Too Much, Never Enough

Social Support at MSF

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CENTRE DE RÉFLEXION SUR L'ACTION ET LES SAVOIRS HUMANITAIRES

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"When I joined MSF as a PC [project coordinator] in 2018, I had already worked a lot in child protection and I was very happy as I was going to be the PC for a paediatric hospital. When we were preparing the [annual plan] I said that we needed a social worker at the hospital. We were increasing to 200 patients, a super vulnerable population: displaced children in an urban setting. There were loads of services around us, loads of other NGOs, and we needed a social worker so that we could refer complicated cases, cases of abuse. In response, the medical coordinator told me, "Absolutely not, Lucie. At MSF, we don't do social work."

Lucie Eches, Project Manager for the Patient Centred Approach, 12 May 2022

Preface

When I was working in Gaza in 2018 and 2019 I was struck by the discussion that the team had about reducing the budget. One way they were exploring to do this was to cut the number of patients that *Médecins sans frontières* (MSF) was paying to transport to the clinic. Finding a set of criteria that worked for our cohort – mostly young, poor men, with devastating leg wounds – was complicated, however. Should it have been on the ability to walk? Almost everyone had difficulty due to the Israeli army's policy of shooting protesters in the knees. What about poverty? Most of our patients were unemployed and very poor. We were struggling to come up with a set of criteria that could orientate our aid for a problem that was not only medical, but also social. At the same time, the social workers in our clinics noted that most of the patients' needs were related to their extremely precarious socioeconomic situation. Yet they did not know where to refer them to get the one thing they needed most of all – cash. For many patients, as a result, their mental health continued to deteriorate, and their recoveries were made more difficult. The question I began to ask myself was: why should we not just give them the cash ourselves?

It was with this experience in mind that when I began working at the *Centre de réflexion sur l'action et les savoirs humanitaires* (CRASH) I seized on the discussions about social support and proposed that I would make it the topic of a project of reflection.

I started the work for this project by doing interviews with 33 MSF practitioners, asking them about examples of social support that they had seen or been involved in during their work with MSF. Often the interviewees turned the tables and asked me a question instead – what did I mean by social support? Did giving protection rations during a nutritional emergency count?

What about giving buckets to displaced families? Was paying patients' transport costs social support?

I felt, at first, that I would be lacking if I did not try to formulate my own definition of what exactly I meant. Steadily, however, it became clear that although people were asking me what I meant by social support they already had a good idea of their own. There might not have been a precise definition that was already accepted by all, but everyone was more or less citing the same sort of examples, a similar set of experiences.

Accordingly, in the first part of the "Practices and Motivations" section I will lay out some of those experiences, a collection of activities that show the moments and types of projects that come to mind when people working for MSF are asked about social support. These examples show the range of social support activities that MSF has undertaken and that we continue to undertake. They also tell us something about what the organisation has done to respond to which problems.

The second part of the "Practices and Motivations" section is inspired by another surprising bit of feedback from the people that I interviewed. They were largely in disagreement with my hypothesis that the provision of social support to patients at MSF was something controversial. This took me a while to understand. Although people started their interviews saying this, they would then often go on to describe moments when social support had provoked disagreement or debate amongst teams and created doubts within themselves. In what was social support, then, not controversial?

I argue that the question is not whether social support is controversial, but at what level it is. After all, the necessity to implement more social support was mentioned in the new President's candidacy letter and is also part of the discussions around patient-centred care, which the

organisation has said is a strategic priority. In addition, as I was working on this project a "Social Support Tool Kit" was being written within the Operations Department. On the surface it might appear, therefore, that we are all turned in the same direction, pointed towards the implementation of more social support, happy to say that it forms a part of 'what MSF does'. At that level, it is not controversial. When one looks at the level of implementation of activities, however, one sees that there are many points where different ideas of humanitarian action, social values, and MSF's remit come into conflict.

It is here that it becomes necessary to move beyond simply listing the activities that MSF has undertaken. If we want to understand the debates that the provision of social support causes then we must examine the motivations for the provision of social support that people cite. It is at that level that we can begin to make sense of all these diverse experiences. I think that those motivations can be broken down into three broad categories, which I will detail in the second part of the introduction.

The bulk of the paper will then be taken up by the report of a field visit to Goma, Democratic Republic of Congo. I wanted to go and see for myself how teams work on these problems. It felt important to me to be able to confront what we say about social support with the reality of its provision, to be able to add to the project the granular detail that comes with discussions about specific operational decisions. The visit was undertaken with an ethnographic approach: completing observations of the teams' work with conversations with team members during which I tried to understand as much as possible their reasoning and motivations for the decisions they took.

The series of questions that the visit raises about our objectives, limits, criteria, and ways of working are completed by insets in the text that contain examples from other contexts that

echo what I found in Goma. These insets show that these are not questions that pertain to one field only, that these projects and their problems are not exceptions at MSF.

It is important to note that this paper will ask many more questions than it will answer. It is not a guide to the provision of social support. My aim is rather to help us identify the questions that we must discuss when providing social support. So, instead of a conclusion, the paper finishes with an exploration of what curiosity means in the context of the provision of social support.

The injunction to be curious was something I heard frequently during my interviews. People had to be curious about where they were working, about the people they were helping. As if social support was a natural extension of curiosity, and a failure to provide it was a result of a lack of it. I began to wonder what was wrapped up in this injunction, which at first seemed so simple. What does it take to be curious? Instead of a conclusion, this piece finishes with a consideration of the questions that this injunction opens.

Introduction - Practices and Motivations

This project started with 33 interviews with MSF practitioners, chosen purposively because of their implication in certain projects or periods associated with the provision of social support, or because they hold a leadership position within the organisation (see Appendix). They were asked to recount their experiences with MSF where social support had been a component of our response, or where MSF had responded to 'social' problems. The intention here is not to precisely reconstruct the history of social support, or social interventions, at MSF, but the interviews undertaken allow me to suggest a rough outline of different 'social' problems that MSF has turned itself to and the moments at which it has done so:

- A series of 'social projects', often concerned with street children and people living in slums, beginning in the 1980s and continuing until the early 2000s;

- Mission France, beginning in the late 1980s, which has connections to those other social projects and yet has a different history and operational logic;

- Projects addressing human immunodeficiency virus (HIV), tuberculosis (TB), and sexual and gender-based violence (SGBV), which came to form an important part of MSF's portfolio in the late 1990s and early 2000s;

- The responses to Ebola in West Africa and the Democratic Republic of Congo after 2014.

In the 1980s the desire to take on social problems amongst a section of MSF volunteers expressed itself in a series of projects aimed at people living in slums in the so-called third world, such as one in Guatemala.[1] There, MSF supported the slum's governing committee with

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[1] Author interview with Rony Brauman, Director of Studies at CRASH and President 1982-1994, 3 May 2022, in French.

money and technical expertise to install a water and sanitation system in the slum and lent political credit to the slum's struggle for legitimacy, thus finding concrete and achievable objectives even in the absence of acute medical needs:

> *There were no medical activities... It was that which bothered me at the beginning... [but] finally we were useful. That's always my argument: if we're not doing medicine, but we're useful for something, really useful, and we are filling a role that no one else can fill, then that's good for me.[2]*

While the complete absence of medical activities was unusual, projects that targeted specific groups in society rather than pathologies or emergency situations were a common feature of MSF programming in the 80s and 90s.

A report was commissioned to Marie-Helène Jouve in 2007 to "provide food for thought for a collective debate on these "exclusion and social violence" projects", against a backdrop of profound questioning of these interventions. The author called on MSF to move away from "the universally accepted definition of humanitarian action" designed to "alleviate vital risk": in a context of great social insecurity, she concluded, "it is a question of providing aid that goes beyond care, so that this medical aid has meaning", and of also focusing the intervention on "the general well-being of the patients"[3].

Often the target of these programs were street children, who were vulnerable to abuse and ill-health:

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[2] Author interview with Brauman.
[3] Marie-Hélène Jouve, Eléments pour une analyse des projets « Exclusion, Violences sociales », MSF-France, 2007.

At the end of 1996 I was sent to Cairo. There were lots of children, and as soon as there

were VIPs arriving the government rounded up all the children in the street to put them

in prison. We wanted to see what was happening with these beggars, who were sometimes

three years old. We worked with a local organisation, we set up a little centre where street

children could wash, eat, and we treated them. And when they were in prison, we asked

that we had the right to visit to at least treat them for scabies, because if one person has

it then everyone gets it.[4]

The beginning of Mission France in 1987 was also often cited in interviews as a moment in which MSF opened itself to actions of a more social type, where links with social services were part of the operational approach. The origins of the mission were very healthcare focused, however. The intention was not to address directly the precarity or poverty of the neglected groups who were having trouble accessing healthcare. It was to provide healthcare to them, refer them to social services, and use the medical activities as a base of legitimacy for advocacy efforts to establish truly universal healthcare in France.[5] Later developments in the mission, however, meant that its programming responded to social exclusion first and medical issues second, particularly as the mission came to focus on protection and shelter activities for migrants.

These projects shared a desire to target a specific population who were perceived to be at a disadvantage socially. This changed with the numerous projects started in the 1990s and 2000s that targeted people living with HIV, TB sufferers, and survivors of sexual violence. Social support here was about the support of a medical objective. The activities might not have been

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[4] Author interview with Marie-Hélène Jouve, Head of Mission and author of a 2007 report on MSF's social exclusion / social violence interventions, 10 June 2022, in French.
[5] Author interview with Brauman.

those traditionally associated with medical action, but the logic of their deployment was to increase the chances of success of treatment. For example, it was common practice to give TB patients two months of accommodation and food, with the aim of promoting adherence to treatment.[6] Social work was also part of the toolkit that MSF deployed when treating TB:

> *Honestly social support is not new. I have a lot of experience since I was national staff in the 90s, in Armenia, Nagorno Karabakh. In a project for TB we recruited a social worker, to study case by case, not with a policy, to say, "ok that's our law", but case by case. She did home visits to try to organise help. If the person needed money to buy food we gave cash so that the patient could decide themselves to buy food.[7]*

The toxicity of early antiretroviral drugs (ARVs), the necessity of close adherence to treatment for TB, and the extreme socioeconomic precarity of the people we were treating were all identified as drivers for the inclusion of more social support in MSF's toolbox:

> *We realised that for the adherence, you needed psychological support, education, but also sometimes, notably for kids who lived in very difficult economic conditions, that it's difficult to tell them, 'take your meds every day', when they didn't have anything to eat that morning.[8]*

> *The HIV projects, they revealed the fact that we had vulnerable people, ill people who could not work, who had to take a medication that was toxic, and they were often*

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[6] Author interview with Jean-Hervé Bradol, Director of Studies at CRASH and President 2000-20007, 19 April 2022, in French .

[7] Author interview with Mego Terzian, President 2013-2022, 5 May 2022, in French.

[8] Author interview with Philippe Blasco, Patient Education & Counselling Advisor, 18 May 2022, in French.

marginalised people, or orphans. Everything that we did around that was what I call social

support.[9]

These programs caused us to expand our understanding of patient behaviour. People did not neglect to take the drugs that they were prescribed or miss appointments just because they lacked the knowledge or the will to do so: they had material concerns that blocked them from maintaining or completing treatment. The conclusion, as a result, was that MSF had to start trying to design programs that responded to those material barriers.

The development of mental health activities and of projects aimed at survivors of sexual violence saw the creation of activities that aimed not only to address material obstacles to accessing care or continuing treatment but expanded the idea of care itself to cover the socio-economic costs incurred by a person being injured or ill:

[In Congo-Brazaville in 2000] I was involved in one of the first transversal projects that was supposed to treat women who were victims of sexual violence in a holistic manner. There was all the legal side, but also a socio-economic aspect, to help the people to reintegrate into a society from which they had been excluded. There were women that became tailors, that we helped to do so, there were women who had been excluded, who had lost their husband, their children. We're coming back to patient- or person-centred. It was aid that was more personalised, following the violence to which they had been subjected, and how the society in which they lived had responded to it.[10]

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[9] Author interview with Léon Salumu, Manager of Cell 5, 23 May 2022, in French.
[10] Author interview with Thierry Allafort, General Director, 9 May 2022, in French.

In another example, in Haiti in the late 2000s, MSF stood as the guarantor for loans made to women survivors of sexual violence that they could use to start businesses with:

The social workers made an assessment based on their previous experience, where they lived, what opportunities existed, if there were government institutions that could help them. We helped maybe around ten, in partnership with a microcredit initiative who gave them a small amount of money to help them set up their business, which was a small thing, like selling food in the road… it was around 500 USD. Not a huge amount. The loans were at zero percent. All ten reimbursed their loans and were completely independent.[11]

The logic of these interventions is based on a radically expanded conception of the pathway of care. Not only does it consider what the patients will be interested by in the provision of healthcare and how they can be helped to access that care, but also what follows their discharge. It takes into account the actions necessary to ensure that the benefit of the provision of care does not become cancelled out by the social or economic detriment incurred by the injury or illness itself.

Sometimes these efforts to understand the environments in which our patients were living and the problems they had led to programming that prioritised non-medical aid, as was the case in the emergency response to the 2005 Pakistan earthquake:

One day we said that it was cold, so we are going to buy these Iranian heaters, not even 10 dollars each, and kerosene, and instead of doing water trucking we did kerosene trucking. And voilà*, the people heated their tents and they stopped coming to the clinic.*

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[11] Author interview with Isabelle Mouniaman-Nara, Deputy Director of Operations, 4 May 2022, in French.

17,000 families, everyone criticised me, everyone was saying that it was not MSF. In what

way is that not MSF?[12]

In reading these examples we begin to see how large the perimeter is for social support at MSF. There is an idea in there somewhere of the kinds of activities that MSF means when it says it is doing social support, a centre of gravity around which diverse experiences orbit. But how do we make sense of these activities? What links heating oil for earthquake victims with tailoring for survivors of sexual violence?

One obstacle to analysing the field of social support becomes clear when people who are all agreed on its necessity in a particular context discuss their ideas for how it should be implemented. It is there that we see that there are different ideas at work, different conceptions of what 'social support' means, and that the different ideas lead to quite different programming.

This is the case with Ebola, where numerous people identified social support as an important element to develop in the context of our responses. However, their explanations of the reasons for providing social support and the way it would be implemented showed quite different intentions at work:

I also bet that in the social [support] was all the relationships that you would create,

someone that you really helped, perhaps he would be more inclined to come to the

hospital when he was really ill... if you had created a relation with them, you would help

them cover their needs, better follow the confinement – because they wouldn't have been

able to if you didn't help them – and so there was surely a public health effect... When we

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[12] Author interview with Mego Terzian.

were struggling with the second vaccine in the epidemic in Congo, I said that ok we need

a second vaccine... but I thought that it was better to work on the social aspect, because

you could – in part – help to control the epidemic through those actions.[13]

Here the operative logic is to use an individual action in the hope that – once reproduced at scale – it would contribute to the reduction of the transmission of the virus, because in effect we would be providing material motivations for the person to comply with public health recommendations. It is social support aimed at increasing the effectiveness of our operations.

Other rationales were more concerned with using social support to compensate for the devastating economic impacts of Ebola and to use the social support to facilitate the use of new treatments, in a way targeted using positive results:

People are scared of being diagnosed with Ebola, OK, but you have to tell them that the

sooner they come the more chance they have to survive... [Ebola] means a huge loss of

money for the family, the house is burnt, the beds are burnt, you lose your job, you are

isolated, so as well as the fear of death I thought that there was a big economic part to

the fear of being diagnosed with Ebola... I thought that we should use money to encourage

people to get tested, but not to pay everyone, not to compensate all of the negatives, only

the positives. I start from the principle that the people who really have Ebola, they know

they have Ebola, because they hide... [The money] might have encouraged them to come

[to the treatment centre].[14]

So here again, part of the reason for the provision is about increasing operational efficiency, though this time more about getting people into treatment than preventing the spread of the

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[13] Author interview with Thierry Allafort.
[14] Author interview with Isabelle Defourny, President 2022- , 19 May 2022, via Teams, in French.

disease. Another part of it is about compensating the socio-economic costs incurred by the person and their family when a person becomes unwell. It resembles the idea from sexual violence projects where the treatment pathway was being extended beyond the treatment of the physical injury to attempt to compensate the costs incurred by it.

Whereas yet another view sought to utilise the same tools – cash and material social support – to catch infections as quickly as possible to give the person the best chance of benefitting from treatment. Yet it did so in a manner that did not distinguish between those who tested positive and those who tested negative, and that recognised the social costs of even being suspected of having Ebola:

> *As soon as we knew that we had a treatment for Ebola, we also knew that if you gave it early to someone infected with Ebola then the chances of survival were very high, and if you gave that treatment too late then you'd die… [but in Kivu] the chance of them actually getting to somewhere they can get a test to prove they have Ebola and get the treatment in time for us to make a difference is limited… we know that the people who eventually develop Ebola are the people who were in contact with Ebola, and the people who are in contact with Ebola have been caring for other people with Ebola. So, we said that we know who's going to get sick… [and you give them] a support package, and so that was basic things like some food, some hygiene supplies, some cash. We didn't want people to disappear off the radar, we wanted people to hang around, stick close to home. The most important part of the package was a mobile phone, with some credit, and we said we'll*

call you every day, but we want you to call us if there's anything weird – even a headache, give us a call... And if you don't get sick, you don't get sick, it's fine.[15]

The three examples all address the same disease with the same will to use social support, and yet each have distinct criteria for the provision of support, distinct relations to the use of medical tools, and distinct objectives. They show that even minor differences in how we think about the use of social support can produce very different programming, which can make it difficult for the teams on the ground to interpret and implement the injunction to provide social support, or to navigate discussions about its implementation.

What I think this brief survey reveals is that social support is impossible to analyse at the level of *what* is done. This is because we are faced with a field that is filled both with examples that do not resemble one another at all and examples of what look at first to be the same activity but on closer inspection are actually trying to fulfil quite different objectives. If we kept our analysis purely at the level of what is done, for example by trying to group actions into categories, we would always come up against this problem: that the actions are simultaneously too similar and too diverse to enable useful categorisation.

Instead, as we see with Ebola, useful comparisons can only begin to be made when we move the conversation away from *what* is done and towards *why* we are doing it. It is, I think, only by looking at the intentions for the provision of social support that we can find a way to analyse the field, to understand what our ambitions are for social support and what discussions we need to have about it in order to implement it usefully.

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[15] Author interview with Natalie Roberts, Director of Studies and Manager of the Emergency Desk 2017-2019, 10 May 2022, in English.

I believe that we can break down the motivations for providing social support into three broad categories:

1. *To help achieve therapeutic success*

This, in its limited sense, is like when we give food to HIV patients so that they can take their medication because it is nauseating on an empty stomach. Actions that are designed to create conditions where the treatment can be followed. Or it can be actions that are part of an understanding of therapeutic success that goes beyond purely clinical indicators to include socio-economic ones, where we recognise that being ill or being hurt has a cost and that the benefit of our medical activity can be outweighed by that cost if we do not help people cover it.

2. *To aid the effectiveness of our operations*

The most frequent activity of this type is the payment of transport costs for people coming to our clinic or hospital. We want to provide services to a certain type of person, we know that they cannot easily access the project, and so to promote the project's reach we remove the economic barriers to coming to us. This can also sometimes take a logic of providing benefits to people to increase the uptake of testing or treatment. Or it can be motivated by what we see as the judicious use of resources: we provide a relatively cheap food ration to the family of a malnourished child to mitigate the risk of the relatively expensive nutritional supplement being shared with other children in the family.

3. *To enhance the 'well-being' of the person*

 This very broad category encompasses a range of objectives and scales of action. At its simplest, it is about increasing the autonomy of the person, for example by giving displaced people cash to buy the things they need instead of imposing our analysis of their needs on them by the provision of a non-food item (NFI) kit. Then there is the idea of responding to a non-medical need or relieving non-medical suffering by providing an immediate improvement of the material conditions of a person: providing food for the hungry, warmth for the cold, shelter for the homeless. Then there are the objectives that target a more fundamental or longer-term change in a person's circumstances, for example providing legal assistance to a migrant in a situation of administrative irregularity, referring a patient to other existing social services, or providing financial assistance to someone to allow them to start a business.

 These categories are inevitably personal, and the lines between them are sometimes unclear or debatable. Others may wish to break down our motivations for doing social support in other ways. That is not a problem. What is important here is not the categories themselves but the necessity to ask ourselves the question about what we are trying to do, what the problem we are trying to resolve is. It is once we have established which objective we are trying to achieve in each case that we can run through a series of questions that allow us to make critical judgements about our provision of social support. What are the limits to what we can do in trying to achieve that objective? What criteria are we basing our actions on? Which people and resources are necessary to achieve that objective? And, finally, how are we going to work with other partners and our patients to achieve that objective? These are the types of questions that I witnessed our teams try to answer in the field visit that I undertook for this project.

Case Study: Goma, Democratic Republic of Congo

Goma, in the far east of the Democratic Republic of Congo and estimated to have a population of 670 000 in 2021, is the location of MSF's sub-coordination for North Kivu, which manages a series of projects providing care to people suffering from violence and the area's poor healthcare system. Since 2015 the city has also played host to its own project. The project profile outlines the main stages of its development:

- From 2015 to 2018 the project aimed to improve access to testing and treatment for people living with HIV in the city, in collaboration with five health centres, with MSF refunding the Ministry of Health for the care offered.

- Between 2018 and 2020 the project was evaluated and reoriented towards testing populations at risk, improvement of the follow-up for people taking ARVs, and the improvement of the identification and treatment of people at the advanced stage of AIDS as well as people in treatment failure.

- Between 2019 and 2021 the project developed four new activities: care for victims of sexual violence,[16] medical care for marginalised people (in this case sex workers and street children), cholera surveillance, and treatment for Covid-19.

- In 2022 the project underwent a series of changes: ending the reimbursement model for the care of marginalised populations,[17] the introduction of a psychosocial team of

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[16] Some people prefer to refer to people who have experienced sexual violence as survivors, instead of victims. In the project documents and in the discussions within the project the team use the term victim. I will therefore reproduce their usage here.
[17] Although it is not mentioned here, the HIV component of the project had also previously moved from a reimbursement model to care provided either by MSF staff or MoH staff under incentives.

three people, the introduction of MSF supervisors in the structures in which we were working, and the provision of abortion at one of the health centres.[18]

In 2022, MSF supported 3 health centres (Murara, Kahembe, CCLK) in their activities "marginalised populations", and seven for HIV activities. Those activities were run by MoH staff benefiting from MSF incentives, and MSF staff, either locally recruited or international.

The project at the time of my two-weeks visit in October and November 2022 was therefore a very complicated one. The project was no longer exclusively an HIV project. Although the idea to start offering care to street children, sex workers, and victims of sexual violence came about because they were identified as populations at risk of contracting HIV, they now did not have to be HIV+ to access the program. Essentially there were four main components of the project:

- Care for people living with HIV, offered at seven health centres. HIV testing, provision of ARVs, monitoring of white blood cell count.

- Hospitalisation (at Virunga Reference Hospital) of people in treatment failure, or with AIDS, or with opportunistic infections.

- Care for "marginalised populations": sex workers and street children. We treated any member of these populations for their medical needs, whether they were HIV+ or not. Outpatient consultations were done at three clinics, and we hospitalised those who needed it.

- Care for victims of sexual violence through outpatient consultations at three clinics.

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[18] I translated from French and summarised this information from the project file ("20221025_CD173_Fiche projet Goma 2023 VF").

At the time of my visit there were more than 4,000 patients in the HIV cohort, which represented about 60% of people living with the virus in Goma. The project conducted around 800 consultations per month for street children, 600 per month for sex workers, 80 consultations per month for victims of sexual violence, and provided about 50 abortions per month.

The patient support activities team (*l'équipe activités support aux patients*) was made up of three social workers (locally recruited in 2022), a supervisor (a locally recruited nurse), and a manager (an internationally recruited psychologist when I visited). In addition, they benefit from the support of a HQ-based Social Support 'Mobile Implementation officer".

They worked with all the groups of people that we offered care to. As mentioned in the project profile, their work had only started in March 2022. A first internationally recruited manager (who was a social worker) had set up the strategy of the team during his mission, with a gap in the manager's position from May covered by the supervisor, with the new manager only arriving in September. The strategy that the team started working with was focused on developing the autonomy of the patient, as the first manager explained during an interview:

> *The confusion is that social work equals social support, but social work is a lot bigger than social support... So, it is always difficult to discuss with colleagues – social work is not very well known, and they don't know what we are going to do. They think that we're going to give money. It's the first thing they said to me when I arrived, 'oh you're here and so now we can give money to our patients.' It's not the approach I wanted to use... Giving 200 Francs to someone to get a taxi with, we see it works, but is it social work? It solves the immediate problem of not having the money for the taxi but it doesn't solve the problem*

of the person having the capacity to pay for their own taxi. The need of the person is not to come to the consultation, it's to find the means to manage themselves to come to the consultation... To hear what people ask for is easy, but to understand what the need is, that takes analysis, it is a deeper work. In social work we make the difference between the demand expressed and the real demand.

As we will see, however, while the team had appreciated some elements of this approach, they had also rapidly come up against the limits implied by the idea of developing the autonomy of the person in a context of extreme deprivation, and appeared to me to be struggling to find an ethical way to position themselves as the ultimate deciders of what constituted a person's "real" demand.

Virunga Reference Hospital, Tuesday 25 October 2022

At Virunga Reference Hospital, a Ministry of Health hospital, I was shown around by the supervisor of the patient support activities team, a nurse by training. He led me into the MSF waiting room, set slightly back and away from the main hospital grounds where people were lined up outside the maternity and doing laundry in the yard. He greeted the people waiting, many of whom he seemed to know well. He told me that we had 2000 people living with HIV in the hospital's cohort, with 30-35 patients seen per day in the clinic.

One of the other nurses in the clinic described the dilemma at the heart of this type of medical work, work that involves a long-term engagement with the person:

We know the patients because we work with them for many years. We have to keep the distance between the emotional part and the professional part. There's a link that's

created but we hold back. The more you know the patient the more you can find solutions

to their problems.

How to balance this need to know the patient, to know in order to care, without ending up caring 'too much'? (Or, perhaps, caring for things that are not ours to care about?) This question animated the structure that had been put in place to care for people with HIV, as well as the questions that it raised for the team.

After a person tested positive for HIV, they were not only seen by the medical team but also by a patient counsellor at least twice in the six months that followed their diagnosis. The aim of those sessions, according to the supervisor, was to help the patient understand the illness and its treatment, as well as "to develop psycho-social competencies". If the medical team or counsellor noticed, however, that the person was having problems following their treatment then they could be referred to the social worker. Their initial task was to understand whether the person's problems were linked to a lack of knowledge or to their social conditions, he said.

One of the project's social workers described to me the team's way of working:

[Before] the patients were lost to follow-up because they were discouraged or stigmatised. So, we give the person the confidence to live, to go find a job. He'll have the confidence and therefore he'll be able to find the solution. For example, there are people that are rejected by the community, and we search for the people who can be a resource for them, with their permission of course. The person has themselves the solution to their economic problem. We do the mapping of the organisations to which we can refer the people. But most of the organisations do not have the means to really work.

In conversation, the supervisor and this social worker went back and forth across the line that separated the desire to have someone be autonomous and the need for people sometimes to be given things to help them out of a situation that they did not have the resources to get out of themselves. They also discussed the problem that posed in a place where many of the other organisations they had hoped to refer to lacked the resources to really deliver. This line provoked unease: how were they to distinguish those who really needed help – help that they had to give – from those who had the resources to help themselves? The supervisor tried to explain this to me:

> *The doctors think that we are there to give money. We are trying to explain that the role of the social worker is not to give social support directly but to help the person to mobilise their own resources.*

> *We worry that if we give mattresses then the patients will tell others and when we do home visits, they'll move stuff out of their houses in order to trick us into giving them things. Though we haven't actually seen this happening yet.*

> *80% of our patients are in difficulty – but we have to dig deeper to understand whether they are able to help themselves or if they require more help. The visit at home is to match the reality with what they have told us. That said, we know that HIV is intrinsically linked with vulnerability.*

> *[...]*

> *The objective is that the person, who has to live with their illness, is able to mobilise their own resources. But if he doesn't manage, what does he need to do so? How can we give them a push so that they can attain a state that's more or less acceptable?*

The social worker also expressed similar hesitations:

> *We think that the social support budget is a bit limited. When we see the person is not able to do things themselves, we are often not able to give the things that would allow them to start helping themselves.*
>
> *[...]*
>
> *[But] I think our strategy is good because if we had started with giving out money we might have given to people without real problems. The objective is not to give. The objective is to help the people realise that they can be autonomous.*

The hesitation between the desire to help and the desire to develop their capacity to be autonomous was evident when the social worker was visited by a woman who was both a patient and a caretaker. At Virunga we did not only provide outpatient care, but also hospitalised those people living with HIV who were in treatment failure, had developed acquired immunodeficiency syndrome (AIDS), or were unwell with opportunistic infections such as TB. The hospital required that each hospitalised patient had a caretaker with them, who was responsible for the basic care of the patient: feeding them the meal provided by the hospital, washing them, dressing them, and so on.

The woman came to the small office for social worker consultations that was set into the side of the hospital building. Outside the door people were queueing to access the laboratory, which was just across from the office. The woman tugged nervously at her headscarf and appeared to be close to tears as she described her situation to the social worker, who translated from Swahili to French to me a summary of what she said. She was an outpatient of MSF's HIV program. Her son was also HIV+ and had been hospitalised because he was infected with TB.

She lived with extended family in Goma, and she felt that they had made her and her children outcasts since she had revealed her HIV status. As she was obliged by the hospital to stay with her son she was unable to go back to her house to collect her ARVs or to get food to eat. She had sent another child back to the house and he had been able to bring her the ARVs, but the family had not given him any food. The woman was hesitant to spend yet more money on transport – a bus ticket within Goma costs between 500 and 1000 Congolese francs – to get back to the house in the hope of getting food as she had already paid for multiple journeys for herself and her children. The social worker told her that she would get her a meal from the hospital's food provider. This was an exception, as even though the caretakers were required to stay with the patients they were not provided food.

The social worker said that she was trying to help the woman work through the larger dilemmas that her family situation put her in. Her father lived in another city in North Kivu and she was wondering whether to pay to send her children to stay with him. The father knew that her son was sick, but not that he was HIV+. It also was not clear how the son would be able to continue his treatment for HIV in the other city, nor what job he would do there. She said she knew, however, that when she died her family in Goma would simply put her children out into the street.

It was difficult here to distinguish what the woman's "real" demand was from what she was expressing. More appropriate, perhaps, was to see that the immediate problems she was facing – being hungry, being worried about money, being worried for her son – were the results of her exclusion from her family, her poverty, and the demands placed upon her as a caretaker. Seen from that point of view, there were different degrees of problem: some to which a response from MSF might be easily obtained, and some to which a response was unlikely to

be forthcoming. We could care for the suffering caused by some parts of her situation, but to cure the situation overall was out of our reach. The social worker was able to obtain a meal for her from the hospital canteen and to refer her to a psychologist "to help her take her medication", but the immediate issue of her finding the money to pay for her transport back and forth from the hospital was left unresolved, as was, unsurprisingly, her dilemma about what to do in the face of her family's rejection of her and her children.

Patient Support Activities Team Meeting, Tuesday 25 October 2022

Later that same afternoon, after we had returned from the hospital, the Patient Support Activities Team held their weekly team meeting in their office, in the upper storey of the old nightclub that had been rented by MSF and turned into the Goma Project's headquarters. The three social workers, their supervisor, and their manager were there, and I listened as they discussed the cases about which they had questions that week. Most of the case discussions turned around questions of whether the team should spend some of the money they had – $200 per month – to provide direct aid to their patients.

The first case was raised by one of the social workers. It concerned a sex worker, 23, who was asking for our help to leave sex work.

> *Social worker 1: We have already discussed her case. We gave her a tablecloth before. She wants a way out of the sex trade, she fears the rejection of her family. She has two kids. She wants our help to start an activity.*

> *Supervisor: It's a girl who was too affected by her profession and she wanted out. We sent her to a psychologist and she was doing better. Then we did some mediation and it helped*

her to reintegrate into her family. But they consider her a burden. Now it's a question of how she can feel useful – to make her feel useful for her family.

Manager: But to help her with what?

Social worker 2: We should help her.

Manager: I think we've done all we can. She wants to change and do something else. There's no organisations now that can do that. Our activities are not up to the point of doing social reinsertion. We can't do anything.

Supervisor: Yes, but it's someone that's developed in a positive way.

Manager: And it's what we've done that's helped her.

Supervisor: And if she was in a good relation with her family, they might be able to help. But she's not. As she spoke of doing braids, perhaps we could help her out by putting her in contact with a hair salon that would accept to train her.

Manager: Ok, we can help her, but I think what would really help is to find an organisation that can do the social reinsertion. Or maybe we can find another relative to help her set up a business.

Supervisor: And what about [the social worker's] proposition for getting her set up to sell donuts?

Manager: Does she know how to do it?

Social worker 2: It doesn't need a lot to do donuts. We can ask her about it.

> *"This question of social support has been there for a long time, but in the most recent times it has become more and more debated. We have more and more demands for it from the team in the field… [they are] coming up with, 'well we have done all this but this patient clearly needs this kind of support', so they have this sense of helplessness… Recently we have a case of orphans, a brother taking care of a younger one, and he's saying, 'well I really want to support this child, my brother, but I have no job. If only I can be sent to do mechanics, that will help me to take care of my brother…' And at this point we are still in a dilemma, in fact, we haven't clearly figured out what is the best thing to do. The best would be to train him to be a mechanic, as an individual approach, but programmatically speaking, are we prepared to address these kinds of needs?"*
>
> *Robert Keango, Medical Coordinator in Uganda, 2 June 2022*

The second case was raised by the third social worker in the team. She described a woman living a considerable distance from the centre of Goma who was co-infected with HIV and TB and had no money to pay to come to her appointments or buy food to take her medications with. She lacked immediate family members to help her, and normally MSF would only pay the transport costs for victims of sexual violence. The team had the following exchange about her case:

> *Manager: There are three problems here. Observance, transport, food. She can continue with education, but the anti-TB meds have a lot of secondary effects. So, if she doesn't get help, we should see if someone is able to help. The only transport we pay is for victims of sexual violence. If she had to come one or two times to the hospital then with the $200 per month we have we could see. If we don't use all the money this month – we've only spent $60 so far – then we can see if we can do a stock of food that we maybe can give out.*

Supervisor: She has to come once a week. We can see if we can give her $10 to see if she can at least come to the appointment. We can give her 5kg of flour and 1kg of sugar. There and back is $2.

Manager: We could ask the medics what the frequency is of the visit to the hospital.

Supervisor: I'm medical, I know. It's once a week.

Manager: So, let's give her $3 to come to the hospital and eat something. For four weeks. But during that time, she needs to find someone to help her after that period is up. And we'll give her the flour that we have now. Every time she comes, we'll give her 2kg of flour, instead of giving her 5kg all at once. And we'll tell her that it's just for a month. People sometimes think that they must eat the biggest or best dish to put on weight. But there are vitamins in beans.

The third case was raised by the second social worker:

Social worker 2: Next case. A patient, infected with HIV and TB. She lives in the street. She has a child of four years. She can't find food. She is asking for a transfer to [her town] to be with her family.

Supervisor: I see a patient who has understood her situation and identified a solution.

Social worker 1: There was another organisation doing transport vouchers. But I don't know if it's feasible at the moment.

Social worker 3: We should pay her transport.

Supervisor: If we validate her demand we have to see if she uses it to go back [home].

Manager: We can pay her transport. But we have to make sure she doesn't stop getting treated in [her town]. And then organise her transport. But let's see first if Heal Africa [a partner hospital] can't put their hand in the till for her. We have to make sure that she doesn't take the money and go back to the street. And we have to see if we can assure her follow-up in [her town].

Social worker 2: I think we have to see with her if she can give us a contact at home. So we can follow up.

Manager: Let's discuss with the Heal Africa team the issue of observance. And then we'll get her $10 to get back to [her town] and eat something on the way.

The fourth case was a 16-year-old boy living in the street who was asking for our help to train as a mason. The team had hoped to reintegrate him with his family, but that had not been possible, and the boy was insisting that he could be autonomous. The manager said that if we could refer him to a centre for accommodation and training then that would be a solution, but that we could not offer training directly ourselves.

The final case was that of a woman living with HIV who had recently been hospitalised multiple times.

Social worker 2: A woman that has been hospitalised a lot of times, she has spent a lot, her kids are not in school. She lives in a hut. She's asking for something to help with starting a small business. And to help rehab her home. We tried to help by training her daughter but we didn't manage. We don't have any funds for training available.

Manager: I think we can give $20 to help. We've got the money this month. But it's nearly the end of the month so we've got to move quickly.

The meeting left me with questions about why we found it so difficult to give money to people in difficult situations even when the amounts being asked for were insignificant and the money was available. Less than half of the (already tiny) direct aid budget had been spent that month, and it was then the end of the month. I wondered if the fact that the budget was so small produced perverse effects, with the team hesitant to spend what little they had for fear it would be needed for another person later on. That did not explain, however, the hesitation to spend what was left of the month's budget at the end of the month. There were evidently deeper worries about what the giving of money signified, as demonstrated by the questions posed about how to ensure people would spend the money we were giving them for the purpose that we intended. Even then, as with the case of the woman who was asking for the money to go back to her family, there seemed to be a question about whether it was really our place to

"[In Malawi] there was something that was very present in the minds of our team, which was a mix of all these kinds of principles that seemed a bit absurd. Like, 'it's absolutely imperative that we are fair. We have to give the most to the poorest… If we give $50 to everyone, well, there will be the woman who has been abandoned by her husband, and the woman who hasn't been abandoned. The second will have much more than the first. And we shouldn't give too much either. And above all they should use the money to come to their appointments, how are we going to control that they do that?' Things in which the person had absolutely no room for manoeuvre, and they cannot do anything with the money that we are giving them. It's interesting because Give Directly [our partner for the cash program] had told us to do exactly the opposite. They said to us that all the time you spend to create categories [of people] it's money that you lose. So, make the minimum number of categories possible. And, secondly, that there's a minimum amount of money to give to people that will be interesting for them.

Isabelle Defourny, MSF France President, 19 May 2022

give it. It was also difficult to discern the criteria on which money was given. The sex worker who wanted to change profession was not given any money, but the woman who had been hospitalised with HIV was (and without any discussion), raising the question of whether there was a moral judgement at work there. Yet, even when we were giving money or items, there sometimes appeared to be a mismatch between the diagnosis of the problem and the action. What good would a tablecloth and a trip to the psychologist do for a woman who was no longer able to tolerate selling sex? Would a one-off payment of $20 really suffice to allow a woman to rehabilitate her house and start a business? The team were concerned to do the right thing for the people they were trying to help, but neither the process for deciding what that was nor the structure for delivering it were in place.

CCLK Health Centre, Wednesday 26 October 2022

CCLK Health Centre sat underneath the verdant hill that marked where the city of Goma began to dissolve into the fields and forests that lay beyond it. It was an impoverished area, one of the doctors at the centre told me:

> *The majority of the population here are very poor. Lots of malnourished kids. Street kids. Sex workers. They are mostly displaced. They try to work in the fields or go look for charcoal in the park, which is a long way from here, perhaps 15km. Many are raped by armed groups on the way.*

I was visiting the centre with one of the social workers. She told me that she had studied rural development, working first with an environmental organisation before starting to work with

MSF during the Ebola epidemic. At CCLK she worked with street children, sex workers, victims of sexual violence, and people living with HIV. We began to discuss the issues that children living in the street had with a social worker from *Bon dieu dans la rue*, a Congolese association that works with street children and that partners with MSF in Goma. The two social workers described how the street children lived in groups in different parts of the city, searching and begging for food, at constant risk of violence, rape, and arrest by the police. Many used drugs and alcohol as a coping mechanism. The centres in the city that aimed to house and educate these children lacked the means to properly do so, they told me. The MSF social worker described the difficulties that the lack of resources caused her in her work:

> *There were three kids who were being sodomised frequently by older kids. We took care of them medically. They didn't want to go back to the street. We didn't have options on Thursday, so they had to go back to the street. On Thursday night they were raped again. Friday, we took them to Kahembe [an MSF-supported health centre with an inpatient department] and they stayed there the weekend. Monday, we took them to a protection centre, but one of the three left because he felt there wasn't enough to eat.*

CCLK was painted a bright yellow. It contrasted sharply with the dull clothes that the street children wore. I could not tell whether the clothes were those shades of brown or khaki to begin with, or if time and dirt had rendered them so. There were eight boys and two girls in the group that the social worker welcomed into the room used for group sessions. Plainly decorated, it nevertheless had individual seats, and was quiet and calm, set apart from the main consultation rooms. The children were aged between 10 and 14. The majority kicked their feet back and forth underneath their chairs restlessly, either barefoot or wearing broken plastic flip-flops. The social worker asked the children how long they wanted to speak for during the group

session. The consensus was one hour: after that they would go and find food. Then the social worker asked what topics they wanted to discuss. They chose collectively education and how to get out of the street and into accommodation and training centres.[19]

The social worker asked them to choose a member of the group to be the moderator of the discussion. As to why they would like to get into school, they had different ideas. The social worker told me that they had said that some wanted to go because they wanted to be respected. Others were shocked to see kids of their age who went to school while they did not, and there were others who had someone responsible for them but who did not have the means to send them to school. For those children, the social worker asked why they had stopped going to school. Four offered answers:

1. The means were too limited. His mum had remarried and her new husband did not want him.

2. There was no money. His mum had died and his father stopped paying for school.

3. Her parents had died. Her aunt had taken her in but would not send her to school. The other cousins all went to school. She said that she was discriminated against within the family.

4. The parents did not have money. His mum searched for charcoal in the park. He had to go with her, he could not go to school. They did not make enough money. There were difficulties at home. He had been forced to leave.

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[19] The discussion with the children was held in Swahili, with the social worker providing me with a summary of their conversations in French.

The mood in the group had become sombre, so the social worker revived the children's spirits by asking them to clap in time with one another, a simple exercise that nevertheless provoked laughter and a distinct lightening of the atmosphere in the room.

Then they wanted to discuss the second subject: how to get out of the street. The social worker asked how many had already been to the centres. None of them had. Then she asked them what they were expecting there, what it was that made them want to get out of the street. They gave the following answers:

1.   The education that he could not get at home.

2.   To be able to shower: he wanted to wash and dress like other children. He felt that other kids excluded him because he was too dirty. He also wanted food.

3.   Food.

4.   Education, clothes, protection – they were exposed to road accidents and big people beat them, he said.

5.   She said that at night they were exposed to bad people. People raped her. She said that she took drugs and people raped her and she did not know who. She took drugs because she was cold and hungry. But then she was under the effects of drugs, and she did not know who had raped her. (She was 12)

6.   The day before yesterday they had been beaten by the gangs, he said. The police saved them from where they ran to. The gang had stolen the money they had on them.

7.   He said that he did not want to go back home because the family were poor. They [the children] needed somewhere to go because they needed stability, education, protection.

Afterwards they said that they needed to go and look for food, promising to come again the week after. They asked for soap to wash with. They also wanted to have their hair cleaned and styled. They noticed the shape of my wallet in my pocket and asked the social worker why I could not give them money to get their hair done. The pharmacist came in with a piece of blue soap for each of the children. They asked if the pharmacist could cut the piece of soap in two so that they could give one up to thieves and keep one for themselves.

The 12-year-old girl who said that she had been raped repeatedly while under the influence of drugs asked if the following Wednesday after the meeting she would be able to go directly to the centre. The social worker told her no because they did not know which centre would take them.

Kahembe Health Centre, Thursday 27 October 2022

The next day I went with another social worker to visit another health centre where we worked with street children. Kahembe Health Centre was in a poor neighbourhood of narrow streets sandwiched between the airport and the Rwandan border, a collection of buildings cramped together, laid out around a series of passageways. The health centre's management had come to see MSF's provision of services to the street children as a problem for their business. The manager told me that their presence meant other patients did not want to come and use their services, depriving them of revenue.

The team were aware about the centre's unhappiness and were planning to move the services to another location. Observations and conversations with them, however, revealed that there were also some worries about what our own services were able to achieve.

The social worker held a group session with the children that were in the centre that day, a mixed group of boys and girls. One of the girls was accompanied by her son, who was less than one year old. Another girl was pregnant. The room where they were being listened to by the social worker was not private. People passed along the side to get out of the back door of the clinic. It was not particularly comfortably furnished either: only some hard benches and a few posters on the walls. The social worker carried out the group session in Swahili and told me about it after he had finished:

> *Some of them are asking to go home to Bukavu or Beni. The kids are asking for education. They need to go look for food, which we can't give them here... One kid is from Beni, he says he left in 2014 because of the war. We'll try to connect him with the ICRC [International Committee of the Red Cross]. Another kid is from Bukavu. We'll try to get DIVAS [Division d'affaires sociales of the Congolese government] to help. All the kids want to be reunited with their families.*
>
> *[...]*
>
> *There's not a [social activities] supervisor in the centre. It's not been given budget [by MSF]. We've not been given the solar panels that we should have. We've not got the toys that we wanted. We haven't got the budget. Neither to do food for them – and they ask for food. That's their primary need. The people living with HIV get juice and a biscuit when they take part in the support group discussions. Why is that not the case with the kids?*

Indeed, while I was talking to the social worker one of the children turned to me and told me that he was hungry while tapping his belly. Later I observed as the social worker did a social assessment with the pregnant girl. She was 17 years old. She said that she was in the street because of problems with her family, that she argued with her mother so much she wondered whether she was her mother at all. The family had agreed to take in her baby after it was born but would not take her back. She spent her days, she said, begging for food.

A short time later I went to see the MSF Nurse Supervisor of the centre who showed me the centre and the patient pathway. As I posed questions to the social worker about how patients were referred to him, the nurse supervisor interrupted to express his view of the social work component of the program:

> *Supervisor: [The social worker] can listen to the patients but can sometimes do nothing. The social, that means action, and that's what's not integrated into the project.*

> *Jacob: What do you think about that?*

> *Social worker 1: I agree. It's $200/month. It's not enough… I don't say that we need a huge budget. But we need something. A person can have resources but so long as they have a problem – like malnutrition – we can't have them develop these resources.*

> *There are some kids that are in the street just because they are poor. They ask for things that MSF is not able to take care of.*

The nurse supervisor was not the only person that expressed frustration with the social work. The psychologist in the centre said to me that:

> *Victims of sexual violence have big social problems. They say, 'ok you've helped me, but I have lost everything, my husband left me.' What can I do? I'm limited psychologically, I*

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want to give them something to help them socially. But I have nothing. I was referring to the social worker, but he has nothing to give them either.

The two times that I saw the social workers interact with the children I was impressed by their sensitivity, the fact that they took the time to properly listen to them, to explore with them the situation that they were in and the response that they wanted to see. Given the violence that they suffer and the exclusion that they were submitted to, I imagine it was one of the few times in their daily lives that they were treated as human beings. That, to me, was already something very important. What I was also left with, however, was the impression that once the social workers had listened carefully to what the children said that they needed they were unable to respond to most of the needs expressed. Food, hygiene, clothing, and shoes were a matter of survival for children in such a precarious situation.[20] Yet during the sessions with our social workers, even while they were being listened to, the children were hungry, thirsty, clothed in rags, and they left for the streets again in the same state.

The team was put in a difficult position by the lack of means that they had been given to provide direct aid. Not only were they in daily conversation with children who were victims of repeated sexual and other forms of violence that the team could do nothing to prevent, but their own colleagues seemed to be frustrated with the services that they were able to provide. Our listening to these children implied an ethical engagement on our part that we were failing to fulfil, and I wondered how the team were able to avoid moral injury in such a situation. They

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[20] The evidence is anecdotal, but one of our partners*, Bon Dieu dans la rue*, told me that since MSF started providing medical care to children, the frequency with which they were asked to fund the burials of street children had gone from once a month to once every two or three months. They felt that the children were no longer dying from their illnesses. This suggested how much the survival of these children was at stake in our work with them.

wanted to help, were being asked to help, and the way the project was set up was frequently forcing them to say 'no'.

Again, here I was struck by the way in which the differentiation between the "real" and "expressed" need was not helpful in thinking through what MSF could or should do to help these children. The demand for food might have been an expression of the deeper societal problem that the child was facing but I thought that the question we should have been asking ourselves was not about the status of the demand formulated by the person but our capacity to respond to it. I could understand that we were unable to fix the issue of child homelessness in Goma. What I saw as incomprehensible was our failure to respond to the immediate and simple needs of the children as they came to our clinic: to feed them if they were hungry, to spend a dollar on a pair of plastic flip-flops, to provide a safe space for them to wash and change clothes.

Budget discussion, Tuesday 1 November 2022

I had the opportunity to observe a project team meeting that was responding to questions from the cell in Paris about the budget. The cell was asking for clarification on the actions planned for the patient support team's activities. The project team reported that there was pressure to reduce the budget that had been proposed for 2023.

I noticed that there was a contradiction between this pressure felt by the team and the plans for the following year: to invest in hospitalisation (an expensive activity), to increase by six the number of health centres we were supporting, and to further develop patient support activities.

What I remarked at the meeting was that the apparent contradiction between the two injunctions – to increase and improve activities while limiting costs – led to a way of constructing the budget that was based more on the constraints that the team felt had been imposed rather than the project's operational realities and ambitions. For example, for financial support for HIV patients, as the team did not have a budget line for this activity in 2022, they only did it exceptionally. However, as they felt that they needed to maintain a small budget in 2023, the team based their estimated expenditure in 2023 on the exceptional expenditure in 2022. Yet that did not represent the actual level of need for this activity because the team had severely restricted itself from providing that kind of support in 2022 due to the lack of a budget line.

I also saw the effects of this way of constructing the budget when one of the service managers said that in her service she was seeing 80 people a month. The team started to try to build a budget based on the figure of 50 people per month, as this would produce a lower amount, until the service manager insisted that 80 people per month was the real figure, and that they should base the budget on this.

I wondered where the blockage was. Had the team proposed something that was not understood or that was not well constructed enough to be understood? Or was the coordination and/or the cell demanding something from the project team that would be difficult to meet?

Whatever the reason, I wondered whether the funding for our patient support work was enough to do it properly: $74,000 out of a budget of about $1.5 million for the whole project. (The supervisor's original proposal for the patient support activities budget had been

$125,000.) And after the meeting, there was a new request to reduce the budget by another $20,000, according to the project coordinator (PC).

The meeting left me wondering what the appropriate financial resources were for an area that we had identified as a priority both for MSF in general and for the Goma project in particular. Should there have been a willingness from the upper echelons of the organisation for a budget increase in line with our ambitions, even in a year where the budget had come under pressure? Or, if a budget increase was not possible, which activities in a diverse and growing project needed to be reduced so that we could focus our resources on our priority, whatever that was agreed to be? Was there a common understanding of the project, its activities and objectives, one that permitted the project team, coordination, and cell to come together and construct a budget that reflected the project's reality and supported its ambitions?

We had been told that about half of the sex workers in Goma were forced into the trade by poverty, and many of them were actively asking us for a way out. Yet we were cutting the few thousand euros from our budget that was intended to serve as economic support to sex workers on the basis that they already had an income. I felt, therefore, that we needed to ask ourselves whether the marginalised populations we had said we wanted to serve were also being marginalised in the construction of our budget.

Patient Support Activities Team Meeting, Tuesday 1 November 2022

Two cases from the second team meeting I observed demonstrated the difficulties the team encountered when they tried to decide on behalf of the patient what their "real" need was. The first case involved a sex worker:

Social worker 1: She's wanting to leave her husband. So, we can see if she can go back to her family.

Social worker 2: It's also [her relative] that beat her. She passed a part of her life in [a] centre. Then she was placed with her [relative]. She began to work as a sex worker because she met other sex workers.

Supervisor: You have to see how she wants to manage the situation. What is her vision of a positive situation if she leaves her husband? The needs that remain – even after family mediation – are socioeconomic. Will her [relative] accept her if she leaves her husband?

Social worker 2: She wasn't very stable [when I spoke to her]. She just wanted to leave her husband and strike out for parts unknown.

Supervisor: What's the issue with her husband? What does he reproach her for? Does she recognise anything in what he says?

Social worker 2: Rumours started that she is a sex worker. That he married a sex worker. He showed a photo of another woman to her at the house and that upset her. She says because she is an orphan she has nowhere to go.

Manager: All couples have problems. The evaluation is to find out how long the problem has existed for, how it can be resolved. We can also develop a situation of resilience so she can stay with her husband despite what he's done. She has nowhere else to go. With [her relative] it's going to be difficult. If it was one person [that she had a problem with] I could understand. But she has problems with [her relative], with [her relative's] wife, with others.

If we give her money for a business, will she just disappear with it? We have to develop a strategy of resilience [first]. To see, secondly, what she would do if she had to leave. And thirdly to see if she has the potential to start a business.

Supervisor: We're going to refer her to a psychologist, we're going to see what she would like to do in terms of a job, and if she can improve her relations with [her relative] and her husband.

Manager: If we take the patient centred approach, it's her, it's her that's at the centre. If we give her something that's not what she wants, we'll be back in the same place.

The second case involved a pregnant girl who was living in the street:

Social worker 1: There's a girl with a kid of four and she is pregnant. She has left the other kid at her grandma's house, but the grandma won't take the other kid. [The girl] wants us to help her get her [as yet unborn] kid taken into a centre to protect it from the street.

Manager: And how is she thinking about getting back to her family?

Social worker 1: She has such bad relations with them. If she goes home, it's sure that she will just go back to the street.

Supervisor: We can try to put her in touch with other organisations. And go see her mother to work with her a bit.

Social worker 3: We have to dig more to see what her issue is with her family.

Social worker 1: There are family problems. Sometimes she goes home and then goes back to the street.

Supervisor: She's pregnant so she'll be stigmatised for that by her family. She thinks that her family is too poor. Is the situation in the street better than at home? If she wants to stay in the street, then can she have something to help?

Manager: I don't think she has need of our support. She wants us to make her life easy. She wants us to take the kid so she can continue her life in the street. A centre is not a good solution. We have to accompany her to the point that she can care for her child. She has developed vices in the street that she wants to continue.

At this point I broke into the conversation to ask whether we were not being judgemental.

Manager: But she has a family that can take care of her. A centre is not the best situation. The baby will not have a place there forever. I don't think that there's a centre that can take a new-born. And there's a family that might... In Europe you have centres. Here you don't.

I found it difficult to reconcile this discussion with the scenes of individual care that I had witnessed during my time with the team – the attention given by each individual social worker to their clients during consultations, the long and thoughtful discussions I had with the supervisor about what the team were trying to do. The meeting was a moment where all the

"The concept of control. There is still a lot of resistance I feel to autonomise patients, in their life, and when it comes to social work I see it in, how do we make sure that if we give them money for transport they use it for transport, how can we control, shall we let them sign a letter – I had this once – that says they commit to use the money for what we gave it them for, and if they don't, we should exclude them from our support."

Angela Modarelli, Mobile Implementation Officer for Patient-Centred Care, 9 June 2022

stereotypes about poor people came out of the woodwork: that they were searching for an easy life; that they would just take the money and run; but most of all that they could not be trusted to know what was best for them, that it was us that had to decide whether it was better for a woman to stay with a man or to leave him. It was evocative that when the manager mentioned patient-centred care, the active subject switched from being the woman to us as MSF, as if it was not her that had a problem but rather that she was a problem for us: "If we give her something that's not what she wants, we'll be back in the same place."

Centre d'Enfants et d'Appui aux vulnérables, Wednesday 2 November 2022

The project in Goma functioned with a series of partnerships, some informal, some formal, to help the team to cover the needs of our patients. One of our informal partners was the *Centre d'Enfants et d'Appui aux vulnérables* (Centre for Children and Support to Vulnerable People), which was run by a Congolese organisation and lay down roads strewn with black volcanic rock not too far from CCLK Health Centre. I watched as a steady stream of bees flew in and out of a crack in the roof of the veranda. A file of children walked past, curiously looking at me and the supervisor as we waited. We were there to meet the coordinator of the centre. He invited us into his office and told us that the centre was intended to provide legal and social protection for children who were in touch with the justice system – either as the suspected perpetrator of a crime, or as someone who had been removed from their families for their own protection. The subject turned to the centre's relationship with MSF:

> *It's a little while that we work with MSF. But you have such a high turnover of staff. We don't know who to contact. And it's an informal contact. We've heard good intentions but nothing has come of them.*

The centre is for the kids [that you work with]. It's almost two or three years that the [MSF] project has started, and you've only referred six or seven kids. At a certain moment we said you have to do more to get kids to leave the street. I don't think it's very efficient [what you do].

[...]

We received lots of promises from MSF: that you would construct us a refectory. Construct us a kitchen. Construct us a water system. Construct us a dormitory.

We've never seen anything from MSF – and you pay other organisations, for what?

[...]

The partnership is not about money. It's about exchange of knowledge. For example, on how to deal with the children's psychological needs. You gave us two days' worth of food. It's useless. The partnership should be about reinforcing us.

MSF brought us a water bladder during the volcanic eruption, and it really saved a lot of lives. But then you didn't even ask us if we might continue to need it – you just came back and took it, quickly, as if you had forgotten it lying about somewhere.

The broken promises in this example may have been extreme, but the theme of lack of clarity about roles and responsibilities was one that I often heard in conversation with the partners that I visited in Goma.

Defining these responsibilities in the social field was undoubtedly complicated because the way we were working with the street children meant that we were not simply looking at immediate relief for them but rather at improving their conditions in the long term. This was

difficult because most actors who wanted to provide long-term solutions sought to reunite the child with his or her family: either through a family tracing process run by the ICRC, if they had been separated by the war; or by having this process undertaken by one of the centres in Goma that operated programs of shelter, training, and family reunification.

These centres had different criteria for accepting children and different lengths of stay. Most of them aimed to take in a child from an already identified family so that they could be reunited relatively easily and quickly. They often preferred to work with younger children. Many also aimed to train the family or the child in a trade in order to improve the socio-economic status of the family, the idea being that the child would be less likely to return to the streets if the family environment was more comfortable.

The problem was that two categories of children were left out: those whose parents were dead or untraceable (and who would not be found by the ICRC because the problem was social and not conflict-related); or children for whom the family represented a danger.[21]

However, even for those who ostensibly met the centres' entry criteria, getting off the street and into a safe environment was not assured, conversations with the team and other actors involved in child protection in Goma revealed. The centres were chronically underfunded and were in even greater difficulty at that time as funds were being diverted to other crises. Some did not provide enough food for the children who were housed there. Others were places where sexual abuse was carried out by other children and by adults. Reintegration into a family was also not guaranteed: even with mediation, problems often reappeared. The vocational training provided by the centres had uncertain results: many people were trained as tailors, for

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[21] Sometimes the family was seen by the team as the ideal solution for excluded people. This can be explained by saying that other options are lacking in the context of Goma context. Yet the family is a place of violence for many people, meaning that it cannot be a solution for everyone.

example, but tailoring is a complex profession requiring manual skills, numeracy and literacy, and its profitability was far from guaranteed. That all these problems existed, and that we knew about them, made me call into question even more our discussion of these accommodation and training centres with the street children during our sessions with them. The centre would be something other than a dream for only a very few of them.

At the *Centre d'Enfants et d'Appui aux vulnérables* the supervisor said that he regretted the fact that while they had free places MSF was not referring the children we were working with. Yet the team expressed a feeling of having nowhere to refer the children they were working with. This mismatch of criteria and expectations was obviously frustrating for everyone involved when the organisations working with street children estimated that there were 3000 or 4000 living in the street at any one time. It was indicative of a wider lack of clarity about what we wanted for the people we were working with, and how far we were prepared to support them to get it.

Reflections

Sitting in the social worker's office at Virunga Reference Hospital the supervisor described to me his thinking about the team's work:

> *The biomedical approach sees a problem with a solution already defined. Have a fever? You get given a paracetamol. For us there are no pre-defined criteria, a protocol that links situation and action. Even if we had all the means in the world, even if we just gave whatever to everyone, we wouldn't have helped.*

It's like public health: if someone comes every day with malaria to the hospital then we have to search for the reasons [they are catching it] and prevent the person from getting malaria.

For us it's the same approach. The problems expressed here are the symptoms of an illness. What are the things that have caused that illness? We have to act on those determinants. Sometimes that means we have to work on things that unlock the person's capacity to be autonomous. We are proud to work on this approach.

The analogy has its merits, but what I saw is that we were often faced with a situation where we could not address the determinants. MSF would not be able to prevent children living in the street in Goma, nor would it be able to prevent women being forced to work as sex workers, nor would it be able to ensure that the families of people living with HIV provided support and care. What we could do, however, was to alleviate the immediate suffering of some of these people by providing material and financial assistance. To use the supervisor's analogy, this was like relieving a person's pain, even in a situation where we did not have the tools to provide curative care.

Yet, as the supervisor went on to tell me, the budget that he had requested – to deal with ten situations per month, to give $100 per month for three months to each person – had been denied. "The problem with the social at MSF," he said, "is that it's done each in his own manner: one will say, oh I think we can do that and another one will say no. And so, in the end, you end up doing nothing." It was striking to me that we had set up a team and given them the task of making changes in the lives of people in difficult situations in an impoverished city armed only with the instructions to develop a person's autonomy and $200 per month for emergencies. The team, I felt, had done a good job of making links with the people that we wanted to help

and identifying how we might be able to help them, as well as making links with the other organisations that were working on the same issues, but had been hamstrung by a lack of support, both technical and financial.

The project was also complicated by the fact that for the three groups of people we were trying to help we were proposing the same types of actions but with sometimes quite different motivations. We were aiming for therapeutic success in much of our work with people living with HIV: creating the conditions for the person to take (and keep taking) their ARVs. For operational efficiency we were paying the transport for victims of sexual violence, having made the bet that if we removed one of the many barriers to access to care for people of that type then it might help us reach more of them. For the 'well-being' of the patients we were doing all sorts of things, from providing meals to a hungry caretaker of a HIV patient to attempting to engineer family reunification for a child living in the street.

The problem was that each of these objectives implied a different series of reflections for the team. The questions about the limits of our actions as they related to getting someone to their appointment once every three months would never have been as complicated as when the question was how we could help someone leave sex work, especially in a context where the state's institutions were non-functioning and non-governmental organisations lacked funding. The diversity of our objectives, combined with the paucity of organisations we could refer to, posed a series of very difficult questions about the role of MSF in the care of the people we were trying to help in Goma. I felt that there was still much to do in terms of thinking through how we helped people, on which bases we built our action, and how we could challenge some of our own prejudices. The willingness and openness of the team was there to discuss but there

was a need for more structure to be put in place to help them have those discussions and develop their responses.

How we will develop our reflections on these questions remains to be seen, however, because the decision was taken at the end of 2022 to handover the HIV cohort, and then to close the project entirely, with the intention to develop a new proposal for the marginalised populations part of the project after its closure. The closure was described by the Director of Operations and Cell Manager as being motivated by: the achievement of the team's objectives with regard to HIV; budgetary pressure which led to a review of the operational portfolio, and in which the Cell Manager expressed the preference to safeguard his projects in conflict zones; and the impossibility in terms of workload for a team to handover an HIV cohort at the same time as rethinking the social components of their work. The reasons for the project's closure were varied. What struck me, however, was the way that in the end they ended up reproducing what might one see as the "typical" MSF projects – hospitals in conflict zones – while closing what is often seen as "untypical" work for us, such as the Goma project. Our operational priorities were clear.

"[In Haiti from 2007 to 2009] we put in place a home-based care project. One of the national physios of the project was also a nurse, and she was detached with a car and a driver two or three times a week, and she went to go do the two types of care. She went with a social assistant to evaluate their condition of life, their food, etc, and for quite a few patients we did rehab in their houses to make sure that the wheelchairs could get in, we did ramps, and we gave them beds, put in bars to make sure they could get up…

The micro credit and that, there were loads of people that said, 'that's not MSF, we are here because we do trauma, we do mass casualty plans, we do burns, we vaccinate: to do things outside of that, that's not MSF.' So, when I left, it was the first thing that the desk cut."

Isabelle Mouniaman-Nara, Deputy Director of Operations, 4 May 2022

'Be curious' – An epilogue

"People are now saying, 'oh, we need an anthropological study' – no, you need a PC and a team who are interested in changing and listening and adapting. What you need is to make sure that you've asked the good questions and answered them as well as you could".

- *Greg Keane, Mental Health Referent, 16 May 2022*

"You do not need to be an anthropologist to do it, to sit down with a small group of patients and say, ok, this morning, what did you do, what did you do at lunchtime? What do you do in the evening? How did you come to the hospital, and who took the decision to come? What was complicated? To understand what our patients are going through".

- *Lucie Eches, Project Manager for the Patient Centred Approach, 12 May 2022*

"In fact, the problem, as ever, is to understand the real difficulties. And it's there that you have to be a bit curious, to be a bit attentive and speak with people. You have to do all that work, which is not necessarily extremely complicated. But you have to take the time to do it".

- *Guillaume Le Gallais, Board Member and Director of Operations 2000-2006, 19 May 2022*

"How do the sick pay to be ill? Expats rarely ask this question. People are not very curious".

- *Jean-Hervé Bradol, Director of Studies at CRASH and President 2000-20007, 19 April 2022*

As warned in the introduction, this paper has asked more questions than it has answered. Impossible, then, to conclude. As an epilogue, however, I wanted to outline some questions or difficulties that occurred to me as I began to think about the injunction to be curious that I heard several times during my interviews. As the quotes above show, for many people curiosity has a central role when it comes to putting in place programs of social support for our patients. That the process is about asking the right questions, asking them well, and listening well to what people tell you. To turn an interest for a person's predicament as they experience it into something that helps them.

It is, of course, true that there is a part of individual responsibility in the provision of social support and care more generally. What interests me here, however, is not defining what the right attitude to take is but rather to consider what institutional problems are concealed by the injunction to be curious. The injunction displaces the problem onto the individual and their attitude, rather than taking into account all that structures the work we do.

Before even considering the injunction to be curious, however, the notion of curiosity itself provokes some questions. Curiosity, in our context, is not necessarily or automatically benign. It recalls a whole history of intervention in the lives of others by the state and its apparatus, as well as charitable institutions. The first recorded instance of a social worker working in a hospital was the employment of Mary Stewart at the Royal Free Hospital in London in 1895. Her employment was a response to concerns that people were misrepresenting their socioeconomic status to get access to the hospital, one of the few options for free care in the city at the time. Her role was literally a gate-keeper – she sat at the entrance to the hospital

carrying out social assessments of prospective patients, determining who was eligible for care. Referrals to charities providing social support were strictly secondary in her duties.[22]

This Victorian idea of the deserving and undeserving poor runs through medicine's engagement with social support. It implies a certain curiosity: to know who deserves help, you have to be interested in them, to have curiosity about their situation and whether it really merits your aid. Hence why we see above the (un)easy shift from wanting to help the neediest, to creating the categories and criteria to judge people with, to creating the tools that ensure you can control those people and the use they make of the aid we give them.

In addition, each time we make a judgement about someone it is very easy for prejudices to slip into the process: prejudices about the poor can come out in the discussions of even well-intentioned teams. For example, in nutritional projects it is sometimes said that mothers are to blame for the lack of recovery of their children either because they are 'not able' to follow properly our instructions or because they are 'deliberately maintaining' their children in a state of malnutrition to resell the nutritional supplements that they are given by us.[23] This finds historical echoes in the genesis of the United Kingdom's National Health Service, which was partially motivated by the lack of healthy men for conscription in the Boer War at the end of the 19th century. Instead of seeing the living and working conditions produced by the Industrial Revolution as the cause for the fact that 33 of every 100 men were too weak to fight, however, the British state decided to blame "ignorance on the part of mothers of the necessary

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[22] Sarah Gehlert, "Conceptual Underpinnings of Social Work in Health Care", in *Handbook of Health Social Work: Second Edition*, eds. Sarah Gehlert and Teri Brown (Hoboken, NJ: John Wiley & Sons, Inc., 2012), 6.

[23] See, for example, Michel O. Lacharité, "Resale of therapeutic food: who benefits from demonising mothers?", *The Souk,* December 26 2022, https://www.soukmsf.org/en/information-debates/resale-therapeutic-food-who-benefits-demonising-mothers

conditions of bringing up healthy children".[24] What followed was the implementation of a paternalist system of 'teaching' mothers how to raise children and home visits for the working class to inspect the results of their care.

> "What stops people doing social support is the stereotype of the unemployed in France, there are always people that say, 'oh yeah with their unemployment benefits they buy a flat-screen TV, they misuse their money.' It's sometimes something that we discuss in MSF, the effects that are caused by that type of support. I think it's a real question, but perhaps do we exaggerate it? It's important to pose that question, but after if we ask the question, it merits that we dig into it. Because sometimes we just say, 'oh no, that'll have that effect', and it's a way to discard it".
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> Stéphane Doyon, Flying Cell Manager, 6 May 2022

As these two examples show the desire to be curious about someone, to get to know their problems, often comes with the temptation to think that we know better than someone what they need. There is a parallel here with the shift from autonomy as it is understood by medical ethics – an injunction to the doctor to respect the will of the patient and their capacity to make decisions about their own care – to the autonomy as it seems to be understood by the social workers in the case studies. There it appears that independence is seen as the basic condition of a dignified life, that the individual free of all dependencies is seen as a functioning member of society and happy person, and that this is a state to be cultivated in, if not imposed on, the person. It is an eminently questionable assumption – which of us is not dependent on someone or something? – and one that becomes almost tautological when the injunction to the person

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[24] Major General Sir Frederick Maurice, quoted in Mary Hannity, "Two-year-olds are often cruel", *The London Review of Books,* 2 February 2023 https://www.lrb.co.uk/the-paper/v45/n03/mary-hannity/two-year-olds-are-often-cruel

becomes 'autonomise yourself'. It is the belief that each of us could find a place in life that corresponds to our desires and qualities, irrespective of the structural factors that in many cases keep us fixed in place, if only we could mobilise our 'resources' in the right way. The injunction to be autonomous is the mirror image of the injunction to be curious. It shifts the responsibility onto the individual to escape the constraints that the world imposes upon them. It responds not so much to the desire of the person themselves but rather to a pre-conceived idea of what the end result of social work should be.

The question of what MSF thinks that result should be remains open, as is the question, therefore, of what our social workers are working towards. Many pre-existing conceptions of the role of the social worker do not easily translate into the work of MSF due to the particularities of our contexts of intervention and our position within them. So, what, then, is the role of the social worker at MSF? Despite their presence within the organisation for many years now, this is not a question that we have sufficiently asked ourselves. Are they there simply to embody the curiosity about the people that we feel is lacking elsewhere? Are they there to do the jobs that do not fit easily into the more established categories, such as nurse and psychologist? I think the answer is more complex. Whatever it is, however, it will have to engage with the meaning of social work outside of a state framework, to try to fix the objectives and methods of a humanitarian social work.

Curiosity, therefore, is not necessarily benign. It is also not neutral: to interest yourself in someone's problems implies the necessity to want to do something about them. There is an institutional engagement implied by the injunction to be curious. If, through the adoption of the patient centred approach, the management of MSF is telling the operational teams to

interest themselves in the social factors of our patients' diseases, then there must be a corresponding willingness to put at those teams' disposition the tools and resources necessary to respond properly to those issues.

> *"We want to review our medical approach based on an accurate understanding of patients' and population [sic] needs, as well as their constraints… We still need to work on the definition and scope of "patient-centred" care. However, a common global element is the recognition of the differing perspective of the patient and doctor, and going beyond the purely biophysical elements of disease and focusing instead on understanding the patient and their illness, situated within their social and cultural context."*
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> *MSF OCP Strategic Plan, 2020 – 2023*

Looking at MSF programming today we see a variety of social support initiatives, as well as projects aimed at treating people in situations of socio-economic difficulty: programs for drug users in Iran, cash distributions for HIV and cancer patients in Malawi, protection and social support for migrants and refugees in Libya. As we see in many of the examples above, however, the provision of social support is often seen as a marginal activity and is not universally accepted. When Goma was closed the decision was partially animated by the perceived requirement to not touch the projects in conflict zones that offered trauma care to those 'directly' affected. That was what, the decision appeared to be saying, we were really there to do. It is that which explains the situation where active opposition to social support is not felt to be widespread but where nevertheless it remains something that MSF does not do naturally.

We often think that it is – in the phrase of one of the team from Goma – the job of somebody else "to put their hand in the till".

The questions about social support are fundamentally about the role and limits of MSF's humanitarian action. Big questions to which there are many competing answers. In an MSF that continues to expand, the temptation is always there to take on more and more problematics that are more or less related to the ideas of medical humanitarian action that have shaped our history until now. We have the luxury of being an organisation without a mandate that can implement the programming it wants in response to the problems it wants to address. This nevertheless poses the problem of finding a common thread that ties our activities together, and of providing frameworks for the teams faced with making big decisions in the field. Should the global paradigm remain medicine, even if we permit ourselves the possibility to sometimes do other things where we are "useful for something, really useful, and we are filling a role that no one else can fill", in the words of Brauman? Or will the parts of MSF arguing for an enlarged conception of our action, one that focuses more on root causes, win out?

Alongside questions about our ideology and orientation are the perhaps less glamourous but no less important questions about how we run our activities day to day. One issue with the provision of social support was felt by some to be the workload that it represented. Was it not just one more task to be added to the already too long list of things that our teams are being asked to do? This profusion of priorities, of injunctions to do more things and to do them better, leaves managers in the difficult position of trying to decide what is more of a priority than all the other priorities. In conversations at headquarters and in the field there is sometimes a kind of dissatisfaction with how we are running our projects. From above, it is expressed in

the impression that PCs do not get out of their offices like they used to. From below it is the PCs reporting that the number of emails and meetings they are expected to deal with leaves them little time for anything else when combined with trying to respond to all the expectations placed on them from above.

How can the space for priorities be created by communicating clearly about what is not a priority, or what is less of a priority than other things? The question is how to allow the space for curiosity about the situations in which we are working to be created by management, for curiosity not simply to be drowned in the flood of daily tasks required by our hierarchical supervisors and technical referents.

This series of interrogations can perhaps be broken down into five questions of quite different types. The first is how we judge what the 'real' needs of people are. The second is what role money and its giving should have in the provision of humanitarian aid, as well as what significance it has. The third is the question of what agency a person should have when receiving aid: not only what they can expect from us in terms of giving them the latitude to decide, but what we can expect from them in terms of how they treat the aid given. The fourth is the question of to what extent MSF should work on the sources of the problems it is trying to address, rather than just the symptoms. And, finally, the question of how we organise ourselves when we have changing institutional ambitions.

These questions – to which there are no 'right' answers – give us a window into the tremendous richness of the subject of social support at MSF. It is a subject that at first appears to be that of a particular technique but that quickly reveals itself to be a question that goes to the heart of the identity and character of the humanitarian action that we want to undertake. What is the

perimeter proper to MSF's action? How do we take care of people, and what should we care about? How do we know the people that we decide we want to help? And how do we work in conjunction with the other organisations – governmental and otherwise – that surround us in the field? These questions are vertiginous when we try to answer them in relation to a global policy or a general approach. Although they are not necessarily any less difficult to answer when posed at the level of the individual case, I hope that this paper has shown that it is through engaging with the particularities of concrete problems that they truly find their sense.

Appendix: List of interviewees

Jean-Hervé Bradol	Director of Studies at CRASH and President 2000-20007
Rony Brauman	Director of Studies at CRASH and President 1982-1994
Mego Terzian	President 2013-2022
Isabelle Mouniaman-Nara	Deputy Director of Operations
Sarah Château	Manager of Cell 4
Ely Sok	Manager of Cell 7
Stéphane Doyon	Flying Cell Manager
Thierry Allafort	General Director
Natalie Roberts	Director of Studies at CRASH and Emergency Desk Manager 2017-19
Pierre Mendiharat	Deputy Director of Operations
Lucie Eches	Project Manager for the Patient Centred Approach
Johanne Sekkenes	Deputy Manager of Cell 5
Greg Keane	Mental Health Referent
Andrea Bussotti	Director of Communications
Abdalla Hussein	Manager of Cell 9
Philippe Blasco	Patient Education & Counselling Advisor
Bertrand Taithe	Professor at the Humanitarian and Conflict Response Institute, University of Manchester
Guillaume Le Gallais	Board Member and Director of Operations 2000-2006
Isabelle Defourny	President 2022-
William Hennequin	Director of Operations
Pierluigi Taffon	Board member, MSF Italy
Léon Salumu	Manager of Cell 5
Khalid El-Sheikh	Deputy Manager of Cell 8
Michel Lacharité	Manager of the Emergency Cell
Eric Manuel de Condinguy	Social Worker in Goma
Marie-Hortense Koudika	Deputy Manager of Cell 3
Sebastien Granier	Head of Field Finance
Jean Hereu	Peru Head of Mission
Marianne Viot	Project Manager for Abuse and Diversity, Equity, and Inclusion
Robert Keango	Uganda Medical Coordinator
Marc Schakal	Manager of Cell 8
Angela Modarelli	Mobile Implementation Officer for Patient-Centred Care
Marie-Hélène Jouve	Head of Mission and author of a 2007 report on MSF's social interventions