ALERT

NURSES AND MIDWIVES ON THE FRONTLINES
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COVER: Self-portraits of MSF nurses and midwives from around the world.
ABOVE: A man leaves a temporary relief station set up by MSF in New York City to provide services including free showers, toiletries, clean socks and underwear, and information on additional resources to people experiencing homelessness during the COVID-19 pandemic.
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Dear Friends,

THIS SPECIAL ISSUE OF ALERT MARKS THE INTERNATIONAL YEAR OF THE NURSE AND MIDWIFE—and what a grinding year it has been for frontline health workers in the midst of a pandemic.

I was raised by a surgical scrub technician who couldn’t go to nursing school. The reverence in her voice whenever she spoke of the nurses at work still rings in my ears. When she introduced me to a nurse, there was a change in tone that meant sit up straight, behave yourself. Nurses have that kind of power.

Now, as an obstetrician, I have been lucky to learn from amazing nurses and midwives along the way. I still remember Tina—a nurse so tiny that she had to weigh down her pockets in order to donate blood. She was tiny and mighty to be sure. And she was always first to grab a sheet and belly up to the stretcher to move a patient in distress. We worked together during the crack cocaine crisis, when social workers carried newborns from the hospital into the foster care system. She showed me where we hid the clean clothes and toiletries for mothers experiencing homelessness. She taught me how to separate a patient from her abusive partner. And how to keep a patient overnight so that she could sleep through the night without fear. Tina showed us our privilege and how to give it away.

The killings of George Floyd, Breonna Taylor, and Ahmaud Arbery have us all thinking about power and privilege lately. In my own reflection, I am mindful of my role and the privilege it brings. How do I use my seat at the table to make MSF even better, even stronger, and more inclusive? How do we address the longstanding issues of structural racism as a public health crisis?

In this issue of Alert, you’ll learn about why we decided to launch temporary operations in the US in response to the unprecedented needs around the COVID-19 pandemic. It is no coincidence that many of our projects have served communities of color—including in New York City, Detroit, Florida, Puerto Rico, and working with Native Americans of the Southwest. The COVID-19 mortality rate for black people in the US is more than twice as high as the rate for white people. Researchers estimate that if the mortality rates were equal, some 17,000 black people would still be alive today.

With these disparities in mind, we are also taking a hard look at how to confront racism and discrimination within our own organization. We often celebrate the extraordinary diversity of our staff—with some 90 percent of our workforce coming from the local communities we serve. But we have more to do to tear down barriers that hinder the recruitment, retention, and advancement of people of color, and to ensure sustained diversity on MSF governance boards and in leadership positions. I am determined to use my term as board president to build an anti-racist organization while holding firm to our principles of impartiality, neutrality, independence, medical ethics, and bearing witness.

Around the world, MSF provides aid to the people who need it most, regardless of race or ethnicity. And we see patients every day who are victims of targeted attacks or who are denied access to health care simply because of who they are. In those settings I’ve learned from nurses and midwives how to just listen. Taking the time to listen to the problem can mean more to an individual than the cure. Those lessons were magnified when I accepted my first assignment with MSF and still resonate in this moment.

I am still listening and learning, and I am grateful for your support of our work.

Sincerely,

Dr. Africa Stewart
President, MSF-USA Board of Directors
THE EMERGENCY AT HOME:

Inside MSF’s unprecedented response to COVID-19 in the United States

The United States has become the epicenter of the COVID-19 pandemic—with more than 4.6 million confirmed cases of the coronavirus and more than 154,000 deaths. As the scale of this emergency became clear in March, Doctors Without Borders/Médecins Sans Frontières (MSF) launched a series of medical humanitarian projects in the country with the goal of helping vulnerable communities with limited access to health care. And in many of these projects, MSF nurses and midwives have been leading vital efforts to strengthen infection prevention and control measures, expand health promotion activities, and get testing and support for the people who need them most.
"This is what nurses do, right?" said Jean Stowell, a family nurse practitioner and midwife and MSF’s head of mission for the US COVID-19 response. "We get information to patients. We make sure they understand it. We make sure they have the resources they need to get better in the hospital—and then go home and be safe. All of this is public health."

As in other countries around the world, the coronavirus is taking a disproportionately heavy toll here on people who were already vulnerable before the pandemic, particularly those who struggle to access or afford medical care. People who are elderly, homeless, forcibly displaced, or living on the move are all at greater risk of contracting and suffering serious cases of COVID-19.

Our teams are also witnessing the stark racial disparities in health care. Many of our projects in the US have served communities of color—including in New York City; Detroit; Immokalee, Florida; Puerto Rico; and working with Native Americans of the Southwest. Black and Latino residents of the US have been three times as likely to become infected as their white neighbors—and nearly twice as likely to die from the coronavirus, according to a July report by The New York Times based on federal data from the Centers for Disease Control and Prevention. The data also showed Native Americans at higher risk in parts of the country.

CARING FOR PEOPLE ON THE MOVE

In Immokalee, Florida, 15,000 to 20,000 migrant farmworkers continued laboring through the spring even as much of the country shut down during the first wave of the pandemic. These essential workers help feed the country, yet most of them have minimal access to health care or to COVID-19 testing. MSF partnered with the Coalition of Immokalee Workers, the Florida Department of Health, and the Health Care Network to implement a multifaceted pandemic response plan, including a public health education campaign in English, Spanish, and Haitian Creole to teach people how to protect themselves from the coronavirus. We also helped run mobile COVID-19 testing sites.
Seeking out the right partnerships to reach the people who need care most is an essential part of MSF operations in the US and around the world, said Imma Bramlage, an MSF family nurse practitioner and medical coordinator for our US projects.

“We don’t just come in and decide what we’re going to do—we think about the key players. Who’s already working on the ground and what are they doing right now?” she said.

“Then we ask: How can we take that big picture and make it a comprehensive health service for the people who need it?”

After two months MSF handed over its projects in Immokalee to the county health department and other local organizations in late June. Increased attention to the high rates of COVID-19 transmission in farmworker communities helped lead to increased testing efforts by county and state officials. With Florida’s “stay-at-home” orders lifted and case numbers starting to climb in non-agricultural parts of the state, it’s critical that officials continue mass testing and contact tracing and provide health services for all communities at convenient times and locations and in preferred languages, in Immokalee and elsewhere.

SUPPORTING THE RESPONSE IN NEW YORK CITY

MSF’s US response began in New York City, the country’s largest COVID-19 hotspot and home to our US headquarters. As we do in every country, our teams took stock of the needs and explored gaps in medical care and other essential services that MSF could help to fill.

“We very quickly saw huge needs among the homeless population in New York,” said Michelle Mays, an MSF nurse and the project coordinator of our New York operations. “There are around 80,000 homeless people in the city, and several thousand of those people sleep on the streets every night. While the city and country were being told to stay at home, where were these people supposed to go?”

We partnered with local organizations to help improve infection prevention and control (IPC) measures to minimize the spread of COVID-19 in facilities serving people who are homeless, housing insecure, or living in supportive housing. MSF assisted some homeless shelters and soup kitchens with handwashing stations, mask distribution, and health promotion activities. And we distributed 1,000 mobile phones to vulnerable New Yorkers who otherwise might not have been able to contact emergency and support services. We also opened temporary relief stations in Manhattan, offering free showers, toiletries, socks and underwear, and information on additional services available.

LEFT, FROM TOP: Meredith Moody, MSF nurse and infection prevention and control manager for the Immokalee project in Florida. | Jessica Gonzalez, a volunteer from the Health Care Network of Southwest Florida. | Sarah Kuech, MSF nurse and health promotion activities manager for the Immokalee project. All photos © Taimy Alvarez/MSF
NURSES ARE TRAINED TO TREAT PEOPLE NOT JUST AS INDIVIDUAL PATIENTS BUT AS MEMBERS OF COMMUNITIES, TAKING A HOLISTIC VIEW OF THE FACTORS THAT AFFECT THEIR HEALTH.
MSF concluded its COVID-19 activities in New York City in early July, handing over one of its relief stations to a local organization, Shower Power. “Access to showers and hygiene facilities is a long-standing issue in New York City,” said Mays. “It’s something that predates the pandemic, but which became critical when all public facilities were shut down.”

A HEAVY TOLL ON OLDER ADULTS IN NURSING HOMES

Over the course of the pandemic, nursing homes have emerged as outbreak hot spots. Elderly residents—many of whom also have underlying health conditions—are at a particularly high risk of infection and complicated cases of COVID-19. And shared living spaces are a perfect environment for the coronavirus to spread. In European countries, among the first that were hit hard as the pandemic spread worldwide, MSF assisted the elderly in nursing homes in Belgium, France, Italy, Portugal, and Spain. We are now applying a similar model to our work here in the US.

MSF sent a team to Michigan, where one out of every three people who died due to COVID-19 was a nursing home resident. By the end of July, there were 78,000 confirmed cases and over 6,100 deaths statewide, and nursing home residents accounted for 7,500 of the cases and 2,000 deaths, according to the Michigan Department of Health and Human Services. Additionally, there have been more than 3,700 cases of COVID-19 among staff working in long-term care facilities, and 22 deaths. With such a heavy toll on the residents and essential workers at these facilities, MSF began working in Detroit in coordination with the city and state health departments to provide health education, IPC trainings, and mental health workshops to staff of nursing homes and residents and staff at adult foster care facilities.

“This outbreak has laid bare a shocking disinterest our society has for some of our most vulnerable people—the elderly—and those who care for them,” said MSF nurse Karin Huster, who served as emergency medical referent in Michigan. “After a four-hour session with our IPC expert, [one] housekeeper started crying. She said no one had ever paid any attention to her in all her years working there. It was then that I knew our team was right where we needed to be.”

FORGOTTEN COMMUNITIES

Native American communities in the Southwest have also been among those hardest hit by COVID-19. For example, Native Americans make up nearly 10.5 percent of the population of New Mexico but accounted for half of the 12,147 cases confirmed there by the end of June, according to the state department of health.

In April, MSF began working in partnership with local officials, community leaders, health care workers, and others from the Navajo Nation and Pueblo peoples in New Mexico and Arizona. Led by veteran MSF nurse and midwife Ruth Kauffman, our team provided guidance on infection preven-
tion and control measures for reducing the transmission of the coronavirus in households, community centers, health and care facilities, and correctional facilities. We also provided logistical support to implement these recommendations, and technical support for health and isolation centers.

Nurses are trained to treat people not just as individual patients but as members of communities, taking a holistic view of the factors that affect their health. "Addressing the outbreak at the community level is essential," said Kauffman. "In the US, like many places, the main focus of the health system at the beginning of the COVID-19 outbreak was on preparing for a potential surge [of cases] in hospitals and making sure beds and ventilators would be available. But in this area, the vast majority of patients are cared for in the community, rather than being admitted to hospitals as inpatients. So we focused on community response and connecting communities to hospitals when needed." MSF developed a program called "Teachers of IPC" and has since handed over the IPC trainings to a local organization, Community Outreach and Patient Empowerment (COPE).

COVID-19 AND CASCADING CRISSES

In Puerto Rico, which is still reeling from the health impacts of two devastating hurricanes in 2017 and a sequence of powerful earthquakes earlier this year, MSF is supporting health facilities, providing health promotion for high-risk communities, and bringing home-based medical care to vulnerable people across the island territory.

"In Puerto Rico, we've seen an acute lack of access to health care due to the COVID-19 pandemic and its influence on health-seeking behavior and the availability of care," said John Hansen-Brevetti, an MSF nurse managing COVID-19 infection prevention and control in Puerto Rico. MSF has two mobile medical teams traveling to homes to provide primary care and supporting "pop-up" clinics in and around San Juan or in remote areas of the island.

When the first cases of COVID-19 were reported in March, Puerto Rico's health infrastructure was already under extreme strain. MSF distributed more than 2,700 hygiene kits, donated nearly 30,000 PPE items to 22 health facilities, and conducted 11 IPC trainings to help essential workers, patients, and others stay safe. As in our other projects in the US, we partnered with local community groups assisting the homeless, the elderly, people with substance abuse disorders, and families affected by recent earthquakes. The team distributed thousands of hygiene kits and provided health education focused on handwashing, wearing face masks, and social distancing.

"In a way, it's fitting that the year of the nurse is also the year of the COVID-19 pandemic," said Hansen-Brevetti. "We saw early on that nurses looking after COVID patients in the hardest-hit cities around the world had to do so without the equipment they needed, but they still did it every day. That's simply what nurses do: we answer the call, in any situation. It's something nurses do in hospitals around the world, and it's something nurses do at MSF."
In countries around the world, health care workers are responding to the COVID-19 pandemic. Doctors Without Borders/Médecins Sans Frontières (MSF) nurses and midwives are at the forefront, active at every level of our operations from patient consultations to infection prevention and control to health promotion to coordinating medical projects. They’re also working to maintain our ongoing projects and keep caring for patients in need amid unprecedented challenges. Here, MSF nurses and midwives reflect on their experiences.

**INNA ONYSCHENKO, Nurse**  
**UKRAINE**

I live in the village of Stariy Krym, on the outskirts of Mariupol city, Donetsk region. Currently, I’m joining the response to COVID-19 in Mariinka Rayon, close to the front line in eastern Ukraine. Ukraine is the only European country facing an armed conflict. This situation has gone on six years already. We have two mobile teams to support the Ministry of Health in providing screening and home-based care for people with mild symptoms of COVID-19. We also collect samples and deliver to laboratories designated by health authorities to test for the virus.

Previously, I worked in another MSF project, also with mobile clinics. From 2015 to 2019, we covered 28 locations where people were trapped by the armed conflict. We treated diabetes, hypertension, and other chronic diseases. We also provided mental health support. In total, we followed up more than 7,000 patients—90 percent of whom were over the age of 50.

Our patients everywhere welcomed us not just as medical teams. We were, for them, members of their family. We knew who had a grandson going to school, or if something happened in their family. We became very close. They came to us and shared their problems and experiences. They happily discussed many issues with us too. Even now, walking around the city, we meet our former patients and they not only greet us but try to hug and kiss us.

When MSF called me to work on the COVID-19 response, my whole family supported me. Now I’m in another city, so I constantly call up my family. I see people very alarmed. Imagine what it is like now for those who also live along the front line. They need our support more than ever.
ANDREA OROZCO, Nurse
VENEZUELA

My name is Andrea Orozco and I am from Caracas. I work at the Hospital Vargas in Caracas as an infection control officer. Since I was a child, I always wanted to help others and that’s why I decided to study nursing. It has been an exciting fight now that I can help my country, my people, and my colleagues.

The biggest challenge with the COVID-19 pandemic has been the economic and social impact that we must face. I would like to change the way we live and communicate. I live with the staff that fight every day for the wellbeing of patients and everyone. Here we are all the same, regardless of race or creed, no matter what country we live in, how old we are or what we do.

CECIBEL JUAREZ, Nurse
EL SALVADOR

At the beginning of the pandemic, I supported an MSF mobile clinic in vulnerable communities affected by violence in Soyapango and San Salvador. The health centers have suspended outpatient consultations and only tend to people with suspected symptoms of COVID-19 and emergencies. Therefore, my job was to care for people who have been excluded from their services.

I have always liked nursing. It is a career of service, very human, that not only focuses on physical health but also on mental health—to comfort, to be empathetic with the patients. I like teamwork because each member contributes his or her knowledge to provide the best possible care for the patients, taking into account the principles of MSF. I love my work. It’s a team job—no matter what your political or religious beliefs are, your financial situation, etc. It’s a service to the community, it’s a human being with the patients. We don’t have borders to care for others, and it allows us to act with impartiality with everybody.

IVORRY GOMEZ, Nurse
US

Since I was a child, my father had destined me to be a nurse. In fact, he wanted me and my younger sisters to all become nurses. Nurses were well-respected, admired, and had job security. However, I was born in Bluefields, Nicaragua, in 1982, and this was a major obstacle in me fulfilling this call.

Nicaragua was at war and there was (and still is) great poverty, with little access to education. I was four years old when my mother and I flew from Managua to Mexico City to cross into the United States. My father could not come with us, as he had to leave to find work. We had to have enough money for the flight and the “fees” for those who made a business out of helping others like us.

Once in Mexico City, our handlers helped us cross the river into Brownsville, Texas. We were caught by immigration as we tried to board our flight to Houston and put in a detention center. My mother remembers that the detention center was filled with other mothers and their children, and how she and I shared a cot together. We applied for and were granted asylum after four days in custody and allowed to unite with my grandparents in Port Arthur, Texas.

My childhood was much like any other immigrant child’s: My education was the single most important thing to me, and a contribution to my family. I knew my trajectory was nursing. I graduated cum laude and had a full scholarship to Lamar University’s nursing school and graduated in 2005 with my bachelor’s of science in nursing.

However, in 2008 my trajectory shifted and I found myself wanting to help others who were refugees, displaced, and in poverty. I was accepted into Baylor University’s Louise Herrington School of Nursing and received my master’s of science in nursing as a family nurse practitioner in 2010. I went on to get my doctor of nursing practice in 2013 because I felt I had to continue to advance my degree in order to better advocate for vulnerable people.

In my quest to be equipped to serve displaced people I earned my master’s of public health from Harvard’s T.H. Chan School of Public Health with an emphasis on global health and population studies. While studying humanitarian crises and global refugee care, I noticed that MSF was always at the forefront of critical responses. So, after graduation, I applied and was accepted for my first assignment in Ethiopia.
JOSEPH BYENDA NYAKAHEKWA, Nurse  
DEMOCRATIC REPUBLIC OF CONGO (DRC)  
It was in my fourth year of humanities studies that I made the decision to become a nurse and not a doctor. I was sick and suffered from severe malaria. I was hospitalized in a room with other patients. Seeing the time the nurses spent taking care of us—especially their proximity to me—I made the decision that one day I would have to do the same for the others. I was struck by their dedication—that’s what motivated me to be able to do the same one day to help others.

I have been working with MSF since 2008. I was recruited during a measles and cholera epidemic in the Mweso health zone in North Kivu. We were saving lives in difficult conditions and amid armed conflict. From 2009 to 2011, we treated many sick people who were shot during the war.

In the city of Goma, where I currently live, the government has taken some measures in response to COVID-19: Social distancing, wearing a compulsory mask, movement restrictions, et cetera. The price of food on the market has gone up a notch. With this situation we are obliged to assist friends and brothers for their survival.

MSF set up new patient circuits in supported health structures and organized training and even planned collaboration protocols with the Ministry of Health before the situation got worse. What makes me happy is having a forecast of our activities, and it gives courage and hope for life. We participate in various meetings organized by the Ministry of Health and the other partners so as not to go it alone, because it is said that unity is strength.

MULUGETA MEKONNE, Midwife  
ETHIOPIA  
I am from Asela, Ethiopia, and I am the MSF midwife activity manager for the Kule project in the Gambella region. I became a midwife because of my mom. When she was in labor to give birth to my youngest brother the nurse of the health center told her that she needed a referral to a hospital due to complications. She gave birth on the way to hospital and it was a male nurse who assisted the delivery and resuscitated the baby, who was fine after a few minutes. My mom was happy with the very supportive nurse. So after I completed my high school education and wanted to join university, my test results obligated me to choose one of the following fields: Laboratory technician, pharmacist, clinical nurse, or midwife. I asked my mother for advice and she suggested midwifery. I graduated and I am happy and proud that I am a midwife, because I am helping laboring mothers and I am the first person who sees or holds a newborn, even before the mother. Always when I go to the ward and see the smiling faces of the mothers it helps me to work with passion. The coronavirus pandemic has affected our ability to provide outreach activities in the refugee camps. Previously we would conduct awareness raising in gathering places such as schools, woman-friendly spaces, food distribution areas, et cetera, and these places were closed down or are too crowded. Even some health actors stopped their activities completely. I do this work because I am happy with my profession and because MSF is a real humanitarian organization.
MUANDZE NGUI-PANG YI-MENYI, Nurse
CAMEROON

My name is Muandze Ngui-pang Yi-menyi. I’m Cameroonian and I’m an MSF nurse at the Mora project. Nursing is a very noble profession—I feel like a heroine. After all, superheroes are those who save lives, so I consider myself one. The proof is that at this time of COVID-19, the whole world is counting so much on nurses and nursing personnel in general. The pandemic requires us to wear masks while working, so giving patients confidence with a smile becomes difficult. Lately, I was smiling at a patient who was not reacting, and it made me uncomfortable. But later I realized that the patient wasn’t seeing the smile because of the mask. There is a barrier that has been created between me and the sick. But I know that God is protecting me. Humanity so far has survived many pandemics, and sooner or later a solution to COVID-19 will be found.

NANCY KAMARA, Nurse
SIERRA LEONE
My name is Nancy Kamara. I am a nurse at the pediatric ICU in Kenema, Sierra Leone, working for MSF. I chose the profession as a nurse to help people who are suffering from any kind of disease regardless of race, position, religion, or cultural beliefs. With this reason, since we are fighting against coronavirus worldwide, I could not see myself staying at home when we nurses are needed most. With this background I will be very happy as a nurse to participate in the healing of patients and helping their hopes be restored when they return to join their families.

AISSATA, Midwife
GUINEA
My name is Aissata, and I work at MSF’s Conakry HIV project as a midwife responsible for prevention of mother-to-child transmission of HIV. I am proud to be a midwife because I have two lives to save—that of the mother but also that of the child. Coming to the aid of my sisters who are in need is a tremendous pleasure for me. With the COVID-19 pandemic we follow protective measures to protect the mother and child, but also to break the chain of transmission in order to eradicate this disease from the world.

TINDANO SEYDOU, Nurse
BURKINA FASO
I am a nurse supervisor and I work with MSF in Kaya, in the region that receives the most internally displaced people in the country. I chose the profession of nurse because I want to help people recover their health. I find moral satisfaction every time after offering care to patients in order to relieve their suffering. This COVID-19 pandemic greatly affected my life and that of my loved ones, but I continued to work to help others. The coronavirus, added to the context of my country, is very difficult. One day I received an internally displaced person who had lost all hope of living, but after medical and psychosocial care, this person wanted to believe in life again—it’s this kind of meeting that makes us happy during this difficult time.
SAKKAR SABA, Nurse
PAKISTAN

I am a staff nurse from Dera Murad Jamali, Balochistan, and I have been working with MSF since 2018 at DHQ Hospital Dera Murad Jamali. I care for patients in the inpatient department and inpatient therapeutic feeding center pediatric wards.

Everyone has their own idea of contributing to the community and has their own way of leaving an impact in the lives of the people that surround them. Mine is nursing. My profession is a source of satisfaction for me, it gives a purpose to my life which is to bring ease and comfort to the ones who suffer in pain.

Why MSF? Because of the principles! MSF instills values that help us in treating the patients regardless of their faith, ethnicity, race, social class, or creed. For MSF a patient is a human being first and everything else later.

Yes, the coronavirus pandemic has left frontline health workers like us vulnerable, and it is imperative to understand that we cannot help others until and unless we are safe and healthy ourselves. It is a tight spot where we have to strike a balance between continuation of medical services as well as strict observation of infection prevention and control. So far, I have been able to walk this tightrope—I hope I am able to keep this up in the future as well.

MAMOUTOU, Nurse
MALI

I chose to work at MSF to preserve life and care for it without prejudice. MSF’s values give me hope. With the coronavirus I was able to mobilize the knowledge I received through training to educate patients about the chain of transmission and how to prevent the spread of the virus. As we are in partnership with colleagues from the Ministry of Health, we have made a donation of soap, masks, and other supplies.

My most significant experience at MSF was during my supervisory work in the health centers of the Koutiala region during the onset of Mali’s political crisis in 2012-2013. When conflict escalated, the number of mothers who brought their babies to us for care decreased because of the risks. We contacted the village chief to arrange accompaniment for the women on their journeys. The consultations returned.

What makes me happy is a patient who gets better after receiving his treatment. It’s also about helping to achieve something good and the satisfaction of seeing my children when I come home.

SEYNI SALEY, Nurse
NIGER

My name is Seyni Saley and I work in the fight against COVID-19 in Niamey, the capital of Niger. I always dreamed of being a nurse to help people. Daily, I make my contribution in improving the management of coronavirus cases. Today, I’m part of the Niamey Commune One Rapid Response Team. I am particularly involved in the transfer of unstable cases. Despite the risk of contamination, my family supports me enormously. This pandemic has really changed our daily lives.

DOULY ANAL, Nurse
INDIA

I am a nurse from Manipur, India. I work with MSF in the Manipur Project in Moreh, India. I have been working for the past nine years in an MSF clinic in Moreh town, which is located at the India-Myanmar border. Right from the beginning of setting up this clinic in a place where there was no care for HIV or tuberculosis (TB), I have been seeing people from varied backgrounds. When you work in the same place for this long, you get to see the same patients for a very long time. So the memorable experiences are always seeing those patients at the clinic who have improved health conditions.

One among these patients was an infant who was in respiratory distress and severely malnourished. The mother had been told there was minimal chance of survival by the previous health care provider. She had heard about the new clinic in town and as one last attempt she came to our clinic. Eventually, the infant was diagnosed with HIV and TB and with paramount care given to her by the MSF team she started improving. To see her now as a beautiful and healthy girl coming to the clinic has been very rewarding.

Seeing these kids grow up to be hale and healthy young people gives me an energy boost to carry on with my tasks at the clinic.
ISRAA HUSSEIN, Nurse
LEBANON

I’ve been working with MSF as a noncommunicable diseases nurse for the past three years, taking care of home-bound elderly patients in MSF’s Ain al Helweh project in southern Lebanon. Ain al Helweh is the biggest Palestinian refugee camp in the country.

Since the pandemic began, I started working on the front lines of the COVID-19 response, starting with the newly opened isolation site in the town of Siblin, jointly run by MSF and United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

Starting May 20, MSF began running mobile clinics in the suburbs of Beirut, where confirmed and suspected cases among migrants and refugees spiked. I was part of the mobile team unit and visited the buildings to run medical check-ups, take testing samples, give education and awareness sessions, and provide moral and mental support to the migrant and local communities in the areas.

Working on the COVID-19 response is a remarkable experience. The most memorable event was when, on my first day working with COVID-19 patients, a young kid was scared when he saw me in full personal protective equipment (PPE). I had to explain what PPE does, and I even showed him a photo of me not wearing PPE. He smiled and gave me the okay to run my nursing assessment.

ALI ABDULLAH AHMED ALZUWAID, Nurse
IRAQ

I am from Mosul, and live in Mosul. Even during the war I was in Mosul. Eighty percent of people stayed during the ISIS seizure of the city. It’s a large city—2.5 million stayed, and life was ongoing. But life then was without meaning and we were threatened with death all the time, even for smoking a cigarette or talking on the phone. I was working as a nurse then, because there were patients among the city’s original citizens.

Since 2018 I am now a nursing supervisor in MSF’s post-operative care facility, treating all chronic and acute injuries. I have a huge responsibility overseeing 29 nurses plus seven nursing assistants. I oversaw all procedures and wound care.

When the COVID-19 outbreak started, we were working with the Iraqi Directorate of Health. They requested support because tackling the outbreak exceeds their hospital capacity. We built 40 isolation rooms to prepare them to receive patients, and we transformed our post-operative care center into a COVID-19 facility caring for patients and suspected cases.

As a supervisor before I had a lot of responsibilities, exchanging emails and schedules. I didn’t see patients that much. Now I take shifts with patients. It is important for the psychological support of patients, and also for my team, that I be engaged. There are some nurses that fear dealing with COVID-19 patients. I as a leader had to show them that I’m on the front line with them. So I enrolled myself in the patient care schedule three times a week, taking full shifts.

There are challenges, including stigma. I live with my parents, my sisters, and my family. Now I have stopped hugging or kissing my family, for fear of infecting them. I isolate myself even during meals. Now I eat alone. They ask me why, and I tell them this is to protect them. It affected me psychologically a bit, but I will get over it. Mostly.
PROTECTING WOMEN’S HEALTH DURING A PANDEMIC

“If you think about times of crisis—whether it’s disease, displacement, or conflict—women and girls are often disproportionately affected,” says Eva De Plecker, a midwife and head of the Doctors Without Borders/Médecins Sans Frontières (MSF) working group on reproductive health and sexual violence. MSF teams on the ground are seeing that the COVID-19 pandemic is no exception.

ABOVE: Women line up in the waiting area of MSF’s mother and child clinic in Choloma, Honduras. © Christina Simona/MSF
BARRIERS TO CARE AND GROWING NEEDS

In many of the countries where we work, medical services have been disrupted by COVID-19, with health staff, facilities, and other resources being diverted to the pandemic response or otherwise unable to function. In our own projects we see two extremes—in some locations teams are responding to an increase in patients as other health facilities are no longer available, while other MSF projects report a worrying decline in patient numbers due to various factors.

In some places, we’re seeing the deprioritization of safe abortion care. In Rustenberg, South Africa, some facilities suspended safe abortion care services early in the pandemic. MSF worked with the local authorities to re-open those services, emphasizing that safe abortion care is indeed essential health care and extremely time-sensitive. These services help prevent unsafe abortion, one of the main causes of maternal mortality.

“While we are still learning about COVID-19 and how pregnancy may be affected by the virus,” De Plecker says, “experience from past epidemics such as Ebola has shown that the shutdown of services unrelated to the outbreak resulted in more deaths than the disease itself.”

Today, the secondary effects of COVID-19 threaten the health and lives of women and girls everywhere in the world, especially in places that already struggled to meet their health needs. Many public health systems are overwhelmed, and face tough choices about which services they can afford to provide. “I fear that routine reproductive health and sexual violence services are not being sustained—that they are less prioritized,” says De Plecker, “and that women and girls will not find the care they need.”

Meanwhile, the United States government is using its leverage to block the inclusion of sexual and reproductive health care in the coordinated international humanitarian response to the coronavirus pandemic. As the largest source of global public health funding, the US has outsized influence on the programs and services provided in other countries.

MSF is deeply concerned about the interruption of sexual and reproductive health programs, and the impact this could have on efforts to reduce the number of maternal deaths. Frontline health providers are already reporting shutdowns of services as a result of COVID-19. We know that even a small reduction in services can cause a dramatic increase in maternal and neonatal deaths, a devastating lack of services for survivors of sexual violence, and an increase in the life-threatening consequences of unsafe abortions. Sexual and reproductive health care is essential, lifesaving health care.

“Today, the secondary effects of COVID-19 threaten the health and lives of women and girls everywhere in the world.”

CLOCKWISE FROM TOP: A woman arrives at MSF’s Mrima hospital in Likoni, Kenya, to receive reproductive health services in 2017. When the COVID-19 pandemic hit earlier this year, many health centers in Likoni shut down as resources shifted. © Paul Odongo/MSF | An MSF emergency team arrives to pick up a patient in the Mathare neighborhood of Nairobi, Kenya, in 2017. © Kiki/MSF | People wait at MSF’s Ayilo hospital in Adjumani, Uganda, where maternity care services were expanded to serve refugees from South Sudan. © Isabel Cortthier

HONORING NURSES AND MIDWIVES
PROTECTING WOMEN’S HEALTH

Logistically, just getting to a facility for care has been a major obstacle for women. Public transportation was halted in many places and strict curfews have banned vehicles from traveling at night.

Experience from previous epidemics has shown that the level of sexual violence and intimate partner violence tends to increase during an emergency, and there have been reports of increased sexual violence in countries most affected by COVID-19. De Plecker is concerned that these victims could be stuck in lockdown, often in small living spaces, with their attackers.

“People who were already in vulnerable situations, now, because of quarantine measures, have no access to the normal social support systems to get help.” Medical and psychological care for sexual violence can be difficult to access in normal times due to stigma, fear of retribution, or a lack of trust in authorities. And it’s extremely time-sensitive. In order to prevent HIV and unwanted pregnancy, women must have timely access to post-exposure prophylaxis (PEP) and emergency contraceptive treatment.

Fear of COVID-19 is also a barrier to care. Some women experiencing complications during delivery could delay going to a hospital until it is too late. “Being in quarantine may influence patients’ health-seeking behavior, they may fear accessing health services [during a pandemic],” says De Plecker. “The consequences can be catastrophic.”

MAINTAINING ESSENTIAL SERVICES

There is no lack of challenges to MSF’s running sexual and reproductive health activities during the pandemic. Travel restrictions have prevented many staff positions from being filled at our projects—including midwife positions. Some staff have been infected with the virus and are unable to work. Infection prevention and control measures mean patients cannot gather at our health facilities, forcing projects to change the way they function. Health promotion teams, so important to communicating accurate information about how and where to receive health services, might not be able to speak to large groups of people in the communities. And patients are having major difficulties just getting to us. However, MSF teams are doubling down to make sure we can deliver essential sexual and reproductive health care, while taking into account safety and accessibility.

MSF’s top priorities are services with the biggest impact on maternal mortality and those that are time-sensitive. “These are services that cannot be postponed,” explains De Plecker, and which must be continued with the appropriate safety measures: emergency obstetric and newborn care, safe abortion care, treatment for unsafe abortions, contraception, and sexual violence care.

Implementing safety measures means having to rethink how we provide these services. For example, providing safe deliveries now means adding space and barriers between beds or creating separate wards when possible for women with and without suspected cases of COVID-19. In our safe abortion care project in South Africa, women need to make an appointment before coming in. Also in South Africa, MSF continues to run its transport service for victims of sexual violence; from 9:00 a.m. to 5:00 p.m. women who call for care are picked up and brought to the facility for treatment, then dropped off. There has been difficulty with follow-up phone calls, however, because people trapped at home with an abuser are often too afraid to speak.

To ensure that women have access to birth control, MSF projects are advised to provide larger quantities of contraceptives so patients don’t have to come back to get refills every month. Other projects are finding ways for women to get free contraception closer to where they live, either working with pharmacies or referring patients to facilities closer to them.

The second priority services are those that must be continued but can be modified: antenatal care (ANC) and postnatal care. “Normally at an MSF project there might be 100 women or more coming for their ANC appointments on one day,” De Plecker says. Since this is now impossible,
these appointments could be spread out over the week, or a triage system might be implemented where staff will only see women face to face if they have complications. At one project in Colombia, most patients live a great distance from the hospital and now have limited access to transportation. MSF doctors there have regular calls with pregnant patients to check on their progress and advise them whether or not they need to come in.

**COVID-19 FORCES ADAPTATION AND INNOVATION**

"If we can say something positive about this disease," De Plecker says, "it’s that COVID-19 created a unique opportunity for MSF to invest more in innovative approaches to offer sexual and reproductive health care services, adapted to patients’ needs.”

As safe abortion care can be safely and effectively supported via self-care and community-based models, more MSF projects have adapted their services accordingly. Some projects offer self-managed medication abortion, which can be done at home, with support from sources such as hotlines, digital platforms, and peer educators.

MSF is also finding ways to continue to provide care for victims of sexual violence, including by offering free transportation services amid the lockdowns and through telehealth counseling.

De Plecker notes that the pandemic has highlighted the critical role played by locally hired MSF staff, who make up some 90 percent of our workforce. "We are so proud and lucky to have our national midwives in the field. We cannot imagine what would have happened without their presence," she says. Teams are adapting to meet the growing challenges. "They have been strong fighters to ensure that sexual and reproductive health services are not deprioritized, and that women and girls have access to these essential and lifesaving services."
“THE ROLE OF NURSES IS ABSOLUTELY CENTRAL TO MSF”

A conversation with Patricia Carrick, nurse practitioner and MSF–USA vice–president
HONORING NURSES AND MIDWIVES

Patricia Carrick (pictured above) is a certified family nurse practitioner and vice-president of the board of directors for Doctors Without Borders/Médecins Sans Frontières in the United States (MSF-USA). She has more than three decades of experience in a range of settings, including acute care hospital nursing, home-based hospice services, and delivery of primary care in community health centers. Pat has completed five medical humanitarian aid assignments with MSF in Malawi, South Sudan, and Sierra Leone. Here, she talks about the vital contributions nurses make to improving patient-centered care.

What is the role of nursing within MSF?

The role of nurses is absolutely central to MSF. Nothing can happen for our patients without nurses. It is nurses who are at the bedside in hospitals, nurses at the consultations in health centers, nurses who provide vaccinations and preventive care in communities. It is nurses who accompany our patients throughout their health care journeys. Nurses have a special role and responsibility in ensuring the quality and patient-centeredness of our care.

Nurses are trained to be listeners—not only to our patients, but to the families and communities of our patients. Part of our role also is to be sensitive to the perspectives and the input of our colleagues and coworkers. Remember, some 90 percent of MSF staff are members of the communities we serve. The knowledge, skills, observations, and insights of our local staff are essential to the success of our efforts. In order to benefit from those gifts, we must listen to and hear each other.

One area in which MSF has long valued nurses is infection prevention and control—a topic that is getting much wider recognition now in the context of the COVID-19 pandemic. Another important aspect of our work—and this is also especially relevant in the context of COVID—is with end-of-life and palliative care. Because we accompany our patients throughout their journey, it is often nurses who are present in the final stages of life and at the time of death. In many places, we simply do not have the availability of lifesaving treatments and technologies. Nurses face this reality with our patients every day, and struggle to help people face moments of suffering and death with compassion and dignity, often under devastating circumstances.
Q&A ON NURSING CARE

THIS PAGE, BELOW. MSF nurse Jerwin Capuras holds one of the youngest patients in the intensive care unit of MSF’s pediatric hospital in Kenema, Sierra Leone. © Vincenzo Livieri/MSF

RIGHT. MSF nurse Hala Hussein works in the Burj al-Barajneh refugee camp in Lebanon, where she was born and raised. © Diego Ibarra Sánchez

BOTTOM. MSF nurse and midwife Hamdi Abdi Osman, nurse aid Fartun Adan Dahir, and nutrition assistant Asad Doll Ali stand together at a morning meeting at an MSF project in the Somali region of Ethiopia. © Susanne Doettling/MSF
HONORING NURSES AND MIDWIVES

LEFT. Lelise Bultoma is MSF’s nursing activity manager in Kule refugee camp in the Gambella region of Ethiopia. © Susanne Doettling/MSF

BELOW. MSF medical assistant Nazrul Islam and nurse aid Mahabuba Khatun triage a patient at MSF’s Jamtoli primary health care clinic in the Cox’s Bazar refugee camps in Bangladesh. © Daniella Ritzau-Reid/MSF

ABOVE LEFT. MSF nurse Bárbara García and Nyamach, a young patient, play with a balloon made from a surgical glove in the inpatient ward of MSF’s hospital in Ulang, South Sudan. © Igor Barbero/MSF

ABOVE RIGHT. MSF nurse Charline Vincent consults with a patient during a mobile clinic at Porte de la Villette, France. © Agnes Varraine-Leca/MSF

LEFT. Louise is the sexual health nurse at the MSF-supported hospital in Kigulube, South Kivu, Democratic Republic of Congo. © Davide Scalenghe/MSF
Q&A ON NURSING CARE

What are the mental health impacts of this kind of work?
It’s important to note that nurses are often de facto mental health workers. While I fully support MSF’s efforts to increase specialized mental health care for our patients, we should recognize the skilled mental health interventions that nurses conduct as a natural part of their everyday patient care—active listening; reframing experiences; validating and sometimes sharing emotions.

At the same time, we absolutely need to support the mental health of our nursing staff as well as that of our patients. Imagine working at the bedside in an Ebola epidemic when as many as 70 percent of your patients are dying. Or in a trauma ward in a war zone where children are mortally wounded because they were playing in the wrong place at the wrong time. We must recognize and address the incredible torment—the sense of sorrow and loss—this can create. Nursing is a soulful occupation. We give from the depth of our souls. But sometimes we need help and support in order to help our own and other souls survive.

We should also recognize how resilient nurses are; how tough people have to be to do this work. In Kailahun, Sierra Leone, during the Ebola outbreak in 2014–15, many of our nursing staff returned every night to homes where they likely had no electricity nor running water at the end of their day’s work in a highly contagious disease ward. One day, as the outbreak was winding down, the staff were talking and playing this grim game—which was worse, Ebola or the country’s civil war? Remember, this was a war in which limbs were deliberately amputated. One woman on our team said, “Oh, Ebola has been much worse.” Her colleagues were surprised until she explained, “For the past year, I have not been able to hold my children.”

That really affected me. Nursing was her job. But I had never recognized the depth of the sacrifices, the incredible selflessness that brought her and so many of her colleagues back day after day, to work that could have cost her or her family their lives.

Now, in your role as an MSF–USA board member, how are you thinking about supporting our staff and strengthening health care capacity in low-resource settings?
One thing I’d like to do is strengthen the representation of nurses within MSF, to recognize current nurse leaders and identify new opportunities for nurses in leadership roles. More broadly, we need to recognize and develop the talents of people throughout MSF who are leaders, who have been working in our projects in some cases for years. I hope we can promote more locally hired staff into leadership roles and elevate the work of local experts.

Now of all moments we must look at how to do things differently. Response to sudden change—this is what MSF is all about. For example, in the face of travel restrictions, perhaps we could consider how much travel is really needed to accomplish our goals. Couldn’t this be the moment to concentrate on remote training and support for local staff? Perhaps this is the moment to combine the strengths from diverse settings to improve nursing throughout our medical projects.

“AS NURSES, WE ARE BOUND BY OUR PROFESSION AND DRIVEN BY OUR ETHICS TO PROVIDE CARE WITH COMPASSION AND RESPECT FOR THE INHERENT DIGNITY AND VALUE OF EVERY PERSON.”

Some people have said we should be “Nurses Without Borders” to recognize the vital role of this profession. What do you think?
Our title, Doctors Without Borders, suggests the hierarchical importance of a single role to the apparent exclusion of others—and, as a nurse advocate, I have always railed against that. What I really think is that all roles are critically important. Who working on an MSF project could live without a logistician or a WASH [water, sanitation, and hygiene] specialist? We have just been talking about the importance of mental health, about being connected to communities—what would we do without psychosocial counselors, health promoters? How would we manage our activities without our drivers, our cooks and cleaners, our human resources and finance managers?
So, yes, it’s important for us to raise up the profiles and voices of our nurses and midwives—absolutely! But it’s also important for us to recognize and credit the contribution of every single role, every single member of every one of our teams.

We talk about the incredible value of diversity in our organization. We say we are, and I truly believe we are, committed to equity and inclusion among patients, communities, and staff. Now, with the disruptions caused by a worldwide pandemic, and the stark realities of racism and health disparities glaringly obvious here in the US, we are called to right action: to raise up the contributions of every employee, to recognize the humanity of every patient; every being we touch. As nurses, we are bound by our profession and driven by our ethics to provide care with compassion and respect for the inherent dignity and value of every person.
MASSACRE IN A MATERNITY WARD

Honoring the victims of the attack on Dasht-e-Barchi hospital in Afghanistan
Doctors Without Borders/Médecins Sans Frontières (MSF) honors the victims of the May 12 massacre of women and children at our maternity ward in Kabul’s Dasht-e-Barchi hospital. Among those killed were 15 mothers and an MSF midwife, Maryam Noorzad. The attackers also killed two young children and six other individuals who happened to be present at the time. More than 100 people found shelter in the safe rooms of the facility, including one woman who gave birth to a healthy baby in the midst of the terror attack.

Mothers, babies, and health staff were deliberately targeted. While the identities of the assailants remain unknown, this horrific crime appears to be part of a larger pattern of attacks targeting the ethnic Hazara community living in the area.

In June, MSF made the painful decision to end our activities in the Dasht-e-Barchi maternity ward due to concerns that similar attacks targeting our patients and staff may be repeated. We remain committed to ensuring that staff receive the necessary support, including psychological assistance.

We are looking for ways to support local initiatives aimed at improving access to health care in this region.

MSF recognizes the bravery and determination of health workers in Afghanistan who continue to offer lifesaving care in the face of relentless attacks. These two personal essays provide a window on the tremendous losses suffered by the community.

BY ZAHRA KOOCHIZAD
MSF MIDWIFE SUPERVISOR

As midwives in Afghanistan, we bring new life into this country under conditions more difficult than in most. Despite some improvements over the past years, Afghanistan has one of the highest maternal and newborn mortality rates in the world. One of the biggest challenges that every midwife and pregnant woman in Afghanistan faces is insecurity. I’ve painfully experienced this firsthand.

I am the midwife supervisor in the MSF-run maternity wing of Dasht-e-Barchi hospital in Kabul. The attack there occurred on May 12. I remember that day: we had very nice weather, the air was fresh, and I felt a sense of peace when entering the hospital. Once I arrived, I saw my colleagues working; they all looked motivated and eager to start a new day of providing services to pregnant women in need. On a daily basis, we are used to tragedy in our communities, but nothing could have prepared us for the horror to come.
In Afghanistan, a maternity ward is one of the few spaces where women are the leaders. The terrorists entered an area where no men are ever allowed to go. They stormed the maternity wing armed with guns, killing pregnant women, new mothers, and newborns. Their leader must be very proud—celebrating victory over an army of one-day-old babies and women wearing only their hospital robes.

A hospital is supposed to be a protected space. It says this under international humanitarian law. And yet the assault on my maternity wing is not an exceptional case—attacks on health care happen frequently here. What is different about this attack than all the others?

As midwives in Afghanistan, we are the silent leaders of our country. We are at the bedside of pregnant women giving birth to the country’s future—and we need to be protected. Midwives like our beloved Maryam, who was killed in the most incomprehensible way as she assisted soon-to-be mothers giving birth.

On the day of the four-hour assault on Dasht-e-Barchi maternity ward, the terrorists not only attacked pregnant women and newborns, but also the decades of work to reduce maternal and newborn mortality in Afghanistan. Because of this attack, the western area of Kabul—with more than one million residents, and women coming from faraway provinces—no longer has access to any comprehensive obstetric and newborn care.

Each month, the MSF-run maternity wing provided quality services to more than 1,200 mothers who delivered their babies there. Most patients who came to Dasht-e-Barchi belong to the Hazara community, a historically marginalized and still poor ethnic minority. They don’t have the means to pay for their treatment in other places.

Giving birth, in my opinion, is one of the most glorious and most critical moments in a woman’s life. My passion to see new life coming into the world and my strong desire to serve my own people made me choose to become a midwife. I am hurt, my life has changed, but I am still committed to continue my work.

BY RASHA KHOURY
OB-GYN AND MSF BOARD MEMBER

I was nursing my four-week-old daughter in the dark, in the early hours of the morning, when I learned of the attack on MSF’s hospital in Dasht-e-Barchi on May 12. My heart felt extinguished. These were my colleagues and friends. I was instantly transported back to life within those hospital walls. Inside the bustling delivery room, I could hear the prayers and cries of women in labor, giving birth, meeting their babies, calling out to family, sipping juice, exhausted, smiling, relieved, crying. I could smell the blood, sweat, and tears.

Since 2016 I have spent more than a year working for MSF in Afghanistan on multiple assignments as an obstetrician gynecologist. This has meant spending thousands of hours in the labor and birth wards, working alongside Afghan colleagues, mostly midwives and nurses. Together, we accompanied women through what often felt like, and sometimes were, death-defying experiences—all the while centering on dignity and strength.

Before Afghanistan, I had never been part of a team that so beautifully cared for the most vulnerable women in one of the most dangerous places in the world to give birth. Where pregnancy can be a death sentence. I watched our midwife...
staff, many of whom were young mothers themselves, work with steadfastness, empathy, and solidarity to safely deliver quality care in spite of the precarious conditions just outside the hospital gates. Many traveled to the hospital every day at great risk to themselves and their families. The hospital was a safe haven, as it should be for both patients and staff. And despite the incessant violence outside, they brought joy to their transformational work. I remember thinking at the time that when I went through my own labor and birth, I would like to come back and be cared for by these midwives.

MSF projects in Afghanistan aim to reduce maternal and neonatal morbidity and mortality with free, high-quality care to all people—regardless of ethnic group, religion, or political status. The Dasht-e-Barchi hospital has been a landmark in western Kabul since 2014, providing safe obstetric and newborn care to over 1,200 women a month.

The attack took the lives of women in labor, women who had just given birth—women and newborns no different than myself and my daughter. MSF midwife Maryam accompanied these women until their and her last breath, living out the meaning of midwife: “with woman.” Her last words were, “I cannot leave her alone.”

The impact of these murders reverberates still. Losing a mother increases the risk of infant mortality. Attacks on health facilities spread terror and often lead to people avoiding or delaying care for fear of violence in the very places they should be safe. The loss of free and affordable health services increases the risk of more death, disease, and suffering. Women and children in Afghanistan cannot afford these losses. Humanity cannot afford this violence. Civilians and health workers are #NotATarget.
It was 2014 and families displaced by conflict were returning to the Abyei area of South Sudan—many of them to find their homes had been destroyed. Bruce Parmelee was there with a nongovernmental organization to help repatriate refugees, distributing shelter kits and showing people how to assemble them. But four months into his assignment, he started to feel weak. Then came a fever. “I’d never really been sick in my life except a cold or the flu,” he said.

One night, he realized “something was dramatically wrong.”

Two colleagues helped him walk to the Doctors Without Borders/ Médecins Sans Frontières (MSF) clinic located in nearby Agok. “I was very comfortable going there,” says Parmelee. “I went there with trust. And when you’re really sick, having trust means a lot.”

There’s a reason Parmelee felt such a strong sense of trust. After selling a successful Harley-Davidson dealership, Parmelee began a new career midlife in international humanitarian work, helping rebuild communities in conflict and post-conflict settings. Over the next 15 years, his work led him across the Middle East and Africa, often in the very same places as MSF clinics.

He had first encountered an MSF team in 2002, in a remote part of Afghanistan’s Bamiyan Province, and soon became a regular guest at staff dinners. “I saw the way they related to the community,” he says. “They didn’t cordon themselves off with huge security contingents or stay far away from the patients they were treating.” And, most importantly, they were providing urgently needed care to people in outlying areas. “When I say outlying, I mean outlying—they had to cross rivers with a Jeep,” he said.

By the time he fell ill in South Sudan, he and his wife had been donating to MSF for many years. It was an easy decision, he says, because he had witnessed “the level of dedication that the MSF doctors have.”

Parmelee never imagined he’d be on the receiving end of that dedication. That night in the clinic in Agok, the MSF team immediately took Parmelee’s vitals and started an IV. He was severely dehydrated. But there was something else—something much more serious. The care he received from MSF stabilized him for the five-day journey home to Binghamton, New York, where he was diagnosed with liver cancer and told he urgently needed a transplant.

“I thought to myself: You’ve had the good fortune to experience a lot in your lifetime,” said Parmelee. “Have trust in the people around you. Have faith that you’ll get through this.” And he did. Less than three years later, at the age of 70, Parmelee traveled to Nepal, trekking up the Himalayas.

Taking it easy isn’t in the cards for Parmelee. He still plans to complete short aid assignments. And he and his wife Debra still make increasingly generous annual gifts to the organization that helped him during his own medical emergency. “I’ll continue to give to MSF until I disappear from the face of the earth,” says Parmelee with a chuckle. They are now setting up a Legacy gift—so their support will have a powerful impact even beyond that.
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ALERT is a quarterly newsletter sent to friends and supporters of Doctors Without Borders/Médecins Sans Frontières (MSF). As a private, international, nonprofit organization, MSF delivers emergency medical relief to victims of war and disaster, regardless of politics, race, religion, or ethnicity.

DOCTORS WITHOUT BORDERS is recognized as a nonprofit, charitable organization under Section 501(c)(3) of the Internal Revenue Code. All contributions are tax-deductible to the fullest extent allowed by law.

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