ACCOUNT

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 60 countries. On any one day, more than 27,000 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.
Vaccinating displaced Somalis against measles

SOMALIA

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AccountAbility

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us annual report 2011

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Dear Friends,

Every year, our annual report provides us with the opportunity to explain to our supporters how we've allocated your generous donations and to give you details about the lifesaving programs Doctors Without Borders/Médecins Sans Frontières (MSF) is running in clinics, hospitals, and feeding centers all across the globe. In short, it gives us the opportunity to be accountable to the people who make our work possible.

This year, we're taking it one step further and focusing on accountability—in practice and principle—throughout the publication. You'll see our usual overviews of the field projects supported by donors like you, along with breakdowns of where we directed our resources, how many patients were treated, in what context, and for what conditions. We also show that, for the seventeenth consecutive year, at least 85 percent of all money raised was spent on program activities (as opposed to fundraising or administrative costs). And, as in years past, we provide a financial case study of a single program, a very busy surgical hospital in Port Harcourt, Nigeria.

What's different this year is an essay that further delves into the question of what accountability means to MSF and describes the steps we take to ensure our accountability to patients, local authorities, donors, our own medical and humanitarian principles, and our association of past and current MSF staff, which plays an active role in both our governance and our decision-making processes.

The essay features excerpts from evaluations carried out and shared publically in recent years—on the response to the 2010 earthquake in Haiti, for instance, or the nutritional crisis in Somalia and the greater Horn of Africa last year. It also includes information about books MSF produced last year to stimulate reflection on the negotiations we conduct in order to open and operate projects in a given country, and on the ways our work is seen by people, patients, and communities in those countries.

All of these—the books, the project evaluations, this annual report—were designed as critical examinations of our work undertaken with the aim of improving the care we deliver to patients, finding ways to better prepare for future crises, and being transparent about the choices we make. They also allow us to promote best practices for others working in the same field. Last year,
for example, our Paris-based epidemiological branch, Epicentre, released the results of its evaluation of MSF’s nutritional programs in Niger, showing that supplementary feeding programs using nutrient-rich supplementary food had cut child mortality in half—a remarkable outcome that can be replicated by others working on this often chronic and far too frequently fatal condition.

Looking ahead, we anticipate staying involved in places such as Sudan, South Sudan, Somalia, Democratic Republic of Congo, and many others, as well as in the shifting, tumultuous events evolving across the Arab world. In these and other contexts, we strive to bring high-quality medical care to our patients and to implement lessons learned over the years of our existence, while also preparing for the unexpected. To that end, we have developed an ambitious four-year international plan that includes improvements in human resources, logistics, medical data, and diagnostics—all designed to improve patient care.

It is thanks to the generosity of millions of private donors around the world that MSF was able to respond quickly and effectively to multiple crises in 2011, and to do so independently and impartially, in accordance with our medical and humanitarian principles. We hope this report illustrates our gratitude and our commitment to accountability, while also doing justice to the hard work of our medical teams and the courage and resilience of our patients.

Sincerely yours,

Matthew Spitzer
President

Sophie Delaunay
Executive Director
What does accountability mean, in practice and principle, for MSF? It’s something that’s at the core of our conduct and identity, and something we’d like to discuss further in this year’s annual report.

It means that we continuously reflect on the impact of our humanitarian action, that we keep the people who support us informed, and that we are transparent and specific about the costs and benefits of our operations. That is why we published lengthy reports about our work in Haiti six months after the devastating January 2010 earthquake and again six months later, after the nation was further stricken by a cholera outbreak. That is why, at the end of 2011, we similarly documented our work in the Horn of Africa—in Somalia, Ethiopia, and Kenya—during the malnutrition crisis that contributed to the death of tens of thousands of Somalis and the displacement of hundreds of thousands more.
It means that we ground our decisions in our medical and humanitarian ethics, and that experienced MSF teams conduct independent assessments of the needs on the ground before we open a project. MSF exists to assist those who would otherwise have no access to medical care. And when it appears that MSF can provide medical services others cannot, we aspire to treat those who need it, regardless of ethnicity, religion, or affiliation, regardless of how they were hurt or what sympathies they might have. But we must answer certain questions when gauging the efficacy of our programs: First and foremost, is what we are doing medically relevant and medically effective—are we saving or improving lives? Additionally, because we are aware that aid can, at times, do more harm than good, we make sure that our presence, especially in conflict zones, is providing comfort to the tormented, not the tormentors.
INDEPENDENT, IMPARTIAL MEDICAL CARE

In an effort to uphold the principles of medical ethics, we fight for access to better treatments and diagnostics in the field, demanding—ceaselessly, if not always successfully—that patients have access to tools and medications available to wealthier nations. We aim to make the care we deliver of the highest possible standard. Our field workers are carefully selected and rigorously vetted, and they must already have relevant experience before they go on assignment. We do not use second-hand or donated medicines. We do not veer from medical goals towards development work. We directly manage all of our own programs as well, communicating directly with the local leadership and with people we seek to help, independently assessing needs, and determining how our aid will be allocated.

Accountability means we protect our independence and vigilantly monitor our own impartiality. If we turned patients away because of their affiliations, we would undermine our principles, our safety, and the humanitarian space we have tried to build, leaving dozens, hundreds, or thousands of people without care. Even in the worst situations, international humanitarian law dictates that there should be a medical space in which a person can access treatment without wondering if they might get arrested, attacked, or killed for doing so.

To preserve that humanitarian space for our action, we maintain open dialogues with all parties, while at the same time staying aware that parties involved in today’s conflicts—like the al-Shabaab, or the Taliban, or the US or British or Pakistani military—might politicize or instrumentalize our work to further their political goals.

Asserting and then demonstrating MSF’s impartial, medically-focused agenda is part of a process that helps us establish trust, and once trust is established, even well-armed fighters, we hope, begin to have faith in the doctors and nurses bumping down those long, dusty roads to reach people in crisis. Then, when our mobile clinics ask local commanders for authorization to access a village cut off by fighting or affected by a measles or cholera outbreak, that trust—and the knowledge that we’ll treat all victims—helps us gain access and protection from local communities. Deliberately working with one party to a conflict or serving some broader military-political agenda would compromise both that trust and our ability to deliver assistance. It would compromise our safety as well, because we do not carry guns, and in only one place in the world, Somalia, do we have armed guards. We must find other ways to protect ourselves and our patients.

“Accountability means we protect our independence and vigilantly monitor our own impartiality.”

WHAT WE CAN AND CANNOT DO

Accountability means that we are honest about what we can and cannot do, that we make decisions based on medical needs alone, and that we do not raise money for places or programs we cannot see through. That is why we told people who wanted to donate to our work in Japan following the March 2011 earthquake and tsunami that we had limited operations there because effective national health and disaster relief networks were already in place. A similar dynamic prevailed following the Indian Ocean tsunami of 2004, when we made...
HAITI The burn unit of Drouillard hospital
an unprecedented offer to return previously-accepted earmarked donations that we would not have been able to spend (many donors instead chose to derestrict their gifts). In the main, we believe that unrestricted pledges give us the ability to direct donor funds where the needs are greatest. On rare occasions—and once in recent memory, in Haiti following the earthquake—we’ve asked for money for specific contexts, but only when we knew the cost of our medical activities would exceed what was budgeted and that additional funds were necessary to meet unprecedented needs.

Accountability means that we reveal how much we allocate to programs, fundraising, and management and administration, and that for more than 15 years now, we have spent more than 85 percent on programs. In 2011, we spent upwards of 86 percent on programs, less than 13 percent on fundraising, and just over 1 percent on administrative costs, including salaries for MSF-USA office staff. Speaking of salaries: We have exceptional, dedicated individuals in the US office, but our compensation structure recognizes and reflects the fact that we aim to serve the world’s most vulnerable people. We provide excellent benefits, but executive pay is decidedly moderate—at the bottom quartile, in fact, for management positions at nonprofit organizations of comparable size.

It means that we discuss with you the reasons we’re in some places and not others, along with the calculations made along the way. This past year, MSF published Humanitarian Negotiations Revealed, a uniquely frank account of some crucial choices the organization made in the last decade, including the extensive conversations we entered into with the Afghan government, NATO forces, and the Taliban

“Accountability means that we are honest about what we can and cannot do, that we make decisions based on medical needs alone, and that we do not raise money for places or programs we cannot see through.”
to delineate our intentions and principles before we re-started operations in Afghanistan in 2009, or the highly restrictive conditions we accepted from the governments of Sri Lanka—during the brutal conclusion to the country’s civil war—and Myanmar, where mobility was severely proscribed but there has been room enough for us to treat more than 20,000 people with HIV/AIDS who would otherwise now be dead. Some decisions were and are hotly contested within MSF, but hindsight allows us to mine them for lessons to apply in the future.

Accountability means understanding there will be instances when the conditions imposed upon us make it impossible to work in an ethical, medically effective, or safe manner. We have in the past suspended or curtailed operations in North Korea, when aid was channeled through a public system that privileged regime allies rather than the most vulnerable groups, and in Goma, in the Democratic Republic of Congo (then Zaire), when militias that had carried out mass killings in Rwanda were using aid delivered to refugee camps to help them prepare for future attacks. In early 2012, we halted a program delivering assistance in prisons in the Libyan city of Misrata because we realized that prisoners we were treating were being tortured again after they received care. And in Somalia, we decided that we could not expand programs any further until our colleagues Blanca Thiebaut and Montserrat Serra, who were abducted in October 2011, were released. These are hard decisions that can mean forgoing care for a great many people, but doing otherwise would undermine our reasons for being there and the principles we hold most dear.

“IT MEANS THAT WE DISCUSS WITH YOU THE REASONS
WE'RE IN SOME PLACES AND NOT OTHERS, ALONG WITH THE CALCULATIONS MADE ALONG THE WAY.”

CONSTANT EXAMINATION
To be accountable is to be willing to review, analyze, and critique our operations constantly, at all levels. In Paris, there is an arm of MSF known by its French acronym, CRASH, that exists for just this purpose and is staffed by some of our most senior officers. In ways headquarters staff focused on day-to-day operations cannot, CRASH reflects on projects and analyzes MSF’s actions in light of past operations and our essential humanitarian principles. A similar unit based in our Geneva office recently finalized a three-year study of how people in the countries where we work see us. The resulting book, In the Eyes of Others, was published in early 2012 and, as with Humanitarian Negotiations Revealed, MSF offered the text for free on our website and organized a number of public forums, webcasts, and interviews to further examine the topic.

We also conduct regular program evaluations and share data and research we’ve collected that might—or should—inform protocols or policies through our Field Research website (fieldresearch.msf.org). Our epidemiological arm, Epicentre, often plays a key role in these efforts, and over the years, MSF has influenced the debate on (among other things) treating HIV in resource-limited countries, treating and preventing malnutrition in chronic settings, and carrying out mass vaccination campaigns during measles outbreaks. And we look not only at what’s happening in a given moment, but also at the factors and dynamics that contributed to the situation—why some groups cannot access care, for instance, why some tools or medications are hard to come by, or why specific agreements or players are preventing treatments and medicines from getting where they are needed most.
“To be accountable is to be willing to review, analyze, and critique our operations constantly, at all levels.”

A COLLECTIVE EFFORT

Overseeing and monitoring all of this is our Association, which is made up of current and former field workers. Its impact is felt across our operations, not least because Association members elect our Board of Directors, almost all of whom (aside from the Treasurer and the Secretary) are former field workers themselves. The Board, in turn, follows field projects closely, questioning the MSF-USA management.
team regularly, greenlighting project grants, and making sure work proceeds in line with the current four-year operational plan. The result is an organization directed by people who know whereof they speak when it comes to field operations and, now more than ever, an organization that looks after its volunteers when they return home. Last year, MSF-USA expanded its psychosocial unit, which gives the people we send out a chance to discuss their experiences with qualified, empathetic counselors or peers who know well the road they’ve traveled.

Lastly, accountability means that we try to infuse reports like this with the same commitment to openness and transparency, recognizing that not everyone can come to the field with MSF, but that we can try to bring the field back to them, doing our utmost to convey the nature and scope of our work, and the ways in which the resources donors so generously entrust us with are used.
In 2011, Doctors Without Borders/Médecins Sans Frontières (MSF) provided humanitarian assistance in 67 countries. MSF-USA supported work in 48 of these countries. Names are indicated solely for those countries and territories in which MSF ran projects in 2011.
Accountability -- US Annual Report 2011

Msf Activities

- Thailand
- Afghanistan
- Armenia
- Turkey
- Belarus
- Cambodia
- Philippines
- Papua New Guinea
- Kyrgyzstan
- Pakistan
- India
- Sri Lanka
- Yemen
- China
- Russia
- Japan
- Lebanon
- Syria
- Palestinian Territories
- Bangladesh
- Bahrain
- Iran
- Iraq

Geographic Focus:

- **Caucasus & Central Asia:** 5 countries (7%)
- **Middle East:** 8 countries (12%)
- **Asia:** 12 countries (18%)
* Entries marked with an asterisk were compiled by staff on the ground in direct contact with MSF patients and do not represent a full overview of relevant activities.

MSF in 2011: By the Numbers

8,407,596 Outpatient consultations

446,197 Patients admitted

1,422,839 Patients treated for Malaria

30,707 New admissions for first-line TB treatment

1,431 Patients treated for sleeping sickness

5,034,546 People vaccinated against measles during outbreak

191,960 Women who delivered babies, including Caesarean sections

188,977 Mental health consultations

821,812 Antenatal consultations

73,135 Major surgical procedures

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Entries marked with an asterisk were compiled by staff on the ground in direct contact with MSF patients and do not represent a full overview of relevant activities.
**Activity Highlights**

- **14,911** Victims of sexual violence treated
- **952,639** People vaccinated against meningitis during outbreak
- **201,639** Patients on first-line antiretroviral treatment*
- **67,956** Severely malnourished children admitted to inpatient or outpatient feeding programs
- **225,550** Relief kits distributed
- **228,750** HIV patients registered under care*
- **54,297** Medical and surgical interventions due to direct violence
- **2,496** People treated for Chagas disease
- **7,627** Patients treated for kala azar
- **130,832** People treated for cholera symptoms
- **96,058,426** Liters of water distributed

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*at end 2011
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 2011 International Activity Report, which is available at www.doctorswithoutborders.org/publications/ar.
AFRICA

“Slowly, slowly, after the surgery, he was improving every day. We carried him here. Now he can walk, he is beautiful.” —MOTHER OF A BOY TREATED BY MSF AT SOMALILANDS’S BURAO HOSPITAL

**BURKINA FASO**

In northern Burkina Faso, where a hostile climate and fluctuating prices limit the availability of food, MSF operates free nutrition programs for children under five. Teams in Loroum province treat malnutrition and provide basic health care at 11 outpatient programs and one hospital-based inpatient center. Activities in five health centers in Yako were handed over to UNICEF. MSF also cared for children with diarrhea, malaria, and respiratory infections, among other maladies, and offered routine vaccinations.

In Titao hospital and in outlying health centers, MSF worked with Ministry of Health (MoH) staff to treat 4,500 children for malaria, the main cause of sickness and death in Burkina Faso, especially among under-fives, bringing the total number of malaria patients treated since the program started in 2007 to 55,000. Heading into 2012 amidst concerns of an acute malnutrition crisis and increasing political unrest, MSF was looking into other program possibilities as well.

**CAMEROON**

In the city of Douala’s Nylon district hospital, MSF has introduced improved first-line HIV treatment using tenofovir (TDF), which has fewer side effects, for more than 1,500 patients. MSF also successfully lobbied the MoH and donors to change standard first-line protocols to TDF-based combinations. In addition, MSF switched 54 HIV patients who were not responding to first-line treatment to second-line treatment.

In the eastern town of Akonolinga, MSF treated 160 patients with Buruli ulcer, a disease related to leprosy that can cause extreme pain, deformities, and long-term disability. The disease is prevalent mainly among poor, rural communities where the complex treatment is unavailable.

MSF also helped the MoH tackle cholera epidemics in March, in Yaoundé—when MSF set up a 300-bed cholera treatment center (CTC) and treated some 1,350 patients—and in November, in Douala, where MSF opened a 130-bed CTC, treating more than 1,000.

**CENTRAL AFRICAN REPUBLIC (CAR)**

In CAR, where disease, conflict, and a failed health system created overlapping health emergencies, MSF supported nine hospitals and 36 health centers and advocating for more donor assistance.

In Mambéré-Kadéï prefecture, MSF offered pediatric services and integrated TB-HIV care in Carnot district—where surveys showed mortality rates three times the emergency threshold—registering almost 520 HIV patients and conducting 5,500 consultations.

In the Zemio border area, MSF carried out nearly 31,000 consultations for people fleeing fighting in DRC and provided HIV treatment as well. In the conflict-affected town of Paoua, in Ouham-Pendé, staff conducted 18,900 outpatient consultations, admitted more than 2,700, and supported seven health centers. At Batangafo, Boguila, and Kabo hospitals in Ouham prefecture, staff carried out some 16,700 consultations, admitted 940 inpatients, and assisted more than 180 monthly births. At Boguila, MSF worked in 14 health posts and ran “surgical camps” that offered otherwise unavailable services.

After screening almost 37,500 and treating 27 people for sleeping sickness, MSF showed prevalence rates in the Maitikoulou area fell from 5.9 percent to below 0.5 percent in three years. Teams also carried out more than 56,000 medical consultations and 35,000 antenatal consultations.

In Bamingui-Bangoran prefecture’s capital, Ndele, MSF held, on average, more than 5,100 consultations a month for displaced people and residents, while surgeons performed an average of 14 operations a month and teams ran mobile clinics and worked in five health centers. MSF also treated more than 212,000 people for malaria, the principal cause of death among children, had 998 HIV patients on ARV treatment at MSF clinics, and, in Batangafo, Kabo, and Ndele, provided care and diagnosis for tuberculosis (TB).

**CHAD**

Chad has the world’s highest under-five mortality rate. MSF focuses on maternal and pediatric services and responds to emergencies. In Am Timan, in the east, staff cared for more than 3,700 children in the pediatric ward, treated another 5,300 for malnutrition, held 7,300 antenatal consultations, and assisted 1,795 births in an MoH district hospital and seven health centers. MSF also treated more than 212,000 people for malaria, the principal cause of death among children, had 998 HIV patients on ARV treatment at MSF clinics, and, in Batangafo, Kabo, and Ndele, provided care and diagnosis for tuberculosis (TB).
for more than 12,700 patients suffering from cholera symptoms and treated 2,800 and vaccinated approximately 575,000 against measles in four regions. Another 3,000 children received nutritional care in Logonê Occidental.

MSF staff vaccinated more than 900,000 people in five regions for meningitis and treated or provided drugs for nearly 6,500 others. In Mandoul region, staff treated more than 2,100 people for malaria, distributed 17,000 mosquito nets, and trained workers to diagnose and treat simple cases in remote villages. Children with complications were sent to the nearest health center or MSF’s malaria ward at Moissala hospital.

War in Libya aggravated instability in the east. Road ambuses and kidnappings grew more frequent, but teams still assisted 1,850 Chadians fleeing violence and vaccinated 3,000 against measles.

**Democratic Republic of Congo (DRC)**

--- $17,620,000

Violence, disease, and limited access to health care plague DRC, which has one of the world’s highest infant mortality rates. In 2011, MSF vaccinated three million children and treated nearly 14,000 during a measles outbreak and treated more than 158,000 for malaria in five eastern provinces. Teams also responded to cholera outbreaks in several provinces and screened tens of thousands of people and treated around 1,500 for sleeping sickness.

MSF has more than 5,000 patients registered for HIV care in DRC, but woeful national ARV coverage means 350,000 of the nation’s estimated one million people with HIV do not get proper care—a number likely to grow if donors withdraw funding.

In North Kivu province, where 500,000 people displaced by conflict were registered, teams in Masisi, Mweso, Pinga, Birambizo, Rutshuru, Nyanzale, and in and around Goma and Butembo provided basic and specialist health care, carrying out more than 404,000 consultations. In South Kivu, where 630,000 were displaced, staff offered services in Kalonge, Lulingu, Hauts Plateaux, Shabunda, and Matili, along with mobile clinics for more remote communities. MSF also supported people in five camps on the South Kivu-Katanga border, and north of Kalemie, in Katanga, as well.

In Katanga and North Kivu, surgeons performed more than 110 fistula repair operations and, in addition to assisting sexual violence victims in established programs, teams responded to mass rape attacks in both North and South Kivu.

Security remained an issue. MSF cars were twice attacked by gunmen who wounded two staff members. And, in November, armed intruders shot and wounded a staff member inside MSF’s residence in Masisi, North Kivu, forcing MSF to suspend mobile activities.

**Djibouti**

--- $200,000

Malnutrition rates rose in 2011 in Djibouti and MSF admitted 60 percent more children to its inpatient therapeutic feeding center than in the prior year (1,029 in 2010, and 1,735 in 2011). Teams also treated more than 2,200 children for malnutrition in six health centers on the Djibouti City outskirts. Eighty-one who tested positive for TB were referred to the national TB program after finishing nutritional treatments.

In order to focus on emergency activities, however, MSF transferred its outpatient program to the MoH and other NGOs. The inpatient feeding program will be handed over in April 2012 as well, though the MoH began revising protocols based on MSF’s petition to both treat and prevent malnutrition with protein-based ready-to-use food containing nutrients vital to a child’s growth (instead of corn-soy blend fortified flour). MSF also supported government cholera responses in July, August, and October.

**Ethiopia**

--- $2,208,969

When war and a dire nutritional crisis drove some 120,000 Somali refugees into Ethiopia’s Liben zone in 2011, MSF set up a medical screening unit, provided basic health care and nutritional support in displacement camps, vaccinated more than 53,000 against measles, and helped enroll tens of thousands of children in nutrition programs.

Meanwhile, in Somali region, MSF provided inpatient and outpatient care, nutrition programs, reproductive health care, and malaria and TB treatment in Degehabur’s regional hospital, primarily serving people affected by the ongoing Ogaden conflict and conducting nearly 4,000 antenatal consultations, delivering 519 babies, and carrying out 270 surgical interventions.

In the town of Wardher, MSF carried out more than 67,000 consultations at health posts and mobile clinics and admitted more than 1,250 people to the regional referral hospital, where MSF provides maternal care and malaria and TB treatment.

MSF also conducted 3,000 monthly consultations in East and West Imey and supported 54 mobile feeding clinics in Oromia region, reaching 4,000-plus patients before handing over the programs when malnutrition decreased. Additionally, MSF started nutritional activities in the Sidama zone of the Southern Nations, Nationalities and People’s Region.

In the northern Amhara region, MSF treats patients with potentially fatal kala azar (visceral leishmaniasis) and co-infected with kala azar and HIV. MSF also treated more than 5,000 patients and vaccinated some 34,500 children for measles following an outbreak.

When fighting in South Sudan pushed tens of thousands of Nuer people into the Gambella region, MSF conducted over 35,000 consultations in Mattar’s health center and 17,000 more in mobile clinics, admitting around 1,200 to the hospital and delivering an average of 17 babies per month. And MSF also provided medical services when 25,000 refugees fled Sudan’s Blue Nile state for Ethiopia’s Benishangul-Gumuz region.

**Guinea**

--- $800,000

Guinea’s underfunded efforts to combat disease and improve maternal care have been hampered by inconsistency and drug
shortages, leaving many patients without care. At the end of 2011, MSF was providing ARVs to 7,440 people in Conakry, the capital, and Guéckédou, in the south, while also supporting HIV care—emphasizing pediatric HIV and prevention-of-mother-to-child-transmission (PMTCT) programs—in five health centers in Conakry’s Matam district.

At MSF’s mother-and-child program in Matam, teams working with national health authorities carried out more than 47,000 pediatric and maternal health consultations in three health centers and conducted outreach and education activities. MSF also treated more than 55,000 people for malaria, supported 16 public health facilities, and trained MoH medical staff, along with 45 community health workers, to diagnose and treat simple cases of malaria.

**IVORY COAST**

---$8,233,000

MSF rapidly expanded its work in Ivory Coast after an electoral dispute triggered factional fighting that killed some 1,000 people, displaced hundreds of thousands, and crippled the health care system. Many medical facilities, for instance, were destroyed in the western Moyen-Cavally and Dixo-Huit Montagnes regions, where MSF offered emergency assistance, conducting close to 100,000 consultations and assisting more than 1,480 births. Teams also carried out more than 77,000 consultations in Guiglo department, opened programs in Bioléquin and Tai in September and December, and carried out more than 33,000 consultations in and around the towns of Man, Zouan-Hounien, and Toulépleu. In March alone, a surgical team in Bangolo performed 147 operations, most for gunshot wounds. Staff carried out some 80,000 consultations in Tabou in Daloa.

In February, MSF opened Abobo Sud hospital on the urban front lines in Abidjan, performing more than 2,200 operations in five months, admitting some 3,890 emergency patients, and assisting more than 4,100 births. When conditions allowed, MSF expanded to eight city health centers and two other hospitals. Staff at Koumassi hospital helped conduct more than 19,800 consultations in April and May and set up cholera treatment units when an outbreak hit.

In Treichville, MSF donated drugs and supplies to the hospital, opened a trauma center, and offered obstetric and gynecological services. At Port-Bouët hospital, MSF renovated operating theaters and carried out more than 4,000 emergency consultations and 1,300 surgical procedures, while assisting 1,250 births and working with Handicap International on post-surgical rehabilitation. At six other health centers, MSF carried out more than 17,700 consultations.

In Yopougon, MSF held some 22,270 consultations at Attié general hospital in April and admitted 950 patients for surgery. A team also ran a mobile clinic in a church sheltering more than 1,000 people. When the violence subsided later in the year, MSF began handing over activities.

**LESOTHO**

---$500,000

In May, MSF opened a program designed to help reduce maternal and infant deaths in Lesotho, where life expectancy for women is less than 47 years and nearly 60 percent of maternal deaths are HIV-related.

MSF supports St. Joseph’s district hospital in Roma, six health care clinics in the surrounding lowlands, and three clinics in Semonkong. All facilities provide integrated HIV and TB care, due to high levels of co-infection, along with PMTCT care.

Overall, MSF enrolled more than 8,000 people in HIV care and 5,300 were started on ARVs. MSF also used a new automated TB test at St. Joseph’s hospital, speeding up diagnosis significantly. Additionally, MSF will buy an ambulance to run between Semonkong and St. Joseph’s and is assessing ways to help improve patient-staff communications. Meanwhile, efforts to shift HIV-care tasks from doctors to nurses continue, as do efforts to train community and village health workers to assist people with HIV treatment.
Liberia

When 150,000 Ivorians sought shelter in Liberia, MSF launched an emergency program for refugees in western Liberia’s Nimba County and mobile clinics and in a health post at the Bahn refugee camp. Staff conducted more than 45,800 consultations—more than 2,700 antenatal, and some 14,500 for malaria—vaccinated children for measles, and provided drugs and support.

In March, MSF conducted more than 38,300 consultations, admitted 226 children to a nutrition program, and carried out more than 1,900 mental health sessions in villages hosting refugees in Grand Gedeh. Safe drinking water was also provided. By the end of the year, the situation had stabilized sufficiently for MSF to hand over the activities.

In Monrovia, MSF works with MoH staff to offer comprehensive care and a 24-hour walk-in service in two hospitals to victims of sexual violence. In 2011, 993 new patients received care, 92 percent of whom were under 18 years old, and 1,115 follow-up consultations were arranged.

Madagascar

Madagascar’s troubled health system took another blow in 2011 when the health budget was cut by 50 percent amid a financial and funding crisis. MSF offered general medical, maternal, and pediatric services in the 20-bed hospital in the town of Bekily, in Androy district, admitting around 150 patients and assisting around 25 births each month, while transferring obstetric and surgical emergencies to Ejeda or Isonala hospital. Staff started testing for TB as well, and teams renovated clinics, donated supplies, and carried out training and consultations in three health centers and mobile clinics in the surrounding area.

Work was temporarily suspended in December following disagreements between MSF and MoH staff over management of patient care, but activities soon resumed. MSF also communicates with the National Office for Disaster and Risk Management in case a natural disaster should strike.

Malawi

In Malawi’s Chiradzulu district, where over 17 percent of people aged 15 to 49 have HIV—the national rate hovers over 10 percent—MSF has been providing ARV treatment and follow-up for a decade. Despite early skepticism, more than 55 percent of patients who started treatment then are still alive, and a total of 22,000 are now on ARV treatment in Chiradzulu, including 2,700 children. To extend the reach and efficacy of care, MSF is shifting some tasks from doctors to nurses in ten health centers across Chiradzulu and having 3,500 stable patients visit medical staff every six months.

In Thyolo district, where MSF began offering ARVs in 2003 and uses the same models, more than 24,420 patients were receiving care. MSF has also started handing over responsibility for HIV services to the improved national treatment program. Furthermore, by year’s end, more than 1,650 pregnant women in Chiradzulu and 1,500 in Thyolo had enrolled in MSF’s PMTCT program, which has shown to lower rates of transmission from mother to child from 40 percent to just 3 percent. MSF also assisted nearly 3,400 births.

Recent studies have shown that male circumcision reduces the risk of HIV transmission, so MSF offers circumcision to adult
patients in Chiradzulu. And because more than 80 percent of TB patients registering for treatment in Chiradzulu have HIV, TB and HIV care have been integrated, allowing patients to get all the treatment they need in one place.

MALI

Progress has been made in reducing child mortality in Mali, but 178 of every thousand children still die before reaching five, at least half due to malnutrition and malaria, which remained MSF’s focus.

Malaria treatment is urgently needed in Kangaba province, where MSF supported 11 health centers, delivering free health care to 6,500 people, about half of whom were children under five. Teams also trained “malaria experts” to screen and treat people living far from health centers. In five years, the area’s mortality rate among children under five has dropped 50 percent, and in April, MSF handed the project over to a Malian association partnered with the French nongovernmental organization ALIMA.

In Koutiala, MSF worked in five health centers and the pediatric ward of the district hospital, treating 53,000 children in 2011—30,000 for malaria—admitting more than 6,600 children, and caring for 4,800 in the therapeutic feeding center.

In Konseguela, MSF works with community health workers to offer comprehensive child health services that include supplementary feeding, routine vaccinations, malaria testing and treatment, and mosquito nets. MSF carried out 20,000 pediatric consultations in the district, and in 2012, MSF plans to start offering antimalarial drugs to all under-fives as a preventive measure during the annual malaria season. Teams also increased activities in neighboring countries for Malians fleeing political instability and violence between several armed actors.

MOZAMBIQUE

MSF provides HIV care in ten facilities across Mozambique’s capital, Maputo, where once paltry coverage has now been expanded to 80 percent of the patients who need it. MSF employed task-shifting strategies to expand the number of people who can provide, and benefit from, basic HIV testing and care. Services have also been decentralized to local clinics, making both HIV and TB treatment more widely available. Overall, MSF teams provided treatment and care to 28,320 HIV patients, including more than 1,600 children, supported a referral center for patients needing special attention, and assisted in caring for patients with complicated conditions.

Overall, some two-thirds of all Mozambicans needing ARV treatment do not get it. However, community ARV groups piloted by MSF in 2008, in which patients take turns visiting health centers and picking up each other’s drugs, have been so successful that the national authorities have adopted the concept and, with MSF’s support, aim to roll it out in 2012. MSF, meanwhile, is taking the concept to Tete province and Maputo, particularly urban slums where HIV prevalence is high.

NIGER

Although harvests were good in 2010, acute malnutrition rates among children stayed near the 10 percent alert threshold, and MSF continued its emergency nutrition programs into 2011, even as insecurity limited mobility for aid organizations. Working with local partners, and endeavoring to decentralize nutrition services, MSF treated a total of 104,000 acutely malnourished children. Overall, the MoH led an effort that treated some 300,000 children and enrolled more than 650,000 in supplementary feeding programs.

In the Maradi region, programs run by MSF and FORSANI, a national medical organization, provided outpatient treatment for severe malnutrition in five health centers, admitted 900 severely malnourished children to Madarounfa hospital, offered supplementary rations of milk-based food to prevent severe malnutrition, and treated 750 children for malaria in Dan Issa.

Teams also vaccinated 14,000 children in the area during a measles outbreak. Similarly, MSF provided maternity and pediatric care, managed an emergency ambulance referral system, and ran nutrition programs at five health centers in Dakoro Department, while providing supplies, drugs, and water and sanitation support in the pediatric ward and an intensive therapeutic feeding center in Guidan Roumdji Department. In all, teams conducted 76,500 consultations in Maradi, including more than 44,000 for malaria.

In neighboring Zinder region, MSF, with community health workers, ran nutrition programs in 18 community health centers and vaccinated 26,700 during a measles outbreak. Staff also worked in Magaria, Dan Tchao, and Dungass, treating a total of about 13,000 children for malaria, 11,000 for diarrhea, and 9,000 for respiratory infections. And in Tahoua, MSF treated more than 43,000 people for malaria and ran nutrition programs in the Madoua and Bouza districts. MSF also provided pediatric and reproductive care for migrants passing through the Agadez region and helped respond to a cholera outbreak in the capital, Niamey, over the summer.

NIGERIA

Insecurity, disease, and a weak health system precludes access to medical care for many Nigerians. Religious tension simmered and the armed group Boko Haram carried out several deadly attacks in the north, threatening to further restrict the mobility of aid groups.

As it happened, MSF conducted some 70,300 consultations with children under five in Sokoto state in 2011, and more than 28,700 antenatal consultations. At Jigawa state’s Jahun hospital, surgeons performed 390 fistula repair surgeries, and other staff responded to obstetric emergencies and assisted more than 5,800 births. MSF also carried out nutritional surveillance and treated more than 16,000 children for severe malnutrition in Kazaure and worked in two health centers in volatile Jos North during the presidential elections.

Since 2010, MSF has treated more than 2,500 children for lead poisoning, contracted due to chemicals used in small-scale gold mining—and first diagnosed by MSF—in Zamfara. At MSF’s emergency trauma facility in Port Harcourt, in Rivers state, which
provides free emergency surgery and health care, staff carried out more than 12,000 emergency consultations, mostly for injuries linked to violence or traffic accidents, and assisted more than 750 victims of sexual violence.

MSF's emergency response team in Nigeria helped treat more than 7,900 patients for measles and 4,800 for cholera during separate outbreaks in the northwest, and helped treat 277 for malaria after deadly outbreaks in two villages. Staff also treated 15,700 people for measles in Bauchi and Katsina and assisted MoH vaccination campaigns against measles in the south and polio in Plateau and Kaduna states.

In Lagos, a city of 18 million, MSF opened the Aiyetoro health center for people in the Makoko slum, a floating health clinic in the Riverine neighborhood of Makoko, and a health post in Badia, providing the area's only free medical services and tending to more than 18,100 patients, administering more than 18,000 vaccinations, and assisting some 1,200 births.

**REPUBLIC OF CONGO** --- $2,500,000

To ensure refugees fleeing violence in DRC received care, MSF supported the 89-bed Bétou district hospital, where roughly half the 400 monthly admissions were women requiring maternity care and one-third were children. Staff assisted more than 2,600 births, treated 80 people for TB, started 60 people with HIV on ARVs, and conducted more than 2,600 monthly outpatient consultations, mostly with children and mainly for respiratory infections and malaria.

MSF supported health centers in Ipenkbele and in Boyele and two mobile clinics along the Ubangi River. Staff offered antenatal care and treated people for severe malnutrition, carrying out nearly 9,000 consultations per month and transferring people in need of specialized care by boat to Bétou.

MSF also worked in Adolphe Cissé hospital's intensive care unit in Pointe-Noir, treating and providing physiotherapy to 140 patients after a polio outbreak in the southwest, withdrawing after the caseload declined and handing physiotherapy over to Handicap International.

**SOMALIA** --- $8,942,437

MSF treated more than 864,000 patients in Somalia, nearly double the 2010 amount, as drought, war, a collapsed health system, and restricted access to aid worsened an already dire humanitarian crisis.

In the Spring and Summer, hundreds of thousands of weakened, malnourished Somalis fled to Mogadishu, or to Kenya or Ethiopia, in search of help, only to find crowded, unsanitary living conditions and little relief. MSF rapidly scaled up in the capital, sending in international staff for the first time since 2009 and offering basic health care, surgery, nutritional support, cholera and measles treatment, vaccinations, and maternal care in 12 new health facilities. From May to December, MSF vaccinated 235,000 children against measles. MSF also set up five cholera treatment sites during a November outbreak.

Staff in North Galkayo, in Mudug region, offered pediatric and maternity services, while teams treated TB in Galkayo and in Jowhar, Middle Shabelle. MSF also treated patients wounded in fighting in North and South Galkayo, while admitting more than 3,500 people—44 percent with war-related injuries—to the Daynil emergency room, outside Mogadishu. In the Afgooye corridor, where nearly 500,000 people sought refuge, MSF conducted more than 27,000 consultations and treated more than 3,300 malnourished children. And after the Kenyan military invaded, teams in Marere treated dozens of civilians after an aerial bombardment killed five and wounded 45, including 31 children, from a displacement camp in Jilib.

Securing access for personnel or programs in al-Shabaab-controlled areas was immensely challenging; in many, unfettered movement was nearly impossible, though MSF did manage to run nutrition activities for children in Kismayo. MSF also used telemedicine to bring specialized care to more than 500 people in high-risk areas.

Nonetheless, MSF's compound in Wadajir, west of Mogadishu, was attacked with grenades twice in March, forcing a temporary suspension of activities. In October, two of our colleagues, Blanca Thiebaut and Montserrat Serra, were abducted from the Dadaab refugee camps in Kenya, where thousands of Somalis had fled, and are still being held inside Somalia while MSF continues to do everything it can to bring them home. And in December, colleagues Philippe Havet and Dr. Andrias Karel Kelluwe were shot dead in Mogadishu, forcing MSF to close two programs that had served 200,000 displaced people and local residents.

In the self-declared republic of Somaliland, MSF supported the Burao general hospital in the Togdheer region and the district hospital in Ceerigabo, and handed over programs in Hargeisa.

Staff carried out 4,000 consultations, assisted more than 2,700 births, and performed 671 surgical procedures.

**SOUTH AFRICA** --- $501,000

Staff at MSF's 10-year-old HIV program in Khayelitsha, which has put more than 20,000 patients on ARVs since it opened, are focused on decentralizing treatment and running "adherence clubs"—where club members get screening, drugs, and support at bi-monthly meetings—in 16 facilities. Overall, teams tested some 50,000 people for HIV in 2011, started more than 450 on ARV treatment each month, and signed up more than 5,000 patients to adherence clubs.

The incidence of TB in South Africa has risen by around 400 percent in the past 15 years. Employing an automated test in its KwaZulu-Natal program that provides faster results, MSF saw diagnoses of TB increase from 13 to 40 patients per month in 2011. Mobile teams also offered testing for TB and HIV in the province.

In Musina, at the Zimbabwean border, MSF provided basic health care, treatment for HIV and TB, and assistance for victims of sexual violence to new arrivals and migrant workers. And in some of Johannesburg's most deprived areas, MSF screened, transferred, or referred some 11,100 people.
**SOUTH SUDAN**

In South Sudan, which became a nation in July 2011 and is plagued by violence, disease, and mass displacements, MSF provided services in eight states and the Abyei border area.

In Jonglei State, site of increasingly deadly intercommunal fighting, MSF carried out around 12,500 consultations in Pibor and more than 11,800 in the villages of Lekwongole, and treated approximately 2,500 patients for malaria, 1,000 children with severe malnutrition, and 500 people with violence-related injuries, including 108 after a December attack during which attackers also killed an MSF watchman and his wife and ransacked MSF’s hospital and clinic.

To the north, MSF’s clinic in Lankien and outreach sites in Pieri and Yuai treated nearly 75,000 patients for anything ranging from respiratory tract infections to malaria to spear wounds. After an August raid on Pieri and surrounding villages, MSF treated over 100 people for injuries—the majority women and children. One MSF staff member and her entire household were killed.

MSF’s hospital in Agok treated some 2,300 patients after fighting in the contested Abyei area. MSF also distributed medical supplies and relief items to displaced people and, in December, supplementary food to 10,200 children.

In November, MSF opened a field hospital in Doro and provided care at the El Fuj border crossing for thousands of refugees fleeing Sudan’s Blue Nile state, while also vaccinating for measles and distributing supplies and water. MSF also provided services for 20,000 refugees who came to Unity state from South Kordofan in Sudan.

In Aweil, in Northern Bahr El Ghazal, MSF enrolled 1,200 children in nutrition programs, assisted in 3,400 births, and admitted almost 3,800 children to the hospital’s pediatric ward.

In Western Bahr El Ghazal, teams performed 12,000-plus pediatric consultations and admitted 1,600 children to Raja civil hospital.

And in Western Equatoria, MSF provided maternal, pediatric, nutrition, and malaria care to some 24,000 patients.

--- $6,803,000

**SUDAN**

In Sudan, MSF provides medical assistance in conflict zones and remote regions, and treats kala azar. Bureaucratic constraints, however, hampered provision of care in some areas, including Blue Nile and South Kordofan.

In 2011, MSF worked with the MoH to screen 3,090 people and treat 729 for kala azar in Al Gedaref state’s Tabarak Allah hospital, using a regimen that reduced treatment duration from 30 to 17 days. Staff also supported free treatment for nearly 20,000 patients with other conditions and vaccinated 44,800 children and treated 620 for measles.

Fighting continues to restrict access to care in Darfur, where MSF maintained five programs despite insecurity and bureaucracy that limited international staff to short “flash visits.” In South Darfur, MSF treated 469 children for malnourishment and set up a program in Shaeria, though the needs were clearly much greater.

In North Darfur, MSF conducted more than 150,000 consultations at a hospital in Shangil Tobaya, ran a mobile clinic in neighboring villages, and offered comprehensive services for the local community and displaced people in Tawila.

In Abushok and Al Salam camps, MSF’s therapeutic feeding programs, treated more than 1,239 children for malnutrition. The project was transferred to the MoH. In Dar Zagawa, near the Chad border, the team supports five health centers and responds to emergencies.

Teams providing specialist care and surgery in Kaguro, and in five rural clinics conducted more than 39,000 consultations and performed 119 major surgeries. And MSF supported the MoH’s response to flooding in Red Sea State, distributing relief kits to 200 households and nutritious food to approximately 1,500 children at risk of malnutrition.

--- $1,700,000
In Uganda, MSF operates HIV and TB programs and assists people affected by years of conflict in the north. In the northern Kitgum and Lamwo districts and the Karamoja subregion, MSF supports hospitals and health centers where staff conducted nearly 17,000 outpatient consultations and 3,365 antenatal consultations and admitted 506 people. As conflict waned and health conditions improved in Kitgum and Lamwo, MSF supported 18 centers providing care for victims of sexual violence.

In Karamoja, where fighting persists, MSF treated patients for wounds and assisted with yellow fever, Ebola, and hepatitis E outbreaks. Some 500 patients started TB treatment as well.

MSF continued to provide treatment and run a PMTCT program at Arua regional hospital in the northwest. Nearly 2,000 new patients were registered, more than 6,400 received ARV treatment, and an average of 25 women gave birth each month.

MSF also cared for 780 patients, many of whom came from DRC for treatment, at an HIV clinic in Oli that will be handed over to the MoH—which will implement MSF’s PMTCT treatment protocol—in 2012. Additionally, MSF provided integrated HIV and TB care to more than 700 patients and treated some 550 children for malnutrition in both Oli and Arua.

On the research front, MSF and the London School of Hygiene and Tropical Medicine surveyed TB and DR-TB patients’ acceptance of home-based care, and in Karamoja, MSF researched how children’s recovery from malaria, diarrhea, or respiratory infections affects their nutrient intake. MSF also studied rapid diagnostic testing methods for HIV.

In Swaziland, almost 26 percent of adults aged 15 to 49 and four in ten pregnant women have HIV. Some 80 percent of TB patients are co-infected with HIV as well, but Swaziland’s effort to expand treatment struggled to generate funds for drugs and supplies.

In Shiselweni, MSF runs 22 rural clinics that offer integrated HIV and TB care and that have used community workers to more than triple the number of people getting tested for HIV.

In Mankayane, MSF assisted MoH staff in improving diagnosis and treatment of 664 HIV-TB co-infected patients and treated 60 drug-resistant TB (DR-TB) patients. In September, MSF built a new DR-TB ward in Nhlangano; MSF also rehabilitated and re-equipped 11 rural clinics in 2011.

Swaziland is very short on medical human resources, so MSF uses task-shifting in its programs to enable more people to receive care, while counselors are taught how to test people for HIV. In 2011, the MoH began developing a national framework for task-shifting, which should significantly increase coverage across the country.

According to UNAIDS, up to 80 percent of Zambians who need ARV treatment receive it. However, with prevention still an issue, MSF focused on PMTCT activities in the northern Luwingu district, working with the MoH to test and counsel nearly 4,800 women in 2011.
The stigma around HIV is still strong, so MSF regularly travels to villages to increase understanding of HIV testing and treatment. MSF also supports maternal health in seven rural centers in Luwingu, where staff offered testing, assisted an average of 110 births, and held some 700 monthly antenatal consultations.

Additionally, MSF trained MoH staff and donated supplies and vaccines, worked with authorities to vaccinate some 558,800 children for measles in Luapula and Northern provinces in May, and ran a cholera prevention program in Lusaka during the rainy season.

**ZIMBABWE**

--- $3,000,000

Only 63 percent of Zimbabweans in need of ARV medication receive treatment. MSF tests for, diagnoses, and treats HIV and TB in public facilities, offers antenatal care and PMTCT, and supports ARV treatment for about 48,430 people. Likely limits on funding from the Global Fund to Fight AIDS, TB, and Malaria undermined plans to improve national HIV care, however.

**AMERICAS**

“When the psychologist listens to me, I cry out of relief. I feel that there are people who will listen and help me.” — CATHERINE, 25, HONDURAS

**COLOMBIA**

--- $4,600,000

In the southern departments of Caquetá, Nariño, Putumayo, and Cauca, MSF clinics provided pediatric and reproductive health care, vaccinations, and referrals in areas affected by a resurgent conflict that has displaced an estimated three million people, conducting more than 54,200 consultations in 53 locations. Some 1,600 people also received mental health care at MSF programs in hospitals in Cauca and Caquetá, and MSF mobile clinics conducted 9,000 general and 780 mental health consultations in Turbaco and Tierra Alta, in Bolívar.

Staff carried out more than 3,900 consultations at MSF’s clinic in Riosucio, offering mental and reproductive health care and assistance for victims of sexual violence. At a clinic in Buenaventura, MSF conducted more than 33,200 consultations and provided emergency assistance, care for victims of sexual violence, ante- and postnatal care, family planning, TB treatment, and treatment for acute malnutrition. MSF also offers counseling and testing services for HIV and PMTCT services.

Teams in Norte de Santander and in the Tame municipality of Arauca provided screening and treatment for Chagas disease, reaching more than 2,000 children under 18 years old. Relatively few patients tested positive, though, so the program was closed. Lastly, MSF provided medical and psychological assistance and water and sanitation services to 4,800 people in 19 emergency interventions, including distributions to 4,430 people after flooding hit Cauca.

**GUATEMALA**

--- $600,000

Between January and November 2011, nearly 4,000 cases of sexual violence were recorded in Guatemala, although the real number is likely far higher. MSF works with the MOH to provide 24-hour emergency care in the general hospital’s emergency department and in clinics in neighborhoods where violence is common. In 2011, staff tended to nearly 780 new patients, carried out more than 1,270 medical consultations, and held some 1,500 follow-up psychological consultations with patients suffering post-traumatic stress and other issues tied to their experiences.

As part of its care, MSF offers medication that reduces the likelihood of contracting HIV or other sexually transmitted infections (STIs) if taken within 72 hours of an assault. Teams also work to raise awareness and to demonstrate that sexual violence is a medical emergency that requires medical attention after an attack.

Additionally, MSF distributed blankets, mattresses, and washing kits to 1,000 families in Escuintla department after a mid-October tropical depression caused flooding.
HAITI

With nearly half a million Haitians still homeless from the January 2010 earthquake and the health system still unable to offer care to those who can’t pay for it, MSF shifted focus from emergency response to more routine specialized services in hospitals.

In March, MSF opened an 80-bed referral center for obstetric emergencies in the Delmas 33 neighborhood—replacing a maternity center destroyed in the earthquake—offering free 24-hour care to pregnant women experiencing complications, postnatal and neonatal care, family planning, mental health care, and PMTCT programs, and assisting in more than 4,000 births.

In Cité Soleil, staff worked in two operating theaters, the emergency department, and the pediatric and maternity wards of Choscal hospital, while also providing care to victims of sexual violence. MSF’s 40-bed stabilization center in Martissant continued to offer maternity care, internal medicine, and mental health services. In Sarthe, MSF tends to wounds, performs orthopedic and reconstructive surgery, and, with Handicap International, offers physiotherapy and rehabilitative services.

In May, MSF replaced its inflatable hospital with a 200-bed hospital in Drouillard, offering a wide range of services, including a burn unit; staff admitted some 29,000 patients, and surgeons performed around 20 operations daily. MSF also ran a 160-bed hospital in Léogâne, west of Port-au-Prince, focusing on trauma and obstetric emergencies and basic health care for women and infants.

At Bicentenaire hospital and two mobile clinics, staff provided emergency, pediatric, surgical, and mental health care to 4,000 patients per month before closing the hospital in July. MSF also withdrew from the MoH’s Saint Michel hospital in Jacmel when needs abated. Meanwhile, MSF treated 170,000 patients for cholera symptoms in 50 facilities nationwide from October 2010 through the end of 2011. Case numbers ebbed early in 2011 but rose again in May, and MSF reopened eight emergency centers in Port-au-Prince. The disease was not yet under control at year’s end, due largely to a lack of safe drinking water.

HONDURAS

Drug trafficking, gang fighting, and the proliferation of guns have made violence commonplace in Honduras. A 2010 MSF survey found nearly 59 percent of children under 18 living on the streets of Tegucigalpa had experienced physical violence within the past year, while 45 percent reported being victims of sexual violence.

MSF teams provide on-the-spot health care, refer people to MoH facilities for advanced treatment, and support four health centers in some of the city’s most violent areas. MSF teams conducted 1,860 consultations in 2011; nurses and psychologists provided training for MoH staff. MSF has also aided development of national protocols for the treatment of victims of sexual violence.

Over the years, generous support from donors has allowed MSF-USA to provide grants for lifesaving field projects around the globe.
In 2011, after major floods in the central and southern parts of China, MSF supplied relief items to 3,860 families in Xincheng county and Gaosui in Guangxi province, Wangmo county in Guizhou, and Baiyi in Sichuan province.

As China’s health care system undergoes significant changes, market incentives and decreased government funding have affected both the cost and quality of care. People flock to cities to find work but have difficulty accessing health services due to a complex registration system and discrimination. Guangzhou, Guangdong’s provincial capital, has also drawn hundreds of thousands of immigrants from across Africa. Many migrant women shut out from social services and other opportunities become sex workers to earn money, and the lack of health care combined with the rapidly growing sex trade has led to a huge increase in STIs. In 2012, MSF plans to offer basic health care in Guangdong, focusing particularly on STIs.

In India, where millions have no access to quality health care, MSF provides free health services in Bihar and Chhattisgarh states, the disputed region of Kashmir, the Nagaland region, and Mumbai.

In Chhattisgarh, where government forces are battling Maoist Naxalite insurgents, MSF runs mobile clinics in 16 locations that provided 68,000 consultations—including antenatal care, nutritional support, malaria and TB treatment, and hospital referrals—to rural communities and displaced people in camps in neighboring Andhra Pradesh. In the town of Bijapur, MSF carried out nearly 20,000 consultations in its mother and child center and treated 5,000 and vaccinated 11,000 for malaria. Staff also screened for TB, performed emergency obstetric surgery, and supported a health center in Konta.

In Kashmir, where decades of instability took a clear toll on health, MSF delivers ante- and postnatal care, vaccinations, and TB screening services at clinics near the Line of Control. Staff psychologists and counselors also saw almost 4,000 patients for mental health counseling.

In the isolated, conflict-affected Nagaland region, MSF rehabilitated the Mon district hospital, improved waste management capacities and basic health care services, and trained hospital staff. The team held more than 30,000 outpatient consultations and admitted 3,044 people. In neighboring Manipur, MSF offers reproductive health services, vaccinations, and an HIV program that provides first-line ARVs and second-line care for drug-resistant patients. Staff also carried out approximately 30,000 consultations with TB and MDR-TB patients and introduced an innovative home-based model of care.
In Mumbai, MSF’s HIV treatment center provides medical and psychosocial care to people excluded from public health services, treats MDR-TB patients, conducts outreach, and carries out operational research on HIV care. And in Bihar, MSF treated more than 1,900 people for kala azar in five local health centers in Vaishali district and more than 2,900 children for malnutrition in a 20-bed inpatient feeding center in Darbhanga district.

**JAPAN**

--- $100,000

The tsunami and earthquake that struck northeastern Japan in March 2011 killed approximately 15,000 people, injured another 6,000, and displaced hundreds of thousands. Because Japanese emergency teams were largely able to respond to the needs of survivors, MSF offered specialist assistance. The day after the quake and tsunami, MSF staff made their way to affected areas and began providing medical care and distributing relief items.

MSF worked principally in the northern coastal towns of Minami Sanriku and Taro, where health care facilities had been totally destroyed, conducting nearly 5,000 consultations, donating two buses, and constructing a temporary shelter for displaced people. Teams also offered psychological support for survivors, particularly in evacuation centers. This was MSF’s first time providing medical assistance in Japan.

**PAKISTAN**

--- $3,720,000

When people displaced by 2010 floods began returning home in 2011, MSF scaled down provision of medical care and water in some areas, but teams in Johi and Karachi in Sindh Province, and in Dera Murad Jamali, in Balochistan, continued running nutrition and relief programs. Staff ran mobile clinics, distributed water, and conducted around 21,000 consultations in displacement camps outside Karachi and distributed around 2,000 temporary shelters in Johi and Jamshoro districts. After rainfall flooded Sindh again in August, MSF ran mobile clinics for displaced families in Badin, Tharparkar, and Moro districts. And during monsoon season, MSF treated 9,774 patients with acute watery diarrhea in temporary clinics in Khyber Pakhtunkhwa (KP) province and in Kurram Agency in the Federally Administered Tribal Areas (FATA).

MSF also continued emergency assistance and mass-casualty preparation activities in northern KP and FATA. Staff in Dargai and Timurgara treated thousands of patients in emergency departments and operating theaters, including more than 18,800 in Timurgara’s resuscitation room. Surgeons also performed more than 2,000 operations. In Hangu, near the Afghan border, teams in Tehsil headquarter hospital saw 1,500 patients per month.

In Kurram, MSF supported local hospitals, provided pediatric care, managed mass-casualty incidents, and ran an ambulance service. After 18 months boosting capacity in Swat district’s town of Mingora, MSF handed activities over to the MoH. Teams continued, however, providing emergency care in Chaman’s district hospital, on the Afghanistan border, treating nearly 9,300 people.

In areas with few maternal care resources, MSF staff delivered more than 7,000 babies in Dargai and Timurgara, opened a 30-bed women’s hospital in Peshawar, and supported local ante- and postnatal care clinics. Additionally, teams in Dera Mura Jamali and Chaman district hospitals delivered comprehensive obstetric care, and MSF offered free neonatal and pediatric care in a newly-opened...
“People from MSF were the first ones to come to us and explain about the disease, about the treatment, about everything.”
— Armenian woman whose nephew and three other relatives are being treated for TB

**ARMENIA** ---> $500,000

MSF worked with Armenian authorities to improve detection, diagnosis and treatment of DR-TB, focusing on patients the national program doesn’t reach, including people with social or psychological difficulties that undermine adherence to a grueling regimen that can last two years.

MSF expanded its program for children with DR-TB, helped improve medical laboratories, and allocated more staff to patient care and counseling in order to make up for personnel shortages on the national level. Staff also expanded their work with the national program in the northern areas of Kotayk, Ararat, and Lori. By year’s end, MSF was treating 290 patients for DR-TB in Armenia.

Staff closely monitors patients both when they are in the hospital and at home. To help them cope with the severe side effects from the drugs and to encourage adherence, counselors conduct individual or group sessions and make home visits, providing food if needed.

**RUSSIAN FEDERATION** ---> $1,200,000

MSF is working to fill gaps in the health system in Chechnya and Ingushetia caused by years of conflict in the north Caucasus region of the Russian Federation. The fighting also contributed to a resurgence of TB. MSF improved access to treatment and facilities in Chechnya, decentralizing treatment and offering patients direct care at home. From January to December, approximately 500 patients were admitted to the TB program. MSF closed its program in the Dagestan city of Khasavyurt, instead focusing on the mountainous areas of Chechnya and Ingushetia that were severely impacted by violence and government counterinsurgency measures. Teams held approximately 8,000 individual and 1,700 group counseling sessions in Chechnya and almost 5,100 individual and 1,020 group sessions in Ingushetia.

In Grozny, Chechnya’s capital, MSF offered outpatient gynecological and pediatric care. Staff also ran mobile clinics in

50-bed pediatric hospital in Quetta, Balochistan’s capital. And in Kulchak, MSF runs a mother-and-child clinic with a birthing unit for Afghan migrants and refugees, nomads, and residents.

**SRI LANKA** ---> $950,000

MSF continued to support people affected by Sri Lanka’s civil war, which ended in 2009, focusing on specialist medical care and mental health services in the north. In Vavuniya, a team performed reconstructive orthopedic surgery on 150 people with complicated war-related injuries before the program was closed in December. Ninety patients with spinal injuries received treatment, physiotherapy, and mental health care at MSF’s rehabilitation program before MSF handed over that program as well.

At hospitals in Point Pedro and Mullaitivu, MSF staff helped

provide emergency care, surgery, and gynecological and obstetric services. Surgeons performed 1,720 major operations and 1,600 minor procedures. More than 6,900 received emergency consultations, and some 5,300 women received antenatal care.

The team in Point Pedro withdrew at the end of the year, while the team in Mullaitivu continued operating five mobile clinics that carried out more than 11,500 consultations and expanded psychological support services at eight sites. Most patients were women displaced by the war. Another 433 people received counselling in Kilinochchi.

**OTHER ASIA PROGRAMS** ---> $1,500

MSF USA also contributed small amounts to MSF programs in Afghanistan, Thailand, and Bangladesh.

**GEORGIA** ---> $1,000,000

In 2011, MSF teams in Georgia worked with TB patients and with a growing caseload of patients with kala azar. It’s not clear why kala azar incidence is rising in Georgia, but deforestation and large-scale migration to cities have been suggested. MSF launched a kala azar program in Tbilisi, the capital, in collaboration with the Parasitological Hospital, admitting more than 130 people, most of them children.

MSF also introduced rapid testing and treatment with liposomal amphotericin B, which reduces the regimen from 30 days to 10.

Meanwhile, TB-linked mortality rates have declined in Georgia, but the number of deaths remains high, and there is great concern about drug-resistant forms of the disease. MSF handed over its main TB programs to local authorities, but the organization is treating DR-TB patients in the autonomous republic of Abkhazia. Overall, 208 patients have started TB treatment, for which MSF also offers counseling.
Doctors Without Borders
MeDecins sans frontieres (Msf)

Shelkovskoy, Naursky, and Shatoy districts. An average of 1,500 women visited clinics each month, 60 percent of whom were diagnosed and treated for STIs, and teams held 1,620 monthly pediatric consultations as well.

What’s more, MSF renovated the cardiac emergency program in Grozny’s Republican Emergency Hospital. The clinical laboratory was functional by mid-2011, and staff admitted more than 800 patients through the end of the year. MSF also performed 17 successful coronary thrombolysis procedures as part of the first cardiac emergency intervention in the organization’s history.

**MIDDLE EAST**

“We managed to dock at Misrata on Sunday afternoon, despite intense fighting in the city over the past few days. The violence caused an influx of wounded people and it was fortunate we could be there and get them onboard.”

–HELMY MEKAoui, MSF DOCTOR, ON THE EVACUATION BY BOAT OF WOUNDED FROM MISRATA, LIBYA

**IRAQ**

$900,000

In Al-Zahra district hospital, Najaf governorate’s main referral center for obstetric, gynecological, and pediatric care, MSF works with hospital staff to build capacity in specialized services such as intensive care, maternal and antenatal care, sterilization, and infection control. An MSF team also renovated an operating theater at Basra hospital and trained staff on emergency patient intake, mass casualty preparation, and post-operative and neonatal care. The program was then handed over to the MoH. Another team offered surgery and obstetric care in Hawijah hospital, where MSF surgeons carried out 212 operations.

In Kirkuk general hospital, MSF treated non-communicable diseases and improved kidney dialysis capacity; 88 patients were receiving dialysis at the end of 2011, three times the prior year’s count. MSF staff also conducted more than 10,700 mental health counseling sessions with some 3,800 patients in hospitals in Baghdad and Fallujah.

Additionally, MSF continued its reconstructive surgery program for wounded Iraqis in Amman, Jordan. The program has expanded to admit patients from other Middle East locales including Gaza, Yemen, Libya, and Syria. In 2011, MSF specialists performed a total of 913 operations and provided psychosocial support and physiotherapy.

**PALESTINIAN TERRITORIES**

$2,400,000

In 2011, the number of attacks, shootings, detentions, demolitions, and violent incidents in the Palestinian Territories increased alarmingly. In the West Bank, more than 700 civilians were displaced by force and factional conflicts also caused injury and trauma.

Against this backdrop, MSF teams provide medical care, short-term psychotherapy, and social assistance and referral in the West Bank districts of Hebron, Qalqilya, Nablus, and Tubas. Staff carried out more than 1,600 medical consultations and more than 4,000 mental health consultations. Staff also held 223 mental health consultations in East Jerusalem’s Shu’fat refugee camp and Silwan neighbourhood.

**YEemen**

$6,960,300

In 2011, MSF filled gaps in medical supplies and offered ad hoc support when protests in the capital led to numerous injuries. Fighting between opposing Islamic groups and government forces in Abyan governorate also escalated, damaging health facilities and prohibiting access to some places.

In Jaar, MSF provided medical and emergency assistance and set up stabilization and ambulance referral systems, caring for some 2,000 people in all and referring 200 to a private hospital in Aden. In Ad-Dali hospital, MSF supported the emergency department, carrying out some 4,400 consultations and referring 120 patients to Aden.

In Radfan district hospital. MSF admitted more than 9,500 patients for emergency care and surgeons performed over 1,160 operations. Civil conflict and changing policies in Saada forced MSF to suspend activities in Al Talh and Razeh hospitals and five area health centers. Nevertheless, in Al Talh MSF held 48,000 outpatient consultations, performed 459 surgical interventions, and admitted 1,900 inpatients.

In Amran governorate’s Khameer and Huth hospitals, MSF mobile clinics carried out 40,000-plus consultations, treated some 1,250 children for severe malnutrition, and assisted 500 births. Surgeons performed around 325 operations, and teams cared for more than 800 inpatients as well.
In the camps around Al Mazraq, MSF treated children for malnutrition, assisted victims of sexual violence, and provided mental health care. MSF also offers care at the only hospital in Al Mazraq. Overall, staff carried out more than 30,000 consultations, treated more than 4,200 patients for emergencies, and provided sexual and reproductive health care to 3,900 people.

**INTERNATIONAL CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES**

Drawing on MSF’s field experience, the Access Campaign advocates for greater access to affordable, effective medicines and diagnostics. In 2011, its work involved building on research showing that treating HIV prevents new cases, combatting moves by pharmaceutical companies and clauses in trade agreements that would limit generic drug production, and pushing donor nations and bodies to uphold funding pledges to crucial global programs on HIV, TB, and malaria.

**DRUGS FOR NEGLECTED DISEASES INITIATIVE (DNDI)**

DNDi is a research and development initiative that brings together activists, foundations, academics, medical professionals and others from around the world to identify and fill treatment needs to fight neglected tropical diseases in developing countries. In just eight years, DNDi has introduced innovative and impactful new treatments for drug-resistant malaria, sleeping sickness, visceral leishmaniasis, and Chagas disease.

**EPICENTRE**

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. It provides crucial, documented evidence that helps MSF shape or adapt programs and communications.

**INNOVATION FUND**

This international fund was created to promote innovation by rewarding methods that improve the way MSF meets health care needs—the use of adapted diagnostic tools for malnutrition in West Africa, for example.

**INTERNATIONAL OFFICE**

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.

**LOGISTIQUE EXPANSION**

MSF is expanding the warehouse at its logistical hub in Bordeaux, France, doubling its size and building new offices to further augment and improve MSF’s logistical capabilities, particularly for emergency responses.
“In 2011, MSF-USA sent 347 expats from 45 states in the US on 431 assignments in 51 countries. In the years ahead, as many projects grow more complex, and as we work to further improve the high-quality medical services we provide, we must ensure that we attract, develop, and retain exceptional medical and management personnel. To this end, we are looking to recruit individuals willing to make multiple-year commitments, to improve our understanding of the development requirements of medical professionals, to further develop our management policies and training programs, and to take additional steps to nurture the psychological well-being of staff during and after assignments. Several of these initiatives are underway at MSF-USA—where a psychosocial care unit has been set up and field-based management training courses are run regularly—and at the international level, where longer-term contracts are being developed. The goal is a working environment that allows people with the necessary technical skills and humanitarian ethic to work with MSF over the period of time they can offer, while augmenting our projects with more purposefully cultivated medical and management teams—all in order to deliver the best possible care to patients.”

Nick Lawson, MSF-USA Field Human Resources Director
Interested in Joining MSF?

MSF is always looking for motivated and skilled medical and non-medical professionals for our field projects around the world. For information on requirements, visit: www.doctorswithoutborders.org. MSF-USA also needs volunteers and interns to work in our New York office. For more information please visit our website.
HAITI
Helene Baribeau, CA, Logistician-Water and Sanitation
Kenna Bifani, OR, Registered Nurse
Justine Crowley, CO, Surgeon
Brett Davis, PA, Deputy Head of Mission
Terufat Deneke, VA, Deputy Logistics Coordinator
Richard Gosselin, CA, Surgeon
Laurel (Ansley) Howe, MD, Registered Nurse
Clark Jones, HI, Registered Nurse
Stephanie Lefebvre, IN, Logisitician-Water and Sanitation
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Susie Ross, CA, Registered Nurse
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Maya Sibley, CA, Project Coordinator
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David Sokoloff, NJ, Logisitician
Gayle Thompson, CO, Logistician-Supply
Brent Turner, NM, Logisitician
Deborah Wilson, MA, Registered Nurse
Emily Wolfe, CA, Logisitician

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Ana Montoya, NY, Obstetrician/Gynecologist

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Theater Registered Nurse
Julia Chang, CO, Registered Nurse
Rachida Davis, PA, Humanitarian Affairs Officer
Mamadou Diallo, IN, Physician
Louise Fang, WA, Operation Theater Registered Nurse
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Pramita Kuruvilla, CA, Physician
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Hannah Megacz, NY, Registered Nurse
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LIBERIA
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Athena Viscusi, DC, Mental Health Officer
Ibrahim Younis, CA, Project Coordinator

LIBYA
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Sergio Borrego, FL, Anesthesiologist
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Arison Ergin, NJ, Surgeon
Maureen Foley, WA, Registered Nurse
Virginia Gil Coss, Dominican Republic,
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Catherine Mullaly, MA, Anesthesiologist
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Phyllis Sinclair, PA,
  Operation Theater Registered Nurse
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Hope Wall, OR, Medical Team Leader

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Luba Nisenbaum, NJ,
  Financial/Human Resources Coordinator
Pamela Wilcox, IL,
  Financial/Human Resources Coordinator

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Paula Hayes, DC, Physician
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Habtamu Mehari Zenebe, FL, Logistics Coordinator

NIGER
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NIGERIA
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  Operation Theater Registered Nurse
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Emily Clifton, GA,
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Andrea Green, CA, Anesthesiologist
Nihat Gurkan, OK, Surgeon
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Douglas Vanderbilt, TN, Surgeon
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Ana Montoya, NY, Obstetrician/Gynecologist
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Teresa Scott, TX, Mental Health Officer

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Anita Repp, CT, Registered Nurse
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Jenni Rousseau, MI, Registered Nurse
Amitha Sampath, NY, Physician

SOMALIA
Pavlo Koloivos, CO, Logistics Administrator

SRI LANKA
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Lorraine Bello, MA, Obstetrician/Gynecologist
Kudzai Dombo, NJ, Obstetrician/Gynecologist
Richard Gosselin, CA, Surgeon
John David Hayes, NC, Obstetrician/Gynecologist
Patrick Heffron, NE, Obstetrician/Gynecologist
Daniel Mansfield, IA, Surgeon
Victoria Mohr, CO, Obstetrician/Gynecologist
Kimberlea Roe, TX, Obstetrician/Gynecologist
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  Operation Theater Registered Nurse
Jeffrey Toussaint, CT, Field Administrator
William Walsh, IL, Surgeon
Wendy Watson, WI, Anesthesiologist

SUDAN
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Maya Sibley, CA, Deputy Project Coordinator

Adam Walters, NC, Logistician-Water and Sanitation
Wendy Watson, WI, Anesthesiologist
Jane Williams, CA, Surgeon
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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Zacarias Asuncion, HI, Surgeon
Jacqueline Bowles, CA, Physician
Gardy Boyer, NY, Logistician-Construction
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Patricia Campbell, NY, Physician
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Amy Caramore, NY, Registered Nurse
Carissa Cousins, FL, Physician
Brian Crather, NH, Surgeon
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Ana Maria Guzman, MD, Physician
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Mary Kemen, IA, Anesthesiologist
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Erie McCracken, NY, Logistics Administrator
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Ronald Napier, CA, Registered Nurse
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Aerlyn Pfeil, OR, Midwife
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Margaret Quan, WA, Logistics Administrator
Leslie Ramirez, TX, Midwife
Liza Ramlow, MA, Midwife
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Dianne Reynolds, MA, Midwife
Robert Rieger, NY, Financial/Human Resources Coordinator
Stephen Rubin, OR, Surgeon
Paul Schreiber, WA, Surgeon
Aditya Sharma, DE, Physician
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Suzette Shipp, GA, Capital Human Resources Officer
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Africa Stewart, GA, Obstetrician/Gynecologist
Jennifer Tierney, NY, Project Coordinator
Steven Virant, FL, Physician
Alexander Wade, NJ, Logisticiant-Supply
Wendy Watson, WI, Anesthesiologist
Elizabeth Wentzel, IA, Medical Team Leader
Sun Yun, PA, Pharmacist

**SWAZILAND**
Jonathon Gass, MA, Epidemiologist
Charlotte Probst, FL, Laboratory Technician

**THAILAND**
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**TUNISIA**
Mayra Rodriguez, CA, Logistics Administrator

**UGANDA**
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Catherine Carr, NM, Financial/Human Resources Coordinator
Ella Gray, MD, Registered Nurse
Sheena Hsu, CA, Pharmacist
Ruth Kaufman, NM, Midwife
Kathleen Rice, FL, Registered Nurse

**Ukraine**
Karen Poster-Verrill, MI, Laboratory Technician

**UNITED STATES**
Amy Segal, CA, Legal Administrator

**UZBEKISTAN**
Jennifer Assmann, SC, Registered Nurse
Navneet Bhullar, PA, Physician
Olga Epstein, GA, Physician
Ann Kane, MO, Financial/Human Resources Coordinator
Karen Stewart, CO, Mental Health Officer
Courtney White, PA, Mental Health Officer

**Yemen**
Fekeremariam Balcha, TX, Financial/Human Resources Coordinator
Andre Heller, CO, Head of Mission
Gaurav Kumar Saxena, FL, Logisticiant-Construction
Roshan Kumaraman, CA, Project Coordinator
Allison Mulcahy, MA, Physician
Pablo Torres, NJ, Logisticiant

**Zambia**
Michael Couturie, CA, Medical Team Leader
Ella Gray, MD, Registered Nurse
Emmett Kearney, IL, Logisticiant-Water and Sanitation
Liza Ramlow, MA, Midwife

**Zimbabwe**
Matthew Grimaldi, MI, Logisticiant
Yousef Turshani, CA, Physician
DONORS IN 2011

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.

HAITI Inside a cholera treatment center in Port-au-Prince
MSF ACKNOWLEDGES OUR DONORS WHO HAVE MADE MULTIYEAR COMMITMENTS

Multyear 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 2011, MSF had received 131 multyear commitments toward this effort, totaling $24,746,095.

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<td>Deane Marchbein, MD</td>
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A boy receiving care at Masisi hospital, with MSF staff in the background

South Sudan
An MSF nurse tests a young boy for malnutrition

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Libya: Staff in Misrata loading a patient onto a boat ahead of evacuation.
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Ms. Wanda B. Staszewski
Mr. & Mrs. Abram B. Stavitsky
Ms. Vesta B. Stearn
Charles & Julie Steedman
Ms. Shirley R. Stein
Ms. Donna S. Steiner
Ms. Julie N. Stelton
Mr. Arthur Stern

Mr. & Mrs. Morton Stern
Joyce Stickney
Carole Boone Stolba
Ms. Carolyn Stoloff
Dr. & Mrs. Harvey W. Stone
Mr. Raymond W. Storck
Mr. Ralph Strader & Ms. Mary Cook
Marianne Strassman
Mary B. Strauss
Mr. & Mrs. Roger Sturgeon
Ms. Kathleen Sundaram
Mr. Gerald Sunko
Rev. Thomas J. Sutherland
Ms. Erna M. Szekeres
Mr. Joan Talbert
Mrs. Vivian Talbot
Ellyn & Jimmy Tanner

Barbara S. & J. Dix Wayman
Ms. Dorothy Weber
Mr. Martin P. Weber
Ms. Molly Weeks
Ms. Monique Weil
Mr. & Mrs. Ronald Weiss
Mr. Gary T. Welsh
Mr. Jonathan T. Welsh &
Ms. Diane Ward
Lucille Werlinich
Kyle Marie Wesendorf
Mrs. Martha West
Mr. & Mrs. Kent Weymouth
Joyce White
Mrs. Karin White
Ms. Shelda White
Mr. & Mrs. Warren Michael White
Dr. Ron D. Whittaker
Dora Wiebenson
W.D. Wilkinson III
Mr. & Mrs. Emerson Willard
Faith M. Wilcox
Paul Wilcox
Ms. Kenda Willey
Mr. Bill Williams
Ms. Jane Williams
Robert J. Williams
Ms. Jean M. Wilson
Mr. Morton D. Winsberg &
Ms. Melanie Simmons
Ms. Kathryn Winter
Mrs. Jess Witt
Dennis M. Wolbers
Mr. Larry J. Wolfson
Ms. Rosalind Wood
Ms. Phyllis B. Woodworth
John & Andree Woosley
Henry & Karen Work
Mr. Walter K. Wornick
Mr. Arthur Wortman
Mr. Allan Wunsch
Ms. Julia Xeros
Ms. Sue Yocum
Ms. Susan A. Yohe
Mr. Ali Yousefi
Mr. Richard Zimler &
Mr. Alexandre Quintanilha
Mrs. Michelle Zimmerman
Lin Zucconi, PhD
Wendy Zukas

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By providing for MSF in their estate planning, Legacy Society members help ensure our ability to respond to the challenges we will face in the future. Each year, many of our loyal supporters join our Legacy Society by naming MSF in a will or trust or as a beneficiary of a retirement plan, or by setting up a charitable gift annuity or charitable trust. As a member of our Legacy Society, you will receive updates about our work around the world and be listed in our Annual Report. For information about MSF’s planned giving program, please call our planned giving officer at 212-655-3771.
In 2011, MSF-USA spent more than $137 million for emergency and medical programs around the world and almost $8 million for program support, advocacy, and communications. For the 17th consecutive year, over 85 percent of expenditures were allocated to program activities.

MSF-USA continued to fund major operations in the Democratic Republic of Congo (almost $18 million), Haiti ($16 million), and Nigeria (over $10 million) throughout the year, and increased its contribution to MSF's programs in and around Somalia when the country's already dire humanitarian crisis worsened amidst drought and conflict.

MSF-USA relies on private funding for its work because it helps preserve our independence and impartiality, allowing us to respond first and foremost to the needs as they exist on the ground. MSF thanks all those who helped make this work possible.

Below is a breakdown of revenues and expenses for 2011.

**STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS**

The following summary was extracted from MSF-USA’s audited financial statements.

### REVENUES

<table>
<thead>
<tr>
<th>Public Support</th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions and private grants</td>
<td>$179,370,765</td>
<td>$263,084,779</td>
</tr>
<tr>
<td>Contributions – pledged</td>
<td>1,420,033</td>
<td>1,363,620</td>
</tr>
<tr>
<td><strong>Total Public Support</strong></td>
<td><strong>180,794,798</strong></td>
<td><strong>264,448,399</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Revenue</th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Income</td>
<td>209,443</td>
<td>320,444</td>
</tr>
<tr>
<td>Unrealized and Realized Gain (Loss) on Investments</td>
<td>(579,533)</td>
<td>21,694</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>68,749</td>
<td>89,060</td>
</tr>
<tr>
<td>Grants from Affiliates</td>
<td>10,108,688</td>
<td>9,015,312</td>
</tr>
<tr>
<td><strong>Total Other Revenue</strong></td>
<td><strong>9,807,341</strong></td>
<td><strong>9,446,510</strong></td>
</tr>
<tr>
<td><strong>Total Revenues excluding gifts in kind</strong></td>
<td><strong>190,602,139</strong></td>
<td><strong>273,894,909</strong></td>
</tr>
</tbody>
</table>

### EXPENSES

<table>
<thead>
<tr>
<th>Program Services</th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and medical programs</td>
<td>137,098,926</td>
<td>165,903,069</td>
</tr>
<tr>
<td>Program Support and development</td>
<td>4,692,594</td>
<td>11,598,854</td>
</tr>
<tr>
<td>Communications</td>
<td>3,247,441</td>
<td>3,249,346</td>
</tr>
<tr>
<td><strong>Total Program Services</strong></td>
<td><strong>145,038,961</strong></td>
<td><strong>180,751,269</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supporting Services</th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management and General</td>
<td>2,244,434</td>
<td>1,972,638</td>
</tr>
<tr>
<td>Fundraising</td>
<td>22,636,178</td>
<td>19,759,636</td>
</tr>
<tr>
<td><strong>Total Supporting Services</strong></td>
<td><strong>24,880,612</strong></td>
<td><strong>21,732,274</strong></td>
</tr>
<tr>
<td><strong>Total Expenses excluding gifts in kind</strong></td>
<td><strong>169,919,573</strong></td>
<td><strong>202,483,543</strong></td>
</tr>
</tbody>
</table>
**NET ASSETS**

<table>
<thead>
<tr>
<th></th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Assets at beginning of year</td>
<td>154,615,348</td>
<td>83,203,982</td>
</tr>
<tr>
<td>Increase/ (Decrease) in Net Assets</td>
<td>12,476,349</td>
<td>71,411,366</td>
</tr>
<tr>
<td><strong>Net Assets at end of year</strong></td>
<td><strong>$ 167,091,697</strong></td>
<td><strong>$ 154,615,348</strong></td>
</tr>
</tbody>
</table>

**Gifts In Kind (expensed in 2010 & 2009)**

<table>
<thead>
<tr>
<th></th>
<th>Management</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Gifts in Kind Expensed</td>
<td>$ 2,413,778</td>
<td>$ 1,226,021</td>
</tr>
</tbody>
</table>

1 In-kind Management gifts expensed in 2010 & 2009 include the estimated fair market value of donated legal services.

**STATEMENT OF FINANCIAL POSITION 2010**

**ASSETS**

<table>
<thead>
<tr>
<th></th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and equivalent</td>
<td>$141,754,065</td>
<td>$156,841,734</td>
</tr>
<tr>
<td>Receivables¹</td>
<td>22,588,291</td>
<td>21,556,643</td>
</tr>
<tr>
<td>Other assets</td>
<td>12,448,239</td>
<td>9,828,942</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$176,790,595</strong></td>
<td><strong>$188,227,319</strong></td>
</tr>
</tbody>
</table>

**LIABILITIES AND NET ASSETS**

<table>
<thead>
<tr>
<th></th>
<th>TOTAL 2011</th>
<th>TOTAL 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants payable</td>
<td>2,732,085</td>
<td>27,496,518</td>
</tr>
<tr>
<td>Other payables</td>
<td>2,695,160</td>
<td>2,577,665</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>4,271,653</td>
<td>3,537,788</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>$9,698,898</strong></td>
<td><strong>$33,611,971</strong></td>
</tr>
<tr>
<td>Unrestricted net assets</td>
<td>159,440,654</td>
<td>141,421,602</td>
</tr>
<tr>
<td>Temporarily restricted²</td>
<td>7,651,043</td>
<td>13,193,746</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td><strong>$167,091,697</strong></td>
<td><strong>$154,615,348</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities and Net Assets</strong></td>
<td>$176,790,595</td>
<td>$188,227,319</td>
</tr>
</tbody>
</table>

1 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.

Receivables for 2010 and 2009 include $15,501,185 and $13,646,637 respectively, in contributions received as of year-end but deposited in the following month of January.

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 funds - $46,533

For 2010 Temporarily Restricted Net Assets include the following: Pledges Receivable - for use in future periods - $3,093,536

Annuity Trusts - $3,767,139

Emergency and specific medical relief funds - $6,133,071

For 2009 Temporarily Restricted Net Assets include the following: Pledges Receivable - for use in future periods - $3,915,105

Annuity Trusts - $3,407,048

Emergency and specific medical relief funds - $111,096

**2011 EXPENSES EXCLUDING IN-KIND EXPENSES**

- **12.71% Fundraising**
- **1.26% Administration**
- **86.03% Programs**

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 available upon request.
HOW YOUR SUPPORT SAVES LIVES
Poverty and insecurity remain problematic in the Niger Delta, resulting in violence and poor access to health care for the most vulnerable. In Port Harcourt, capital of Rivers State in southern Nigeria, MSF runs an emergency trauma facility that helps to bolster local hospital capacity.

With 75 beds, Teme hospital provides free emergency surgery and medical care. MSF surgeons in Port Harcourt (and several other projects) have pioneered the use of internal fixation to repair fractured bones. This approach, first used by MSF in 2005, uses implanted hardware to allow patients to regain mobility much more quickly than the older traction system, which can require months of hospitalization. Because of the threat of infection, internal fixation requires extremely stringent sterilization and hygiene standards—standards that MSF has implemented in trauma hospitals like the one in Port Harcourt, as well as in war zones and the aftermath of natural disasters.

In 2011, MSF staff held more than 12,000 emergency consultations in Port Harcourt, up from 10,850 in 2010. Three-quarters of these consultations were related to violence or road traffic accidents. MSF surgeons carried out an average of 340 operations a month. Teme hospital also assisted more than 750 victims of sexual violence with medical care and counseling, compared to 645 in 2010.

The trauma facility in Port Harcourt cost $4,248,153.79 in 2011. The table below provides a breakdown of how funds were allocated in the project.

### 2011 EXPENSES EXCLUDING IN-KIND EXPENSES

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport / Freight / Storage</td>
<td>7.22%</td>
</tr>
<tr>
<td>Consultants And Field Support</td>
<td>0.08%</td>
</tr>
<tr>
<td>Medical And Nutrition</td>
<td>30.80%</td>
</tr>
<tr>
<td>Operation Running Costs</td>
<td>1.30%</td>
</tr>
<tr>
<td>Training And Local Support</td>
<td>0.10%</td>
</tr>
<tr>
<td>Expatriates Staff</td>
<td>15.30%</td>
</tr>
<tr>
<td>Logistic And Sanitation</td>
<td>7.90%</td>
</tr>
<tr>
<td>National Staff</td>
<td>37.30%</td>
</tr>
</tbody>
</table>

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**NIGERIA** A doctor at MSF’s program in Port Harcourt
Board of Directors

President
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 a field coordinating team in a project tending to the medical needs of asylum-seekers in detention in the United States, and in Cambodia, coordinating MSF's response to epidemic dengue. A member of the Board of Directors of MSF-USA since 2006, he chaired the Program Committee and was elected president in 2008; he has also served on the board of MSF's International Council, and chaired its international Association Standing Committee. In addition to his work with MSF, 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 attending physician at the Farrell Family Health Center in Washington Heights.

Vice-President
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, Lebanon, Libya, Nigeria, and South Sudan. She was formerly the business manager and chairperson of the anesthesia department as well as the director of the Intensive Care Unit at Lawrence General Hospital in Lawrence, MA. Dr. Marchbein now works for MA General Hospital at one of their community hospital satellites and serves on the Board of Directors of the Fanconi Anemia Research Fund.

Treasurer
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. Prior to founding Hyperion, Mr. Engelkemier was a managing director for Citigroup in the global equities business, overseeing Japanese equity derivatives trading and equity trading for the Americas, co-managing the US equity derivatives business, and managing global systematic trading. During his career at Citigroup, he 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 building out the Brazilian office. Early in his career, Mr. Engelkemier lived for ten years in Japan, first as a guest researcher at the Communications Research Laboratory in Tokyo before joining Salomon Brothers in the mid 1990s. 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.

Secretary
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 Bogazici Universitesi 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, a US Institute of Peace Fellowship, and a NEH/American Research Institute in Turkey grant. Al-Tikriti is currently associate professor of Middle East history at the University of Mary 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. She worked in South Africa, Cambodia, and Iran with the organization before joining the Paris office from 1996 to 2001 to oversee programs in Burundi, Democratic Republic of the 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, before rejoining the Paris office as Deputy Director, then Director of Operations. She is currently the President of the French section of MSF.

Kelly Grimsaw joined MSF in 1999, establishing a tuberculosis program in Turkmenistan. She has since worked as a nurse practitioner and project coordinator in China, Sierra Leone, Indonesia, and Zambia, assisting people 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 MSF-USA’s Speaker’s Bureau throughout the country and the Refugee Camp in the Heart of the City exhibits. She currently works in nursing education.

Suerie Moon is special advisor to the dean and instructor at the Harvard School of Public Health, and 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, UNITAID, 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. 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. Nadimpalli’s first assignment with MSF was in 2005, when he spent a year in Liberia as the sole physician in a remote field hospital. He has since provided emergency care in post-civil war Sri Lanka; managed a trauma hospital and coordinated an emergency cholera response in Nigeria; and, most recently, treated people living with HIV in Malawi. Nadimpalli has also worked with a rural HIV program in Mozambique (with Friends in Global Health), with patients at the Indian Health Service in Pine Ridge, South Dakota, and at Common Ground Health Clinic in New Orleans. He has volunteered at the India Medical Association Free Clinic and the Apna Ghar Domestic Violence Shelter, and has been the literacy director in a Los Angeles housing project. Nadimpalli received his medical training at the University of Illinois at Chicago and completed his residency at Tulane. He holds a BS in biochemistry and a BS in economics from the University of California at Los Angeles.

Dr. Michael D. Newman attended the University of Cincinnati Medical School and completed his general surgery residency at Cottage Hospital in Santa Barbara, California. He began working with MSF in 1995 as a general surgeon in a project in Liberia and has been on multiple missions since then. Newman practices general surgery at Ohio’s Fayette County Memorial Hospital. His research work has been published in the New England Journal of Medicine and A Journal of Social Justice. He is a member of the American College of Surgeons and the Ohio State Medical Association. After working in New Orleans following Hurricane Katrina, André Heller Péarch joined MSF as a logistician and later transitioned to program management roles in a host of different projects, mainly in conflict and post-conflict settings. Following assignments in Chad, Central African Republic, Democratic Republic of Congo, Sri Lanka, Pakistan, and a stint in MSF-USA’s Field Human Resources Department, he was named head of mission in Yemen in 2010. Heller received an MSc from the London School of Economics and Political Science in September 2011 and was a regular guest lecturer at St. George’s Medical School. At the same time, he completed an interim field assignment in Yemen and worked with the MSF-UK office representing MSF in fundraising and recruitment venues. In October 2011, he was named graduate of the last decade by his alma mater, Colorado State University, for his accomplishment and dedication to humanitarian action. And in December 2011, Heller became an MSF head of mission in South Sudan, where he currently lives and works.

Amy Segal joined MSF as a logistician in 2003. She has worked with MSF in Uganda, Sierra Leone, Indonesia, Nigeria, and Kyrgyzstan. Amy transitioned to humanitarian field work after twelve years in television and film production. She has also worked in prison reform and as a project manager for private clients, and she has provided research support to journalists and lawyers as well. She lived in Russia for six years during its transition from the Soviet Union, then worked in Malaysia before returning to the San Francisco area in 2000. Amy earned a BA in history at Yale University and an MS in humanitarian assistance studies at the University of Liverpool’s School of Tropical Medicine in England.

B O A R D  O F  A D V I S O R S

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Co-Chair of the Board

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Goldman Sachs

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Simpson Thacher & Bartlett LLP

Robert Bookman
Creative Artists Agency

Charles A. Hirschler

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Mayer Brown LLP

Laurie MacDonald
Parkes MacDonald Productions

Larry Pantrir

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Montefiore Medical Center

Richard Rockefeller, MD

Garrick Utley
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Robert van Zwieten
Asian Development Bank

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Richard Rockefeller, MD

Garrick Utley
Neil D. Levin Graduate School, SUNY

Robert van Zwieten
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FROM 1971 TO TODAY