HAITI: BEYOND EMERGENCY
EVENTS AND RECRUITING

MSF NEWS

On May 30, MSF HIV/AIDS Policy Adviser Sharonann Lynch was honored with a Health GAP Founders Award, a richly deserved recognition of her critical role in founding the activist organization and her contributions to the fight for the rights and dignity of people living with HIV/AIDS. After joining MSF in 2006, Lynch spent four years working in HIV/AIDS and TB projects in Lesotho and South Africa. She has also worked extensively on advocacy issues related to access to medicines, intellectual property and drug pricing, and donor and national government policies. An account of her recent trip to Mozambique is featured in this issue of Alert.

WORK WITH MSF

Between July 1 and September 30, MSF will hold recruitment information sessions in the following cities:

- July 18: New York, NY
- August 8: San Francisco, CA
- September 18: Seattle, WA
- September 19: New York, NY
- September 20: Portland, OR

All prospective medical and non-medical aid workers are welcome to join us for a presentation and Q & A to learn more about MSF’s field work. A human resources officer will discuss the recruitment process, and an experienced MSF aid worker from the local area will share stories of life in the field. Visit www.doctorswithoutborders.org/events/public for more information and to register, or participate in one of our regularly scheduled recruitment webinars.

Please note that there is an urgent need for midwives and operating room staff and for French-speaking applicants to work in countries such as the Democratic Republic of Congo, Chad, Niger, and Haiti, where some of MSF’s largest projects are located.

MSF-USA SPEAKING EVENTS

MSF-USA plans to bring live events—panel discussions, lectures, and talks—to Los Angeles, San Francisco, Portland, Seattle, and Denver this fall. In addition, we will continue to hold webcasts about MSF activities, advocacy campaigns, books, and medical interventions available around the world via the Internet. Please check our website, www.doctorswithoutborders.org, for event details.

MSF IN PRINT

Over the past 40 years, Doctors Without Borders/Médecins Sans Frontières (MSF) has developed a reputation as an emergency medical humanitarian organization willing to go almost anywhere to deliver care to people in need. Yet when questioned about MSF, people in countries where it works had different perceptions. One thought MSF was from Saudi Arabia and financed by Muslim charities. Another thought it was a China-based corporation. And yet another believed MSF requires everyone who enters their medical facilities to be armed (quite the opposite, in fact). These are just some of the surprising revelations found in In the Eyes of Others: How People in Crises Perceive Humanitarian Aid. Co-published with Humanitarian Outcomes and NYU’s Center on International Cooperation, the book is a result of MSF’s attempt to better understand how its work and principles of neutrality, impartiality, and independence are perceived by those who receive its emergency medical care. A variety of scholars, researchers, students, and other humanitarians also contribute essays expanding on issues of perception and exploring the many facets of humanitarian action today.

The book is available in paperback from Amazon and as a free PDF download at www.doctorswithoutborders.org/perceptions.
Dear Friends,

In January 2010, a massive earthquake hit Haiti and necessitated the largest emergency response in MSF’s history. In this issue of Alert, we return to Haiti to look at how that response has evolved, and continues to evolve, in Port-au-Prince. In the years since the earthquake we’ve spent a lot of time discussing MSF’s activities in Haiti, and with good reason—high-quality, free-of-charge health services are still sorely lacking, and the nation remains susceptible to large-scale cholera outbreaks. MSF has been and remains the largest medical organization responding to these unmet needs. Teams are providing a number of essential services today, such as the burn unit at MSF’s Drouillard hospital, which you will learn more about in these pages.

But we shouldn’t forget the other crises, in other countries, that would have been among MSF’s largest-ever emergency responses before January 2010, and remain significant medical emergencies today. Being able to respond to those emergencies is the main reason MSF exists, and we have in this issue a discussion with the director of MSF’s emergency desk, or “E-desk,” in Paris, Dr. Mego Terzian, about how MSF prepares for and responds to emergencies as they happen.

In the Haiti story, we touch on the transition from the emergency phase into the post-emergency phase, when gains made during the emergency phase must be protected and the patients tended to must be further nursed back to health. In Haiti, hospitals like Drouillard illustrate MSF’s conviction that ongoing needs necessitate ongoing involvement, and that where few options for care exist, we must provide that care and, at times, the facilities in which it occurs.

With HIV, MSF—and particularly some determined, visionary individuals within the organization—started treating people living with HIV/AIDS before it was deemed practical, affordable, or even useful. That was more than a decade ago, and MSF has now treated hundreds of thousands of people and helped establish a baseline for treatment that is widely accepted (even if not widely enough) around the world. In this issue’s field journal, MSF HIV/AIDS Policy Expert Sharonann Lynch discusses traveling to Mozambique to study community antiretroviral groups and the members who work together to make sure they all get the treatment they need. It’s an incredible, inspiring initiative that was beyond anyone’s imagination back in 2001—when HIV/AIDS was essentially a death sentence in so many places, and thus very much an emergency.

The needs don’t end when the emergency is declared over. In places like Haiti, they are in fact amplified because other actors leave. MSF will continue to respond to an emergency as a holistic, kinetic entity, and, with generous support from people like you and the continued dedication of our field workers, stand ready to understand and fulfill its role, delivering assistance to the people who need it most.

Sincerely,

Sophie Delaunay, Executive Director, MSF USA
It’s mid-morning at MSF’s Drouillard Hospital, a sprawling, bustling facility situated next to Cité Soleil, one of the poorest neighborhoods in Port-au-Prince, Haiti’s capital. People with crutches, bandages, and external fixators used on bone fractures sit on benches near the entrance to the outpatient ward waiting for follow-up treatment. Family members speak softly to each other as cell phone ringtones go off constantly.

With the onset of spring, the mango trees on the hospital grounds are starting to bear fruit. The steady buzz of motor scooters dodging potholes and pedestrians on the street outside rises in volume each time the security gate rolls open. In one of these moments, a beat-up white car accelerates onto the grounds and comes to an abrupt stop in front of the triage station next to the emergency room. A door opens and a woman maneuvers herself out of the back seat holding her young daughter, who is naked. The girl’s face is blank with shock; her thin back is bright red with burns.

The mother takes a seat in a white plastic chair, her daughter still in her arms, and the doctor begins applying pads to the burns, following the blazing red wound that covers the child’s back and creeps over one shoulder onto her chest. “How was she burned, madame?” the doctor asks.

In a halting voice, the mother explains that they don’t have electricity or gas where they live and must use a portable coal stove for cooking. Earlier that morning, she says, “when I was climbing the stairs with the stove and the spaghetti in the boiling water, these things slipped and fell on her.”

The doctor calls for morphine to be prepared. One nurse takes the girl’s temperature, while another asks for information.

“What is the age?”
“Seven years old.”
“What is her name?”
Her mother hesitates, as if searching for the answer. “Dattchina… Dattchina Sary Chérilus.”

Dattchina’s mother stands once again with her now-bandaged child clinging to her neck and walks the roughly 10 meters to the ER. The Haitian doctor who runs the ER, Josue Bince, directs her to lay Dattchina on a gurney. A nurse covers the girl with a hospital gown and readies the morphine.

“About 15 percent of the skin’s surface area was burned,” Dr. Bince says. “We are going to prepare her for surgery. We’ll wash and clean the affected area, and then apply the ointment following the MSF protocol, and then she will be moved to the burn unit.”

Next to the gurney, her mother sits with her handbag in her lap, cellphone clutched in one hand, eyes wide with worry.

**EVERYTHING IS CONNECTED**

Outside the hospital grounds, the residents of Cité Soleil live in concrete block structures or in tent settlements. When they venture out, they have to pick their way along the roads, dodging speeding motor bikes and beat-up cars, trying to keep themselves or their children out of harm’s way. Nearly 40 percent of the hospital’s admissions stem from traffic accidents.

The lack of a functional sanitation system means the sides of the roads in poorer neighborhoods serve as dumping grounds. As a result, undulating hills of trash and effluvium host luxuriant pigs and skittish goats and small fires emit toxic plumes of smoke. Conditions like these helped cholera spread like wildfire through the city’s slums in the fall of 2010, again last year, and, in all likelihood, in the year ahead, particularly when the rains come.

It’s now been more than two years since a 7.0-magnitude earthquake destroyed much of Port-au-Prince’s already fragile infrastructure and many of its homes. Large numbers of people who were displaced by the quake are still living in tent settlements scattered across the city. Many others, like Dattchina and her mother, have only rudimentary housing with no facilities or services. In either case, families cook
Doctors Without Borders / Médecins Sans Frontières (MSF) operates the Drouillard Hospital in Port-au-Prince, Haiti, one of three hospitals MSF runs in the city. Operating 24 hours a day with a capacity of 208 beds, the center provides free care to victims and the general public. The hospital responds to medical and surgical emergencies and major burn cases and offers physical therapy and mental health follow-up care. Below is a schematic showing current and planned facilities as of late Spring 2012.
<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
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<tr>
<td>Physiotherapy Sessions</td>
<td>27,536</td>
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<tr>
<td>Mental Health Sessions</td>
<td>9,718</td>
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<tr>
<td>Surgical Procedures</td>
<td>6,672</td>
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<tr>
<td>Orthopedic Admissions</td>
<td>1,741</td>
</tr>
<tr>
<td>Burn Unit Admissions</td>
<td>355</td>
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</table>

Facilities for Infants & Children
Emergency Care
New Emotional Trauma Services
Revised Mental Health Unit
Improved Physical Therapy Unit
Improved Access

Color Legend:
- Project Under Study
- Project Underway
- Project Completed
A HAITI EMERGENCY

over open fires, use candles for light, and hope exposed electrical wires don’t become live at the wrong moment. It amounts to perfect conditions for fires and burn accidents.

MSF’s Drouillard Hospital is the only place in Port-au-Prince where people can receive free treatment for severe burns. Between May 2011 and May 2012, staff treated 428 such patients. On the morning Dattchina arrived, the hospital’s burn unit was already near capacity. The patients included four survivors of a fire in a tent settlement the previous day, two men electrocuted by live wires, and at least 15 children—among them one little girl whose dress had caught fire when she stepped over a candle and several children burned in kitchen accidents similar to Dattchina’s.

In addition to the burn unit, which receives referrals from all over the city, Drouillard provides orthopedic and abdominal surgery, internal medicine, pediatrics, physiotherapy, mental health services, and a 24-hour ER, all for free. The programs are aimed primarily at residents of Cité Soleil, but they attract people from all over the city who have no money to pay for health care.

It’s a broad scope of activities for an MSF project, but many of the services are interconnected: burn and surgery patients often require physiotherapy and mental health care. Inside the physio unit, for example, there was a baby whose fingers were severely burned when a candle fell and lit his bed on fire. He had already received treatment in the burn unit and was now receiving regular therapeutic massages.

“I do this to keep the skin on the burned hand flexible,” said Marie-Yalba Coriolan, a physiotherapist who works primarily with burn patients, as she rubbed ointment onto the boy’s fingers, pressing and kneading the finger joints while cooing to him. If he does not receive this therapy, she added, “the skin will get hard and the fingers will become difficult to move.”

Back in the burn unit itself, Pierre Joseph was kneeling next to a hospital bed, talking to two women flanking a two-and-a-half-year-old boy. Joseph, a psychologist, provides mental health care to any patient at Drouillard who needs it. The little boy in the bed had been badly burned across his arm and chest by boiling water that his aunt was using to prepare his bath. Joseph was helping the women deal with some very sensitive issues that surfaced due to the accident. The boy’s father had died during the earthquake and his mother had been unable to care and provide for him, so his aunt was raising him while his mother worked to earn money.

“Guilt is a subject that comes up pretty often,” Joseph said. He points out that many parents who end up caring for their children here are among the 80 percent of the population living below the poverty line. While trying to make money, usually by selling things on a small scale, they are likely to leave their youngest children in the care of children who are themselves only eight or ten years old, and accidents happen. “As a psychologist,” he explained, “you’re there, above all else, to prepare the parents, in case there was negligence, so they know what to do to prevent this from happening to the child again.”

RELATIVELY LUCKY

A nervous look on her face, Dattchina is rolled from the ER into a special operating room for burn patients. Her eyes scan the room as the nurse-anesthetist speaks to her kindly. In a whisper, Dattchina asks the nurse-anesthetist her name.

“We do almost everything for the burn patients in this operating room,” says surgeon Lunel Salomon. “We do the stan-
standard dressings. We often have to do amputations, tissue debridement. We do almost all surgical procedures that a burn patient may need here."

Once the nurse-anesthetist puts Dattchyna under full anesthesia, the surgery team begins the procedure. Three people hold her in position and the surgeon cleans, treats, and wraps her back, chest, and arms.

“Before her,” says Dr. Salomon, “we had a patient who had very deep third-degree burns. For this child, the wound is not very deep. In theory, she should recover without any major problems. There should be very little scarring, perhaps some discoloration of the skin."

Her eyes fluttering open, but still under the effects of anesthesia, Dattchyna is rolled out of the surgery block and down the hallway towards the burn unit, where her mother will soon join her. Every two or three days a surgical team will clean her wounds and change the dressings while she heals. If all goes well, Dr. Salomon says, she should be able to go home within two weeks. In a ward full of children and adults who have all been casualties of a brutal, normalized neglect, the little girl may be one of the relatively luckier patients. And, in fact, nine days after Dattchina was admitted, she was discharged in good condition and her mother took her back home.

**MSF IN HAITI**

In addition to the hospital in Drouillard, MSF runs an 80-bed referral center for obstetric emergencies in Port-au-Prince’s Delmas 33 neighborhood and works in two operating theaters, the emergency department, and the pediatric and maternity wards of Choscal hospital in Cité Soleil, while also providing care to victims of sexual violence. MSF’s 40-bed stabilization center in Martissant offers maternity care, internal medicine, and mental health services, and MSF tends to wounds, performs orthopedic and reconstructive surgery, and, with Handicap International, offers physiotherapy and rehabilitative services in Sarthe. MSF also runs a 160-bed hospital in Léogâne, west of Port-au-Prince, focusing on trauma and obstetric emergencies and basic health care to women and infants, and teams throughout the country have treated well over 170,000 patients for cholera.
How does an Emergency Team differ from a regular MSF team? The Emergency Team is always on standby to intervene in sudden crises. If we are already running programs in the country affected, we send in the Emergency Team to act as reinforcements. It carries out an exploratory mission, recommends any program openings, then sets them up using a parallel coordination system to allow the regular team to carry on its original programs as best it can.

Who is on the Emergency Team? In Paris, we have 20 people in our Emergency Pool right now—doctors, nurses, surgeons, anesthetists, pharmacists, logisticians. We need many different profiles. They’ve all left their regular jobs and are on standby to go within 48 hours to an emergency mission anywhere in the world. They are under contract for at least 12 months. We have Africans, Americans, Europeans, many different nationalities in the pool.

To qualify, you need to have at least 24 months MSF field experience in different types of missions. One must be epidemics, and one must be conflict zones. And because the Paris team works in so many Francophone projects—around 65 percent of our projects are in French-speaking countries—people must also speak French as well as English.

How does MSF decide when the Emergency Team should be deployed? It depends if MSF has a presence in the country or not. If we have no presence in a country, like in Libya and Ivory Coast last year, we have to start from scratch. For instance, in Libya, we started off by using the media and contacts we have on the ground to follow the beginning of the armed revolution.

Then three or four days after the violence started in the east of the country, we sent a small exploratory mission of three people—a doctor, a logistician, and a coordinator—to Misrata. They had to go by boat because the whole town was surrounded by government troops and this was the only way to gain access. After two or three days, the team proposed we open a trauma center, so we sent in reinforcements and materials, again by boat. We were there with the Emergency Team from Brussels, which decided to run a hospital for women and children in the same town.

Were there any particular difficulties? A major difficulty was finding local nursing staff. Before the war broke out, most nurses came from overseas—including India and the Philippines—and they had all left. So, despite the security risks, we sent in 19 international staff—including surgeons, nurses, and doctors—to set up 25 trauma beds. For at least two months, the team managed this small 24-hour trauma center with very few national staff members with them. In six months in Misrata, we treated 1,200 men, women, and children, all trauma-related, and conducted 525 surgical interventions, all violence-related.

And in Ivory Coast? For Ivory Coast, it was the same process. The crisis started in late 2010-early 2011, following the elections. We followed the situation at HQ for two to three weeks via the media and the local network we were still in touch with, having worked there previously. We then sent in one coordinator, one doctor, and one logistics officer to evaluate the situation. They proposed an intervention and we sent in reinforcements and supplies right away.

How do you get permission to set up so quickly? Because we are a medical organization, the Ministry of Health is always our first contact. And because our organization is well-known, even if we are not operational, we don’t usually have any problems setting up meetings. The Ministry of Health describes the situation and makes recommendations on where we should go and what we should do, and once we have the green light, we do our own evaluation and
decide what to do and what not to do. We worked in one hospital in an Abidjan neighborhood where there was a lot of violence going on. The Ministry of Health staff had left this particular hospital, so we set up an emergency room, operating theater, and a hospital ward for post-operative care. We stayed throughout the fighting.

*How long does the Team normally stay in-country?* Every emergency mission opens during the acute phase—which lasted two months in Ivory Coast. Then we must stay on for a few months to hand over the project to the Ministry of Health, because following the emergency phase, local authorities are always in difficulty. We stayed in Abidjan for seven months.

*How does the Team work when there is an MSF presence in the country already?* If we have a presence in the country already, like in Pakistan during the floods, or more recently in South Sudan, things can go very quickly because the Emergency Team will not have to spend time contacting the authorities, finding cars, or identifying a place to set up an office and a place to sleep. All this is done by the national coordination team already in the country. If we have no offices or presence in a country we probably lose at least 48 hours setting everything up.

Traditionally there is a separate coordination for emergency programs so as not to disturb the ongoing programs. Just recently, for example, around 20,000 refugees arrived in a place called Yida in South Sudan. The national coordination team sent an experienced colleague to evaluate the situation and after two days, he recommended MSF open a primary health clinic and a 20-bed hospital for secondary care. So they turned to us, and we sent an Emergency Team, which immediately set up a coordination office in the capital, Juba, that could also oversee any new explo and program openings. We opened two new projects in one month, managed them for three months, then handed them over to the national coordination team.

*What operations do you feel MSF did well?* I would say, in recent years, our response to the earthquake in Haiti, and then, several months later, the cholera outbreak. It was a big emergency and a big intervention from our Emergency Teams across the network. Ivory Coast, too, was very significant. I only talked about one project, but we actually opened five projects last year. Libya was very important, as well, the fact we were capable of sending a team of 19 people to Misrata, which was surrounded and only accessible by boat. It was very dangerous and one of our most important missions.

*Do you provide mental health support to Emergency Team members?* We were a bit late to address the mental health needs of our staff, but now we have a special psychologist dedicated to supporting people returning from the field, and especially from insecure and dangerous places. They meet with the psychologist and are provided with follow-up support if they need it.

*Where are your people right now?* We have a team in Mali working with people affected by the violence there, and another working with refugees who’ve fled to Niger. We also have teams working on the nutritional crises in Mauritania and Senegal.

*Are there different security protocols from regular programs?* On its first explo, the Emergency Team normally takes some time to understand the country, including meeting with other nongovernmental organizations working there, before doing its own security evaluation. Two to three weeks after opening a project, it creates the first security guidelines and rules we need to follow in the country.

*How could MSF improve in its emergency responses?* I think we were a bit late with the Arab countries. We were late deciding what to do after the demonstrations started. In Tunisia and Egypt, we overestimated local capacity in terms of medical response and underestimated the needs, so it was several weeks before we even sent in explo teams. We learned that we need to be more reactive. Even if we estimate there is good quality of care in a country, we realized we need to at least send in a team.
PROJECT UPDATE: THE SAHEL

A complex series of nutritional crises is unfolding across the nations of Africa’s Sahel region. MSF is expanding its nutritional activities to address this seasonal “peak” in malnutrition rates, while also developing longer-term approaches it can integrate into its regular programs in order to help provide lasting ways to mitigate this chronic health crisis. The map on the opposite page shows MSF’s projects in the area.

**Burkina Faso** Young Malian refugees in one of Burkina Faso’s refugee camps. Burkina Faso 2012 © Aurelie Baumel/MSF

**Mali** An MSF staff member distributes shelter kits to displaced people in the village of Aglai, Timbuktu area. Mali 2012 © Foura Sassou Madi/MSF

**Chad** A group of mothers wait to have their children checked at a MSF ambulatory treatment feeding center in Dougine. Chad 2012 © Catherine Robinson/MSF

**Mauritania** A child is monitored at an Outpatient Nutritional Rehabilitation Center. Mauritania 2012 © Victor Raison

**Niger** A nomad with his cattle in the Maradi region. Niger 2012 © Julie Remy/MSF
Sharonann Lynch is MSF’s HIV/AIDS Policy Adviser and a veteran of the HIV advocacy and policy arena. Based in New York, she recently traveled to Mozambique to study Community Antiretroviral-Therapy Groups, or CAGs, in which groups of patients support each other and individuals take turns picking up medications for other members. CAGs are part of MSF’s broader effort to decentralize HIV care by bringing it closer to where patients live and empowering nurses and community health workers to carry out treatment and testing tasks that only doctors had done in the past.

I wanted to see how community ART groups were functioning in Mozambique’s Tete Province. There’s been a lot of excitement about this model because we’ve seen that it makes treatment more feasible and that it can help improve adherence to treatment.

Essentially, CAGs came out of an idea from Win Van Dam, who worked for MSF and has been advising MSF on strategies for providing chronic care in resource poor settings. It was fascinating to see how this creative, innovative strategy—which came not from headquarters, but from the field, as
they so often do—was being implemented more than a year after it was originally piloted. It also ties in with a challenge laid out by Eric Gomare, medical director for MSF in South Africa. Most of our HIV projects are still facility-based, meaning patients have to cross the threshold to get to us. Eric said, “what can we do to leave the clinic, to step over that threshold ourselves and to have more outreach in the community?”

The Mozambique project focuses on community-based services that bring care closer to patients so they don’t have to travel to hospitals or larger health facilities. In this context, the CAGs are a fantastic strategy. They are self-formed groups, a group of seven in which one takes a turn each month fetching medicine for everyone else. It’s what they call in science an “elegant” strategy—a simple solution, even if it’s still adaptive rather than mitigative.

It’s evolved, too. There were community ART groups made up of adults on ARVs. Then, they’ve piloted—and they’re presenting data already at the International Aids Conference this July—children’s CAGs, which are CAGs with children and their caregivers. They also have a sex worker CAG and two TB [tuberculosis] CAGs, because there’s a lot of co-infection, and a PMTCT [prevention-of-mother-to-child-transmission] CAG, too.

Overall, the CAGs have been incredibly popular, one, because it’s an elegant strategy, as I said, and, two, because it’s so effective. You’ve got people who are committed to looking out for each other, who are united by mutual self-interest, and who are showing the lowest attrition rates we’ve ever seen, just 2.3 percent. And I think that’s because the distance they had to travel to get treatment in the first place was so long and so frustrating. They really had to fight for it, and now they want to protect it.

And now they’ve been on ARVs for a while. And it was really inspiring to hear CAG members say, “Don’t worry about us. We’re fine. We’ve got our treatment. It would be great if you could bring it even closer to our nearest clinics, but even more importantly: help us fight HIV in our community. We are still raising HIV positive babies. We are still caring for HIV positive neighbors who are ill.”

These people are living, walking, breathing, talking proof of the benefits of HIV treatment. Not only can they attest to it for their own benefit, but they are hell-bent on helping their communities get the benefits as well. So they convince other people to seek treatment. They convince other people to get tested. It wasn’t anything MSF asked them to do. They essentially took it on by themselves.

They are as fed up as people in MSF about the limitations that still exist on HIV care, how centralized it still is. In a sense, both MSF and the CAGs are demanding a shift in the paradigm—a shift from the focus on the individual, even from the patient perspective, to family, to community, to the larger beyond.

There’s this great science* that shows, yes, treatment saves lives, that it reduces new HIV infections, prevents orphanhood, all that great and good stuff. The big two barriers that MSF can help with are the two questions the New York Times asked in their editorial about this new science: is it operationally feasible? And is it affordable? And we can say yes, to the first and yes, with action, to the second. You have to take certain steps in order to make it affordable.**

These CAGs are very poignant examples of how massive scale-up can be feasible and also be successful. Government officials from neighboring countries have gone to see the CAGs for themselves, and are pondering whether it would be suitable for their own contexts, which is great. The point is that even for such a resource-poor setting as rural Mozambique, this is something that works.

*Studies released last year showed that HIV treatment can reduce transmission by 96 percent.

**MSF has advocated for a minimal Financial Transaction Tax, among other measures.
DONOR PROFILE

Ron and Tracy Pease lost their son Joshua to a car accident in 2001, when he was in college. To honor his memory and celebrate the spirit with which he lived, the Peases started holding an annual music festival near their home in Chappel Hill, Texas, donating the proceeds to MSF. “In the earliest days it was mainly personal friends and customers from my lawn sprinkler business,” says Ron, but it’s grown, and this summer, up to 175 people are expected.

They raise money from donations and a silent auction of items brought by attendees. They chose MSF because Joshua supported it and because they appreciate MSF’s medical work, its transparency, and its tradition of bearing witness. “We don’t raise vast sums, but we believe in the story of the loaves and fishes—we believe that MSF can take those loaves and fishes and stretch them,” Ron says. “We know lives have been saved and great work has been done with the money we’ve been able to donate.”

SNAPSHOT DRC 2012 © Emily Lynch/MSF

Heightened violence in Democratic Republic of Congo’s North and South Kivu provinces is forcing the displaced to take shelter with host families, like this one in Kalungu, which has 10 members of its own but has taken in nearly three dozen more.

MSF THANKS OUR LEGACY SOCIETY MEMBERS

By providing for MSF in their estate planning, Legacy Society members help ensure our ability to respond to the challenges we face now and 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 life insurance policy, financial account, Individual Retirement Account (IRA) or other retirement plan, 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 Beth Golden, Planned Giving Officer, at (212) 655-3771.

STRENGTHEN YOUR COMMITMENT

MSF would like to thank all of our donors who have pledged to our Multiyear Initiative. With their annual commitments of $5,000 or more, these generous supporters provide MSF with predictable and sustainable funds, enabling us to respond effectively and rapidly to emergencies around the world and helping us to better plan for the future.

To date, we have received pledges totaling over $25 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. You can also learn more by visiting us online at doctorswithoutborders.org/donate/multiyear.