MEDECINS SANS FRONTIERES
無國界醫生

BORDERLINE

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A decade of saving patients and weathering challenges

Sam Taylor

Executive Director, MSF Hong Kong

Going into 2020, another decade of the 21st century is now behind us. For the past ten years, I have been part of Médecins Sans Frontières (MSF), taking part in many projects of this organisation. Each and every time I meet patients, I have reflected and been deeply grateful for the fact that all of the work we do is only possible because of you. Thank you for the commitment you have shown us through the years.

Ten years ago, our medical teams treated more than 358,000 patients in the aftermath of a massive earthquake that struck Haiti, and around 60 percent of the total number of patients affected by the subsequent cholera outbreak in the same year. Haiti's health facilities struggled to deal with these two massive emergencies coming one after the other. MSF was able to respond quickly to help, yet this came with a big challenge of informing the Haitian population of what MSF could, and could not, do. Despite our best efforts, there were times when our teams or treatment centres were attacked because of people's mistrust and misunderstanding about foreign aid. But even so, MSF still strives hard to launch and run the best possible medical and emergency responses at times and in places where domestic health providers are too overwhelmed by urgent medical needs.

As we enter into a new decade, we observe that in many places local authorities and responders are increasingly competent to deal with emergencies, oftentimes the first to be on the ground in times of crisis. Our teams saw this when Mozambique was hit by a cyclone last year and Indonesia suffered from earthquake and tsunami the year before. Through coordinating with local governments and organisations which are able to address their people's needs, we could allocate our resources to places where assistance is non-existent or provision of medical care is very limited.

In the insecure and volatile eastern part of the Democratic Republic of Congo, the country's biggest-ever Ebola outbreak started raging in 2018. The national health authorities have been leading the response, while MSF has been providing the medical support needed to complement the existing resources being mobilised. This represents a stark difference from the response to the 2014 Ebola epidemic in West Africa, when MSF battled the disease for months as the outbreak engulfed three countries with unprecedented severity and at a scale unseen in its history. At that time, we were stretched beyond our limits and issued an impassioned call demanding the international community to devote a greater share of its resources to fight the outbreak.

From natural disasters to conflict situations, the safety of our patients and staff is a priority. Yet there is no guarantee that our hospitals are spared from violence. Some of you may remember when our hospital in Kunduz, Afghanistan, was bombed, killing many of our patients and colleagues. The hospitals and facilities we support in Yemen and Syria have also been attacked on numerous occasions. The most recent incident happened in southwestern Yemen, where our hospital in Mocha was severely damaged by an attack in November last year. When hospitals are attacked, we are normally forced to suspend our medical activities, and people are left without much-needed, often lifesaving, medical care.

Moving closer to home, Hong Kong has faced enormous challenges in the past months. We are aware of the medical needs generated from the rapidly evolving situation, and have been in frequent contact with many domestic medical facilities and practitioners to identify when they would not be able to respond sufficiently and therefore when MSF's additional medical care would be required. Because of our concern about a potential lack of professional medics in the Hong Kong Polytechnic University in mid-November last year, our medical team entered the campus to assess independently and assist the patients remaining inside.

The first weeks of this new decade do not indicate any reduction in volatility around the world. There is no doubt that humanitarian assistance will be needed by millions of people in many countries this year, and in the years to come. Amidst the challenges, our teams will remain determined to provide impartial medical care and to help people in the most difficult circumstances.

Your support is an essential part of this mission. When patients in troubled corners of the globe thank an MSF medic for helping them, in reality they are also thanking you.

I join them in thanking you for your precious support.

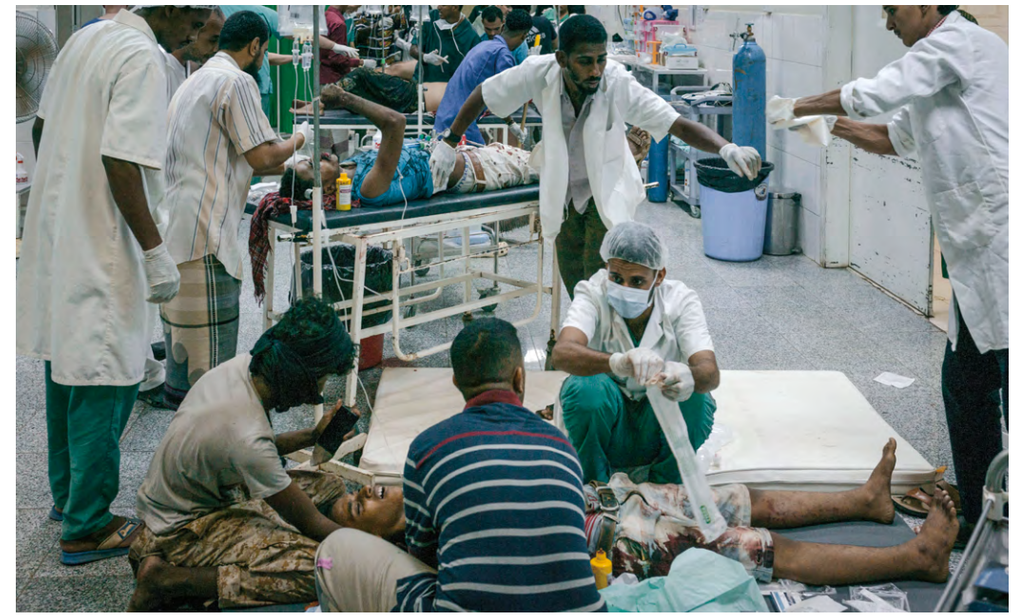
The uphill struggles

As a new decade has just begun, our medical teams and our patients are still facing many serious challenges.

The last decade was a testing time: we worked hard to provide medical care to some of the world's most vulnerable and deprived people, yet the need for humanitarian assistance remains so great, while the space for us to work keeps shrinking because of insecurity and other reasons.

We maintained our effort to respond to the year-long Ebola outbreak in the Democratic Republic of Congo (DRC) that had begun in 2018, but a deadly measles epidemic as well as unceasing armed violence and banditry further complicated our work. In Yemen, a series of targeted attacks on MSF medical facilities not only hindered our delivery of assistance but also patients' access to health facilities, leaving those injured and ill without essential medical care. On the other hand, we have made progress in rolling out a decentralised and simplified model of care for treating hepatitis C in Cambodia. Today, it is feasible to put more patients on treatment, even though exorbitant drug prices are still keeping treatment out of reach for millions of people across the world.

Despite the many challenges ahead of us, MSF strives to adapt our work and approach for the benefit of the patients we assist and treat.



War-wounded patients receive emergency care at an MSF-operated hospital in Aden, Yemen.

© Guillaume Binet/MYOP

DRC: Responding to epidemics and conflict simultaneously

Armed conflict, violence and displacement has become a way of life for millions, especially people living in the eastern DRC for a generation or more. Health needs are enormous and longstanding and the health capacity is desperately limited. Preventable and treatable diseases including malaria and HIV/AIDS have taken a heavy toll. Our work in DRC remains one of MSF's largest projects, yet our ability to provide free and lifesaving medical care is at times constrained by insecurity.

Since 2018, our teams have been responding to the tenth Ebola outbreak in the country, which is the largest-ever in DRC and the world's second-biggest in history, with nearly 3,400 cases. The epidemic spread from northeastern to eastern provinces, and across the border to Uganda.

MSF expressed its fears that the Ebola response, led by the Congolese health authorities, would not be able to bring the epidemic under control in a climate of deepening community distrust. Despite a rapid and large response with encouraging progress on new vaccines and treatments, people were dying in their communities and did not trust the Ebola response enough to come forward for treatment. Several health facilities had been attacked, including MSF's Ebola treatment centres in North Kivu province, which forced us to suspend our medical activities in two areas.

Away from the media spotlight, DRC was also experiencing a country-wide measles epidemic, the largest measles epidemic in the world in 2019 and the deadliest the country has experienced since 2011-2012. In 2019 alone, over 288,000 people contracted the disease and 5,700 died. A well-conducted vaccination campaign should have been effective to prevent new cases and to reduce infant mortality by 50 percent. However, immunisation coverage was extremely low in some regions of the country due to the lack of vaccines or vaccinators, or patients having difficulty in accessing health structures. During the year, measles spread to all 26 provinces of the country.

Meanwhile, in North Kivu province, a series of armed clashes led to more people suffering from gunshot wounds, and a surge of displaced families arriving in already overcrowded camps where access to water and sanitation was severely limited. More than 685,000 displaced people in this troubled province live in camps or are hosted by local families, and face worrying levels of malnutrition and violence.

With these complicated crises happening at the same time in DRC, MSF urged for a much larger humanitarian response to assist people urgently in need.

How did MSF respond to the epidemics and violence?

In the Ebola-affected areas, MSF continued through 2019 to run treatment centres, worked on decentralising Ebola diagnosis closer to the community level, and was a key partner in trialing a new vaccine.

In 2019, measles killed more people than Ebola in DRC, and the cases are believed to be under-reported across the country. Our teams have been providing measles patients with appropriate care, and conducting vaccination campaigns in various provinces since the outbreak started in early 2018.

Between January 2018 and October 2019, a total of 46,870 patients were treated, and more than 1,460,000 children vaccinated by our teams in 54 health zones. MSF also set up a surveillance system to identify new areas affected by the epidemic, in order to start intervention as soon as possible.

Meanwhile, MSF teams have been working in the territories of Masisi, Rutshuru and Walikale in North Kivu province, where people suffer from a little-known humanitarian situation. From January to September 2019, we treated more than 11,220 malnourished children, 2,310 victims of sexual violence and 1,980 people with weapons injuries.

Health workers move a patient to hospital after he was cleared of having Ebola inside an MSF-supported Ebola treatment centre in Butembo, DRC.

© John Wessels

An MSF doctor treats a girl who is suffering from measles in Ituri province, northeastern DRC. In 2019, MSF launched emergency measles responses in many parts of the country including much-needed measles vaccination campaigns.

© Alexis Huguet

Yemen: Health facilities under attack

Since war broke out in Yemen in March 2015, public structures including hospitals and clinics have been bombed and shelled on a massive scale. MSF hospitals and health centres have been attacked at least six times.

In October 2015, fighter jets repeatedly bombed an MSF-supported hospital in Haydan, Saada governorate. Less than two months later, an airstrike hit an MSF mobile tent clinic in Houban, Taiz governorate, wounding eight people including two MSF staff and killing one person. In January 2016, MSF-supported Shiara hospital in Razeh, northern Yemen, was hit by a projectile, resulting in six deaths and eight injuries, most of whom were medical staff and patients. In August that year, the MSF-supported Abs hospital in Hajjah governorate was hit by an airstrike, killing 19 people, including an MSF staff, and injuring 24 others. .

Again in Abs, a newly constructed cholera treatment centre by MSF, which was supposed to serve a population of one million, was hit by an airstrike in June 2018.In November 2019, an MSF hospital in Mocha, southwestern Yemen, was partially destroyed in an aerial attack.

Attacks on medical facilities not only kill and injure people, but they also deprive populations of health services when they need

The Haydan health centre was one of two MSF-run health facilities in Sa'ada governorate, Yemen. However, it was bombed by an airstrike in 2015.

© Yann Geay/MSF

them the most, and hamper the work of humanitarian organisations like MSF. MSF has worked ceaselessly to try to explain to the warring parties the need to keep medical and civilian infrastructure safe, and we continue to run multiple facilities throughout the country. The next decade will need to see huge efforts to prevent hospitals being hit in conflicts around the world.

MSF teams opened a surgical field hospital in Mocha, Taiz governorate, Yemen, in August 2018, to provide emergency medical care to war wounded. The MSF Mocha hospital was the only health facility performing emergency surgery for the local population in the area. However, it was partially destroyed in November 2019.

© Guillaume Binet/MYOP

The collapse of the Yemeni health system

After five years of war, the Yemeni health system is in ruins. Many public health facilities are no longer fully functional, lacking medical staff, proper equipment, medicines and medical supplies, which puts thousands of people at huge risks of illness and death.

While Yemenis have to travel long distances to access healthcare, the continued depreciation of Yemeni currency in the last five years has increased the cost of transportation. Patients often seek help at clinics and hospitals only when their conditions become very severe. Women who develop complications during pregnancy and childbirth arrive late due to financial difficulty and long travelling time, which reduces the chance of survival for both mother and child. People with war-related injuries lose precious hours to be treated by medics, which could cost their lives.

In 2018 alone, more than 535,000 medical consultations were performed at MSF hospitals and clinics, and our medical teams conducted over 24,600 major surgeries. The health system in Yemen needs immediate and comprehensive support, even if the conflicts subside, to avoid the resurgence of disease outbreaks, such as cholera, diphtheria and measles. In 2019, MSF teams worked in 12 hospitals and provided support to more than 20 health facilities located in 12 governorates.

Cambodia: Using affordable drugs and new model of care to treat hepatitis C patients

Hepatitis C virus is a blood-borne virus which can lead to liver damage, liver cancer and death. According to the World Health Organization, an estimated 71 million people have chronic hepatitis C virus infection globally, 72 percent of whom live in low- and middle- income countries.

After many years of ineffective treatments, two new direct-acting antiviral (DAA) drugs, sofosbuvir and daclatasvir, have been approved for treating hepatitis C in 2013 and 2015 respectively. With these DAAs, 97 percent of patients who complete the 12-week treatment course can be cured. However, less than five percent of hepatitis C patients worldwide benefit from them, the unaffordable price of the drugs being one of the main reasons.

Initially, a person's 12-week combination treatment course costs $147,000, pricing it far out of reach for people paying out of pocket around the world, and also for many governments struggling to provide treatment in the public sectors. In 2017, MSF negotiated successfully with generics manufacturers to procure sofosbuvir and daclatasvir for just US$120 per treatment, allowing the scale-up of treatment in almost all MSF projects.

In 2016, MSF opened the first clinic in Cambodia to provide hepatitis C treatment free of charge. MSF also implemented a simplified and decentralised model of care which only takes a maximum of 10 days to start the treatment, and only five medical appointments with only one requiring doctor consultation. The other appointments can be managed by nurses, and the team has demonstrated that good quality of care can be maintained.

Today, access to such DAAs remains limited worldwide because pharmaceutical corporations have charged unaffordable prices, and in some places, blocked the entry of affordable generics by renewing patents. Because of this, many countries reserve treatment only for people with the most advanced stages of the disease. MSF is challenging patent barriers in China and Europe through legal oppositions in court to help patients to have access to treatment.

MSF carries out information and education activities during an active hepatitis C case finding campaign in a village in Moung Ruessei district in Cambodia.

© Simon Ming/MSF

In 2016, MSF set up a hepatitis C treatment clinic in Preah Kossamak Hospital in Cambodia and introduced a simplified and decentralised model of care. However, the high price of the medicines and diagnostic costs remain barriers for patients to access to treatment worldwide.

© Todd Brown

How does a simplified hepatitis C diagnosis work?

Previously, even when patients were admitted to the treatment programme, it took up to 140 days before starting the 12-week DAAs treatment, and patients had to visit the clinic 16 times to complete the diagnosis. In addition to time constraints, the transportation cost of medical follow up could be a burden for patients.

With the simplified and decentralised model of care, all patients receive the same treatment regardless of the type and stage of their liver disease, which means they no longer need most of the pre-treatment analyses previously required. Additional tests and monitoring of DAAs, which used to take place before and during treatment, are no longer necessary. Reducing the number of consultations can reduce travel expenses and time. The rapid diagnosis with no delay between screening and treatment initiation, and the reduction of treatment cost, allow MSF to screen and treat more patients.

A year in pictures 2019 – Bringing neglected patients into the spotlight

Over the past year, MSF teams encountered enormous challenges when providing medical care to people facing armed conflict, epidemics, pandemics, natural disasters, or neglect and exclusion.

Aiding populations trapped in conflict meant constant weighing of risks and making difficult choices. Our teams persisted to treat people on the move even though adverse sentiments and resistance from communities hosting them exist.

Our doctors treated patients with neglected diseases, but some of these lifesaving treatments had remained out of reach for most patients because they were very expensive.

Many of these difficulties and our field stories remain out of the spotlight. That is why we have selected some of the MSF projects in 2019 that were rarely covered by the media. We strive to bring to your attention the plight of our patients, with the hope to improve their situations.

Caring for neglected patients

A bus transports Syrian-Kurdish refugees from the Syria-Iraq border to the Bardarash refugee camp, where MSF workers provide medical care, conducting 120 to 180 consultations per day.

© Moises Saman / Magnum Photos

Striving to work in conflict

Children of displaced families gather at an old construction site where they now live. The upsurge of violent conflict in Nigeria since 2018 has forced thousands of people from Zamfara, the northwestern state, to flee their homes. With farms burned, crops destroyed and the constant risk of new attacks, displaced people are unable to return to their villages to plant or harvest crops. From January to September 2019, our teams in Anka town treated nearly 7,500 malnourished children.

© Benedicte Kurzen/NOOR

Responding to natural disasters

An MSF team walks to reach a village to assess health needs after Cyclone Idai tore through southern Africa and devastated Malawi, Mozambique and Zimbabwe in March 2019. In Chimanimani, Zimbabwe, many roads were completely wiped away due to flooding.

© MSF

Improving access to healthcare

In Telangana, India, an MSF doctor attends to a patient who, after enduring pain for a week when he could no longer pass urine, walked 10 kilometres with his wife and son to find medical care. Longstanding, low-intensity conflict has left large sections of Andhra Pradesh, Chhattisgarh and Telangana without access to medical services. MSF teams operate mobile clinics to provide treatment for malaria, respiratory infections, pneumonia and skin diseases, as well as sexual and reproductive health and vaccinations.

© Tadeu Andre/MSF

People protest outside the office of pharmaceutical corporation Johnson & Johnson in Sao Paolo, Brazil. It was part of an MSF global campaign to demand the corporation to lower the price of bedaquiline, an essential tuberculosis (TB) drug so it can be made available to people with drug-resistant tuberculosis (DRTB). TB remains the world's deadliest infectious disease, having killed 1.5 million people in 2018. Worldwide, more than 80 percent of people with DRTB still do not have access to the drug because of the corporation's monopoly control over bedaquiline access and pricing.

© Julia Chequer/MSF

A group of Rohingya refugees wait in line for the assignment of their new homes in the Kutupalong camp, Cox's Bazar, Bangladesh.

© Pablo Tosco/Angular

Emergencies: considerations on how best to help

In the early hours of 25 August 2017, the Myanmar military launched "clearance operations". The targeted violence resulted in more than 700,000 Rohingya, a marginalised ethnic minority from Rakhine state, fleeing into neighbouring Bangladesh. The vast majority arrived within three months.

MSF already had a team working in the refugee camps near Cox's Bazar, Bangladesh. They witnessed thousands and thousands of exhausted Rohingya crossing into Bangladesh – some very sick. Most had walked for days through jungles and mountains. Together with the Rohingya who had sought refuge in Bangladesh since the early 1990s, more than 900,000 refugees are today in and around Cox's Bazar, living in extensions to pre-existing camps and makeshift settlements, spontaneously formed new settlements, and amongst the host community.

A Rohingya man carries wood through the Kutupalong-Balukhali mega camp, which in 2018 became the largest refugee camp in the world.

© Robin Hammond/NOOR

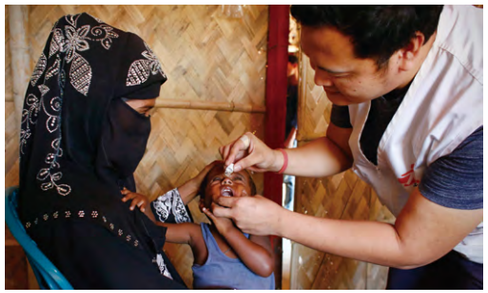
In a place where we have teams already present like in Bangladesh, we are actively on the lookout and monitor continuously for changes and new situations that could have grave medical consequences.

Our teams carry out independent monitoring and assessment of needs to confirm and weigh up what assistance is provided and what additional medical response would be needed. As a medical organisation, we focus on identifying medical needs, and if humanitarian assistance is sufficient.

We look into the magnitude of the situation, such as the size of population affected, the loss of life in a given period and the causes, the number and types of illness or injury. In addition, we consider if patients have problems accessing healthcare (e.g. the number and distance of functioning health posts or clinics, whether medications or treatments are free), the capacity of local health facilities and practitioners to treat injuries and illnesses, and the added-value and impact that MSF teams could bring.

MSF has worked with the Rohingya for decades – in Myanmar since 1994, in Bangladesh on and off since 1985, and in Malaysia starting in 2004.

Poverty is widespread in Bangladesh. The country is already trying hard to meet the needs of Bangladeshi nationals, respond to aftermaths of cyclones and flooding on a yearly basis, and for decades has been hosting refugees. Bangladesh does not have adequate resources and capacity to support more refugees from this massive influx.



Between August 2017 and June 2019, MSF teams performed over 1.3 million medical consultations in Cox's Bazar.

© Vincenzo Livieri

In October 2017, MSF clinics in Cox's Bazar received five times the number of patients who had sought treatment during the same period in the previous year. Our teams quickly called for a scale-up in response.

As in many other emergencies, the needs of a population-in-crisis evolve and change with time. At the peak of the influx, MSF teams on the ground worked in proximity with many other aid organisations. Months later, some aid providers left and the overall humanitarian assistance dwindled. Two years on, the number of Rohingya refugees remains huge, and their needs have not diminished. The aid available now for some families is not sufficient even for daily survival.

A Rohingya girl carries a bucket of water back to her tent dwelling in the refugee camp. Since the biggest ever influx of Rohingya refugees into Bangladesh in August 2017, the unacceptable living conditions continue to trap refugees in a cycle of suffering and poor health. Watery diarrhoea remains one of the main morbidities treated by MSF medical teams.

© Dalila Mahdawi/MSF

Therefore, today in Bangladesh, we continue to run fixed clinics and have increased our activities. When required, we respond to disease outbreaks, carry out mass vaccinations, and distribute hygiene kits. When people have lived under prolonged stress, mental trauma can become a major health concern, and our teams also conduct mental health activities. Between August 2017 and June 2019, we performed over 1.3 million medical consultations, and continue to treat tens of thousands of patients every month.

That is why MSF teams on the ground always keep an eye on evolving medical needs. We regularly assess the availability of assistance, quality of care to the sick and injured, and evaluate our own responses in different phases of an emergency. This helps to ensure what we are providing is relevant and timely, and is helping population groups that are the most vulnerable.

Monitoring and assessment – considerations

Situational factors

- Displacement
- Local situation, including security

Demography

- Overall population; refugee and internally displaced populations
- Age and gender
- Primary source of income

People's health

- Mortality
- Psychological conditions of residents
- Acute malnutrition level among children
- Availability of primary healthcare, essential drugs and vaccines

Basic needs

- Food, water, clothing, etc.
- Sanitary facilities
- Shelter

Living environment

- Crowdedness, transportation, climate, etc.

Assistance and coordination

- If there is local and international assistance
- If there are coordinators in medical services, water and sanitation, etc.

Logistics support

- Transport and communications facilities
- Energy supply
- Cold chain for storage and transportation
- Financial resources allocation

“MATERNITY! NOW!”

Daniel Campbell (Dan), a trained first responder and a logistician from Scotland, and Luise Jaehne, a midwife from Germany are both currently on assignment with MSF in Leer, South Sudan.

Dan learns a few new skills from Luise. Soon after, he finds himself helping to save life in a medical emergency. Told from two different perspectives, this story takes us inside the team at an MSF maternity ward.

Dan Campbell

© MSF

Luise Jaehne

© MSF

“Dan! Maternity! Now!”

The calm yet stern voice commands down the radio.

I am not a midwife, but a logistician.

I have always been interested in learning about medical skills like attending a birth. Yet, throughout the various training sessions I have received, very little detail has been given to the subject of maternal health..

Luise, our midwife, kindly agreed to teach me the basics. Armed with a pelvic training model and a baby doll, we start from scratch.

The day before, a woman arrived in maternity experiencing “placenta praevia” – the placenta preceding the baby during birth obstructs delivery by blocking the cervix.

In Leer, we do not have operating theatre and cannot perform a caesarian section. I now realise that it is unlikely for both the mother and child to survive.

Dan

When I started teaching Dan, I already had a thought in my mind: he could offer a pair of extra hands in such a low-resource environment.

That morning, we received another seven-month-pregnant mother already in labour with a partial placenta praevia. She had begun bleeding the night before.

Despite having a very skilled and dedicated maternity team, I lack the facilities available back home - blood transfusion in case of haemorrhage, an incubator for pre-term babies, and even running water!

Much faster than our anticipation, the mother started pushing! Sarah, our local midwife just managed to catch the tiny and very limp baby. It was all too obvious that we would need help.

Luise

South Sudan has one of the highest maternal mortality rates in the world. In Leer, local communities have suffered from years of armed conflict, which severely limits their access to medical care. As a result, the most vulnerable groups, such as pregnant women and children, are affected by medical complications and preventable diseases.

© Mathieu Fortoul/MSF

In April 2019, MSF re-opened a new facility in Leer providing basic medical services, with the objective to improve access to maternal, reproductive and emergency care for the local communities.

© Sarah Pierre/MSF

“Luise, I’m here!”

I am not greeted by a loud voice with which I am familiar, but a calm, collected yet authoritative one:

“I need you to clear a table”.

“Done! What next?”

I am asked to pass Luise a cotton cloth in which she wraps the baby. I set up the oxygen concentrator, and place the nasal cannula around the baby’s face. Then, Luise, a nurse and I ventilate the child together.

“Dan, I need to be with the mother. Monitor the breathing and keep the baby warm”.

Dan

I find myself standing helplessly. The baby cupped in one hand, trying to force a glove onto the second, using only my teeth, while instructing Sarah to get a delivery kit and cut the umbilical cord. A wave of relief washes over me as Dan arrives.

My first instruction to Dan is simple but essential. I need a clean and sturdy surface on which to do cardiopulmonary resuscitation (CPR).

A few minutes later, I feel confident to leave Dan alone with the baby. I know he will tell me immediately if something happens.

Luise

Knowing that Luise not only has the mother to help but also another very seriously ill pregnant woman, I give her updates of the baby regularly. To my surprise, the baby is holding steady, with eyes open!

I lose track of time, only becoming aware of my surroundings again when Luise re-emerges. We open the cotton and find out that baby is a girl! Luise passes me an umbilical cord clamp and asks me to clamp the cord. I take the clamp, and with all my blacksmith strength, I am unable to close it!

“Am I doing it wrong? Is it broken?”

I pass the clamp to Luise and, in one fluid move, she effortlessly closes the clamp that had so effectively defeated me. Luise then passes me an open packet, with a scalpel inside. She asks me to “shorten” the cord!

“What if I cut her?”

“You won’t,” comes the calm yet authoritative response.

After I cut the cord, Luise takes the now stable baby to her mother, whom I help to sit up.

I wash my hands and leave, as the emergency situation is over. I have been involved in a number of medical emergencies, but none that ended so well. I am overwhelmed by a euphoric shock!

The next day, Luise and I go to observe the weighing of the baby. The 1.7 kg girl screams in protest. Looking up, I see the calm, smiling woman sitting up in her bed, lovingly watching her child.

Dan

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An MSF Information Education and Communications Manager in Malawi interacts with an HIV patient to try and find out how she feels.