Dear Friends,

In this issue of Alert, we want to highlight a new campaign, “Because Tomorrow Needs Her,” which is designed to focus attention on women’s health.

Women and children make up the majority of patients in MSF facilities worldwide; in many cases, saving a mother’s life amounts to saving two lives, because children who lose their mothers are statistically less likely to survive. That’s a challenge, however, because women often have less access to health care than men do, with profound consequences.

We know, for instance, that 15 percent of all pregnancies will be “complicated,” and that pregnant women with complications, and their babies, are much more likely to die if they cannot access emergency obstetric care. There has been progress, but at present, 800 women still die from pregnancy-related complications every day.

The difference between life and death can be explained almost entirely by the access to high-quality secondary-level health care. When I worked in Afghanistan at the MSF maternity hospital in Khost, my days often began at dawn, when families finally felt safe to travel on highly insecure roads. Women presented near death, having spent the preceding night bleeding or laboring unsuccessfully at home. In the two years since MSF opened this hospital, not a single woman who arrived alive has died. (And, in fact, Caesarean sections make up roughly one-third of all the surgeries our teams carry out in war zones.)

Health care providers and governments can take some relatively simple steps to improve the situation for women and their children—better ambulances and referral systems, waiting houses near hospitals for pregnant women, prenatal care and vaccination programs for young children. But in some places, it’s difficult to get these initiatives implemented, and there are other issues at play as well. Some patients can’t afford transport, for example. I met women in the Congo who walked for days to reach our hospital or who camped out in nearby forests in anticipation of needing care.

“Because Tomorrow Needs Her”—a book, a multimedia presentation, and more—tells these stories while also focusing on sexual violence, the need for prenatal and antenatal care, the effort to prevent the transmission of HIV from mothers to their children, and much more. We are printing the book’s introduction here. I hope you will read it, and then share my anger at the injustices many women face, while appreciating their strength and their dedication to their families.

Related to this, we have a field journal from Sierra Leone about working with pregnant women with Ebola. And we also have a piece about MSF’s years-long effort to develop a modernized health information system that can help us catalog and improve our medical practices. As innovative as some of our projects are, our data collection methods are often rather antiquated. I can’t tell you how many hours I’ve spent transcribing paper logs onto Excel spreadsheets, or how many times Headquarters requested that I search for some piece of missing data.

Built using open-source software, and constructed after detailed consultation with those working in the field as well as HQ, this is an exciting and much-needed initiative, an important adjunct to delivering direct medical care to the most vulnerable and encouraging broader medical attention for the most difficult populations to reach.

Yours,

DEANE MARCHBEIN
President, MSF-USA Board of Directors

Board of Advisors
Daniel Goldberg, Co-chair of the Board
Susan Lieutaud, Co-chair of the Board
Meena Ahamed
Elizabeth Beschl Robinson, Goldman Sachs
Victoria B. Bjorklund, Esq., PhD
Simpson Thacher & Bartlett LLP
Veronique Brossier, Software Engineer, The New York Times
Charles Hirschler
Gary A. Issac, Esq., Mayer Brown LLP
Mitchell Karto, MD, Seattle Medical Associates
Sheila Leatherman, University of North Carolina at Chapel Hill School of Public Health
Laurie MacDonald, Parkes MacDonald Productions
Chantal Martell
John O’Farrell, General Partner, Andreessen Horowitz
Larry Panter
Darwin Portnoy, MD, MPH, Assistant Professor, Albert Einstein School of Medicine

US Headquarters
333 Seventh Avenue, 2nd Floor
New York, NY 10001-5004
T 212-679-6800  F 212-679-7016
www.doctorswithoutborders.org

Alert is a quarterly newsletter sent to friends and supporters of Doctors Without Borders/Médecins Sans Frontières (MSF). As a private, international, nonprofit organization, MSF delivers emergency medical relief to victims of war and disaster, regardless of politics, race, religion, or ethnicity.

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

Editor: Phil Zabriskie
Deputy Editor: Elias Primoff
Contributors: Laurence Lombart, Jeremy Ravinsky, Kimberly Smith
Design and Information Graphics: Melanie Doherty Design
Comments: alert_editor@msf.org

Above: A baby is delivered via Caesarean section in Rutshuru, Democratic Republic of Congo.
(C) Andre Quillien/MSF

Cover: Yvonne Baradahana, 49, waits to receive fistula repair surgery at MSF’s Urumuri Center in Gitenga, Burundi. (© Martina Bacigalupo/VU)
By Meinie Nicolai, President, MSF-Belgium

In 2006, I was part of an MSF team that was conducting an exploratory visit in Equateur Province, an isolated, underdeveloped area in northern Democratic Republic of Congo (DRC). One day, we visited a threadbare local hospital in a dusty village along the Congo River, where we were hoping to launch a medical response to a recent outbreak of sleeping sickness.

As I entered the facility, I saw a body lying on the floor, covered by a blanket.

“Did someone die?” I asked.

“Yes,” I was told. “That is a young woman who died giving birth.”

I never learned the young woman’s name, but I’ve never forgotten her. I knew that health facilities in that area were desperately short of resources and trained health personnel. I knew that many women around the world don’t have the power to make crucial decisions, such as whether or not to spend money to hire a vehicle to get themselves to the nearest hospital, even when they desperately need to go. And I knew the statistic that tells us that some 800 women die due to pregnancy-related causes every day. But I also knew it did not have to be that way. And seeing her lying there, like an afterthought, hit me hard.

It also made me angry. As a nurse, seeing a woman die needlessly because she could not access medical care made me want to shout from the rooftops. That was years ago, but I’m still angry about it now, because deaths like these are happening with horrifying frequency to this day—and they can be prevented.

There has been progress in the realm of women’s health. Between 1990 and 2010, there was a 47 percent drop in maternal mortality worldwide, according to the World Health Organization.ii The United Nations Millennium Development Goals adopted by the international community in 2000 further sought to reduce global pregnancy-related deaths by three-quarters by 2015.
This is welcome news, to be sure. But in many countries where MSF works, a shocking number of women are still being lost. At present, 38 times as many women die in childbirth in Afghanistan as they do in the United Kingdom. Maternal mortality rates are 178 times higher in Central African Republic than in Japan, and 220 times higher in Chad than in Sweden.

MSF has demonstrated that it doesn’t have to be this way, that simple, inexpensive interventions carried out by trained health staff could save many of the 800 women who die every day from pregnancy-related causes. To cite just one example: In 2012, the organization started ambulance referral systems in the districts of Kabezi in Burundi and Bo in Sierra Leone. These are countries with some of the world’s highest rates of maternal mortality but very few hospitals or qualified medical workers.

Previously, complications during pregnancy were a likely death sentence for mother and baby alike. With the ambulance referral system, however, when a woman shows signs of complicated labor, the local health clinic can call for an ambulance. The ambulance arrives and takes the patient, escorted by a nurse or midwife, to a hospital where trained staff are on hand and surgical and blood transfusion services are available, for free, around the clock. The results have been dramatic: The maternal mortality rate in Kabezi dropped 74 percent; in Bo, it fell by 61 percent.

**MSF AND WOMEN’S HEALTH**

MSF is a medical humanitarian organization that works in roughly 70 countries to treat people who have been affected by conflict, natural disasters, disease, epidemics, severe privation, and long-term neglect. At root, our mission is to provide lifesaving medical care to those who cannot otherwise access it.

I’ve been with MSF for more than 20 years, first working as a nurse in the field, then running projects in several countries before becoming director of operations. I now serve as president of MSF’s office in Belgium. While we are not specifically a women’s health care organization, most of our patients are women and children. In project after project, I’ve seen our waiting rooms and wards full of pregnant women, women who’ve been injured or fallen ill, and women with their children. I’ve seen the lengths women will go to in order to care for their children, walking great distances in dangerous circumstances to make sure they get vaccinations and treatment, or risking everything, including rejection from their husbands, to prevent transmitting HIV to their unborn babies.

These are remarkably strong women and they are anything but victims. Many perform backbreaking labor in addition to running their households and caring for their children and other family members. During conflicts and other events that cause displacement, they often take on even more responsibility, frequently acting as the sole caretaker of their family members. Yet in spite of the huge burdens they
A young girl passes a pharmacy in Port-au-Prince, Haiti, where abortion drugs are available without either prescription or advice on how to take them.
© Andre Quillien/MSF

In Kabezi, Burundi, new mother Chantal learns “kangaroo care,” in which the baby is tied to the mother’s chest for warmth and bonding.
© Martina Bacigalupo/VU

An MSF nurse assists a woman giving birth in a field in Burundi.
© Matteo Bianchi Fasani

A mother and father hold their day-old baby at the MSF hospital in Masisi, DRC.
© Yasuyoshi Chiba/Duckrabbit

An MSF midwife delivers a baby at a small referral health center in DRC.
© Yasuyoshi Chiba/Duckrabbit

Patient Yvonne returns home after a successful fistula repair surgery in Gitega, Burundi.
© Martina Bacigalupo/VU
shoulder, they rarely possess the power to decide when they themselves can get lifesaving care.

On the day I saw the young woman lying dead under a blanket in DRC, I reaffirmed a decision I had made early in my career to be one of the voices within MSF that pushes the organization to pay particular attention to the specific needs women have in the contexts where we work. I am still one of those voices, and I’m glad to say I’m one of many, as you’ll see in the rest of “Because Tomorrow Needs Her,” our print and multimedia presentation of MSF’s experience with the most pressing issues of women’s health [see womenshealth.msf.org for more].

Put simply, women have distinct health risks that men do not have, and these risks must be attended to. Let’s start with the obvious: women get pregnant and bear children. Worldwide, more than a third of all deliveries have complications, and 15 percent of all deliveries involve life-threatening complications—conditions likely to kill women if they cannot access emergency care. Globally, at least 287,000 women do in fact die during or shortly after childbirth every year. Many could have been saved by effective surgery, trained medical workers who recognized the severity of their condition, transfusion services, prompt transport to medical facilities, or closer proximity to existing ones.

In far too many cases, though, these things are simply unavailable. My colleagues and I have lost count of the cases we know of in which women in labor could not find or afford a ride to the hospital; or a woman walked for hours or days while in labor only to learn that there was no doctor she could see until the following morning, if at all; or that she would be charged far more money than she could pull together to get the care she urgently needed.

The women and girls who manage to survive a life-threatening complication without emergency care, the so-called lucky ones, will usually lose their baby and may develop an obstetric fistula, which, while not immediately life-threatening, can have profound consequences for their health and future. Many women with fistulas not only carry the grief of a lost child; they also face rejection by their husbands, their families, and their communities.

When a woman does manage to deliver her baby successfully, the lack of sufficient newborn care in many places jeopardizes her child’s ability to survive the first few weeks of life.

When a woman does manage to deliver her baby successfully, the lack of sufficient newborn care in many places jeopardizes her child’s ability to survive the first few weeks of life. A newborn’s chances of survival are even slimmer if the birth was prolonged and complicated. In 2013, 2.8 million babies died before they were a month old, mostly due to asphyxia, infection, and pre-term or low birth weight complications. Again, access to properly-trained medical workers and relatively basic care could have saved many of these children.

There are solutions. Good referral systems with ambulance services are one. Maternity waiting houses are another. In places where a woman lives far from the nearest hospital, she can spend the last weeks of her pregnancy in a house near a working hospital, alongside
other pregnant women who can then count on getting the care they and their babies need when they give birth. That’s exactly what MSF offers in Masisi, DRC, at a 70-bed maternity waiting house that is almost always filled to capacity. This is another simple intervention with profound consequences.

The challenges women contend with go beyond childbirth, of course. For a host of reasons, women are more vulnerable to contracting HIV and they struggle to get treatment if they do. They also bear the terrible burden of possibly passing the virus to their child.

Just growing up female can lead to health risks: In many countries, the custom of female genital mutilation (FGM) persists. In 2013, 3.6 million girls were affected. FGM has no health benefits and is extremely painful and debilitating, with both immediate and lifelong health consequences.

In wartime, access to health care often declines, affecting everyone. For women, though, conflict results in even fewer options in maternal or pediatric care, or vaccinations for their children. Conflict also creates environments of rampant exploitation of women and girls and of rape used as a weapon. Displacement in general, whether due to economic necessity or man-made or natural disasters, leaves women and girls more vulnerable to sexual violence and trafficking.

In many of the places where MSF works, women have no access to birth control and little control over their sexual lives. If a woman or girl has an unwanted pregnancy, there are very few options. If she carries the pregnancy to term, she could bear harsh social consequences. If she decides to seek an unsafe abortion, as millions of women with no access to safe abortion do every year, she risks severe injury, even death.

These issues and the suffering they bring about are not new or unknown, yet they still have not been adequately addressed. MSF tries to help as many people as we can; more often than we’d like, we are the only medical organization in the places where we work. In 2013, for instance, we assisted with more than 182,000 births, provided medical care for more than 11,000 survivors of sexual violence, and offered prevention of mother-to-child transmission care to nearly 16,000 mothers living with HIV and their babies.

We’re the first to say, however, that many women are beyond our reach, that there are many services that we do not offer at present (such as treating breast cancer), and that there are policy and human rights debates we don’t get involved in beyond the framework of our medical activities, such as the fight for women’s rights.

At the same time, though, we do advocate for the people we treat. We call on the international and humanitarian communities—along with national governments and parties to conflict—to act when lives are at stake.

“Because Tomorrow Needs Her”—the book, the multimedia site, and the related events we are staging—is part of that effort, part of the call to all involved and to all who care that more should be done to address
WOMEN’S HEALTH

the specific medical needs of women and girls around the world. It is a collection of first-hand accounts from MSF aid workers—midwives, OB/GYNs, physicians, nurses, and counselors—who have treated women and girls in a host of different countries and contexts over the past two decades. Their stories, which are available both online and in print, illustrate how limited access to health care can have devastating consequences for women the world over. They also show the tremendous impact that care can have on an individual’s life.

This is not an academic book, or a policy book, or an “aid” book. It’s an attempt to bring together the views and experiences of people who’ve been in the field and who can articulate both the depth and scope of the needs that exist—along with the opportunities to provide meaningful assistance. It includes the voices of women describing their stories and obstacles in trying to get the care they need. And it’s capped off by journal entries from an MSF OB/GYN who encountered seemingly insurmountable challenges nearly every day of the six months she spent providing care for women in Sierra Leone. Despite the struggles, she saw clearly the impact her work had on the lives of her patients.

A CALL TO ACTION

In early 2014, I visited an MSF project in Bangui, Central African Republic. The country was and still is, as of January 2015, in the midst of a conflict that has killed tens of thousands and driven around one million people—20 percent of the population—from their homes.

At the Bangui airport, MSF has a makeshift field hospital next to a refugee camp where huge throngs are seeking sanctuary. We provide health services and emergency first aid, as we’ve done in many places over the years. But we also have a delivery room and a space to treat survivors of sexual violence. These, too, are an integral part of MSF’s response. Bullets are often fired over the clinic and our staff members have to lie down until the shooting stops. But we have no plans to stop providing a space for women’s health.

These women will not be afterthoughts. They cannot be, because, as the title of this book says, tomorrow needs them.

This is true in Afghanistan, Pakistan, Sierra Leone, Burundi, Colombia, South Sudan, DRC, and in every other country where MSF works—in every other country, period. As an organization, we look forward to the day when women the world over have access to the kind of medical care many of us in the developed world take for granted; to a future where no girl or woman has to die because she could not reach a hospital in time; and to the day when I can be confident of entering a remote rural hospital without seeing the body, shrouded on the floor, of a woman lost in childbirth.

I hope this small project goes some way to furthering this dream. And I thank you for your interest in the global crisis of access to medical care for women and girls.

2 WHO, HRP. Maternal Mortality Fact Sheet, 2014
4 MSF, Safe Delivery: Reducing Maternal Mortality in Sierra Leone and Burundi, November 2012
As part of the “Because Tomorrow Needs Her” project, we will publish entries from a journal OBGYN Betty Rainey kept while working in a high-risk obstetric unit at the Gondama Referral Center in Sierra Leone in 2012. The first entries are below. Subsequent entries will be published each week at womenshealth.msf.org.

JUNE 1: Arrival
I’m writing in the car. Made it here late last night after an eight-hour flight to Brussels, then a six-hour flight to Lungi Airport, Sierra Leone. About an hour later I was on a boat to Freetown. The MSF driver picked me up when I got off the boat and we drove to the MSF house. Even though it was dark, I was smacked in the face by the profound poverty. Rows and rows of homes that were nothing more than lean-tos made of sticks, tin, cloth—no bigger than one bedroom in my home, and these were the homes of entire families.

I slept five hours and am now on a six-hour car trip to Bo. I skipped the briefings in Freetown today because they are so busy they need me in Bo right now.

Whereas Freetown was dirty and noisy, the countryside is lush, tropical. It’s amazing what the women can balance on their heads. Their clothing is so bright and beautiful. I don’t know how it is so because none of the shanties have electricity, water, or even windows or doors.

I’m tired but I’m going to work.

JUNE 2: My First Day
My OBGYN partner was evacuated yesterday due to possible exposure to a patient suspected of having Lassa fever—the Lassa virus is endemic here.

One of my first patients had had a botched illegal abortion that extruded to the abdominal cavity. She was septic and very ill, only 16 years old. [Note: She later died of infection.]

There is lots of death here. According to the handover reports from other doctors, there have been one to four maternal deaths per month at the Gondama Referral Center. UNICEF reports that 11.7 percent of infants born alive in Sierra Leone died in 2012 and more than 18 percent of children under five died.

JUNE 3: How MSF Got Here
I just finished my rounds. I did a dilation and curettage (D&C) for an incomplete spontaneous abortion or miscarriage and heavy bleeding. Then a Caesarean section for a woman who had been in labor for three days with a baby too large in relation to her pelvis to come out vaginally—she had a placental abruption and was bleeding.

Baby and mom are now doing well.

I learned that this hospital dates back to the war in Sierra Leone in the mid-nineties. MSF treated victims of the civil war, then refugees fleeing Liberia’s civil war. It became Gondama Referral Center in 2007. Now it is here for the entire community and beyond as a measure to reduce maternal and child mortality.

JUNE 4: A Day’s Work
After 24 hours on call, I am still wide awake due to the Lariam (mefloquine hydrochloride) I’ve been taking to prevent malaria. My mind has been spinning with the day’s activities—four C-sections for four live babies, one placental abruption, one hemorrhage/placenta previa, one transverse lie, one obstructed labor, and one D&C....
AN ADDED BURDEN: PREGNANT WITH EBOLA

In the early months of 2015, the number of new Ebola cases dropped significantly in West Africa, which is unquestionably good news. There very much remains a need to stay vigilant, however, as complacency could allow the disease to spread anew in countries with dangerously fragile health systems. There are also a host of carry-on effects associated with Ebola. A surge of malaria is one. Finding ways to treat pregnant women who contract Ebola is another.

MSF midwife Ruth Kauffman worked in a maternity unit MSF established for pregnant women with Ebola, or those suspected of having Ebola, in Kissy, a suburb of Sierra Leone’s capital city, Freetown. Opened in January 2015, the center is enabling medical teams to provide specialized care for pregnant women and helping MSF and others better understand the effects of Ebola on this vulnerable group. Here, Kauffman, who has also completed MSF assignments in South Sudan, Myanmar, Uganda, and India, discusses how MSF is proving that pregnant women can survive the disease.

Before this outbreak, all we really knew about pregnancy and Ebola was that usually the women die either while pregnant or else during the birth. As Ebola is a hemorrhagic fever, once a woman goes into labor, she will most likely bleed to death.

We also knew that unborn babies don’t survive, as the virus appears to concentrate itself in the placenta and in the amniotic fluid which surrounds the fetus.

As the number of people infected in other outbreaks was low—too low to gain an understanding of how Ebola impacted pregnancy—little research had been done. But as we’re seeing so many more people infected with the disease in this outbreak, we are learning a lot more about Ebola.

We were surprised that two pregnant women at MSF’s center in Guéckédou, Guinea, and two more in Foya, Liberia, had managed to recover from Ebola, give birth, and survive. Once a woman is better, it seems that the best thing for her to do is birth the fetus, as it has become a ball of concentrated virus in her body. So we began to look at how to do this in a controlled way that is safe for the people assisting the birth and that will ultimately help the woman survive.

Kumba was seven months pregnant with her third child. She had arrived at the center with a high viral load, and had been there for about a month. Kumba knew that her baby was going to be born dead; she had felt no movement for some time.

We wanted to induce Kumba’s labor in as controlled a way as possible. We didn’t want her to go into labor in the middle of the tent. Not only would it be undignified for her, but if there was a lot of infected blood and amniotic fluid around, then it would be risky for everyone. Kenema hospital, in central Sierra Leone, lost a number of its nurses to Ebola after they attended the birth of an Ebola-positive colleague. Strict infection control is vital.

We needed a place that would be clean and afford some protection—both for Kumba and for those attending her. Luckily, the team had just finished constructing a small building for people who needed extra privacy, so we were able to use it for the birth.

We were wearing the standard protective clothing for Ebola, but with extra-long gynecological gloves on top of the three other layers of gloves. When you are attending a birth, you move around a lot and you really need to make sure that your mask doesn’t slip and that your headgear doesn’t ride up. You can’t stay inside the high-risk zone, in all your protective gear, for more than an hour at a time. So you also need someone on standby who can come in to relieve you. We had two nurses waiting outside who, even though they didn’t have much experience [with] birth, were able to monitor Kumba’s vital signs and reassure her.

Before inducing labor, we gave Kumba antibiotics, on the assumption that she would have an infection from carrying around a dead fetus for some time. We also assumed that she would bleed during labor, so we had a lot of anti-hemorrhagic medication ready for after the birth.

Kumba’s labor took about a day and a half, and it went as well as we could have hoped. With Ebola, you don’t want to touch the baby and you don’t want to pull the placenta out; you leave all of that to happen on its own.

What was really amazing about this birth was that, by the next morning, Kumba was stable. She wasn’t bleeding much, and we were able to take out the IVs and the catheter.

The other pregnant woman at the center was Musa. She had arrived with her two-year-old child, who also had Ebola, and both were now on the way to recovery. We told Musa that we weren’t going to be able to help her with the birth too much, and she would need to do it herself. This was hard, but with limited time inside the high-risk zone, you have to decide when you’re going to be most useful.

The biggest risk for the mother is right after the birth. If you’re in there for 30 minutes of pushing time, then you don’t have a lot of time or energy left for the next stage: making sure the placenta comes out properly and that [the mother] doesn’t bleed.

The birth went really well and within a couple of hours Musa was ready to get up.

Birth is so special, even in these circumstances. Whatever the culture, you are immediately intimate with the woman. To be a part of this intimacy is so rewarding—and even more so in the context of Ebola.

Musa and Musa’s experiences really confirmed me that, with the resources and with specialized care, pregnant women can be helped to survive Ebola. We may not be able to save the lives of their unborn children, but we can save theirs.
The idea came from a longstanding need to collect health information and project data in a timely, accurate fashion, and to make that data work for us to tell us what we need to know. We need to do a better job at data collection, and we need better tools for doing it.

The principle goal of the HIS project is to establish a system that allows us to capture project data in a much more efficient way, and in a way that’s more easily visualized and transmitted. We’re not necessarily trying to collect more data, but to better use and organize what we do collect.

How did the previous system work?
For about a decade we’ve relied on standardized spreadsheets to collect and collate medical data for inpatients [IPD], outpatients [OPD], and OB/GYN patients. We also used specialized databases for information regarding HIV/AIDS and tuberculosis that were developed in-house.

However, they were built mostly for use by headquarters and for epidemiologists rather than for workers in the field. That’s one of the principles we want to promote in this new HIS project: creating a health information system that’s usable at the field level, that isn’t just about putting numbers in a spreadsheet and sending them to headquarters.

Can you give an example of how the new plan compares with the old system, in practice?
Previously, if you wanted to know how many cases of malaria were diagnosed in the outpatient setting in 2014, you would have to go through each country one by one, look at individual database files, copy the numbers, and add them together. We’d spend weeks at the end of each year doing analysis of that year’s data to write the annual report.

The idea here is to continue to collect aggregate data about the number of people diagnosed with malaria, diarrhea, pneumonia, upper respiratory tract infections, etc., and to expand the range of services in which we can do that. When this system is up and running we’ll be able to collect and organize information not just from OPD, IPD, and OB/GYN, but also from individual services like emergency rooms, intensive care units, surgery, antenatal care, vaccinations, and epidemics like cholera and measles.

And all this information will be presented in a single interface, so users won’t have to juggle different databases to enter information for different contexts. It’s all browser-based, so users can just log on and engage with the application.

It can also be used offline, though, which is important in places MSF works where internet service is unreliable or nonexistent. In offline or limited-connection settings, users can still log on. When connection is established the data is transmitted to a cloud-based data warehouse that’s accessible to users globally.

Once the data is stored it can be accessed by staff members in headquarters and then medical coordinators in capital cities of countries where we work. They’ll be able to access data for individual projects and for whole countries, a process that until now has been pretty cumbersome.

Who is working on this project?
There is a mix of recycled software and new development that we are incorporating into the architecture of the system. The recycling part refers to the District Health Information System (DHIS2), which was developed by the University of Oslo and is used in over 16 countries—MSF works in some of them—as a national system. It’s being customized for MSF’s needs. The new development is in collaboration with ThoughtWorks, an international software company that has experience in developing and implementing information systems globally. We have been working with them for over a year and hope to continue over the next several years.

How is the HIS be maintained once it’s up and running?
We’re building a team to manage the system. We have an implementer and a program manager here in New York, and we’re going to bring on a trainer to help familiarize headquarters staff with the software. We’re also building a help desk and hiring epidemiological staff to monitor and evaluate the data.

I think the most important thing about a project like this is to look past the numbers—there’s a tendency, I think, to assume that quantifying things is in itself satisfactory. But why bother collecting data if there’s nothing to be learned from it? In the end it’s not just about collecting the best data or writing the best software—it’s about having new conversations about why that data is important and how it can help us. It’s about finding ways to further facilitate the self-reflection and self-evaluation that is so integral to MSF’s work, and to provide the best emergency medical care we can to our patients all over the world.
### DHIS2 HEALTH INFORMATION SYSTEM

1. **Compile Data & Transfer from Paper to Electronic Files**
   - Collecting data from around the world
   - Compile data in the field
   - Electronic versions

2. **Transfer Data to Secure Holding Location**
   - Viable connection
   - No connection

3. **Data is Released to DHIS2**
   - Electronic versions

4. **DHIS Analyzes Data**
   - Receives data
   - Collates, categorizes, organizes

5. **Authorized Users Visualize Data and Create Indicators**
   - Organized Data
   - Visualize into charts & graphs

6. **Data Informs Future Decisions**
   - Resource allocation, program planning, quality of care assessment, surveillance of disease

### Tracking Measles Data

**DHIS2 in Use**

**Examples of Indicators Collected**

- **Country:** Ethiopia
- **Project Name:** Itang & Leitchuor
- **Facility:** All hospitals, health centers, and mobile clinics
- **Service Location:** Outpatient Department
- **Diagnosis:** Measles <5 years & measles >=5 years

**Examples of Data Produced**

- **Diagnoses of Measles in Outpatient Departments in Demo Country** (data for demonstration only)
  - Total Number, March-Oct, 2014
  - By Location, March-Oct, 2014
  - By Age, March-Oct, 2014

**Diagnoses of Measles in Outpatient Departments in Demo Country**

- **Total Number, March-Oct, 2014**
  - Total Number, March-Oct, 2014

- **By Location, March-Oct, 2014**
  - Location 1: 472
  - Location 2: 13
  - Location 3: 82
  - Location 4: 84
  - Location 5: 471

- **By Age, March-Oct, 2014**
  - Total Number of OPD Measles Diagnoses per Month
  - < 5 years
  - >= 5 years
Over the past few years, MSF has seen again and again that interactive gamers have both a natural affinity for philanthropy and an undeniable impact on our work. In fact, Summer Games Done Quick (SGDQ)—one of the most popular online gaming events—was MSF’s top fundraising event in 2014.

This is one result of a larger phenomenon: As gamers find communities in online role-playing games and electronic sports (a.k.a. competitive gaming), and connect via online streaming platforms like Twitch, their passions and their desire to “do good” are becoming ever more intertwined.

MSF is among those benefitting from this trend. SGDQ, for example, is one of two charity marathons organized by Games Done Quick. It brings together a collection of highly skilled gamers—known as speedrunners—who aim to complete their favorite games as quickly as they can.

During the summers of 2011, 2013, and 2014, top speedrunners from around the world have gathered to raise money for MSF; all donations raised before, during, and after the weeklong marathon have helped us further our mission. In 2014 alone, players and spectators of SGDQ raised $718,155 for our programs while live streaming 523,635,900 minutes of gameplay to 3,644,200 viewers around the world!

In partnership with MSF and its Vital Pact campaign (see right), SGDQ also works with companies to augment the impact of its fundraising. In 2014, Humble Bundle, a digital content distributor, collaborated with SGDQ to offer a digital game bundle as part of the event, with all proceeds going to MSF. What’s more, The Yetee, a t-shirt site, donated a portion of its sales to MSF as well. Company sponsors for SGDQ 2015, which takes place this coming July, are currently being recruited, with the goal of surpassing last year’s total.

“The community behind the Games Done Quick events continues to be extremely tight-knit, even as it grows each year,” says Andrew Schroeder, event director of Games Done Quick. “Their passion for both gaming and helping others is evident to anyone who watches, and I cannot think of a better charity for everyone to come together and support than MSF. It is nice to work for a charity that is as supportive of our efforts as we are of theirs.”

DONOR PROFILE: SUMMER GAMES DONE QUICK

MSF AND THE “VITAL PACT” CAMPAIGN

The collaboration between SGDQ and MSF is part of a larger effort, one that shows how the union of unexpected partners can bring fantastic results. In part because of its relationship with SGDQ and the gaming community, MSF launched the Vital Pact: Fandom Where It’s Needed Most campaign, which engages fandom communities that champion MSF’s mission. “Fandom” is an umbrella term for passionate subcultures of fans who rally around a common interest. In recent years, fandom communities of video games, comic books, TV, film, and genre fiction have become enthusiastic and engaged supporters of MSF.

Vital Pact was born of MSF’s desire to both encourage and recognize the philanthropic inclinations of these fan groups by providing tools and generating opportunities for them to raise funds and awareness for MSF’s mission. Through Vital Pact, fans can create fundraising projects that tap into the collective power of their communities. Vital Pact provides fundraising platforms, digital collateral, and promotional items, in addition to promoting fan-driven events via Vital Pact social media channels. The campaign also offers fan-focused companies and content creators opportunities to collaborate with MSF to create consumer activation promotions with a charitable component.

Already, we’ve seen fans come together in amazing ways. A group of board game players started Pandemic Parties, whereby players of the co-operative board game Pandemic hosted game parties and raised funds for MSF’s Ebola response. With 110 parties in 21 countries, Pandemic Parties raised over $50,000 in just two months. Additionally, fans of comics, genre fiction, and video games have donated over $550,000 to MSF through Humble Bundle, a pay-what-you-wish digital bundle website that partners with publishers and content creators to assemble collections of digital media, with purchasers designating a portion of the price to charity.

For information on Vital Pact visit vitalpact.org or contact us at vital.pact@newyork.msf.org or (212) 763-5745.
JOIN OUR LEGACY SOCIETY

Naming MSF as a beneficiary on a retirement or other account is a simple way to leave a legacy to the organization without writing or re-writing your will or living trust. Please ask your IRA administrator or institution for the appropriate form.

If you have already named MSF as a beneficiary of your estate, please tell us so we can welcome you to our Legacy Society.

To learn more about beneficiary designations or other legacy giving opportunities, please contact Laurel Combs, planned giving officer, at (212) 347-3153 or laurel.combs@newyork.msf.org.

STRENGTHEN YOUR COMMITMENT

MSF would like to thank all of our donors who have made commitments towards the Multi-year Initiative. With annual commitments of $5,000 or more, these generous supporters help provide MSF with a predictable revenue stream that better serves our ability to respond rapidly to emergencies and ensure the continued operation of our programs. To date, we have received commitments totaling more than $33 million towards the initiative.

To find out how you can participate, please contact Mary Sexton, director of major gifts, at (212) 655-3781 or mary.sexton@newyork.msf.org, or visit doctorswithout-borders.org/support-us/other-ways-to-give/multiyear-initiative.

INCREASE YOUR IMPACT

Does your employer have a matching gift program? Many companies have matching gift programs that will double or even triple the impact of your gift. Companies will sometimes also match donations made by spouses, retirees, and board members. Because conditions and criteria for gift matching vary by employer, please check with your company’s Human Resources Department for details. MSF is happy to confirm your gift or to satisfy any other requirements your company may have.

If you or your company are interested in learning more about our work, or have any questions about our matching gift program, please email corporate.donations@newyork.msf.org or call (212) 783-5745.

STOCK DONATIONS

Did you know you can donate gifts of securities to MSF? Making a stock gift is simple and offers a number of valuable financial benefits. You can donate appreciated stocks, bonds, or mutual funds, and the total value of the stock upon transfer is tax-deductible. Also, there is no obligation to pay any capital gains taxes on the appreciation.

MSF currently maintains an account with Morgan Stanley Smith Barney to offer donors an easy way to transfer securities hassle-free. For more information on how to make a security donation please visit our website doctorswithoutborders.org/support-us/other-ways-to-give. You can also call (212) 679-6800 and ask to speak to our Donor Services department.

JOIN THE MSF TEAM IN THE 2015 NEW YORK CITY MARATHON

Experience all five boroughs of New York City in the world’s largest marathon, all while being a part of a larger team delivering emergency medical care in crises around the world. Enjoy the support of over two million cheering spectators in one of the most thrilling and memorable marathons you’ll ever run. Fundraise a minimum of $3,000 and enjoy these benefits:

- Run in the New York City Marathon as a member of Team Doctors Without Borders with a guaranteed race entry.
- Meet an MSF aid worker back in the US from his or her latest mission, with your fellow teammates, at our exclusive Runners Reception the day before the NYC Marathon.
- Fully supported with an athletic training program including webinars, nutrition tips, and stretching pointers, including access to TrainingPeaks online athletic training tools.
- Exclusive MSF jerseys, totebag, and more, only available to Team Doctors Without Borders runners.
- Step-by-step instructions for how to hit your fundraising goal long before the deadline, with ongoing fundraising coaching and support.

For more information, visit events.doctorswithoutborders.org.

ABOVE MSF doctor Wael Kilani consults with patients in an ambulatory [health clinic] in Kuteynikovo, Ukraine, where MSF is running mobile clinics twice a week. © Corinne Baker/MSF
Doctors Without Borders/ Médecins Sans Frontières (MSF) works in nearly 70 countries providing medical aid to those most in need regardless of their race, religion, or political affiliation.