Dear Friends,

Like a lot of our staff, when I tell people that I work with Doctors Without Borders/Médecins Sans Frontières (MSF)—and that I’ve worked in field missions in Afghanistan, Democratic Republic of Congo, Haiti, Syria, and elsewhere—they want to know more. What is it like to work “over there”? Where does the organization get its money? Do you take people who don’t have medical backgrounds? When do you open and close programs? How do you manage the security of your teams?

People who have generously supported our work over the years often have similar questions. People who come to work in the US office do, too. Whether they concern our field staff, our programs, our fundraising, or some other aspect of our work, they almost always translate into some variation of the big query: How does MSF work?

Last year, we used an issue of Alert to address some of the questions we hear most often. In this issue, we’re doing it again. The reason is simple: We want you to know. We want you to understand that we are trying to provide emergency medical care where it’s needed most, irrespective of religion, nationality, ethnic group, or other affiliation.

It’s part of speaking directly to the people who make this work possible—something I am happy to be doing now in this forum, the opening letter of Alert, in this issue and the issues to come. In truth, we as an organization spend a lot of time explaining ourselves—because we want to be transparent, as noted, and because it helps our ability to carry out our programs in the field. We need to tell people—be they government officials, would-be patients, or parties to a conflict—what we are doing and why, to convey our sense of what it means to be independent, impartial, and neutral.

We need them to understand that we are trying to provide emergency medical care where it’s needed most, irrespective of religion, nationality, ethnic group, or other affiliation.

In most places, explaining ourselves and our work helps us maintain the safety of our programs and personnel. Tragically, recent incidents where hospitals were attacked and looted in South Sudan and Central African Republic—where three staff members were also killed—remind us that there is still a great deal of risk involved in this work, and that the sanctity of our medical programs is not always guaranteed.

We need to do everything we can to avoid repeat occurrences, but the needs are so great in so many places that we cannot retreat. So we will continue to talk about how MSF Works, in this and in other places, because it remains one of the best ways we know of to help our teams provide lifesaving assistance to those who need it most.

Sincerely yours,

DEANE MARCHBEIN, MD
President, MSF-USA Board of Directors

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WHAT DOES MSF LOOK FOR IN ITS FIELD WORKERS?

A conversation with Melissa Bieri, an MSF-USA recruiter, who has completed field assignments as a logistician in South Sudan and Malawi.

Do all field workers need medical backgrounds?
MSF needs all types of people. Medical staff, of course, but we also need staff to support the medical activities, so we need people who can do financial management, bookkeeping, and human resources. We also need logisticians who can do fleet management, mechanics, water and sanitation, and more.

What do you look for in a prospective field worker?
The people who are successful in the field are those who are flexible and willing to learn. With MSF, you’re working and living with people from all over the world, which can be difficult. Adaptability is also important; you don’t know what is going to happen from one day to the next. The reality is that you’re away from your home and your family, and the work, though rewarding, is still really difficult. It has to be something that you really want to do.

We ask that people meet certain specific requirements in addition to the professional requirements. For example, we want to know that they have been uncomfortable in the past. Maybe they’ve done medical volunteer trips or they’ve worked in resource-poor settings. It can also mean they’ve traveled a lot, so they’ve been exposed to different cultures and living conditions.

How long are missions?
First missions are usually 9 to 12 months, though operating room staff—surgeons, ob-gyns, and anesthetists, who are likely to be on call 24/7—make 1 to 3 month commitments. This provides consistency. The majority of the people we hire are from the communities we work in—the staff in our South Sudan projects, for instance, will be mostly South Sudanese. It’s hard for them when there’s a high transition of managers or people coming from the outside.

You recently worked in South Sudan. Does fieldwork help in your role as recruiter?
Being in South Sudan showed me once again that the people who succeed in the field are people who figure out how to take breaks and get reenergized instead of burning out. It also gave me a fresh perspective of how important MSF’s work is and made me feel more committed than ever to the organization. And it was a reminder that even if you’ve done 10 field assignments, you need to approach each one humbly, to try to let go of your ego; the moment you think you “know MSF,” you close yourself off to learning new things and having new experiences.

Do MSF field workers get paid?
First mission field workers get a monthly stipend of around $1,500, a per diem, and full benefits. We cover basic living costs, too. Pay rises as people complete more assignments and take on more responsibility.

What kind of training do people get when they first join MSF?
We offer a nontechnical training called Information Days, sort of an induction course to MSF, as the last stage of the recruitment process. We also brief you before you go to the field.

For most medical staff, there are no trainings before you go to the field. That makes some a bit nervous. If I’ve never seen cholera or treated malaria before, how will I know what to do? But we believe your training in the US has given you the skills to hit the ground running. We also have protocols and guidelines. If there’s a cholera outbreak, there are specific guidelines to follow, for medical and non-medical staff.

Non-medical staff like administrators and logisticians generally get some training before going to the field. A financial administrator, for example, would learn our way of bookkeeping. Logisticians spend a week going over everything from electricity to vehicle maintenance.

In the field, you also usually have a supervisor or medical or logistics referent who guides you, and you’ll usually have a handover with the person you’re replacing.

How can someone build a career with MSF or integrate MSF work into their career at home?
Both tracks are possible. Some field workers commit to a single mission only, but many enjoy the flexibility of being able to undertake missions during different periods in their careers, as circumstances permit.
ARE YOU INTERESTED IN WORKING FOR MSF?

IN THE FIELD

Can you say yes to all of the following?
Have you worked or traveled outside the US?
Do you have experience as a supervisor, manager, teacher, or trainer?
Are you able to work and live with a diverse group of professionals?
Do you consider yourself to be flexible and adaptable?
Are you committed to MSF’s principles? (What are these principles? See bottom of page 5.)

SUPPORT OUR WORK IN OTHER WAYS:
Donate now.
Hold a fundraiser or awareness raising event for MSF.
Participate in an endurance event to raise money for MSF.
Lend your support to one of our advocacy campaigns.
Share and follow MSF news and updates through social media.

APPLY ONLINE

MSF field work is definitely for me! What’s next?

Work in the Field
Benefits & Opportunities
Life in the Field
Applying to MSF
FAQ
Recruitment Events
Voices from the Field
IN THE OFFICE

Visit the website to learn about opportunities to work or volunteer in our New York office.

Complete 2 years of experience. Then return to this step.

Are you available for 9 to 12 months? Or, if you are a surgeon, anesthesiologist, nurse anesthetist, or ob-gyn, positions that may be accepted for shorter assignments, are you available from 1 to 3 months?

Do you have at least 2 years of experience in one of these professions?

Less frequent turnover of international field staff benefits our locally hired staff and patients. If you join us in the field, you’ll also need time to acclimatize to your project and to the context in which you’re working. If you can’t yet give this amount of time to MSF, come back to us when you can!

Once you meet all of the requirements, come back and try again.

Answers may be found on our website.

We recommend that all prospective aid workers attend a recruitment info session online. Review each level of our Work in the Field section before you apply.

Others may determine that working with MSF is a way of life and want to sign a longer-term contract. It’s up to each individual to figure out what works for them, but it all starts with getting to the field and seeing if you enjoy the work.

Then you learn what the possibilities are. A nurse might want to continue working in the field, or try to become a nurse manager, or, with experience, a project coordinator. You can also try to be a medical coordinator who oversees all our medical activities in a country, or a medical referent, or a head of mission.

In the US, a field human resources officer can try to guide you and help you access the various trainings that MSF offers. These may cover a certain language, or certain medical treatments and protocols, or management and leadership, or something else that helps build the skills and knowledge required to be effective in the field.

In terms of integrating the work into their careers, some people can make arrangements with their employers where they work six months, then have a six- or nine-month opportunity with MSF—or a month or so for surgical staff. They find a way to balance the two, rather than choosing one or the other.

So you try to determine if someone is right for MSF and if MSF is right for them?

Exactly. A lot of people get excited about the possibility of working with MSF, but then they talk to friends and family about the places they might get sent to and they decide they don’t want to stress out their families by going to the field. Some people ask, “Am I really willing to go wherever you want to send me? Can I make this commitment?” We make our own evaluations at each stage, but we also hope that people remove themselves from the process if they think MSF may not be right for them. We don’t want to invest in somebody and send them to South Sudan or Central African Republic only for them to then decide it’s not a fit.

**MSF PRINCIPLES**

**MEDICAL ETHICS:** We carry out our work with respect for the rules of medical ethics, in particular the duty to provide care without causing harm to individuals or groups. We respect patients’ autonomy, confidentiality, and their right to informed consent. We treat patients with dignity and respect for their cultural and religious beliefs.

**INDEPENDENCE:** Our decision to offer assistance in any country or crisis is based on an independent assessment of people’s needs. We strive to ensure that we have the power to freely evaluate medical needs, to access populations without restriction, and to directly control the aid we provide. Our independence is facilitated by our policy to allow only a marginal portion of our funds to come from governments and intergovernmental organizations.*

**IMPARTIALITY AND NEUTRALITY:** MSF offers assistance to people based on need and irrespective of race, religion, gender, or political affiliation. Our decisions are not based on political, economic, or religious interests. MSF does not take sides or intervene according to the demands of governments or warring parties.

**BEARING WITNESS:** When MSF witnesses extreme acts of violence against individuals or groups, the organization may speak out publicly. We may seek to bring attention to extreme need and unacceptable suffering when access to lifesaving medical care is hindered, medical facilities come under threat, crises are neglected, or the provision of aid is inadequate or abused.

**ACCOUNTABILITY:** MSF is committed to regularly evaluating the effects of its activities. We assume the responsibility of accounting for our actions to our patients and donors.

* MSF-USA does not accept funding from the US government.
WHAT DO YOU TAKE TO THE FIELD?

Matt Stearns, a logistician from Massachusetts now in Nigeria working on a lead poisoning project, shared his “field essentials packing list” with us:

Clothing
- Two pair lightweight active cargo pants [pockets are important in the field]
- One pair loose cargo shorts
- One pair active shorts
- Three (or so) MSF t-shirts
- Five pair thin gauge athletic socks
- Five pair underwear
- One pair closed-toe sandals, to protect against scorpion stings and double as a “shoe” in more formal situations
- One pair moisture-wicking trail runners
- One lightweight belt
- One or two collared shirts [for more formal/official situations]
- One synthetic active t-shirt for workouts
- One stowable lightweight rain jacket
- One fleece or thermal top
- One stowable down vest
- Lightweight work gloves
- One bandana or lightweight hat [for sun protection]
- One pair decent sunglasses, with retention cord
- One pair of favorite jeans

Practical
- Headlamp
- AAA batteries
- Duct tape
- 3 Sharpie markers [for labeling]
- Travel lock
- 2 or 3 small carabiners
- Refillable water bottle
- Power adapters
- Leatherman
- Small case for organizing cords, headphones, etc.
- Two tubes super glue

Personal
- Sunscreen
- Moisturizer
- Lip balm
- Dental floss
- Insect repellent
- Roll-on deodorant [stick applicators melt in tropical climates]
- Toothpaste
- Toothbrush
- Broad-use liquid soap
- Ear plugs
- Eye mask for sleeping

Edibles
- Ten packs of “energy gels” [with caffeine, carbs, and electrolytes to combat heat-induced lethargy and low energy]
- Three bottles travel-sized Tabasco
- Five packets of ginger chews [helps ease “field belly” issues]
- Energy bars
- Two large bags of M&Ms [arrival gift to team]
- One personal reusable coffee/tea filter
- One small camp mug
- A pound or so of your favorite coffee or tea

Sanity
- Travel speaker
- iPod shuffle filled with regional pop or traditional music relevant to the mission context.
- Smartphone
- Aggressively protective water- and dust-proof case for phone
- Three pairs in-ear headphones [field life is brutal on headphone wires]
- Lightweight e-reader [filled with good books]
- Portable USB charging pack
- Two USB charge cords and USB power adaptors
- Jump rope [for cardio workouts in security-restricted contexts where running or walking is impossible]
- Decent notebook
- Playing cards
How is MSF different from other NGOs?
For one, I think our threshold for risk is higher than others in terms of exposure in the field, and in terms of testing innovations, especially in situations where there are no other good therapeutic options. Sleeping sickness is a good example; the existing treatments were so toxic that we had to move on, to try to invent new things.

So we accept a dimension of risk. But we do not transfer risk to other organizations or subcontract to other groups because we think there is too much risk for our own staff. The fact that we are so uncomfortable with the remote control approach, where projects are managed from afar, is a sign that we don’t want to just transfer risk. If it’s our project, it’s our risk, and it’s our responsibility.

The majority of the leadership has field experience, too. Not all organizations can say that.

MSF has reconfirmed its associative nature at every stage of its history. As a result, MSF’s leadership is different from other organizations. It’s clearer in the US, where the board is also composed mostly of medical people and people with field experience. This has an impact on the way the association is governed. There are advantages and disadvantages, to be frank. People with extensive field experience can find it challenging to work at the macro level of the organization and not to be involved in daily operations, and more experts from outside fields might provide new input and new ideas. But at the same time, the field experience at the top of the organization is the best guarantee that decisions will first and foremost serve the needs of operations, of the teams on the ground.

How does the US office interact with the rest of the movement?
Formally, we interact through platforms at the group and international level, where peers meet and work on agreed-upon agendas. This could be a meeting of the Directors of Communications, or a meeting of the Field Human Resources directors. There is a Director General platform, and a core Executive Committee, which I’m a part of.

MSF-USA also has fiduciary responsibilities that are set together with the board and the program committee and then reviewed in highly formal exercises. Likewise, if we have received funding from a specific foundation for a specific project, we will consult with the operational center in charge of the project so we can report back to the donor about how and where their pledge is being used.

Then there are more informal contacts between people in different offices at all different levels. It could be when the operational centers want us to organize advocacy rounds with representatives of the United Nations or the US government. It could be between fund-raising teams discussing different campaigns and priorities, or between communications teams. It could be related to the 400 people the US office sent to field projects last year, pairing them with specific programs, or getting requests from programs that our Field HR team then tries to fill. The examples are numerous.

When we open projects, are there specific things we look for?
There must be a need for and an added value in MSF’s presence. If we don’t feel there is an added value, or if we feel anybody could do it, we’re not going to do it. And we wouldn’t do it if it’s not in the scope of our main ambitions—working in unstable situations, on acute medical issues, with neglected populations, when there is a gap that is not being filled. If those conditions are there, then the question becomes whether we have the means and the access, what the security issues are, and so forth. But this only happens after we’ve determined that it makes sense for us to work there based on what MSF is and what it does.

Do governments influence when and how we work?
Being independent doesn’t mean we do not listen. Whenever we can, we try to establish a sort of partnership with the government in a country. We want to be useful, so we welcome their ideas of where the needs are. The decision to open will be based on the combination of how we reconcile the needs they feel they have, the needs we think they have, and our ability to respond to these needs.

They never force us to work somewhere. This is why we are independent—we can always decide not to do something. But we welcome the government’s requests or ideas in terms of geography or in terms of needs. And then independence is really about deciding on our own if this is something that matches what we consider is within our mission, expertise, and capacity.

Can others influence things like whether we have women in our projects, or people from certain nationalities?
No, I don’t think that this is a line that we are ready to cross. We are very practical. There are countries where we know we won’t have a single patient in the maternity ward if there are no female doctors. We adapt to those realities so we can provide the best possible care. But it would never be a directive from someone else.

The same for nationalities. If it might compromise our security or effectiveness, we might not send people of certain nationalities to certain countries. We did so in Mali. And for many years we didn’t send Americans to Afghanistan. But we do not let others tell us when and where we can do this. It’s based on practicality and
You deal with a lot of bad news. What keeps you coming to work every day?

Looking at the three major crises of the moment, South Sudan, Central African Republic, and Syria—or let’s say four, because we should include Democratic Republic of Congo, which is a forgotten crisis—the humanitarian needs are huge and there are no political solutions in sight. So, yes, the circumstances are very depressing. But they also make humanitarian action so meaningful, because it is the only hope that people have. It is the only possible response. If you have no political solution in sight, at least you can help people survive until the political landscape improves, or in case it improves. It is depressing, but at the same time, there’s nothing more useful for these populations, at this stage, than some of the things we can provide: medical care, water, food. If the situation stabilizes, they will have different priorities—cultivating their lands or going to school or getting a job. But for the moment, for a refugee from Syria, or in Syria, or someone in parts of CAR or DRC, it’s really about surviving.

WHO IS ON MSF-USA’S BOARD OF DIRECTORS, AND WHAT DO THEY DO?

Deane Marchbein, MD, an anesthetist from Massachusetts, is the President of MSF-USA’s Board of Directors and has completed field missions in DRC, Syria, and, most recently, Afghanistan.

Unlike most US non-profit boards, which are largely composed of major donors, MSF-USA’s board is chosen by the association, a group largely drawn from returned field workers that is responsible for providing oversight and electing the board.

Most board members have significant field experience, a clear understanding of field realities, and a strong commitment to the mission of MSF. A majority of board members must, by statute, have medical backgrounds as well. But we recognize that we need professional skills that may not be represented in the association, so we appoint a treasurer and a secretary who may ultimately join the association but are not necessarily drawn from it.

The board oversees a budget of approximately $200 million a year, so it’s important that the treasurer has a strong background in finance and can, when needed, provide a different perspective and ask difficult or challenging questions. The same is true for the secretary, who focuses on governance and legal issues. MSF-USA’s secretary has traditionally come from the law firm of Simpson Thacher & Bartlett LLP; one of the firm’s partners was a founding member of MSF-USA and the firm continues to provide the organization with enormously valuable pro bono legal services.

Perhaps the most important function the board serves is selecting MSF-USA’s general director, the leader of the US office and our representative in the international movement. They also contribute to the strategic plan and approve the annual plan, which articulates the goals of the office—and by extension, the organization.

The founders of MSF believed that commitment to the social mission and field perspective were absolutely crucial to making sure that MSF could stay relevant and evolve while staying true to itself. So, having a board that’s composed of people who not only intellectually understand the work but also feel it in their gut is a way of making sure that we hold to our principles.

HOW DOES MSF INTERACT WITH THE US GOVERNMENT AND OTHER REGIONAL ORGANIZATIONS?

MSF engages bilaterally with many US government offices in both the executive and legislative branches. We are in contact mostly with the State Department, the White House, and the Department of Defense on the executive side. Within the State Department there are different offices that are in charge of funding humanitarian assistance on behalf of the US government, like USAID.

On the legislative side it’s mostly with Congress—sometimes specific representational offices, sometimes the specialized foreign affairs committees. We also engage with people in the embassies of the countries in which we work. The US is one of the main donors in terms of humanitarian assistance worldwide, so they...
...having a board that’s composed of people who not only intellectually understand the work but also feel it in their gut is a way of making sure that we hold to our principles.

are key players in any humanitarian crisis. We engage for many different reasons—to alert, to inform about specific humanitarian situations that we’re witnessing. We also sometimes engage to get a sense of what their policies are, so we can adapt our operations on the ground if need be.

Another important aim of our engagement is to keep certain global health issues on the agenda, such as access to medicines and vaccines and better treatments for diseases like HIV and drug-resistant TB. We also share our views on the impact of specific decisions a political actor makes; sometimes we agree, sometimes we disagree, but we maintain that dialogue. We do not request funding from the US government, and this plays a major role in ensuring that we are able to have open discussions that are not biased by the exchange of funding.

DOES MSF PUBLISH MEDICAL DATA FROM ITS PROGRAMS?

MSF published 150 articles in medical journals in 2013 on topics such as HIV/AIDS, tuberculosis, malaria, cholera, and neglected tropical diseases. Drawing on MSF’s field experience, these papers “add to the global evidence base that advances best practice,” says Dr. Patricia Kahn, MSF-USA’s medical editor. They help MSF improve its own work and can also contribute to national and international guidelines for diagnosing, treating, and preventing diseases.

For example, after the huge cholera outbreak in Haiti in 2010, the World Health Organization established a stockpile of an orally-administered cholera vaccine for use in emergencies. “Haiti has had a big impact on global thinking regarding the oral cholera vaccine,” says Dr. David Olson, MSF’s deputy medical director. “Everybody was so helpless to deal with the outbreak, it sort of sharpened the mind.”

There was not much literature on its use in epidemic settings, however, and the global community remained unsure of how to incorporate vaccine use during outbreaks. But then, in 2012, MSF responded to a cholera outbreak in Guinea by working with the Ministry of Health to carry out a mass vaccination campaign using the oral vaccine. It was one of the first times it had been used in response to a sudden outbreak. Initial results were encouraging. Over the next few weeks, teams vaccinated more than three-quarters of the population in two districts where cholera first appeared.

Last year, MSF published a study in the open source journal PLoS Medicine that used its experience in Guinea to show that the vaccine could be administered quickly to a large population at a reasonable cost. While cholera vaccinations are not 100 percent effective, and they are no substitute for clean water and medical treatment, they may save lives when used in the right way. [In the coming months, MSF will publish another paper on the overall impact of the campaign.]

Before the paper, though, there was the medical action. In Guinea, MSF was in a position to try something few other global health agencies could. “Someone has to take that first step,” says Olson. “Even if it’s imperfect, it’s the first building block in trying to construct a more perfect way of doing these things.”

WHAT IS VIRAL LOAD MONITORING AND WHY IS IT IMPORTANT TO HIV/AIDS CARE?

Viral load monitoring means tracking the level of the virus in a patient’s blood over time. It helps providers see if treatment is working or not and it’s been a standard part of HIV care in developed countries for many years. Until recently, though, it has been deemed too difficult to do in places where MSF works.

Previously, the prohibitively complicated logistics of transporting blood had meant that field clinics in less developed countries could only use the slow, not particularly sensitive CD4 test to gauge the health of the immune system. But MSF teams working in Malawi’s Thyolo district found another way when they began collecting spots of blood drawn by finger pricks on filter paper.

The advantages are manifold, says Teri Roberts, MSF diagnostic advisor: the paper needn’t be refrigerated when it’s transported to labs with testing options more advanced than the CD4. The blood spots can be tested in groups of five to reduce the number of tests needed (and if any sample shows a high viral load, the individual samples are retested). Trained community health workers can carry out the finger pricks and collect the samples themselves, which lessens the human resources burden. Most of all, it provides a way to do more effective viral load monitoring on a much wider scale and therefore better understand how patients are responding to treatment.

MSF is also participating in clinical trials of Samba, a device that may enable viral load monitoring in district health centers. “We will hand these projects over to the Ministry of Health at some point, and we want this to be adopted by other regions where MSF is not present,” Roberts says. “We tried to look for very simple, affordable, sustainable, feasible solutions, and this was the way to do it.”
HOW DO YOU MANAGE SECURITY IN PLACES WHERE YOU CAN’T COUNT ON RESPECT FOR MEDICAL FACILITIES?

Jordan Wiley spent the past year working as an emergency team field coordinator in Syria and CAR.

The best thing we can do is maintain really solid communication with the community around us. In the places we work, security always involves a huge amount of coordination to maintain the closest possible contact with all actors on the ground. That means local government, rebel groups, local religious groups, anybody who’s anybody, really.

You make the rounds and speak with as many people as possible; every single day you’re collecting information and trying to verify, re-verify, and cross-check. For me, having those local contacts is the most important thing. It’s important to remember that contexts change all the time, but incidents usually don’t happen randomly. Usually there’s some type of precursor or warning to potential threats or incidents. If we can catch wind of something ahead of time, we can keep our teams more secure.

There are also behavioral things we can do to reduce risk—implementing curfews for staff, for example, or avoiding certain neighborhoods. There are also lots of things we do to improve our physical security: building fences, hiring guards, and so forth. In particularly dangerous contexts, like CAR, we also construct heavy-duty safe rooms with reinforced walls and ceilings to protect from stray bullets, grenades, and other explosives.

At the end of the day, our most important tool is communication.

WHAT IS IT LIKE WHEN YOU’RE FORCED TO LEAVE A PROGRAM?

Tim Harrison, a registered nurse from Massachusetts, has worked with MSF in South Sudan on several occasions, most recently in Malakal, from which the team had to be evacuated due to extreme violence in the area.

“It was a remarkable experience and then ultimately it was one of the most disappointing experiences because of the way that we lost the ability to control the space,” Harrison says. He was part of a small team initially sent to treat kala azar. “There were five of us to start with, three medics, the project coordinator, and a logistician.” Then fighting came to Malakal, and wounded patients and others started arriving at the hospital. “Ultimately, the hospital became an IDP camp,” he says, but as the days passed, the chaos of the moment overwhelmed any sense of sanctity the hospital once enjoyed. “We couldn’t control weapons in and out of the hospital,” he recalls. They had a checkpoint for weapons at the hospital gate, but “there were 50 other ways to get in.”

 Civilians and staff would report what they’d seen. “The stories were just devastating,” Harrison says. “Door-to-door fighting. I remember a very skilled clinical officer we worked with closely came in, and he’s in his 50s, a fellow who’s lived his whole life in South Sudan. He said he’d never seen anything like it. And this is a country that had 35 years of civil war. He was clearly traumatized. Eventually he moved into the hospital because he couldn’t stay at home any more. He brought his family.”

The violence would not abate, however. “We simply had no more room to be able to function, and our own safety, and the safety of everybody in that hospital, was at risk. The team sat down on a Sunday and, as we did constantly, went through the risk and the benefit of our being there. Can we do the job? Are the people going to benefit? Can we continue to work? We decided we would stay. But by Wednesday, everything had changed. The hospital was just a tinderbox; any one small event would just set off the entire place. Everybody was living there, IDPs, cows, goats, soldiers. There was alcohol all over the place.”

A drunk soldier shooting his gun into the air confirmed what they knew. “There’s nobody in control of this militia now, nobody that you can call and say, ‘Your guy just shot up our compound, you better do something about it,’ because there’s just nobody in charge… Michael, the PC, had a conversation with the opposition force leader, and he said that he thought it was a really good idea that we leave. He was acknowledging that there was no way to control what was going on.”

The decision was crushing, the logistics daunting. The airport was closed. The town was on a river and there was no way to just drive away. “We ultimately went to the UN compound. That really felt—first of all, it’s a defeat that you have to seek safe haven. What does this look like to the community, that MSF… we’re not running away, but you are, I think, acknowledging that the chaos is not something that you can continue working in.” What’s more, he adds, it meant, and still means, acknowledging that much of their mission went unfinished and, worse, that many people, including medical staff and patients, could not leave. They had to stay behind and endure whatever came next.
FIELD JOURNAL: RESPONDING TO EBOLA

Caitlin Rose, a nurse from Washington, DC, recently returned from Macenta, Guinea, where MSF was working with Guinea’s Ministry of Health to contain an outbreak of Ebola. Her duties included contact tracing—working to follow the path of the highly contagious disease as it moved through the community.

The project was supposed to be an exploration, so it was a small team, just three or four other people who arrived a few days before me. But they found cases right away, so they set up an isolation ward and more staff was sent in. I took over contact tracing and was working with a mixed team of Guinean and MSF staff to locate people whom the sick, dying, or dead had been in contact with.

Ebola is highly contagious outside isolation, so when dealing with patients or suspected cases we always wear gloves and N95 respirator masks, and we always have a bottle of 0.5 percent chlorine solution with us to spray down our gloves between taking a temperature or touching a suspected patient. You have to keep a two-to-three meter distance between yourself and others to keep the risk of droplet contamination as low as possible. If you find someone who is sick, you alert the ambulance team and the water and sanitation and logistics people right away.

Contact tracing is fairly low-risk because most of the people aren’t sick. It’s very important, however, because it’s one of primary methods of breaking the cycle of transmission. We actually didn’t find a lot of infected people but we did monitor a lot of potential cases—taking temperatures every day, going through symptoms, checking and double-checking to make sure they hadn’t made contact with anyone else.

The outbreak in Macenta wasn’t difficult to trace. A doctor in town had gotten infected and transferred the disease to a lab. From there, lab staff caught it and then passed it to a relative. It was a fairly logical progression. We knew who was at greatest risk: the immediate family members of people we had in isolation, and the baby of a mother who died from the disease.

There were other challenges, though. This is the first time there’s been an outbreak of Ebola in Guinea, or in most of West Africa, and it’s a very frightening disease. This particular strain, Ebola Zaire, is extremely lethal and usually kills eight to nine out of ten people. People get very sick very quickly, and foreign aid workers arrive in outlandish protective gear. It’s very hard to reconcile traditional cultural and religious beliefs with the strict medical protocols of Ebola. That’s hard to understand and hard to explain, and rumors spread that MSF had brought the disease, because we showed up and started isolating patients who walked to the ambulance, walked into the hospital, but later died.

There were violent protests and we were evacuated, but after several days of negotiation with local authorities, MSF returned. Some patients have since been discharged from isolation, but the outbreak has not yet been declared over.

When we arrived, because we’d never worked in Macenta before, some local health staff thought MSF dealt solely with Ebola. This isn’t the case, of course, but I think a situation like this does sum up what we actually do: take risks to go places that others aren’t, and to provide care to people who are really need it.
A CONVERSATION WITH THOMAS KURMANN, MSF-USA’S DIRECTOR OF DEVELOPMENT

Where does MSF-USA’s funding come from?

In 2013, 92 percent of our donations came from more than 630,000 private individuals, and the other 8 percent came from foundations and corporations. We have what we could call a financially democratic pyramid; we are not dependent on a few top donors; 57 percent of our revenue is being generously donated by donors that give to us less than $500.

Can people earmark their donations for specific projects?

Our philosophy, in line with our humanitarian principles of impartiality, independence, and neutrality, is to prioritize giving that is not earmarked. This allows us to stay flexible and to allocate money where our medical assistance is needed most.

We accept earmarked donations when it corresponds to a wish of the donor. Major donors, particularly foundations and corporate partners, do often want to allocate their donation to a specific project. It is one of our fundraising principles to accommodate the wish of the donor. And we will at exceptional times launch specific campaigns for ongoing projects that need funds. But in both cases, we have to be sure that we can actually spend the money where and how it’s intended to be spent, that the needs are there, and that we have teams that can address them.

Are there specific projects you see needing more funding now and in the year ahead?

Syria, Central African Republic, and South Sudan are still underfunded. These are examples of places where there is space for earmarked funds. Across our offices in the world, campaigns focused on these places have not received the response we’d hoped they would. The contexts are complex, the crisis is human made, and it’s very difficult to see progress, which I think gives donors pause. Unfortunately, the needs are the same regardless.

How do you ensure that MSF-USA can meet its financial contribution to the entire MSF movement?

Globally, MSF is trying to increase fundraising to a level that corresponds with the massive operational needs our teams see in the field, and we have, after an in-depth analysis, identified a few countries where we see potential. The US is one of them, and we intend to increase revenue from the US over the coming years based on our current five-year plan, which outlines our strategic priorities.

We are pursuing several new initiatives designed to get our message, the message that so many have responded to so generously, to more people. A primary focus of our efforts will be to inspire even more people to give on a regular basis, because monthly giving helps keep our responsive if and when emergencies occur. It provides the organization with increased financial stability and predictability of revenue, which is important for our project management in the field.

How do you balance the need to invest in new initiatives with the need to keep our expenditures at a certain level?

We have to keep a healthy balance between investments and revenue in order to keep our administrative spending at an acceptable level. But we do see growing needs for field projects and we would like to continue to develop and expand programs that bolster our ability to run more vaccination campaigns, offer new treatments that have shown strong results so far—seasonal malaria chemoprevention, for instance—and to support our efforts in conflict zones and isolated areas where we see fewer and fewer other agencies working. We have to convey these needs to the public and help them understand the great impact they can have by supporting these efforts.

Why do you think people give to MSF?

We asked donors this in focus groups last year, and their answer was very clear. They support us because they see us as an emergency organization. Donors admire the doctors, the people who go to the field and dedicate their lives and their time to our lifesaving activities. They respect that we are an organization that is independent and goes into areas others do not, in crisis situations, in war situations, where assistance is most needed.

WHAT IS MSF-USA’S FINANCIAL CONTRIBUTION TO THE REST OF THE ORGANIZATION?

MSF-USA contributes the largest single proportion of private funding to the MSF movement. More than 20 percent of the private funding for MSF’s medical humanitarian activities around the world comes from our supporters in the US.

The support we receive from individual donors means we can provide a steady and reliable source of flexible funding. Some other MSF country offices do accept public funding under certain conditions, but it’s usually designated for a specific purpose and sometimes can’t be secured until an emergency has already happened. On the other hand, since our funding comes primarily from individuals, and to a lesser extent from private entities like foundations or corporations, it’s usually unrestricted. Our supporters trust us to allocate their donations where they are most needed, allowing our teams on the ground to be reactive. MSF teams can respond quickly to emergencies, because they know there is a pool of unrestricted, un-earmarked, funds set aside for that purpose.
HOW DOES MSF ENSURE MONEY GETS WHERE IT’S MEANT TO GO?
Marion Deudon is MSF-USA’s Desk Finance and Administration Controller.

The best way to keep track of where our money goes is to set the budget for projects ahead of time and then reconcile expenses after the fact. We have a purchasing policy that we apply to all of our purchases made in the field, and one for what is done at the headquarters level. These are standard, so the field policy is the same in all the countries in which we work. There is a validation process for any purchase being made. Somebody is always checking expenses.

It’s also important to note that supplies could also potentially be diverted. Having a box walk out of a warehouse is just as damaging as having cash walk out of a safe. So there are checks and balances in place to ensure security.

The validation process involves a lot of paperwork, and all of this goes through several hierarchical levels of reporting. There is always someone managing logistics and financial administration at the field level. The program coordinator is also involved in the validation of purchase decisions and expenses. At the next level, in each country we have financial coordinators and logistics and medical coordinators who supervise the people in the field and report back to people in headquarters. In these ways we can keep both funding and supplies secure.

DO YOU TAKE MONEY FROM THE GATES FOUNDATION?
No. The Gates Foundation and MSF share many common objectives in working to address urgent global health needs in developing countries, and to ensure that appropriate vaccines, drugs, diagnostics, and other lifesaving interventions are developed and delivered to populations in need. MSF is strategically engaged with the Gates Foundation on a number of levels, ranging from high-level meetings to ongoing and frequent technical and working group consultations on issues of concern to both organizations.

As a medical treatment provider working in some 70 countries, however, MSF has medical and operational priorities that do at times differ, and sometimes conflict, with the work of the Gates Foundation and the initiatives they support. In cases where we feel the needs of our patients are not adequately addressed or prioritized, MSF does not hesitate to voice its concerns. At this time, MSF believes that our strategic engagement with the Gates Foundation, as well as our ability to voice criticism or concerns on specific issues over which the Foundation has enormous influence, is strengthened by our financial independence from the Foundation. In fact, MSF is one of the few major global health actors not receiving Gates funding.

HOW IS REFRIGERATION RELATED TO TRYING TO VACCINATE MORE CHILDREN?
Kate Elder is MSF Access Campaign Vaccines Policy Advisor.

Vaccines require constant refrigeration at very specific temperatures from the time they’re picked up at the manufacturing facility until we administer them to patients. It’s a long journey. It starts where they’re made, in places like India and Belgium. Then they’re stocked at an MSF supply warehouse in Bordeaux or Brussels, where we load shipments to the field onto trucks with ice-lined boxes. They’re transferred to airplanes because delivery by plane is faster. When they reach their destination country, we move them immediately to fridges in an MSF storage facility, then logisticians assemble orders bound for vaccination sites. Finally, the last leg of the trip, from capital to patient, gets them to children in remote towns and villages.

This is the “cold chain,” and any break in this chain threatens the efficacy of the vaccines. The last leg poses the biggest hurdle because we’re often in regions where temperatures are quite high and refrigeration and electricity are unreliable or non-existent. Our teams have to pack vaccines in coolers and, depending on the terrain, carry them on foot or transport them on motorbike, four-wheel-drive vehicle, or boat. We have to move quickly to ensure that the vaccines don’t spoil in the heat.

While working to strengthen the cold chain is important, MSF is also advocating for another alternative: urging pharmaceutical companies to develop vaccines that are easier to use, with greater tolerance for heat so that they can be kept outside of refrigeration. That would help us reach many more children and probably save a lot of lives in the process.
WHAT’S HAPPENING IN HAITI NOW?
After the 2010 earthquake in Haiti, MSF launched its largest-ever emergency intervention, hiring thousands of new staff, treating more than 350,000 patients in the 10 months that followed, then treating hundreds of thousands more during a massive cholera outbreak. MSF had been in Haiti for almost two decades prior to the earthquake, though, and still has extensive operations in the country, including, in Port-au-Prince, a trauma surgery and burn center in the Drouillard neighborhood, the 107-bed Nap Kembe surgical and orthopedic hospital in Tabarre, a stabilization center in Martissant, and a 143-bed emergency obstetrics program in Delmas 33. MSF also runs a 160-bed, full-service hospital in Leogane, to the east. On these pages are images from Delmas 33 and Drouillard.

Clockwise, from top left: An MSF nurse cradles a newborn at Delmas 33; patients awaiting care at Nap Kembe in Tabarre; a patient receives physiotherapy at Nap Kembe; a mother holds her injured child as a radiologist prepares to X-ray his arm; a mother feeds her baby, who was born premature but healthy; a patient who lost his leg to a road accident recuperates; a newborn rests next to his mother.

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Doctors Without Borders/ Médecins Sans Frontières (MSF) works in nearly 70 countries providing medical aid to those most in need regardless of their race, religion, or political affiliation.