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MEDICAL ACTION
DOCTORS WITHOUT BORDERS/MEDECINS SANS FRONTIERES (MSF) is an international independent medical humanitarian organization that delivers emergency aid to people affected by armed conflict, epidemics, malnutrition, natural disasters, and exclusion from health care in more than 70 countries. On any one day, more than 30,000 individuals representing dozens of nationalities can be found providing assistance to people caught in crises around the world. They are doctors, nurses, logistics experts, administrators, epidemiologists, laboratory technicians, mental health professionals, and others who work together in accordance with MSF’s guiding principles of humanitarian action and medical ethics. The organization received the Nobel Peace Prize in 1999.
CENTRAL AFRICAN REPUBLIC  A young boy peeks around the corner in MSF’s hospital in Paoua.
Friends, as you’ll see in these pages, and as you likely know already, Doctors Without Borders/Médecins Sans Frontières (MSF) works in many locations where resources are limited, logistics are challenging, safety is of great concern, and circumstances don’t exactly lend themselves to the kind of advanced medical care to which many of us are accustomed. Some of our teams, for example, work knowing that they won’t have a steady supply of electricity. Or that security conditions could curtail their mobility. Or that rains might wipe out roads, making it necessary to use planes, motorbikes, or even donkeys to transport materials.

We accept that these conditions are part of our working environment; after 40 years of doing this work, we expect it. But we still aspire to provide the best and most effective medical care possible. In 2012, we brought this aspiration into the hospitals we established in war-ravaged Syria and into the expansive projects we set up to care for Sudanese refugees who were streaming into South Sudan. It holds when we work with neglected populations and neglected diseases, and it holds when we run services that address specific gaps in care—like the burn unit we run at Drouillard hospital in Port-au-Prince, or maternity programs in Sierra Leone and Burundi. Where we can, we also develop, refine, and institute practices that broaden access to care—decentralizing services for HIV/AIDS patients, for instance, or offering treatment for people co-infected with HIV and tuberculosis under one roof.

Some of the examples given above are further explored in the case studies offered in the pages that follow, each of which, in one way or another, highlights something integral to this organization’s identity: MSF is, at root, a medical organization that searches out ways to deliver medical care to people who need it and otherwise would not get it. We constantly remind ourselves of this, because it is all too easy for an organization to veer away from its central purpose towards issues outside its area of expertise. You might even consider this document a record of the conversation we have amongst ourselves on a regular basis—and part of the effort to keep patients and our medical and humanitarian ethics at the center of our efforts.

We are proud of this work and we stand by it. At the same time, however, we know we must continue not just tending to patients, but also advocating for changes in policy and practice that would benefit many more people who currently need help—pointing out gaps in the availability of medical treatments and medicines, for instance, or lobbying for more global health funding and less restrictive trade agreements. And, as we look ahead, we aspire to take additional steps to measure, ensure, and improve the quality of the care we provide. We stand ready to adapt when necessary, to learn from past experiences—successes and shortcomings alike—and to go beyond the numbers of how many people were treated for a given disease, or in a given situation. We are thus challenging ourselves to find ways to better track and understand both the efficacy and the long-term impact of the care we deliver.

This allows us to improve the services we provide. This approach also, we believe, allows us to be a prominent voice calling on humanitarian groups and institutions to think about the effectiveness of what they do, not just the volume of it, and to consider the results of projects, not just the splashy inceptions.

We remain forever cognizant that little of this would be possible without your support. Reflecting on our work and being ready to adapt our responses when needed is part of our ongoing effort to best serve our patients and to make ourselves accountable as an organization. Looking back at 2012, and ahead into this year and beyond, we will maintain this commitment, and continue striving to use our medical expertise and experience to reach and assist as many people as we can. Thank you for being part of this effort.

Sincerely yours,

Deane Marchbein
President, MSF-USA

Sophie Delaunay
Executive Director, MSF-USA
What follows are case studies that describe MSF’s medical action, work done both reactively and proactively in order to deliver the best possible care in places where it’s needed most. From a burn unit in Haiti to surgery in Syria to cholera vaccination programs in Guinea, these projects all proceeded with a similar goal: to provide patients in need care they otherwise would not receive, and to do so at the highest level possible.
A DEDICATED BURN UNIT IN PORT-AU-PRINCE  MSF has been working in Haiti since 1991, a time during which the country has been stricken with everything from widespread streetfighting to devastating natural disasters, including the 2010 earthquake and the cholera outbreak that followed. Through it all, MSF teams have tended to patients, assisted in births, and provided access to medical care for hundreds of thousands of Haitians who otherwise would have gone without. Among them have been innumerable people suffering from burn injuries, many of them linked to cramped living conditions. The dangers of burns also increased after the 2010 earthquake, as those rendered homeless were forced to move into shanties and tents and the overall quality of housing declined throughout Port-au-Prince. More than 300,000 displaced people, in fact, still live in temporary shelters where domestic accidents involving cooking stoves and boiling water are distressingly common, as are injuries connected to fires associated with carelessness, defective equipment, or bad wiring.

Seeing the high mortality rates and overall damage caused by these types of injuries, MSF incorporated major burn treatment into its programs. Before the earthquake, teams at MSF’s Trinité hospital had been caring for burn victims, but last year, MSF went further and opened the first dedicated burn unit in the country, in the 127-bed Drouillard hospital MSF built to replace Trinité, which was damaged by the earthquake, in the Cité Soleil neighborhood.

In 2012, staff at the Drouillard burn unit treated 481 burn victims, and since the housing problems in Port-au-Prince are far from solved, they will likely remain busy in the year ahead. “Unfortunately, the unit is always full,” says Dr. Guyguy Manangama. “On average, we receive more than one new admission every day.”

The program draws on MSF’s experience in Haiti and on collaboration with other specialist hospitals, Dr. Manangama notes: “MSF has developed expertise in burn treatment over the last 10 years, thanks particularly to a partnership with the Edouard Herriot Hospital in Lyon, France.” The care doesn’t happen in a vacuum, either. Drouillard offers a range of complementary treatments for burn patients. The emergency, surgery, physical therapy, and mental health departments work closely with the burn unit, doing all they can to speed care and recovery—marshaling everything that’s been learned during past work in Haiti in order to treat the patients of the present and the future.

SURGERY IN A TIME OF WAR

Soon after Syria descended into all-out war between the national army and an array of opposition groups, the country’s once-capable health system became a casualty of the fighting. Medical structures were targeted and destroyed, health care workers threatened or killed—all at a time when people who’d been shot or injured in bombing or missile attacks desperately needed surgery and trauma care.

Treating war injuries is never easy, but the situation in Syria has been particularly challenging. At first, MSF provided medical supplies to networks of doctors already in the country while trying to lay the groundwork to eventually provide direct care to victims of the war.

With the government in Damascus refusing to grant MSF (or most other NGOs) access to the country, however, our teams were forced to work clandestinely. MSF set up its first ad hoc hospital facility in a house in an opposition-held area in northern Syria. Thereafter, teams set up other hospitals in northern Syria where it was possible and safe to do so, including one in a cave.

Despite the challenges, MSF performed more than 1,000 surgeries inside Syria in 2012 (and many more in 2013). The work has been specific to the context in Syria, but it’s also an extension of the surgical care MSF has delivered in war zones and other extreme circumstances—the Lebanese Civil War of the 1970s and 80s, for instance, or the Soviet-Afghan conflict and the Afghan civil war that >
In 2010, MSF doctors and nurses responded to outbreaks of measles and meningitis in northern Nigeria by traveling across vast landscapes, visiting remote villages to provide treatment and vaccines. Along the way, team members heard a disturbing rumor: in the village of Yargalma in Zamfara State, a settlement of only 2,000 people, more than 40 children had died in three months, and no one knew why.

An MSF team sent to investigate arrived to find six children at the local health dispensary suffering from high fevers and seizures. “When we see a child with these symptoms, we first think of infection,” recalled MSF nurse Kaci Hickox, who was part of the team. “Malaria is always present in this part of the world. Meningitis also affects the brain and can cause fevers and seizures.”

Every symptomatic child was given treatment for severe malaria and meningitis, which seemed like plausible diagnoses, but they didn’t get better. Something else was responsible for the sickness. It was known that gold mining was taking place in the village, but the picture didn’t become clear until MSF logistician Frank Peters started asking questions. “He saw women breaking stones, their babies on their backs,” Hickox said. “He was shown machines used to grind down rocks, sending fine dust far and wide. He realized that a heavy metal such as lead, arsenic, or mercury was probably getting released as well.” Samples were sent to Europe for testing. Results confirmed the theory: the children were suffering from severe lead poisoning.

It wasn’t just Yargalma. In total, an estimated 400 children in Zamfara State died as a result of lead poisoning associated with gold mining. Through late 2012, MSF had treated more than 2,000 children, reducing mortality significantly, and several villages were environmentally cleansed of the deadly particles. In addition, MSF worked with experts from the World Health Organization and the US-based Centers for Disease Control to define new protocols for chelation therapy in situations with such widespread lead poisoning; none had previously existed.

Some unsafe mining practices continue, however, and the Nigerian government’s promise to fund further clean-ups went too long unfulfilled. MSF therefore launched a public advocacy campaign designed to spur the government to devote the necessary resources to remediate the problem. At any time, MSF is ready and willing to treat those who need care—to finish a job that started when teams on the ground chased down a rumor and figured out how they could help.
In Burundi and Sierra Leone, the act of giving birth can be fatal. Would-be mothers in both countries have precious little access to obstetric care—there are only three registered obstetricians in all of Sierra Leone, for example, and only one in Burundi who works outside the capital—because civil wars and a lack of resources have crippled the health care systems of both countries. Poor roads and limited transportation options compound the problem, making it difficult to reach medical care of any kind.

Many women thus try to delay seeking care as long as they can, or avoid it altogether. As a result, the national maternal mortality rate in Sierra Leone was the third-highest in the world in 2010, with 890 deaths for every 100,000 live births, and Burundi was fourth-highest, with 800 deaths for every 100,000 live births. (For perspective: the maternal mortality rate in Sweden is 4 in 100,000.)

In order to counteract these deadly trends, MSF initiated programs in Burundi’s Kabezi District and Sierra Leone’s Bo District that set up free-of-charge central referral facilities and emergency ambulance services to bring women from remote health centers to hospitals where they could deliver safely, 24 hours a day, seven days a week.

Technically speaking, these were not the most medically sophisticated or resource-intensive responses—the annual costs amounted to about $2 per person per capita in Bo district and $4 in Kabezi—but they efficiently addressed clear and present needs, and the results have been dramatic. In 2011, with the programs up and running, maternal mortality decreased by 74 percent in Kabezi and 61 percent in Bo. “If MSF were not here, many of these women who come to us every day would be dead,” says Betty Handey, an MSF obstetrician from Indiana who worked in the hospital in Bo. “The best part of my job is feeling that I make a difference and experiencing the gratitude that I get from my patients.”

The MSF programs in Kabezi and Bo have proven that lifesaving emergency obstetric care doesn’t have to be expensive or state-of-the-art to substantially reduce the number of women who die in childbirth, a powerful lesson for donors, governments, and other NGOs working to save the lives of mothers and children worldwide.
TREATING CHILDREN WITH MDR-TB IN TAJIKISTAN

In 2012, MSF teams in Tajikistan opened the country’s first project dedicated to treating children suffering from multidrug-resistant tuberculosis (MDR-TB). Though linked to a disease once thought to be on the wane, the number of MDR-TB cases in Tajikistan (and several other countries) has risen in recent years, as people have either received substandard care or been unable to adhere to the lengthy, grueling treatment regimen for TB. Tajikistan, one of the poorest former Soviet countries, has been particularly hard-hit and now has the highest rate of TB in what the World Health Organization designates as the Eastern European region. MSF, based in part on its refusal to accept the neglect of certain patient populations, has run TB programs in many former Soviet countries, but in Tajikistan, as elsewhere, finding ways to treat children has been an especially vexing issue. Because there’s been so little research and development for TB over the past 50 years, there are no pediatric versions of the tests or drugs needed to detect and combat the disease. Children therefore must use the same tests and drug formulations as adults do, taking regular doses of large, hard-to-swallow pills for up two years and enduring debilitating side effects that include fever, headaches, hearing loss, nightmares, even psychosis. And they still only have a 50 percent chance of being cured.

Before MSF launched its program, not a single child in Tajikistan had received treatment for MDR-TB. At the end of 2012, MSF was treating 30 children in MSF’s TB ward at Machiton hospital, near Dushanbe. To improve both prospects and the experience, our medical teams take innovative approaches to care—dissolving drugs in a flavored liquid, for instance, so they’re easier to ingest, and fashioning a special sputum induction room, the first of its kind in Central Asia. They also lead adherence and prevention education efforts for children and families and make it possible for children to complete the regimen at home.

More significant changes are needed, however, if we want to offer better treatment options to more children infected with DR-TB. That’s why MSF has mounted a sustained advocacy campaign to highlight TB’s resurgence and to call for research and development around the disease, for children and adults alike. This includes using new tests to detect TB resistance and welcoming the anticipated release of two promising new medicines that can combat TB and DR-TB. “The current standard treatment for MDR-TB has too many obstacles to a successful outcome, from duration, to toxicity, to efficacy,” says Dr. David Olson, MSF medical advisor. “We need an entirely new regimen that is patient-friendly and effective. The new drugs coming into use finally offer an opportunity to construct such a regimen. We need to find a way for these new drugs to reach our patients ASAP.”

VACCINATING IN CHOLERA’S PATH

One-fifth of the world’s population, or 1.4 billion people, is at risk for cholera. At present, the customary response to outbreaks is to treat those who’ve contracted the illness and conduct public awareness campaigns designed to help uninfected people avoid the disease. Until recently, vaccination was a small part of the conversation.

That is changing, however. Oral cholera vaccines have been used preventively in a handful of instances, and pilot studies have demonstrated that vaccination can also be effective even after an outbreak has begun. In 2010, the World Health Organization added vaccination to its cholera outbreak response guidelines as well, even though large “reactive” cholera vaccination campaigns were widely considered too difficult to implement on short notice given the logistical challenges of delivering hundreds of thousands of refrigerated vaccine doses to remote areas and mobilizing communities to get the two-dose vaccine.

In April 2012, however, after cholera cases began appearing along the border between Sierra Leone and Guinea in West Africa, MSF tried to find a middle ground of sorts. With the rainy season approaching, the stage was set for a devastating epidemic. Rather than wait for people to present with symptoms to respond, MSF, working with the Guinean Ministry of Health, identified and vaccinated populations that were at imminent risk of contamination—populations that were in the disease’s path, so to speak.

Dozens of teams spread out across hundreds of vaccination sites. Within six weeks, and with tremendous community support, teams immunized more than 170,000 individuals—nearly three-quarters of the population in the target area. Over the next six months, it became clear that the campaign had significantly reduced the impact of the region’s outbreak on this population.

These results surpassed MSF’s own expectations, demonstrating that rapid mobilization in remote areas is both feasible and effective, and paving the way for the vaccine’s wider use during future outbreaks.
TAJKISTAN > An MDR-TB patient receives care (top) while her family receives counseling (bottom).
RAPIDLY SCALING UP DURING EMERGENCIES In late 2011, refugees fleeing fighting in Sudan started flowing into South Sudan’s Upper Nile and Unity states. The following spring and summer, the numbers jumped dramatically, to more than 170,000. A full-fledged emergency was underway.

The refugees massed in remote, barren stretches of an under-developed country still scarred by decades of civil war with Sudan, which it was part of until early 2011. There was no medical care and no way to reach it. MSF, therefore, as it has in many emergencies over the years, had to import a full complement of medical personnel and services, and build facilities in which they could be housed.

That meant mobilizing emergency teams of field workers from numerous countries around the world (including dozens from the US) and hiring local and national staff as well. It meant getting the necessary materials to the location sites, driving them in when possible, or using planes and/or boats when rains rendered roads impassable. It also meant mounting a concerted advocacy campaign when MSF epidemiological teams documented mortality rates in the camps well above the emergency threshold, along with an unusually frank appeal for funds when budget projections for the emergency response rose well above what had been allocated for South Sudan programs in 2012.

On the ground, teams were treating malaria, diarrhea, respiratory tract infections, and malnutrition, making the most of the resources available. Early on, said Dr. Matthew Horning, who worked in the Yida camp, “We had only the most basic medications, equipment, and laboratory tests. We did tests for malaria and we could do a basic urine test, and we could do hemoglobin and blood sugar, and that was it.” As MSF scaled up, teams ran measles vaccination campaigns, built inpatient facilities and emergency rooms, conducted surgeries, even drilled boreholes to reach potable water.

By the end of the year, even as the pace of the emergency subsided somewhat, MSF was still running three field hospitals and seven health posts and providing around 5,500 consultations per week across four refugee camps. Medical teams also stood ready to respond to any new crises, like the Hepatitis E outbreak that occurred late in the year.

It was extremely challenging work, and many lives were lost due to the size and severity of the emergency. But by marshaling available resources, calling on lessons learned during bygone emergencies, and pressuring other organizations to do their share, MSF made a profound difference.

“Seeing MSF’s ability to respond quickly and make changes—to really bring about an improvement in the health and lives of the people—was really incredible,” said Jon Johnson, a nurse from Virginia who also worked in Yida. “It was an honor to be there.”
A NEW TOOL IN THE FIGHT AGAINST MALARIA  

Malaria, which kills more than 1,500 people around the world every day, is a leading cause of illness and death in many countries in which MSF works. The majority of its victims are children under the age of five in sub-Saharan Africa, where malaria’s vector, the *Anopheles* mosquito, thrives.

MSF is therefore constantly confronted by the question of how to reach as many children as possible across vast regions where health care provision is limited or non-existent. In the summer of 2012, teams working in Mali and Chad implemented a new approach, something called “seasonal malaria chemoprevention,” which basically means treating all children in a given location for malaria during the times when the disease is most likely to proliferate. The working theory is that treatment during the months of highest incidence (usually the rainy season) makes it possible to both treat existing cases and prevent new ones.

Using this approach, MSF treated 160,000 children under five in Mali and 10,000 more in Chad. It was a significant step, says Dr. Estrella Lasry, MSF tropical medicine advisor, with encouraging results. “This was the first time children had been treated at this scale outside research conditions. Results showed more than a two-thirds drop in simple malaria cases and a significant drop in severe malaria in the weeks that followed. The number of transfusions in the hospital in Mali also decreased over 70 percent. We saw malnutrition levels go down, too, an important and unexpected outcome.”

The numbers treated in Mali and Chad represent a fraction of the malaria cases MSF treats in a given year, and an even smaller fraction of all malaria cases worldwide. Furthermore, the evidence only shows that this approach is effective in places where malaria is seasonal. MSF has also already identified several ways to improve its implementation and data gathering operations in the year ahead.

That said, seasonal malaria chemoprevention is an important new tool in the battle against malaria, one that looks very promising for certain contexts. “We had good results and our main objectives were reached,” says Lasry, “but we are still looking at ways to improve this intervention.”
In 2012, Doctors Without Borders/Médecins Sans Frontières (MSF) provided humanitarian assistance in 72 countries. MSF-USA supported work in 55 of these countries. Names are indicated solely for those countries and territories in which MSF ran projects in 2012.
Countries in RED received MSF-USA funding
Countries in GRAY received funding from other MSF offices
MSF IN 2012: BY THE NUMBERS

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient consultations</td>
<td>8,316,000</td>
</tr>
<tr>
<td>Patients admitted</td>
<td>472,900</td>
</tr>
<tr>
<td>People treated for cholera</td>
<td>57,400</td>
</tr>
<tr>
<td>Antenatal consultations</td>
<td>784,500</td>
</tr>
<tr>
<td>Major surgical procedures performed</td>
<td>78,500</td>
</tr>
<tr>
<td>Malaria cases treated</td>
<td>1,642,800</td>
</tr>
<tr>
<td>Routine vaccinations</td>
<td>432,000</td>
</tr>
<tr>
<td>People vaccinated against measles in response to an outbreak</td>
<td>690,700</td>
</tr>
<tr>
<td>People vaccinated against meningitis in response to an outbreak</td>
<td>496,000</td>
</tr>
</tbody>
</table>

* These highlights do not give a complete overview of activities and are limited to where MSF staff had direct access to patients.
### OUTPATIENT CONSULTATIONS
Largest country programs, by number of outpatient consultations (not including specialist consultations).

<table>
<thead>
<tr>
<th>Country</th>
<th>Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMOCRATIC REPUBLIC OF CONGO</td>
<td>1,674,000</td>
</tr>
<tr>
<td>NIGER</td>
<td>878,000</td>
</tr>
<tr>
<td>SOUTH SUDAN</td>
<td>869,300</td>
</tr>
<tr>
<td>SOMALIA</td>
<td>612,700</td>
</tr>
<tr>
<td>CENTRAL AFRICAN REPUBLIC</td>
<td>590,400</td>
</tr>
</tbody>
</table>

#### Key Program Indicators:

- **Babies delivered, including by Caesarean sections**: 185,400
- **Relief kits distributed**: 61,000
- **Malnourished children treated in inpatient, outpatient, or supplementary feeding centers**: 347,800
- **New admissions to first or second-line TB treatment**: 30,780
- **Individual or group mental health consultations**: 191,300
- **Patients medically treated for sexual violence**: 10,600
- **HIV patients registered under care at end 2012**: 310,500
- **Liters of water distributed**: 197,000,000
Projects described in this section were made possible in part by generous contributions from individuals, foundations, and corporations in the United States. The great majority of funds MSF collects are unrestricted to any particular project, which is essential to MSF’s ability to react to emergencies as they unfold. The dollar amounts here reflect the total MSF-USA funding directed by MSF to field programs in a given country. These amounts are part of total project costs presented by MSF International in its 2012 International Activity Report, which is available at www.doctorswithoutborders.org/publications/ar.
BURKINA FASO $123,000

In 2012, MSF offered assistance to refugees in Burkina Faso who had fled fighting in Mali. Teams provided care in the Mentao camp, in Soum province, and in four camps near Deou, in Ouédalan province, where staff supported a health post and conducted mobile clinics, offering basic health care, antenatal care, treatment for malnutrition, and vaccinations.

A pre-existing malnutrition program in Titao was closed because admissions had decreased steadily for several years, but teams working in Titao’s hospital also treated patients for malaria and provided basic health care to children under 14 years of age.

BURUNDI $800,000

MSF teams in Burundi focus mainly on maternal health, trying to make up for gaps in service that can be fatal. Staff in Kabezi, in Bujumbura Rural province, run the Center for Obstetric Emergencies, or CURGO, which provides free 24-hour care. On average, 250 women were admitted each month, and three ambulances transported women in need from 24 health centers. Data showed that combining a referral system with emergency obstetric services helped reduce maternal deaths in Kabezi by 74 percent.

Additionally, MSF offers fistula repair surgery at the Urumuri health center in Gitega, along with physiotherapy and psychosocial support, and works to raise awareness of the condition through medical staff training and a telephone information line, among other measures.

In response to the country’s high malaria burden—the disease causes more than a third of deaths of children under the age of five—MSF opened a severe malaria program in Kirundo province.

CAMEROON $1,000,000

When a measles epidemic hit, MSF set up a treatment unit in a hospital in North region’s capital, Garoua, that mainly tended to patients under five years of age suffering from malnutrition and respiratory complications. MSF also donated treatment kits for some 1,835 patients and trained medical workers in 102 health facilities in 22 northern districts. MSF set up another emergency response in the north when flooding displaced thousands of families in the Extreme North region.

An MSF team in Akonolinga district’s main hospital tested for and treated Buruli ulcer, a very painful neglected disease that can lead to irreversible deformities, providing surgery and physiotherapy as well. The staff also provides care to some 100 patients co-infected with Buruli and HIV.

Additionally, MSF trained hospital staff and provided medicines and other supplies for the treatment of 5,000 HIV patients in Douala’s Nylon district hospital and Soboum health center.

CENTRAL AFRICAN REPUBLIC $6,199,957

Conflict pitting the Séléka rebel coalition against government forces displaced thousands and lengthened CAR’s already sizable list of health needs. MSF teams already working in five regions across the country launched extra mobile clinics after many national health posts and hospitals were abandoned. An emergency surgical team began work in Kaga-Bandoro, and donations were made to hospitals and clinics in affected areas.

With its health systems short on facilities, staff, and medicines, CAR’s population has little access to basic care. Mortality rates in several regions are above emergency levels. Working with the Ministry of Health (MoH) in seven hospitals and more than 30 health posts, MSF provided basic and specialist care, maternity and pediatric services, surgery, and treatment for HIV, TB, sleeping sickness, and malaria.

MSF’s sleeping sickness team in Batangafo rolled out a new diagnostic test and participated in clinical trials of a new oral last-stage treatment developed by the Drugs for Neglected Diseases initiative (DNDi; see p31). The mobile sleeping sickness team screened more than 4,500 people for the disease in the southeast.

CHAD $4,014,708

Amid overlapping health emergencies, MSF treated more than 23,000 children for severe malnutrition at a number of projects across the north. Teams also treated 5,180 children at nearly two dozen feeding centers in the Wadi Fira and Salamat regions. MSF ran an emergency nutrition program in the Batha region’s Fitri district as well, while also screening for and treating malnutrition in 27 surrounding villages and providing routine vaccinations for children. And in June, MSF treated 3,800 children in feeding centers in the Hadjer Lamis region.

A team at Massakory hospital in Hadjer Lamis provided emergency care for children younger than 15 and treated children under five for severe malnutrition with complications. Staff in six nearby health zones vaccinated more than 17,000 children against measles and treated 182 patients for meningitis. MSF also ran meningitis vaccination campaigns and treated hundreds for the disease.

In the Mandoul region, MSF treated more than 62,000 for malaria and trained health workers to diagnose and respond to simple cases. Furthermore, between July and October, when prevalence increases, teams in Moissala district distributed antimalarial medicine to children, a preventative approach known as seasonal malaria chemoprevention that resulted in a 78 percent reduction in simple malaria cases over the next eight weeks.
Teams in Am Timan focused on treating malnutrition in children, providing reproductive health care and emergency obstetric care to women, treating HIV and tuberculosis (TB), and administering prevention of mother-to-child transmission (PMTCT) services for HIV. MSF also runs a women’s health village in Ouaddai region that tends to women who developed fistulas during labor. Working with the MoH, MSF also provided surgical and post-operative care to 166 women.

DEMOCRATIC REPUBLIC OF CONGO $17,098,542

Amid escalating violence in the east, health needs in DRC remained enormous. When M23 rebels attacked Rutshuru and Goma in North Kivu province, MSF continued working at Rutshuru hospital (with a reduced team) and various others locations—including Kanyaruchinya and the Mugunga III camp—to provide care to displaced families. Teams also ran a cholera treatment center following an outbreak and operated on 60 war-wounded in Goma’s Virunga hospital.

Elsewhere in the east, MSF resumed activities in Masisi hospital and nearby health centers one year after curtailing them following a security incident. Teams provided comprehensive services in Mweso, Kitchanga, and Pinga as well. In South Kivu, MSF supported hospitals and health centers in Kalonge, Minova, Shabunda, Kimbi Lulenge, and Baraka.

Security remained a concern. Two staff were briefly abducted in Nyanzale, causing a suspension of services. Programs in Pinga and an emergency malaria response in Walikale were also interrupted. The compound in Baraka was robbed, and in February, staff were evacuated from projects in Hauts Plateaux.

In Katanga province, MSF provided basic health care, maternity services, and nutritional support for people displaced by conflict in South Kivu. When fighting reached Katanga itself, MSF tended to displaced people in Mitwaba, Dubie, and, while it was accessible, Shamwana.

In Orientale province, MSF provided basic and specialist services, maternal and child health care in particular, in Geti, admitting more than 820 patients, two-thirds of them younger than 5, to the emergency department. MSF also supported Dingila hospital in Bas-Uélé—admitting 1,070 patients, more than half with malaria—and the general hospital and three health centers in Niangara, in Haut-Uélé.

In Bas-Uélé, MSF worked with the MoH to screen 60,000 for sleeping sickness, which is more prevalent in DRC than any other country, and treat nearly 1,110. MSF staff at Kinshasa’s Centre Hospitalier de Kabinda provided antiretroviral (ARV) treatment to some 4,700 HIV patients (other projects elsewhere offered HIV care as well). Teams treated tens of thousands during a malaria outbreak in Orientale, Équateur, and Maniema provinces, and responded to measles outbreaks in Orientale, Katanga, South Kivu, Bandundu, and Équateur provinces.

Some 1,160 patients were treated for cholera in Orientale’s Ituri district, along with 1,550 in Goma and 300 in Katanga. When Ebola hit Haut-Uélé in August, MSF treated 18 patients and provided psychosocial support.

ETHIOPIA $2,597,556

In 2012, MSF continued to assist Somali refugees and local communities in southern and eastern Ethiopia, providing general consultations, measles vaccinations, surgery, antenatal and postnatal services, and TB treatment at the border town of Dolo Ado, in Liben zone. MSF also screened roughly 30,000 children per month for malnutrition and other diseases, and carried out more than 1,000 individual mental health consultations in five refugee camps in the area.

In the west, MSF worked with the Regional Health Bureau to carry out more than 60,000 consultations for South Sudanese refugees at the Mattar health center and through mobile clinics. When 12,000 Sudanese refugees were transferred to Bambasi, MSF treated 500 for malnutrition, immunized 3,500, and distributed food rations to 4,000.

In the Somali region, MSF provided basic and maternal care, an inpatient clinic, treatment for TB and kala azar, and mobile clinics in West Imey and East Imey. In Ogaden, MSF offered emergency obstetric care, antenatal consultations, malnutrition treatment, and medical and psychological care for victims of violence at the hospital in Degehabur. MSF also supported Wardher hospital with TB and malnutrition treatment, reproductive health care, assistance for victims of sexual violence, and vaccinations. Another team works in Danod health center.

In the Southern Nations, Nationalities and Peoples Region’s Sidama zone, MSF assisted more than 50,000 women and 34,000 children in programs offering antenatal and postnatal care, a residency for expectant mothers, 24-hour emergency service, medical and psychological care for victims of violence, surgery, and treatment for obstetric fistulas.

MSF worked with the federal Bureau of Health to launch outpatient DR-TB treatment in Dire Dawa, while also treating patients with kala azar, including those co-infected with HIV, in Amhara region.

GUINEA $1,500,000

Though HIV prevalence in Guinea is relatively low compared to some African countries, access to care is still an issue. MSF supports 5,800 patients on ARV treatment in Conakry and offers diagnosis, treatment, and psychosocial support at five health centers and at an outpatient clinic in Matam district. Teams also provide basic health services to pregnant and breastfeeding women and children under five at three centers in Matam. In 2012, staff carried out 57,000 consultations for children under five and assisted 7,000 births. MSF handed over the HIV program in Guéckédou but supplied ARVs for 1,670 patients through March 2013.

Starting in April, MSF vaccinated more than 150,000 people for cholera—with a double dose of a drug called Shanchol—following outbreaks in Boffa and Focariah prefectures, the first time MSF or anyone else had used this vaccine reactively after the start of an outbreak. Early reports showed that it helped reduce the number of new cases significantly. Staff also treated
50,000 people during another cholera outbreak in Conakry in June and conducted preventive water, sanitation, and educational activities as well.

MSF and community health workers treated 77,000 people for malaria in 2012, and MSF supports prevention and treatment activities in Guéckédou’s local district hospital, six health centers, and nine health posts.

**IVORY COAST $4,900,000**

As the conflict that followed disputed presidential elections in 2011 subsided and the humanitarian situation improved, MSF started handing activities from its wide-ranging response back to returning MoH staff in Guiglo, Bloléquin, Nikla, and Guinkin. A team remained at the hospital in the western town of Duékoué, however, managing surgical emergencies, internal medicine, and maternal and pediatric services. In July, staff in the emergency department treated 56 casualties after an attack on a displacement camp.

And in Taï, south of Duékoué, MSF supported MoH teams providing outpatient, maternal, and pediatric services in a 20-bed facility that sees more than 2,000 outpatients every month.

**KENYA $3,469,738**

MSF remained the sole provider of health care in the Dagahaley refugee camp in Dadaab, where teams ran a 200-bed hospital and four health centers, providing Somalis with vaccinations, antenatal consultations, and mental health care, carrying out 14,000 consultations and admitting 1,000 patients from the refugee and host communities each month. MSF also ran feeding programs for children ages 10 and younger and admitted more than 2,200 severely malnourished children for inpatient treatment. Teams responded to hepatitis E and cholera outbreaks as well.

Despite the needs, however, MSF did not send international staff to Dadaab due to a succession of security incidents, particularly the October 2011 abduction of Montserrat Serra and Blanca Thiebaut, who were held in Somalia until July 2013, when they were finally freed.

Elsewhere, MSF provided psychosocial support to 900 people affected by intercommunal clashes in the Tana River district. In Homa Bay, MSF cared for more than 10,500 people living with HIV/AIDS and registered 345 patients in its TB program.

In Nairobi, MSF teams at four clinics in the Mathare and Kibera slums saw more than 10,000 patients each month, providing services that include testing and care for HIV and TB, maternal and pediatric care, treatment for chronic diseases, and cervical cancer screening for women with HIV. MSF offered medical and psychosocial care to dozens of victims of sexual violence each week as well. And work was completed on a health center in Kibera that will house a 24-hour maternity unit.

At the Kacheliba hospital in West Pokot district, MSF treated 500 patients for kala azar and trained health workers before handing over the project to the MoH. Staff also provided reproductive health care and treatment for 4,800 people in North Eastern province’s Ijara district before handing over that project as well.

**LESOTHO $500,000**

In Lesotho, where health care is severely lacking and more than half of all maternal, infant, and under-five deaths can be attributed to HIV, MSF offers maternal and pediatric care, along with HIV and TB care, expanding its reach by shifting some more basic tasks from doctors to nurses. MSF provides support to St. Joseph’s district hospital in Roma, six health clinics in the lowlands, and three clinics in the remote Semonkong area, running an ambulance service as well.

Amid funding delays, MSF advocated for support for counselors who provide one-to-one support during HIV and TB testing and treatment. MSF also pushed for increased, more responsive viral load testing and received a grant from UNITAID to develop and implement related programs in eight HIV programs in Africa, including Lesotho.
MALAWI $2,300,000

MSF provides HIV diagnosis and care in Malawi and aims to improve access to treatment. In Chiradzulu, MSF had about 33,860 HIV patients in 2012. Some 2,600 pregnant women received PMTCT services as well. As in Lesotho, MSF decentralized care by shifting some tasks from doctors to nurses. Staff at 10 health centers offer antenatal care and PMTCT to pregnant women, counseling, and integrated HIV and TB care.

Over the past 15 years, MSF’s program in Thyolo has started some 48,000 patients on ARV treatment. All 24 sites in the district currently offer comprehensive HIV care, including PMTCT option B+, which puts pregnant women with HIV on lifelong ARV treatment. MSF intends to hand the project over to the MoH in 2013 and focus more on specialized areas such as early infant diagnosis and integrated HIV-TB care.

MSF also supported 30 students in the Malamulo scholarship program, which trains young people who pledge to work in Thyolo’s rural areas, and mentored health staff in Nsanje and Chikhwawa as well.

MALI $1,500,000

Conflict and a coup virtually split Mali in two by April—Tuareg and Islamist groups controlled the north, an interim government the south—and instability simmered throughout the year. Some 340,000 people were displaced; 145,000 fled the country.

MSF provided basic medical services at three health posts in the north and assumed responsibility for the 65-bed Timbuktu hospital (emergency department, pediatric ward, surgical and maternity services). Staff also carried out 50,000 consultations in 10 regional health centers.

In Gao, MSF conducted 65 daily consultations in two health centers, ran mobile clinics in rural areas, and managed Ansongo’s 40-bed hospital.

In October, MSF began providing outpatient and inpatient services, maternity care, and surgery at a referral hospital and a health center in Douentza, conducting 500 weekly consultations. Teams also assisted Malian refugees in neighboring countries.

MSF treated hundreds of children at four outpatient and two inpatient therapeutic feeding centers in the Mopti region. Staff also treated 4,800 children for malaria and admitted 4,400 to an inpatient feeding center at Koutiala hospital in Sikasso, treating 3,000 additional children at six outpatient feeding centers.

MSF offered preventative and curative care for children in a health center in Konseguela, conducting more than 80,000 consultations there and in four other health centers. Community health workers in 19 surrounding villages also detected and treated malaria, and distributed mosquito nets, vaccinations, follow-up consultations, and supplementary food for children younger than two.

Between August and October, when malaria is most potent, MSF provided anti-malarial medication to more than 165,000 children in Koutiala district—another seasonal malaria chemoprevention campaign, like the one in Chad—which reduced consultations for simple malaria by more than 66 percent in subsequent weeks and reduced hospitalizations for severe malaria by 70 percent.
MOZAMBIQUE $1,800,000

In a country where less than half of HIV patients can access ARVs, MSF provides HIV care at three programs and is trying to integrate and simplify care for specific patient groups. Staff at the Primeiro de Maio health center in Maputo’s Mavalane neighborhood tailor treatment to children and adolescents and offer integrated care for pregnant women with HIV and people co-infected with HIV and TB. In Chaminculo, also in Maputo, MSF works with the MoH at the Centro de Referencia de Alto Mae to provide care for patients suffering from Kaposi’s sarcoma and in need of second- or third-line treatment.

In Tete, MSF helps promote community and patient involvement in HIV treatment by conducting community outreach around TB diagnosis and also by supporting patient groups that take turns picking up drug refills and encourage adherence.

NIGER $1,800,000

Chronic malnutrition and other health crises have long plagued Niger. While authorities have implemented effective policies and studies show that childhood mortality dropped 45 percent from 1998 to 2009, malnutrition rates remain high and drug supplies frequently run low.

MSF tries to improve health care for children under five and pregnant women, emphasizing early treatment and prevention of malnutrition and other illnesses. Teams in the Zinder, Maradi, and Tahoua regions run outpatient feeding programs in 38 health centers; there are inpatient feeding centers in Zinder, Magaria, Madarounfa, Dakoro, Guidan Roumdji, Madaoua and Bouza hospitals.

Staff in Zinder and Magaria handed over activities to the MoH, and MSF handed over its inpatient feeding center at the Dakoro hospital as well—though MSF still provides pediatric care, maternal care, and obstetric surgery. Eight additional outpatient centers were handed over to ALIMA/BEFEN. A program in Agadez for migrants was closed.

During a summer spike in malaria, MSF’s intensive care and pediatric units in Guidan Roumdji had a 200 percent occupancy rate. Malaria treatment units were also set up in Dan Issa and Madarounfa (where MSF partnered with FORSANI) in Maradi and Madaoua in Tahoua.

Staff in Madarounfa and Madaoua also traveled throughout rural villages to provide diagnosis and treatment where needed. In Zinder, staff provided vaccinations, screened for malnutrition, and treated the three leading childhood killers—respiratory infections, diarrhea, and malaria.

MSF provided care for Malian refugees in the Tillabéri region, carrying out more than 334,000 outpatient consultations, admitting nearly 19,000 people to hospital, vaccinating 22,000 children against measles, and setting up cholera treatment centers following an outbreak.

NIGERIA $8,200,000

Rising insecurity further limited already inadequate health services in the north. At MSF’s obstetric program at Jahun hospital, some 6,800 women gave birth and another 284 underwent fistula repair surgery. In Sokoto state, staff offered basic health care, maternal care, pediatric services, vaccinations, and malnutrition treatment in and around Goronyo, carrying out more than 70,000 pediatric consultations and 28,500 antenatal consultations. The emergency team also treated tens of thousands of patients following malaria, measles, and cholera outbreaks.

After flooding in the east, MSF provided basic and emergency health care to affected people, particularly children and pregnant women, and distributed hygiene kits and mosquito nets.

In Zamfara state, a team has treated 2,500 children for lead poisoning linked to unsafe mining practices since 2010. MSF has also advocated for the sustained remediation effort necessary to remove the threat from the area, which finally began in early 2013.

MSF provides basic health services, emergency care, and maternal care in the Badia and Makoko slums in Lagos. It withdrew from a floating clinic in the Riverine lagoon settlement after providing nearly 20,000 consultations and receiving assurances that the MoH would keep up activities. MSF also closed its trauma center in Port Harcourt after tensions in the Niger Delta eased, having carried out 9,000 emergency consultations and treated 500 victims of sexual violence in 2012 alone.

REPUBLIC OF CONGO $2,000,000

According to the UN, some 59,000 refugees from DRC were still sheltering in Bétou, in Likouala department, in early 2012. At Bétou hospital, MSF strengthened capacity to meet the needs of these refugees and local residents, offering obstetrics, a nutrition program, and a laboratory, and reorganizing hospital departments for surgery, outpatients, and emergency medicine. Most of the roughly 2,600 monthly outpatient visits were children, most of whom had respiratory infections or malaria. MSF also provided emergency assistance to refugees along the Ubangi River.

Working with the national TB and HIV control programs, MSF registered 97 TB patients for treatment and treated 77 people living with HIV.

On March 4, explosions in a munitions depot in Brazzaville killed 200 people and left 1,000 injured and 15,000 homeless. MSF treated the wounded at two public hospitals, setting up triage tents at the University Hospital and donating medical equipment for surgery. Over 1,000 displaced people in two camps received medical and psychological care. MSF also managed safe water provision and sanitation and monitored for cholera and measles at five other locations.

MSF also ran programs among the indigenous Aka pygmies in northern Congo, implementing a new WHO protocol to treat 17,500 people for yaws, a contagious and dangerous but curable skin infection. MSF also responded to a cholera outbreak in Pointe-Noire in November.
SIERRA LEONE $1,000,000

The government’s free health care program for children under five and pregnant and breastfeeding women introduced in 2010 has yet to take hold, as evidenced mainly by preventable maternal and child deaths. In Bo, MSF runs a 220-bed obstetric and pediatric hospital, the Gondama referral center, which has five ambulances that transport pregnant women and children from nine community health centers, and others that take patients with complications to Freetown and patients with Lassa fever to Kenema hospital. MSF’s data showed the programs helped lower the rate of maternal deaths in Bo district by 61 percent.

Between July and September, MSF treated 5,000 patients during a cholera outbreak in Freetown and supported treatment of 427 others at Bo government hospital.

SOMALIA $9,189,704

With Somalia’s infrastructure largely destroyed by war, MSF worked to address gaps both in areas controlled by the government and by opposition groups—though it held off opening any new emergency projects while colleagues Blanca Thiebaut and Montserrat Serra, who were abducted from the Somali refugee camps in Dadaab, Kenya, in October 2011, were still in captivity.

In the meantime, MSF supported a children’s hospital in Mogadishu, while mobile teams carried out consultations, referrals, and routine vaccinations further afield. Clinic and mobile unit teams provided services in several other locations in the capital as well, focusing particularly on women, children, and the displaced. MSF also managed the 60-bed Daynil hospital on Mogadishu’s outskirts, providing emergency, nutrition, pediatric, surgical, maternity, and intensive care services. Operations suspended in March due to security issues resumed in September.

In the Afgooey corridor between Mogadishu and Afgoye, MSF supported a 30-bed community hospital, the only health facility in the area, offering outpatient consultations, emergency services, maternity care, and an outpatient feeding program. Staff screened children for malnutrition and measles in nearby displacement camps as well.

Teams in Dinsor, Bay region, offered inpatient care, nutrition and maternity services, treatment for kala azar, and TB care. In the frontline cities of Jawhar and Balcad, MSF supported a maternity hospital and ran four clinics focused on mother-and-child care, nutrition, vaccinations, and TB.

MSF also supported pediatric, TB, and maternity services in Galkayo North, and a hospital offering emergency, maternity and pediatric care, TB treatment, and surgery in Galkayo South. In Marere, in Lower Juba region, MSF offered maternity care, emergency obstetrics, surgery, and TB treatment, while mobile teams provided basic health care and treated malnutrition in displacement camps. In Jilib, staff ran a measles isolation unit and treated cholera. MSF also treated child malnutrition, measles, and cholera in Kismayo.

In Somaliland, staff provided care and water and sanitation services in Hargeisa, Mandheera, and Burao prisons; psychiatric support in the Berbera mental health clinic; and, working with the MoH, inpatient services at Burao general hospital.

SOUTH AFRICA $1,000,000

An estimated 5.6 million South Africans live with HIV. The government last year announced that it would adopt fixed-dose combination ARTV treatment in the coming years and expand PMTCT care as well—both positive steps for further treatment scale up.

In KwaZulu-Natal province, meanwhile, MSF is increasing testing and treatment coverage and moving to initiate treatment earlier, which has shown in studies the potential to reduce transmission of the disease. In 2012, staff tested more than 23,000 people, working with community leaders and traditional healers to gain acceptance.

In Khayelitsha township, MSF continued its operational research on HIV and TB treatment and created more community adherence clubs, wherein members visit health centers every two months and help each other stay on treatment. Surveys showed that 97 percent of club members stayed in care. There are now 180 clubs with 4,500 members in Khayelitsha (The Western Cape Department of Health has also set up more than 400 clubs). Nearly 200 patients also started treatment for DR-TB, which is particularly prevalent in Khayelitsha.

MSF mobile clinics tended to Zimbabweans in South Africa who cannot access medical care. Teams in the border-town of Musina offer basic health care and testing and treatment services for HIV and TB, and teams in Johannesburg provide care and water and sanitation assistance.

SOUTH SUDAN $10,422,759

Amidst a massive influx of refugees fleeing war in Sudan’s Blue Nile and South Kordofan states, MSF launched a huge emergency response in South Sudan. Some 110,000 refugees struggled into Upper Nile state’s Maban county, where mortality levels in some places doubled the emergency threshold in July. While calling for a more robust humanitarian response, MSF ran three field hospitals and seven outreach clinics, conducting up to 8,000 weekly medical consultations for people suffering from the effects of their long flight from aerial bombardments and deprivation—malnutrition, skin and respiratory infections, and diarrhea in particular. In Unity state’s Yida camp, where another 60,000 refugees sought sanctuary, MSF offered inpatient and outpatient care and operated four feeding centers. Teams provided expansive water and sanitation services as well, and also conducted vaccination campaigns and responded to outbreaks.

In Jonglei, intercommunal clashes caused widespread displacement. MSF’s hospital in Pibor and two outreach clinics
in Lekwongole and Gumuruk together carried out some 32,000 consultations. The Pibor and Lekwongole facilities were damaged in December 2011 during attacks that killed hundreds of men, women, and children, and the Lekwongole and Gumuruk facilities were ransacked in 2012 during raids that drove thousands from their homes—after which MSF established a makeshift clinic in the bush to treat the wounded and ill.

In northern Jonglei, MSF carried out 100,000 consultations, treated 30,000 patients for malaria, and treated another 1,000 for kala azar in a hospital in Lankien and a clinic in Yuai. In Abyei, MSF’s hospital in Agok conducted 29,200 consultations, helped deliver 860 babies, and treated more than 3,500 children for malnutrition.

MSF also ran wide-ranging programs in Bentiu, Unity state (malnutrition and TB care); in Leer (kala azar, malnutrition, TB); a full-service hospital in Nasir in Upper Nile state; at Yambio hospital in Western Equatoria state and 10 other health posts (general care and malaria treatment); at Northern Bahr El Ghazal’s 250-bed Aweil civil hospital; and Gogrial, Warrap state (outpatient services, malnutrition, and measles).

**SUDAN $1,030,471**

Along with conflicts in South Kordofan and Blue Nile states—which humanitarian groups are not allowed to enter but which spawned refugee emergencies in South Sudan—periodic unrest affected parts of North and South Darfur as well. In South Darfur’s Shaeria area, MSF provided maternal care and other services at the MoH hospital and three clinics in remote villages.

In North Darfur, teams provided comprehensive services in Tawila and basic care in five health centers in Dar Zaghawa. MSF continued advocating for improved access to care for residents and displaced people elsewhere in North Darfur, but improved stability in Shangil Tobaya allowed MSF to hand over its project there to the MoH. MSF also assisted the MoH with a yellow fever response in North and Central Darfur, supporting a vaccination campaign that reached 750,000 people.

In Sennar state, MSF trained medical staff in kala azar diagnosis and treatment, and mobile teams screened people for the disease. MSF also supported kala azar care and screening in Al-Gedaref state and assisted patients co-infected with TB or HIV.

When heavy rains caused flooding in August in Al-Gedaref and Sennar, MSF distributed relief kits and plastic sheeting, delivered drinking water, built latrines and showers, and trained health staff in the diagnosis and treatment of acute watery diarrhea. Staff also conducted mobile clinics, provided care for malnutrition, and vaccinated children against measles.

**SWAZILAND $4,900,000**

With Swaziland facing dual HIV and TB epidemics, MSF is working with the MoH to decentralize care for both, testing and treating patients at local health posts and promoting adherence to treatment. MSF is providing integrated TB-HIV treatment as well in places like Matsapha.

MSF also decentralized TB and DR-TB treatment to four health facilities in the Manzini region. Success rates improved to 75 percent and the first MDR-TB patients successfully completed their drug regimens.

Given research showing that ARV treatment for HIV also decreases transmission, MSF and the MoH are implementing a program in Shiselweni that will test and treat all pregnant women in the district, putting those who test positive for HIV on ARV treatment straightaway. MSF also reached out to traditional healers to discuss HIV and TB care and enlist their help in referring people with symptoms to clinics.

**UGANDA $2,390,000**

From March to May, MSF responded to a cholera outbreak in the Northern region’s Nebbi district, treating 600 patients. Teams also provided technical expertise following outbreaks of Ebola and Marburg hemorrhagic fever in August and October, respectively, managing an Ebola ward in Kagadi hospital in Kibaale district, for example, and working with the MoH to halt transmission of the diseases.

From July to October, teams provided medical care to refugees from DRC, managing severe malnutrition and treating 500 children
at the Nyakabande and Rwamwanja camps in Western region.

MSF maintained its HIV and TB program in Arua as well, though HIV treatment is now far more available than it used to be. Many patients come from DRC, where access to care is very limited. By the end of 2012, MSF was providing more than 6,600 people with ARVs and had nearly 900 patients co-infected with TB in treatment.

**ZAMBIA $1,990,075**

Only four of ten women who give birth at health care facilities in Northern Province have a skilled health worker present, and the ratio is worse in rural areas, where preventable deaths related to pregnancy and childbirth are too frequent.

MSF ran maternal health programs in the Luwingu district hospital and seven rural health centers, assisting births and providing family planning and ante- and postnatal care. Clinic staff refers emergency obstetric patients to the hospital, where 163 Caesarean sections were performed. A surgical team also offers fistula repair, and MSF provides PMTCT services and outreach activities designed to reduce stigma around HIV.

**ZIMBABWE $3,150,000**

As Zimbabwe struggles with HIV and TB epidemics, MSF provides comprehensive HIV and TB care, including rapid testing, treatment, counseling, PMTCT, and medical and psychological support for victims of sexual violence.

In Tsholotsho, MSF works in the hospital and 14 rural health facilities, including a family clinic at the district hospital, where MSF provided medical and psychological support to 100 victims of sexual violence.

In Gokwe North district, MSF staff in two rural hospitals and 16 health centers tested 13,900 people for HIV and registered 2,200 patients for care, started 325 people on TB treatment, and tended to victims of sexual violence. In Beitbridge, MSF supported the MoH with HIV and TB care, working in six rural health facilities.

In Buhera district, MSF mentored MoH staff in 26 clinics ahead of a handover of services and delivered a new TB testing machine that tested some 320 people each month. Teams in Gutu and Chikomba districts trained staff in 23 clinics in preparation for a rapid scale-up of HIV treatment. A new TB testing machine was also installed in Gutu Mission Hospital.

In Epworth, MSF focused on TB diagnosis and care and was treating 40 patients for MDR-TB. In Harare's Mbare neighborhood, a program for victims of sexual violence offers medical care, counseling, and referrals for psychological, psychosocial, and legal support. Working with local partners, MSF cared for 900 new and 925 follow-up patients, more than half under 16 years of age.

Additionally, MSF provided psychiatric care in Harare's maximum security prison and eight other prisons. MSF also assisted Harare city authorities following a typhoid outbreak.

**AFGHANISTAN $5,700,000**

Insecurity and a lack of trained health workers continue to limit access to medical care in Afghanistan.

In Kunduz, MSF runs the only trauma center in the north, providing free, high-quality surgical care to people wounded by conflict, traffic accidents, and “mass casualty incidents.” In 2012, MSF added a new emergency room, a larger outpatient clinic, and better physiotherapy services. Staff treated a total of 10,000 patients and carried out some 1,500 operations (see p. 62).

At Kabul's Ahmad Shah Baba hospital, MSF continued running an emergency department, an operating theater, an outpatient clinic, a maternity ward, and a TB clinic. Mental health services were offered as well.

In Lashkargah, in Helmand province, MSF continued to support one of only two functioning referral hospitals in southern Afghanistan, providing surgery, internal medicine, and maternity, pediatric, and emergency services. Staff in the outpatient clinic saw over 7,000 patients per month, surgical staff carried out more than 3,000 surgical procedures, and some 900 severely malnourished children were treated as inpatients.

MSF's newest program, a 56-bed maternity hospital in volatile Khost province, opened in March. Staffed only by female doctors and nurses, the hospital can help more than 1,000 women give birth every month and manage obstetric emergencies as well. In May, however, a bomb attack wounded seven and forced MSF to suspend operations. After several months of talks with community leaders and other parties, MSF received assurances that allowed it to reopen the hospital in December.

**BANGLADESH $800,000**

MSF teams in Bangladesh run a clinic for unregistered Rohingya refugees from Myanmar living on the outskirts of the Kutupalong camp, in Cox's Bazaar, along with Bangladeshis in the area. Services include basic health care and maternal and mental health services. The clinic has a small inpatient unit, a stabilization unit for severely malnourished children, a diarrhea
In Timergara, MSF supports the emergency department and mother-and-child health center. MSF also responded to a spike in acute watery diarrhea in Hangu and Timergara from July until October. And in Peshawar, MSF runs a 30-bed hospital specializing in obstetrics and gynecology and also conducts antenatal and postnatal consultations in 11 district health centers.

In the Federally Administered Tribal Areas’ Kurram agency, staff provides pediatric services at separate hospitals in Shia and Sunni communities. In Balochistan, which is plagued by conflict, natural disasters, and a lack of development, MSF provides neonatal, obstetric, and pediatric care in Chaman and Dera Murad Jamali hospitals.

MSF runs a 60-bed pediatric hospital in Quetta as well and is opening several additional health units. In Kuchlak, a team runs a mother-and-child health clinic and a birthing unit, while also treating patients for cutaneous leishmaniasis. Mental health teams work in both Quetta and Kuchlak. And staff set up mobile clinics and provided water-and-sanitation assistance in September after severe flooding.

In October, MSF and local partners opened a clinic in Karachi’s Machar Colony that provides basic health care and emergency services, including maternal health care, and mental health services.

In Pakistan, MSF focused on urgent needs in communities affected by insecurity. In Khyber Pakhtunkhwa province, MSF works in the Hangu hospital’s emergency department and operating theater, serving mainly Afghan refugees and other displaced people.

In Kuchlak, a team runs a mother-and-child health clinic and a birthing unit, while also treating patients for cutaneous leishmaniasis. Mental health teams work in both Quetta and Kuchlak. And staff set up mobile clinics and provided water-and-sanitation assistance in September after severe flooding.

In October, MSF and local partners opened a clinic in Karachi’s Machar Colony that provides basic health care and emergency services, including maternal health care, and mental health services.
MSF runs a second center in Tari, in Southern Highlands region, and runs an emergency surgery program at Tari hospital. Teams also trained health staff in 20 of the country’s 22 provinces to better respond to victims of domestic and sexual violence.

MSF is helping refurbish several health facilities in the Autonomous Region of Bougainville, that were badly neglected and damaged during decades of violence. This included building a six-bed TB ward, where staff support clinical care and maternal health care, as they do in five other health centers as well. Staff also ran a maternity waiting home in Buin for women in the final stages of pregnancy.

ARMENIA $835,000

In Armenia, MSF focuses on improving access to DR-TB treatment. Teams in Yerevan, Armavir, Kotayk, Ararat, Lori, and Shirak provide medication, counseling, and adherence support.

MSF also signed an agreement with health authorities to improve ventilation in the DR-TB ward of Armenia’s main TB hospital in Yerevan to help reduce retransmission of the disease. And MSF launched a three-year study of infection patterns among children with DR-TB; 23 children were diagnosed and began treatment.

GEORGIA $500,000

As the number of kala azar cases in Georgia continued to rise, MSF worked with Tbilisi’s Parasitological Hospital to improve detection and to introduce liposomal amphotericin B for treatment. When training was complete, MSF handed over the program to national health authorities, along with supplies of liposomal amphotericin B.

Teams also treated patients with MDR-TB in the autonomous republic of Abkhazia and continued to provide medical care, including surgery and eye care, to patients in Sukhumi.

KYRGYZSTAN $2,300,000

Budget cuts and drug shortages hampered Kyrgyzstan’s efforts to manage one of the highest DR-TB burdens in the world. MSF offered comprehensive, free care for people with DR-TB and people co-infected with HIV and TB in Osh province’s Kara Suu district, where DR-TB rates are particularly high and where MSF helped renovate the TB facilities. Staff screen for TB, DR-TB, and HIV throughout the district, caring for those who need it and offering psychosocial support to encourage adherence.

MSF also works in Bishkek’s detention system, screening inmates for TB and treating and counseling people with the disease. The team offers nutritional and psychosocial support as well. Additionally, MSF conducts awareness-raising activities and advocates for improved ventilation and living conditions for prisoners, while also supporting the national reference laboratory with technical capacity, supplies, staff supervision, and training.

RUSSIAN FEDERATION $1,450,000

Years of war, the collapse of the health system, and social stigma collude to limit TB and DR-TB care in the north Caucasus. MSF therefore works with the Chechen MoH to implement a comprehensive TB program that includes diagnosis and treatment for people with DR-TB, counseling, and special services for children and people co-infected with HIV and TB.

In Grozny, MSF works in the cardiac unit of Republican Emergency Hospital—one in six Chechens has heart disease—training staff and donating medical equipment and essential medicines. Almost 750 patients received emergency care in 2012.

MSF closed programs for women and children in three Grozny outpatient clinics after patient numbers decreased. Staff had provided some 15,700 pediatric consultations and 8,800 gynecological consultations since 2007.

Since 2002, MSF counselors have provided psychological support in remote regions of Chechnya and Ingushetia to individuals suffering from anxiety, mood disorders, and grief caused by psychological and physical violence. The program in Chechnya continues. Services in Ingushetia, however, ended in September after officials indicated that the assistance was no longer required.

UKRAINE $1,863,800

TB and DR-TB are growing problems in the Ukraine, particularly in prisons, but there’s not yet a comprehensive national response. In June, MSF began working in the hospital for prisoners with TB and three pre-trial detention centers in the eastern region of Donetsk. The team provides treatment, psychological support, and adherence counseling to patients with DR-TB and those co-infected with HIV.

Staff has also worked to improve lab facilities and infection control at the detention centers, and to replenish supplies of medications when needed. When patients are released, MSF makes sure they can continue treatment.

“AFTE...MORE OR WOULD DIE.”
—MARIAM, TB PATIENT, ARMENIA

"AFTER TAKING THE DRUGS FOR TWO WEEKS AND FEELING LIKE I WAS PASSING THROUGH HELL, I BEGAN TO THINK I WOULD LOSE MY MIND OR WOULD DIE."

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—MARIAM, TB PATIENT, ARMENIA
**BOLIVIA** $62,190

In addition to training local health staff, MSF teams in Bolivia carry out screening and treatment for Chagas disease in the communities of Aiquile, Omereque, and Pasorapa in Narciso Campero province, where Chagas prevalence tops 40 percent in general and nears 80 percent for people older than 45. Both treatment and screening are as rare as they are necessary; without them, the disease can cause severe damage, ultimately killing a patient, likely through heart failure.

To this end, MSF signed an agreement with the Bolivian organization Puente de Solidaridad and the local hospital allowing patients with heart and intestinal complications to be referred for specialist treatment free of charge.

Additionally, lobbying by MSF and others helped guarantee sufficient stocks of benznidazole, the most commonly used medicine for Chagas, which ran out in 2011 when the drug’s sole manufacturer ceased production. MSF also introduced a pediatric formulation for younger patients developed by DNDi.

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**GUATEMALA** $800,000

In Guatemala, MSF focused its work on victims of sexual violence, bringing medical care and outreach to an often overlooked group. MSF handed over its program to the MoH in 2012, but not before it had provided medical and psychological care, along with social assistance, to some 4,000 people in five locations, including the...
emergency department of the city’s general hospital and in the Public Ministry, where assaults are reported.

MSF also advocated on behalf of victims of sexual violence. There is now 24-hour health care available, and survivors of sexual violence can get medical attention before a crime is reported. Far more of the people coming to MSF facilities were coming within 72 hours of being assaulted, as is advisable, and medical staff in public health facilities (many trained by MSF) now offer treatment as well.

Additionally, MSF donated medicines and provided counseling in San Marcos department after an earthquake destroyed hundreds of homes in the Pacific Coast area in November.

**Haiti $13,700,000**

As the rebuilding effort following the 2010 earthquake stumbles along, access to health care remains a huge issue, as it was before the disaster. MSF is filling gaps in emergency care by providing a wide range of services in four hospitals, along with care for cholera, which has affected some 638,000 people since it first afflicted the country in 2010.

MSF runs a 130-bed obstetric and neonatal emergency hospital in Port-au-Prince’s Delmas 33 neighborhood, offering free, round-the-clock emergency care for women experiencing complications. In 2012, 7,980 patients were admitted to the hospital and teams assisted 6,360 births. The hospital also provides reproductive health care services (family planning, PMTCT, neonatal and postnatal care) and has a cholera center for pregnant women.

MSF’s Nap Kenbe surgical center in Tabarre, in eastern Port-au-Prince, provided emergency trauma, orthopedic, and abdominal surgery for some 1,200 victims of gunshots, domestic violence, and road accidents. At MSF’s 127-bed Drouillard trauma hospital near Cité Soleil, staff provided emergency care to 19,700 patients, carried out 8,000 surgical procedures, treated 480 people with burns in the dedicated burn unit [see p.5], and provided medical and psychological support to 150 victims of sexual violence.

MSF treated 61,200 patients at its Martissant clinic, where it provided pediatric care, maternity services, internal medicine, cholera care, and mental health services. In Léogâne, west of the capital, staff at MSF’s Chatuley hospital assisted 6,000 births and carried out 3,600 surgical procedures in a facility offering 24-hour emergency care, while also offering lab services, radiology, physiotherapy, mental health care, and outpatient care for pregnant women and children under five.

Overall, MSF treated nearly 25,000 people for cholera, while also distributing hygiene kits and conducting water chlorination and outreach activities.

**Honduras $963,492**

Large numbers of people in need of urgent care due to violence in Tegucigalpa further tax an already overstretched medical system. To wit: violence-related admissions at Tegucigalpa University Hospital, the city’s only public trauma hospital, doubled over the past five years.
MSF teams visit more than 20 locations in the city’s most violent areas every week, offering assistance to people unlikely to receive medical attention elsewhere. Social workers, medical staff, and psychologists provide preventive care, first aid, and psychological support. Patients needing further attention are referred to four health centers supported by MSF.

**MEXICO** $559,708

MSF launched a program in Oaxaca and Chiapas states to tend to the needs of migrants coming north from Belize and Guatemala. Teams improved water and sanitation facilities in shelters and built facilities for medical and psychological services.

In a complex context laced with fear and anxiety, teams had to seek out would-be patients, especially among vulnerable groups of women, children, unaccompanied minors, and victims of violence, kidnapping, and human trafficking. Many had conditions related to the journey: respiratory infections, skin diseases, dehydration, gastrointestinal disorders, and the physical and mental consequences of violence and sexual violence.

For example: Some 1,200 migrants passed through a shelter built to accommodate 70 in Lechería during one week in June. MSF provided health care and worked to improve living conditions. After tension with local residents forced the closure of the shelter in July, the migrants moved to makeshift camps where government agencies offered basic health care and MSF focused on more complex health issues. MSF also distributed more than 6,500 hygiene kits and did water and sanitation work as well.

**UNITED STATES** $30,262

Despite a comprehensive emergency response by the authorities following Hurricane Sandy, MSF filled temporary gaps in medical service in select sites in New York and New Jersey. Teams of returned field workers and staff from MSF’s New York office provided medical and mental health care at evacuation centers in Brooklyn and Staten Island in New York and in Hoboken, New Jersey. They also worked in high-rises in the Rockaways where elderly, disabled, or chronically sick people were confined without electricity, water, or access to their medicines.

Teams focused on facilitating continuity in medical care for people with chronic conditions such as diabetes, heart disease, hypertension, and upper respiratory tract infections. Pharmacies were damaged and closed, so teams identified pharmacies elsewhere that could provide the necessary medicines that staff then delivered to patients.

**EGPYT** $300,000

In August, MSF opened a mother-and-child clinic in Abu Elian, on Cairo’s outskirts—the closest medical center had been an hour away—and carried out nearly 9,000 consultations, most for respiratory tract infections, intestinal parasites, skin diseases, and diarrhea. The project also had a 24-hour emergency referral system for pregnant women.

MSF opened a clinic for women in Nasr City, a migrant hub, offering medical and mental health care, treating more than 430. MSF staff in Qalubia governorate trained MoH doctors and nurses in TB care, focusing on infection control. And in response to the alarming prevalence of hepatitis C, MSF proposed a new model of care that it could implement with the MoH in remote areas; it is awaiting approval.

In November, MSF donated medicines and supplies to the El-Arish hospital in southern Sinai, which treated Palestinians wounded during Israeli military operations in Gaza.

**IRAQ** $1,100,000

MSF expanded its work in Iraq when it became the main health care provider for Syrian refugees in the Domeez camp, where it delivered basic medical services and mental health care, distributed hygiene kits, and ensured access to safe water and adequate sanitation.

Elsewhere, teams managed a 24-hour operating theater and performed more than 300 emergency procedures each month in Kwijah general hospital’s emergency department. In Baghdad and Fallujah, MSF’s mental health teams treated some 3,800 people and conducted 10,700 counseling sessions. Staff also helped the MoH roll out a model of care based on MSF’s work, including a hotline for people in distress.

After increasing the capacity of Kirkuk general hospital’s dialysis unit from 22 patients in 2010 to 100 in 2012, MSF handed services over to the MoH, but its surgical team carried out 26 operations on patients with kidney disease and other team members provided training to hospital staff. MSF also trained staff and implemented new infection control measures in Najaf’s Al-Zahra hospital, the area’s main referral center for obstetrics, gynecology, and pediatrics.
JORDAN $5,100,000

While Jordan covers most of its own medical needs, MSF is helping address additional health burdens resulting from the country’s status as something of a refuge for people facing trouble in their homelands. Since 2006, for instance, MSF has operated a specialist surgical program in Amman for victims of conflict. Initially opened for Iraqis, it now serves people from Yemen, Syria, Libya, Gaza, and Egypt as well. Admissions of Syrians alone increased the number of operations carried out by 77 percent from 2011. More than 100 Yemenis were admitted as well. Physiotherapy and psychosocial services are offered, too.

MSF’s outpatient department in Amman’s Jordanian Red Crescent hospital compound also treats Syrian refugees for both acute needs and chronic conditions. Teams conducted more than 350 medical and surgical consultations each month.

To provide effective care, referrals for additional expertise are sometimes required. MSF has established relationships with Handicap International, the Center for Victims of Torture, the Jordan Health Aid Society, UN agencies, and specialist hospitals in Jordan.

PALESTINIAN TERRITORIES $2,500,000

The Israeli embargo, the financial crisis, and chronic inflighting among Palestinian parties contributed to the further deterioration of the public health system in Gaza and the West Bank. MSF teams perform specialized surgery, post-operative care, and physiotherapy in Nasser hospital in Gaza’s Khan Yunis city; most patients are children with burns. During Israel’s “Pillar of Defense” military operation in November, the post-operative clinic received wounded patients and conducted minor surgery. MSF also sent an emergency team to Gaza and donated drugs and medical supplies.

In the West Bank, where MSF offered medical, psychological, and psychosocial care in Nablus and Hebron, the number of psychological consultations increased by 50 percent. In East Jerusalem, where MSF provides psychological and social services, patient numbers tripled. Almost half were 18 or younger. Anxiety, depression, behavioral issues, post-traumatic stress, and conditions related to domestic or settler violence were common.

LEBANON $1,900,000

Some 200,000 Syrians sought refuge in Lebanon in 2012 (and more in 2013), but many were unable to access the care they needed. Some 63 percent of unregistered refugees had received no assistance whatsoever, according to an MSF study. Many lived (and still live) in overcrowded, substandard structures and cannot afford medical care.

MSF offered basic care and mental health services in the north and east, working at six health facilities in the Bekaa Valley. When winter neared, MSF distributed blankets, hygiene kits, milk, and diapers. Staff provided mental health support as well.

One MSF team provided basic health care, treatment for chronic diseases, and mental health services in Tripoli’s Dar Al-Zahra hospital. Another provided mental health care and trained emergency room staff in Tripoli’s government hospital. Near the end of the year, MSF started offering basic health services in the city’s poorest and most volatile neighborhoods, too.

In several locations, MSF provided mental health services to Palestinian refugees in overcrowded camps that had further swelled with the arrival of Palestinians who’d been living in Syria. MSF handed over mental health services at the Burj el-Barajneh camp after holding more than 17,500 consultations over four years. Staff also coordinated a trauma care course for doctors and nurses throughout the country.

SYRIA $3,320,658

As conflict intensified and medical needs mushroomed, MSF continued to petition Syria’s government for permission to provide impartial medical assistance on all sides of the conflict. When its entreaties failed, MSF began working in opposition-held areas, setting up a 15-bed trauma surgery in Idlib that conducted 665 surgical procedures and provided emergency treatment to 2,230 patients; another hospital in Idlib—first in a cave, then on a converted farm—that treated more than 7,200 patients; and a third in Aleppo governorate that treats war-wounded patients and offers obstetric and other forms of emergency care, as well as basic health services, and where staff performed 70 surgical procedures each month.

As the year progressed, MSF expanded its activities to basic health care, vaccinations, and maternal care. In the Deir Ezzor area, MSF also helped patients with chronic illnesses whose treatment had been interrupted, and the organization donated tons of medicines and medical supplies to health facilities in Aleppo, Homs, Idlib, Hama, Deraa, and Damascus governorates. This included a large donation of medical supplies and relief items to the Syrian Arab Red Crescent in Damascus.

At year’s end, MSF was still lobbying the government for official permission to work in the country. Teams in Iraq, Jordan, Lebanon, and Turkey were also providing care to some of the hundreds of thousands of Syrian refugees who had fled to those countries.

YEMEN $7,466,936

Violence and instability in Yemen both prevent access to health care and limit MSF’s ability to operate. In 2012, despite MSF’s ongoing outreach and insistence that weapons are forbidden in its facilities, activities in certain areas had to be suspended. Huth health center in Amran governorate was closed by the MoH, for instance, after armed men threatened MSF staff.
In contrast, staff working at Al-Salam hospital in Khamir expanded, opening a new nursery, a pediatric ward, and an intensive care unit, while also broadening maternity services. An outpatient feeding program was handed over to the MoH so MSF could focus on more complex conditions. Mobile teams also traveled regularly to the remote Osman and Akhraf valleys to screen for and treat malaria and malnutrition.

In April, MSF opened a 40-bed emergency surgical center inside Al-Wahda hospital compound, in Aden, for patients from Aden and from MSF-supported facilities in Abyan and Ad-Dali. Teams referred patients needing specialist reconstructive surgery to Sana’a or Amman, Jordan. By year’s end, most people displaced by earlier civil unrest had returned home, allowing MSF to withdraw from these facilities.

In Ad-Dali governorate, MSF managed surgical referrals to Aden from Al-Naser hospital, while also donating drugs and medical supplies to the operating theater.

In Abyan governorate, staff provided emergency, surgical, and maternity services in Jaar until public health authorities reopened Al-Razi hospital in June. MSF also donated drugs and supplies to Lawdar hospital and other health facilities.

Staff treated 395 patients for measles following an outbreak in Amran and Ad-Dali and 83 for dengue following an outbreak in Abyan. Additionally, an MSF team provided mental health assistance to migrants in Hajjah governorate, along one of the main routes from the Horn of Africa to the Gulf states.

ACCESS CAMPAIGN $1,095,187

Drawing on MSF’s field experience, the Access Campaign advocates for greater access to affordable, effective medicines and diagnostics. In 2012, it campaigned for more affordable and better-adapted vaccines, advocating for policies that support further scale-up of optimal HIV treatment and continuing to push back against efforts to impose stricter intellectual property measures than international trade rules require, which would pose a serious threat to the provision of medical care in developing countries.

DRUGS FOR NEGLECTED DISEASES INITIATIVE $1,447,842

DNDi is a not-for-profit research and development organization that brings together researchers, activists, medical professionals, foundations, public health institutes, and others from around the world to identify and fill treatment needs to fight neglected tropical diseases in developing countries. In ten years, DNDi has introduced six innovative and impactful new treatments for drug-resistant malaria, sleeping sickness, visceral leishmaniasis, and Chagas disease.

EPICENTRE $430,000

A nonprofit research center founded by MSF in 1987, Epicentre conducts epidemiological assessments and studies that allow MSF to better understand medical and nutritional needs, improve treatments, and develop high-quality health care initiatives in its field projects. Among other studies in 2012, its work in South Sudan showed that mortality levels among Sudanese refugees were above emergency thresholds, and its work in Chad and Mali showed the benefits of seasonal malaria chemoprevention.

LOGISTIQUE EXPANSION $1,288,201

MSF is expanding its logistical hub in Bordeaux, France, doubling the size of the warehouse and building new offices to further augment and improve MSF’s logistical capabilities, particularly emergency responses.

MSF INTERNATIONAL OFFICE $2,552,87

MSF’s International Office coordinates common projects on behalf of MSF’s 19 sections worldwide and supports MSF’s advocacy efforts with the United Nations and other international bodies.
INDIA > Staff in Manipur visit with an MDR-TB patient at his home.
In 2012, we sent out 376 field workers from the US, numbers highlighted by a sizable contribution of surgical specialists to certain programs and of several positions to emergency projects in Syria and South Sudan. We saw results from some of our more prominent strategic initiatives as well. As a result of the targeted outreach we’ve done, for instance—including 46 recruitment events that drew more than 2,500 people—our applicant pool continued to improve. >> Our efforts to allow applicants to make working with MSF a part of their career path, rather than a departure from it, is proving beneficial, too. More and more people are making multi-year commitments and serving in more senior roles. Last year, in fact, 28 percent of those we sent to the field served in team leader or coordinator roles. This shows us that the more we invest in our field workers and their professional growth, the more they invest in the organization. >> In 2013 and beyond, we want to build on this momentum. We’ll continue to expand field management training sessions. We’ll also continue to invest in our psychosocial care unit, which now conducts pre-departure briefings for field workers, as well as briefings for them upon their return, so they’re better prepared to deal with whatever comes up during their assignments. And we’ll continue to refine our compensation structure both to reflect the complexity of the roles people are asked to fulfill and to be more adaptable to an individual’s career management. Ideally, all of this will yield more benefits for all involved—for the individual, for MSF, and, above all else, for the patients we aim to assist. —NICK LAWSON, DIRECTOR OF FIELD HUMAN RESOURCES, MSF-USA

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MSF is always looking for motivated and skilled medical and non-medical professionals for our field projects around the world.
MSF-USA also needs volunteers and interns to work in our New York office. For more information, please visit doctorswithoutborders.org
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PARLEZ-VOUS FRANÇAIS?

MSF is in urgent need of French-speaking staff to provide assistance in countries such as the Democratic Republic of Congo, Chad, Niger, and Haiti, where some of MSF’s largest projects are located. "Successful applicants who meet MSF’s criteria and speak French will be eligible for more positions and will usually be matched more quickly with an assignment," notes MSF-USA Field Human Resources Director Nick Lawson. “Nearly half of MSF’s available field positions are in francophone countries." If you are interested in contributing your professional—and French—skills to MSF’s medical humanitarian work, we encourage you to visit doctorswithoutborders.org/work/field for more information about MSF recruitment.

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MSF is extremely grateful for the financial support it receives from individuals, foundations, and corporations. Your generosity allows MSF to respond to emergencies based on medical humanitarian needs and to operate independent of political, economic, or religious interests.
I want to applaud MSF’s self-critique and introspection. It speaks of the highest integrity, and the ultimate commitment to achieving organizational effectiveness in line with its mission.

—CHRISTINE M. SIMONE

MSF ACKNOWLEDGES OUR DONORS WHO HAVE MADE MULTIYEAR COMMITMENTS

Multiyear pledges provide MSF with predictable and sustainable funds, enabling us to respond effectively and rapidly to emergencies around the world and helping us better plan for the future. By the close of 2012, MSF had received 167 multiyear commitments toward this effort, totaling $31,335,001.

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<tr>
<th>Amount</th>
<th>Donors</th>
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<tbody>
<tr>
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<td>Audrey Steele Burnand, Mr. James Chambers, Sue &amp; Bill Gross, Katherine Curtis Springer Trust, Estate of Regina Jean Spence</td>
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140 Yemeni staff and treats an average of 1,500 patients per month, free of charge.
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SOMALIA > A view of a Rajo displacement camp in Mogadishu.
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Mr. Richard Zimler &
Mr. Ali Youssefi
In 2012, MSF-USA increased its support for emergency and medical programs around the world to more than $162 million, an almost 19 percent increase from 2011. Another $8.9 million was spent for direct program support, advocacy on behalf of our patients and programs, and public education and communications. MSF-USA’s donors supported operations in 56 countries worldwide. In all, over 86 percent of total 2012 expenditures went to program activities—the eighteenth consecutive year during which over 85 percent of MSF-USA’s annual spending went to our medical programs. The support of individual donors is critical to MSF-USA’s ability to quickly and impartially fund humanitarian interventions around the globe. As demonstrated repeatedly, the willingness of so many of our donors to provide unrestricted gifts enhances both our efficiency and effectiveness, allowing for the greatest possible impact on the ground. Below is a breakdown of revenue and expenses for 2012.

<table>
<thead>
<tr>
<th>REVENUES</th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PUBLIC SUPPORT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions and private grants</td>
<td>$184,147,094</td>
<td>$179,370,765</td>
</tr>
<tr>
<td>Contributions pledged</td>
<td>5,158,361</td>
<td>1,424,033</td>
</tr>
<tr>
<td><strong>Total Public Support</strong></td>
<td><strong>189,305,455</strong></td>
<td><strong>180,794,798</strong></td>
</tr>
<tr>
<td><strong>OTHER REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment income</td>
<td>212,526</td>
<td>209,443</td>
</tr>
<tr>
<td>Unrealized and Realized Gain (Loss) on Investments</td>
<td>573,071</td>
<td>(579,539)</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>46,164</td>
<td>68,749</td>
</tr>
<tr>
<td>Grants from Affiliates</td>
<td>10,671,977</td>
<td>10,108,688</td>
</tr>
<tr>
<td><strong>Total Other Revenue</strong></td>
<td><strong>11,503,738</strong></td>
<td><strong>9,807,341</strong></td>
</tr>
<tr>
<td>Total Revenues excluding gifts in kind</td>
<td><strong>200,809,193</strong></td>
<td><strong>190,602,139</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROGRAM SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency and medical programs</td>
<td>162,566,427</td>
<td>137,098,926</td>
</tr>
<tr>
<td>Program Support and development</td>
<td>5,363,430</td>
<td>4,692,594</td>
</tr>
<tr>
<td>Communications</td>
<td>3,600,491</td>
<td>3,247,441</td>
</tr>
<tr>
<td><strong>Total Program Services</strong></td>
<td><strong>171,530,348</strong></td>
<td><strong>145,038,961</strong></td>
</tr>
<tr>
<td><strong>SUPPORTING SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management and General</td>
<td>2,635,325</td>
<td>2,244,434</td>
</tr>
<tr>
<td>Fundraising</td>
<td>24,517,940</td>
<td>22,636,178</td>
</tr>
<tr>
<td><strong>Total Supporting Services</strong></td>
<td><strong>27,153,265</strong></td>
<td><strong>24,880,612</strong></td>
</tr>
<tr>
<td>Total Expenses excluding gifts in kind</td>
<td><strong>198,683,613</strong></td>
<td><strong>169,919,573</strong></td>
</tr>
</tbody>
</table>
Medical Action Financial Report 2012

### NET ASSETS

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net assets at beginning of year</td>
<td>$167,091,697</td>
<td>$154,615,348</td>
</tr>
<tr>
<td>Increase/ (Decrease) in Net Assets</td>
<td>(6,179,263)</td>
<td>12,476,349</td>
</tr>
<tr>
<td><strong>Net Assets at end of year</strong></td>
<td><strong>$160,912,434</strong></td>
<td><strong>$167,091,697</strong></td>
</tr>
</tbody>
</table>

### ASSETS

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and Equivalent</td>
<td>$127,857,643</td>
<td>141,754,065</td>
</tr>
<tr>
<td>Receivables¹</td>
<td>26,201,070</td>
<td>22,588,291</td>
</tr>
<tr>
<td>Other Assets</td>
<td>14,588,518</td>
<td>12,448,239</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$168,647,231</strong></td>
<td><strong>176,790,595</strong></td>
</tr>
</tbody>
</table>

### LIABILITIES AND NET ASSETS

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants Payable</td>
<td>–</td>
<td>2,732,085</td>
</tr>
<tr>
<td>Other Payables</td>
<td>$2,908,267</td>
<td>2,695,160</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>4,826,530</td>
<td>4,271,653</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>7,734,797</strong></td>
<td><strong>9,698,898</strong></td>
</tr>
<tr>
<td>Unrestricted Net Assets</td>
<td>149,148,202</td>
<td>159,440,654</td>
</tr>
<tr>
<td>Temporarily Restricted¹</td>
<td>11,478,756</td>
<td>7,651,043</td>
</tr>
<tr>
<td>Permanently Restricted</td>
<td>285,476</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td><strong>$160,912,434</strong></td>
<td><strong>$167,091,697</strong></td>
</tr>
<tr>
<td>Total Liabilities and Net Assets</td>
<td><strong>$168,647,231</strong></td>
<td><strong>$176,790,595</strong></td>
</tr>
</tbody>
</table>

¹ Receivables for 2012 and 2011 include $18,718,556 and $16,831,591 respectively, in contributions received as of year-end but deposited in the following month of January.

Received receivables for 2011 and 2010 include $16,831,591 and $15,501,185 respectively, in contributions received as of year-end but deposited in the following month of January.

² For 2012 Temporarily Restricted Net Assets include the following:

- Pledges Receivable - for use in future periods - $5,368,994
- Annuity Trusts - $4,515,673
- Term Endowments - $1,586,251
- Emergency and specific medical relief fund - $7,838

² For 2011 Temporarily Restricted Net Assets include the following:

- Pledges Receivable - for use in future periods - $2,462,024
- Annuity Trusts - $3,666,036
- Term Endowments - $1,476,450
- Emergency and specific medical relief fund - $46,533

² For 2010 Temporarily Restricted Net Assets include the following:

- Pledges Receivable - for use in future periods - $3,093,536
- Annuity Trusts - $3,297,745
- Term Endowments - $469,394
- Emergency and specific medical relief fund - $6,333,071

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MSF-USA is recognized as tax-exempt under section 501 (c) (3) of the Internal Revenue Code. A copy of the most recent annual report filed by MSF-USA with the New York State Attorney General may be obtained, upon request, by contacting MSF-USA at 333 Seventh Avenue, 2nd Floor, New York, NY 10001-5004, or the Attorney General’s Charities Bureau at 120 Broadway, New York, NY 10271. A list of all of the MSF offices that received funds from MSF-USA is also upon request.
Before the opening of the MSF surgical hospital in Kunduz Province, northern Afghanistan, people in the region suffering from severe injuries had two options: they made the long and dangerous journey to Kabul or Pakistan, or they visited an expensive private clinic. As a result, few patients received the trauma care they needed.

Opened in August 2011, MSF’s surgical hospital in Afghanistan’s conflict-wracked Kunduz Province remains the only trauma center of its kind in northern Afghanistan. In 2012, some 10,000 patients were treated at the hospital, the majority of whom are victims of so-called “general trauma”—road traffic accidents, domestic violence, or civilian gunshot wounds.

The 55-bed surgical hospital, composed of container buildings and refurbished sections of a 50-year-old former hospital, is fully equipped with an emergency room, two operating theaters, an intensive care ward, and X-ray and laboratory facilities. In addition to general trauma, the ongoing violent conflict in Kunduz has resulted in large numbers of people with injuries sustained from bomb blasts, shrapnel, and gunshot wounds. Here, some 20 international and 300 Afghan staff provide specialized surgical care and follow-up treatment, including physical therapy, for all of these conditions. “The only label we use is ‘patient,’” said Dr. Dorian Job, MSF medical coordinator in Afghanistan. “Every injured person has the right to receive medical treatment, and we make no distinction between civilian and combatant.”
### OVERVIEW EXPENSES

<table>
<thead>
<tr>
<th>Category</th>
<th>EXPENSES, BUDGETED</th>
<th>EXPENSES, ACTUAL</th>
<th>PERCENTAGE OF BUDGET SPENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expatriate Staff</td>
<td>1,455,813</td>
<td>1,286,545</td>
<td>88%</td>
</tr>
<tr>
<td>National Staff</td>
<td>1,720,150</td>
<td>1,629,481</td>
<td>95%</td>
</tr>
<tr>
<td>Operational Running Costs</td>
<td>134,311</td>
<td>109,119</td>
<td>81%</td>
</tr>
<tr>
<td>Medical &amp; Nutrition</td>
<td>1,901,303</td>
<td>1,829,300</td>
<td>96%</td>
</tr>
<tr>
<td>Logistics &amp; Sanitation</td>
<td>751,406</td>
<td>770,708</td>
<td>103%</td>
</tr>
<tr>
<td>Transport, Freight &amp; Storage</td>
<td>538,414</td>
<td>287,098</td>
<td>53%</td>
</tr>
<tr>
<td>Consultants &amp; Field Support</td>
<td>11,783</td>
<td>16,693</td>
<td>142%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>0</td>
<td>490</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 6,513,180</strong></td>
<td><strong>$ 5,929,434</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>
Dr. Deane Marchbein joined MSF in 2006 to work as an anesthesiologist in MSF’s surgical program in Ivory Coast. She has worked with MSF in Democratic Republic of Congo, Haiti, Libya, Nigeria, and South Sudan, and as a medical doctor in Libya and Lebanon. She was formerly the business manager and chairperson of the anesthesia department at Lawrence General Hospital in Lawrence, Massachusetts, where she also served as the director of the intensive care unit. Dr. Marchbein now works for MA General Hospital and the Cambridge Health Alliance and serves on the board of directors of the Fanconi Anemia Research Fund.

Dr. Adi Nadimpalli, a pediatrician and internal medicine physician, is a clinical assistant professor of internal medicine at Tulane University and a physician at East Jefferson Hospital in Metairie, Louisiana. In 2005, during his first MSF assignment, he spent a year in Liberia as the sole physician in a remote field hospital. He has since provided emergency care to civilians in post-civil war Sri Lanka; managed a trauma hospital in Nigeria; served as field coordinator during an emergency cholera response, also in Nigeria; and, most recently, treated people with HIV/AIDS, including people co-infected with TB, at an MSF program in Malawi. Additionally, Adi worked with Friends in Global Health in an HIV program in Mozambique, with the Indian Health Service in Pine Ridge, South Dakota, and at the Common Ground Health Clinic in New Orleans. He has volunteered and provided medical care and community services at the India Medical Association Free Clinic, the Apna Ghar Domestic Violence Shelter, and a Los Angeles housing project, where he served as literacy director. Adi received his medical training at the University of Illinois at Chicago and completed his residency at Tulane University. He holds a BS in biochemistry and a BS in economics from the University of California at Los Angeles.

Bret Engelkemier is the founder of Hyperion Advisors, LLC, a firm specializing in strategic and tactical advisory services for capital market risk management and product development, business restructuring, fund raising, and acquisitions. Previously, Mr. Engelkemier was a managing director for Citigroup in the global equities business. He held trading, risk management, and management roles, including head of Japanese equity derivatives trading, co-head of the US equity derivatives business, head of equity trading for the Americas, and global head of systematic trading. During his career at Citigroup, Mr. Engelkemier was involved in a number of acquisitions and investments for the global equity business, oversaw the division’s investment portfolio in exchanges and associated market structure investment, and served as Citigroup’s representative on the board of the Boston Options Exchange and the Philadelphia Stock Exchange. Mr. Engelkemier also had a lead role in setting up and recruiting talent for the Brazilian office. Early in his career, Mr. Engelkemier lived in Tokyo, Japan, where he worked as a guest researcher at the Communications Research Laboratory and Salomon Brothers. He holds a BS from the University of Illinois at Urbana-Champaign and an MS from the University of Texas at Austin, both in aerospace engineering.

David Shevlin is an attorney at Simpson Thacher & Bartlett LLP, where he is senior counsel in the Exempt Organizations Group. He advises a variety of international and domestic exempt organizations, including both private foundations and public charities. Shevlin also advises a number of endowed universities, foundations, hospitals, and cultural institutions with respect to the investment of their endowments. He regularly speaks and writes on topics of relevance to private foundations and public charities.

Nabil Al-Tikriti, an expert on the modern Middle East, earned a BA in Arab studies from Georgetown University, an MA in international affairs from Columbia University, and a PhD in Ottoman history from the University of Chicago in 2004. He has also studied at Bogaziçi Üniversitesi in Istanbul, the Center for Arabic Studies Abroad in Cairo, and the American University in Cairo. He is the recipient of several grants and scholarships, including a Fulbright Award, a US Institute of Peace Fellowship, and a NEH/American Research Institute in Turkey grant. Currently associate professor of Middle East history at the University of Maryland, Washington, he has also served as a consultant, election monitor, and relief worker at a number of field locations in Europe, Asia, and Africa.

Dr. Marie-Pierre Allie joined MSF in 1990, working in South Africa, Cambodia, and Iran with the organization before joining the Paris office from 1996 through 2001 to oversee programs in Burundi, Democratic Republic of Congo, Sudan, Mali, Niger, Cambodia, Thailand, Vietnam, Papua New Guinea, and China. Dr. Allie went on to work as a public health physician in France and served on the board of MSF-France from 2004 to 2007, later rejoining the Paris office as deputy director and going on to become director of operations and then president of MSF-France.

Ramin Asgary, a specialist in management of complex humanitarian emergencies and refugee health, started with MSF in 1997 and has since worked in the former Soviet states, Sudan, Liberia, Haiti, Ethiopia, Madagascar, Argentina, and on the Kenya/Somalia border. He has founded and directed clinics for refugees and asylum seekers; worked extensively in health and human rights advocacy; developed training curricula in global health for medical students, residents, and public health students; and published dozens of manuscripts on global health. He completed his residency in internal medicine and social medicine at the Albert Einstein College of Medicine, a fellowship in preventive medicine and an MPH in community medicine at Mount Sinai/NYU, an MPH in refugee health at Columbia University, and a diploma in tropical medicine at Johns Hopkins University.

Dr. Navneet Bhullar attended medical college in Amritsar, India, and later trained in internal medicine at the University of Missouri hospital and clinics in Columbia, Missouri. She then served as medical director of a clinic in the medically underserved
area of Matoaka, West Virginia, for four years. Bhullar has been with MSF since 2006, having worked in Hmong refugee camps in Thailand and with Congolese refugees in Uganda. She coordinated a filariasis eradication campaign in West Papua, Indonesia, in 2008 and, most recently, spent six months in 2011 at MSF’s MDR-TB project in Nukus, Karakalpakstan, a semi-autonomous region of Uzbekistan. In September 2011, Bhullar completed an MSc in tropical medicine and international health at the London School of Hygiene and Tropical Medicine, combining her thesis work with her field work in MSF’s Nukus project. Bhullar has also volunteered with the Sierra Club and in children’s summer camps in Philadelphia.

Kelly Grimshaw joined MSF in 1999, establishing a TB program in Turkmenistan. She has since worked as a nurse practitioner and project coordinator in China, Sierra Leone, Indonesia, and Zambia, assisting those affected by civil and ethnic conflicts as well as the HIV pandemic. Kelly also provided assistance and program oversight as medical coordinator in Angola, Liberia, Ivory Coast, and Nigeria, with responses to cholera, Marburg hemorrhagic fever, meningitis, and measles outbreaks. In the US, she has volunteered her services to the MSF-USA Speaker’s Bureau throughout the country and MSF’s Refugee Camp in the Heart of the City exhibits. She currently works in nursing education.

Martha (Carey) Huckabee began working for MSF in Somalia in 1992 as a food logistician. For the next ten years she worked primarily in emergency contexts in Africa, particularly in South Sudan and West Africa. This field experience was complemented by work at the MSF operational center in Brussels. Martha returned to the US in 2002 and served as an MPH and an MA while also starting her first stint on the MSF-USA board of directors. Her most recent field experience was in 2009, when she went to Malawi with her family to serve as head of mission. Currently living in Kalamazoo, Michigan, she is the executive director for a local nonprofit and is also working on her PhD, which examines the experience of being a beneficiary of MSF, including the experience of being photographed for advocacy campaigns.

Suerie Moon is special advisor to the dean and an instructor at the Harvard School of Public Health, and an associate fellow in the sustainability science program at Harvard’s Kennedy School of Government. Previously, she worked for MSF’s Access Campaign and for MSF offices and missions in New York, Geneva, Paris, Goma (Democratic Republic of Congo), and Beijing. She has also been a policy consultant for MSF, Oxfam, UNICEF, and the World Health Organization. She received a BA in History from Yale University, an MPA from the Woodrow Wilson School of Public and International Affairs at Princeton University, and a PhD in public policy from Harvard’s Kennedy School of Government.

Dr. Matthew Spitzer, a family physician, joined MSF in 1999, establishing primary care services and training medical providers in Khampa Tibet, southwestern China. He worked in Sierra Leone as field coordinator, in a project tending to the medical needs of asylum seekers in detention in the US, and in Cambodia, coordinating MSF’s response to epidemic dengue. Elected to MSF-USA’s board of directors in 2006, Dr. Spitzer later chaired the program committee and, from 2008 to 2012, served as president. He also served as a member of the MSF-France conseil d’administration, on the association standing committee, and on the board of MSF’s International Council, and made field visits to Kenya, Uganda, Afghanistan, South Africa, and Colombia. In addition, Dr. Spitzer worked for 10 years in San Francisco at the St. Anthony Free Clinic and its affiliated drug rehabilitation program. He also worked providing primary care and acute trauma care in San Quentin State Prison and taught in the case-based curriculum of UC-Berkeley’s joint medical program. Now based in New York City, he is assistant professor of clinical medicine at Columbia University’s Center for Family and Community Medicine and a member of the interdisciplinary faculty seminar Narrative Health and Social Justice.

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