*; Helen Ottens-Patterson, *Head of mission*; Riccardo Defrancesco, *Nurse*; Georgina Brown, *Medical coordinator*

Serbia: Joan Hargan, *Medical team leader*

Sierra Leone: Charlie Kerr, *Logistician*; Wendell Junia, *Laboratory manager*

South Sudan: Sofia Vincent, *Nurse*; Philippa Nicklin, *Doctor*; Louise McKenna, *Doctor*; Seán Reynolds, *Humanitarian affairs manager*; Meabh Bhuinneain, *Doctor*

Sudan: Sofie Karlsson, *Midwife*; John Canty, *Project coordinator*; Sarah Clowry, *Humanitarian affairs manager*

Syria: Orla Sheridan, *GIS activity manager*; Matt Cowling, *Humanitarian affairs manager*

Ukraine: Thomas Marchese, *Emergency coordinator*

Zimbabwe: Michael Parker, *Project coordinator*

Cover image: MSF mental health counsellor Zamzam plays games with a Sudanese child in the malnutrition ward of MSF's clinic in Adré transit camp, eastern Chad. Photograph © Ante Bussmann/MSF

▼ MSF health promoter Aristote Saidi Wanyama shares facts about the infectious disease mpox in Buhimba camp near Goma, Democratic Republic of Congo.Photograph © Michel Lunanga

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TEL **020 7404 6600**
ADDRESS **Médecins Sans Frontières, Chancery Exchange, 10 Furnival Street, London EC4A 1AB**

Charity Registration Number 1026588

ABOUT
Dispatches is written by MSF staff and sent out quarterly to our supporters to keep you informed about our medical work around the world, all of which is funded by you. Dispatches gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. It is edited by Marcus Dunk. It costs £0.72 to produce, package and send using the cheapest form of post. It is an important source of income for MSF and raises three times what it costs to produce. We always welcome your feedback. Please contact us using the methods listed, or email: **dispatches.uk@london.msf.org**

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