ALERT

HOW MSF WORKS

QUESTIONS ANSWERED, EXPLORED, AND RAISED
Dear Friends,

How does MSF work? It’s a deceptively simple question with at least as many different answers as we have patients all over the world. However, there are some common threads. From the most basic nutritional assistance for malnourished children to the most complex medical research, all of our work is guided by the principles set out in our charter: upholding medical ethics, maintaining impartiality, bearing witness on behalf of our patients, ensuring we remain accountable to both our donors and beneficiaries, and preserving our independence.

In a time when global politics are in a state of flux, our independence is more important than ever—and we owe that independence to donors like you. Independent support from our millions of private donors means that MSF is not beholden to the United Nations, the United States government, or any other entities, and that our funding never comes with expectations that might run counter to our mission. It means you can be sure that MSF’s decision to intervene in a country or crisis is based solely on the medical needs, and not on political, economic, or religious interests.

With that independence comes responsibility, both to our patients and our supporters. In each issue of Alert, we try to feature deeper discussions about our operations; to be transparent about our work, and to hold ourselves accountable. To that end, this issue—the third in our “How MSF Works” series—will once again address common and not-so-common questions about the work we do, the ways it is accomplished, and the decisions behind the choices we make.

We’ll explore MSF’s organizational structure and the reasons for it, and touch on the ways in which MSF interacts with both governments and other nongovernmental organizations. We’ll examine new solutions to old problems, like using geographic information systems to track epidemics, and we’ll discuss how MSF is tackling relatively new challenges, like the fight against antimicrobial resistance. And we’ll go into more depth about the nature and importance of independence in a conversation with MSF-USA’s executive director, Jason Cone.

None of this would be possible without your generosity. In 2016, you contributed more than $350 million—the most ever in MSF-USA’s history, and in a year largely devoid of any “headline” crisis like the 2010 earthquake in Haiti or the 2014 Ebola epidemic in West Africa. Your support allows us to both prepare for the next headline and to continue providing emergency medical care where others can’t or won’t go, in Yemen, South Sudan, Nigeria, Central African Republic—wherever the needs are greatest. That’s how MSF works.

Sincerely,

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Unrestricted funding is an important part of MSF’s financial independence. The fact that the vast majority of donations we receive are not restricted to a particular country or project allows us to be very nimble and responsive with our operations. Additionally, roughly 30 percent of MSF’s $968 million operational budget (2015) is unallocated, meaning that it’s held in reserve for emergencies. That flexibility means that we can respond as quickly as possible in a crisis.

We know MSF does not accept any funding from the US government. Does it accept donations from any others? Currently, less than 5 percent of MSF’s total funding comes from governments or institutions like UNITAID, a multilateral funder based on a tax on airline tickets in Europe. And that figure will shrink to around 1 percent by the end of 2017. Our choices about accepting such funding are always practical—how will it impact our capacity to respond? Are the requirements associated with accepting this funding too onerous? Do they limit our capacity for action? Those are the questions we have to ask. Our choices should always be based on the needs of patients, not on the priorities or whims of governments.

In June 2016, MSF made the decision to reject funding from the European Union (EU) based on its policies regarding migrants and refugees. How was this decision reached? This decision was made in response to the so-called EU-Turkey deal, under which refugees—the vast majority of them from Syria—would be...
denied protection in Europe and forcibly sent back to Turkey or other countries in exchange for various political and financial incentives. We saw this deal as an abdication of the humanitarian imperative, if you will; of the kind of assistance the EU was meant to be supporting through the Directorate-General for European Civil Protection and Humanitarian Aid Operations [ECHO], its humanitarian arm. It was in complete contradiction to the foundational principles of international humanitarian law and refugee conventions that Europe was responsible to uphold.

ECHO was going to be used as part of a mechanism to send people back to places where their lives could be endangered. And so, as an organization that had been receiving funding through ECHO, as well as from some EU member states supporting the policy, MSF decided to reject future funding from the EU and from Norway. This decision had serious implications for MSF’s funding, but we felt that, as a humanitarian organization, it was a necessary move given our commitment to our patients and the impact that European policy was going to have on people we felt were in danger—people who were already being held in dire conditions in Greece, Italy, and elsewhere, who were at risk of being sent back to places like Afghanistan and Syria.

It’s important to note that rejecting these funds will not affect MSF’s medical programs around the world. We maintain emergency funding reserves that allow us to respond immediately to a major crisis, and if required these will be used to fill the gap and support our projects. This decision means MSF will rely more than ever on private donors to fund our medical activities.

How would MSF be affected if other organizations that do accept funding from the US and other governments lost that support?

I believe MSF should always try to fill the gaps. Obviously our focus is on emergency medical action, but we’ve done things like general food distributions in places like Darfur, Sudan; in Niger during the 2005 famine; and, most recently, in northern Nigeria and Central African Republic. We step in wherever we see the needs, and unfortunately the needs seem to be growing.

We’ll keep adapting to remain as effective as possible, but we certainly can’t meet all the needs. That’s why reports of significant funding cuts—particularly cuts in US funding for international organizations—are so worrisome. The US provides 40 percent of the funding for UNHCR, the UN refugee agency, and a huge proportion of global health funding for HIV, tuberculosis, and malaria. Most of the other large US-based humanitarian aid organizations also get anywhere from 40 to 70 percent of their funding from the US government. So a significant retrenchment in funding for humanitarian aid could have serious consequences for the capacity of many organizations to respond when crises occur.

So how do we address this challenge? On the one hand we will prepare to have to do more. On the other hand, we will raise our voice about the need to retain those levels of support, because of the impact funding cuts will have on things like the progress made on HIV, and on efforts to contain malaria. At the end of the day, all of our choices—about funding, about speaking out, about advocacy—come down to providing the best care possible to our patients.
WHERE DOES MSF FIT INTO THE WORLD OF HUMANITARIAN AID?

Jason Mills is MSF’s humanitarian affairs representative.

Including the UN system, humanitarian aid amounts to about a $28 billion field. Of that, roughly $22 billion comes from governments. About $6.2 billion is private funding. That means MSF alone makes up more than one-quarter of that market. In this day and age, as budgets shrink or get cut, it’s important that somebody speak out independently without fear of having their budget slashed for political reasons. Private funding gives us the independence to make our own choices about how and where we operate, and gives us a powerful voice to advocate on behalf of our patients. Importantly, it allows MSF to move quickly and confidently into an acute emergency—as we did in northern Nigeria in 2016, for example—helping to lead the broader humanitarian community in emergency response.

HOW IS MSF STRUCTURED?

Jason Cone is MSF-USA’s executive director.

Structurally, MSF is a movement across many countries. There are 21 section offices around the world. Of these, five are operational centers, located in France, Belgium, the Netherlands, Switzerland, and Spain.

This decentralized approach is intentional. Unlike many other nongovernmental organizations (NGOs), our structure allows us to prioritize our capacity to rapidly tackle emergencies, with the operational centers focusing on crisis response and the other sections providing support through advocacy, recruitment, fundraising, and more. We’ve seen the benefits of this approach in our rapid response to the 2010 earthquake in Haiti and subsequent cholera outbreak, and our multifaceted approach to the Ebola epidemic in West Africa. It’s also useful when working to gain access to patients trapped in conflict as quickly and effectively as possible, as we did in Libya in 2011. At that time, teams from different MSF operational centers crossed into Libya from points in Tunisia and Egypt, while others came through Mali or flew directly to Tripoli.

There are global decision-making structures that bring everyone together to set policies and discuss big-picture ideas like ethical guidelines, movement-wide policies, or public positions, but each of these operational centers can act as a separate entity as needed. That’s how we’re most effective.

WHAT DOES IT MEAN FOR A HOSPITAL TO BE “SUPPORTED” BY MSF?

Mike White is MSF’s deputy operations manager for Ethiopia, Haiti, Liberia, South Sudan, and Sudan. Jason Mills is MSF’s humanitarian affairs representative.

MIKE WHITE: Often when people think of MSF projects they picture doctors setting up tents in remote areas where there is little or no access to medical care. While this isn’t an inaccurate description of our work, it’s only part of the picture. In truth, much of MSF’s work happens in regions where there is some
WHERE DOES MSF FIT INTO THE WORLD OF HUMANITARIAN AID?

TOTAL INTERNATIONAL HUMANITARIAN FUNDING: **US$28 BILLION**
(2015)

- **GOVERNMENTS**
  - Total: US$21.8BN

- **PRIVATE**
  - Total: US$6.2BN

- **MSF**
  - US$1.6BN
  - (26% of all private funding worldwide)

**SOURCES:** Development Initiatives based on OECD DAC data, UN OCHA FTS, UN CERF, UNCTAD, UNHCR, World Bank data, SIPRI, IMF, and Development Initiatives’ unique dataset for private voluntary contributions.

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**MSF WORLDWIDE**

- **$1.6 BILLION**
  - Total Income (2015)

- **Operations in 69 Countries** (2015)

- **36,882**
  - Staff (2015)

**PROGRAMS MANAGED IN 5 “OPERATIONAL CENTERS”:**

- **MSF-SPAIN**
- **MSF-BELGIUM**
- **MSF-HOLLAND**
- **MSF-FRANCE**
- **MSF-SWITZERLAND**

**21 SECTION OFFICES AROUND THE WORLD**

Fundraising / Communications / Human Resources

Example: MSF-USA is a section office
health infrastructure that is just in need of medical support.

That support can take many different forms, depending on the context. For example, in Aweil, South Sudan, MSF supports a ministry of health (MoH) hospital. We work together with the South Sudanese MoH to keep the pediatric and maternal health programs running smoothly, to the point that the facility has both an MSF and an MoH hospital director. Similarly, in southern Chad, where malaria is the leading cause of death for children under five years of age, MSF supports Moïssalla District Hospital. We run the unit for the treatment of severe malaria within this hospital, and support MoH health centers with routine immunization, referrals, drug donations, and health education.

We also provide support in the form of capacity building. A perfect example is in Liberia, where the Ebola outbreak has ended but has left much of the existing health systems distressed. MSF has made the choice to continue working in Liberia post-Ebola, opening the 94-bed Bardnesville Junction Teaching Hospital to address the gaps in the health system while providing free pediatric care.

JASON MILLS: Syria is a particularly interesting—and completely unique—context to examine when discussing how MSF supports health facilities. In Syria, every clinic and hospital needs to be approached differently, as some are private, some are public, some were private before the war began and became public when the original owner was forced to flee—no two situations are ever alike. As a result, there is no “one size fits all” solution to providing support.

Furthermore, we still haven’t been able to negotiate access to government-held areas, and MSF had to withdraw all international staff from many opposition-held areas due to the risk of abduction. So how do you keep an MSF health facility running without international staff? In Syria, it was possible because of the extremely high qualifications of our local staff, who typically make up 95 percent of the payroll. We send supplies of drugs, fuel for generators to keep the lights on, and medical equipment, and our local colleagues run the hospital.

In some parts of Syria MSF donates supplies to health facilities run by public or private doctors as well. At these hospitals we have an ongoing relationship with the staff; we might consult with them via Skype and make donations of supplies, but it’s not an MSF hospital with an MSF sign outside. This is not our normal way of working—bringing in international staff who are “outsiders” to a conflict helps to reinforce our principles of independence and impartiality. This approach is very much a compromise based on the extremely complex nature of the Syrian war, and the tremendous needs. When you’re faced with a crisis on the scale of what’s happening in Syria you have to think pragmatically, and that’s what we did.
HOW IS MSF USING NEW TECHNOLOGIES TO KEEP ITS PROJECTS RUNNING SMOOTHLY?

Matthew Brady is an MSF financial coordinator in Democratic Republic of Congo (DRC).

M-PESA (Swahili, meaning mobile-money) is a banking service run entirely on cell phones. It was launched in Kenya 10 years ago and has really taken off with the proliferation of cell phones in recent years. Essentially, through a combination of text messages and security codes, people are able to use their phone to send and receive money, check account balances, make purchases, and deposit and withdraw cash. All of this is facilitated by a vast network of agents and vendors scattered across the country.

At the beginning of 2016, MSF introduced M-PESA as a pilot project in its programs in North and South Kivu, DRC. In areas where cell phones are more common than paved roads and options other than cash are few, M-PESA provides a feasible way for MSF to access financial resources.

In South Kivu, we no longer pay any of our staff with cash and they are seeing the benefits of this new system. Not only does it reduce the security risk that comes with carrying cash, it’s also quick, flexible, and secure. Many of our projects in DRC are in remote locations and staff often need to send money back to their families, which can be slow and quite tricky. But with M-PESA, transfers are as simple as sending a text message and as secure as a bank transfer.

M-PESA has not only streamlined our payments to staff, but we also use it to pay most of our local suppliers—construction materials, water and sanitation equipment, even daily workers.

The next step is to evaluate using M-PESA in the rest of our projects in DRC, and hopefully one day in other countries such as Chad or Central African Republic as M-PESA continues to roll out and as parallel systems are introduced. From a global perspective, mobile payments really are the frontier in creating access to capital for people previously left out of the financial system. At the more local level, at least for MSF, it means more efficient operations, and, ultimately, patient care.

HOW DOES MEDICAL RESEARCH FIT INTO MSF’S WORK?

Patricia Kohn is MSF-USA’s medical editor. Carrie Teicher is an MSF doctor working for Epicentre, MSF’s research and epidemiological arm.

PATRICIA KAHN: The purpose of MSF’s medical research is simple: to improve patient care. Our goal is to find more effective diagnostics, treatments, and strategies for delivering care, and to improve the evidence base for the care we and others provide in the difficult contexts where we work.

Sometimes this research involves developing new tools. For example, Epicentre, MSF’s research arm, is testing a new vaccine against rotavirus, which causes severe diarrheal disease and is a leading killer of children under five in developing countries. They also worked alongside other research organizations in demonstrating efficacy of a new Ebola vaccine. Often MSF research involves improving or adapting tools that already exist. Take drug-resistant tuberculosis (DR-TB), a major, neglected public health issue. As the largest non-governmental care provider for DR-TB in the world, MSF is working to better understand and expand access to two new TB drugs—the first in half a century—which seem to be more effective. We are also testing new combinations of existing TB drugs to find shorter, more effective regimens with fewer side-effects.

Yet another example is from the oral cholera vaccine: although the shortage in global supplies of this effective vaccine make it very difficult to do mass preventive vaccination campaigns, our research showed that a rapid, targeted campaign can help contain the spread of an outbreak that has already begun. We’ve also demonstrated that the use of a single vaccine dose in outbreaks, as opposed to the standard two doses, is also a useful strategy that allows us to protect more people and stretch our limited supplies further.

Sometimes our research is aimed at finding more feasible ways to deliver care. A good example comes from HIV. For many patients, getting their medications every month has considerable costs in time or travel expenses, if the clinic is far away, or in lost wages. To ease this burden, MSF introduced community antiretroviral groups (CAGs) into some HIV projects in South Africa, Mozambique, and DRC. CAG members provide each other with peer support, and they take turns each month traveling to the clinic and collecting medication for one another. Our research shows that people in

\[\text{From a global perspective, mobile payments really are the frontier in creating access to capital for people previously left out of the financial system. At the more local level, at least for MSF, it means more efficient operations, and, ultimately, patient care.}\]
CAGS are significantly more likely to stay on treatment over time.

Most MSF research is published in peer-reviewed medical journals—in 2016 MSF and Epicentre published more than 240 journal articles across a wide range of fields, from HIV and TB to surgery, malnutrition, vaccines, women’s health, and neglected tropical diseases. Sharing the knowledge we gain in the field sometimes changes how we or other humanitarian medical caregivers treat patients, or influences national or international care guidelines. Contributing to the global health discourse and informing policies around treatment protocols or best practices in epidemic response ultimately helps both MSF patients and the wider field of humanitarian medicine.

CARRIE TEICHER: Epicentre was founded by MSF physicians who wanted to bring scientific rigor to finding more efficacious solutions to challenges in the field. As a research institute at MSF, we work on clinical research, operational research, and epidemiology. The scope of our research is quite wide, running the gamut from prospective observational studies to randomized controlled trials. Epicentre brings together research and epidemiological expertise from medical and operational departments all over MSF.

Epicentre has two large research centers in Niger and Uganda that conduct high-level research in sub-Saharan Africa. At any given MSF operational site, there may be multiple research projects underway. Aweil, South Sudan, is an excellent snapshot of Epicentre’s work where multiple studies are ongoing. We currently have a retrospective malaria health-seeking behavior survey about to start, which will allow us to describe the health-seeking behavior of the population in the catchment area of the MSF hospital. The results of our research will inform our strategy for responding to malaria and other outbreaks.

Another recent retrospective study looked at pediatric severe malaria patients who were admitted to our hospital in Aweil. The data from this study will help describe the devastating peak in malaria last year and help inform what MSF can do to improve care in the upcoming year.

In Aweil there is also an exciting study looking at the feasibility of training clinical officers (COs) to use portable ultrasound diagnostics in order to help with the diagnosis of lower respiratory tract infections in our hospital. By training COs to use this technology we are increasing the capacity of the staff to use point-of-care ultrasound as a diagnostic tool for pneumonia.

We’re also conducting an ongoing study of morbidity, mortality, and neurodevelopmental outcomes among newborn children in Aweil. We are looking at all of the babies who come to our hospital and following their progress for the next two years. These health and developmental assessments will provide a much clearer picture of how our patients are doing.
Here’s an example: In 2015, at a refugee camp for Burundian and Congolese refugees in Tanzania, we knew where each tent was located, and we knew, on average, how many people lived in each one. We also knew that there were water taps placed around the camp that in theory supplied adequate safe drinking water for the number of people living there. But how could we be certain about where people were getting their water, and if they were getting enough? Did we really know that people were receiving that water, or were there taps going unused?

To answer this question, we placed MSF team members at each tap in the camp to count the number of people using each one. We were then able to take that data and apply it to our map of the camp using GIS software. The results of this study showed us that while there were theoretically enough taps in the camp based on the population, in reality there were gaps when it came to which camp residents were able to reach which taps [see map and data]. Visualizing this kind of data helps us adjust our operations and keep them as efficient as possible.

**PETE MASTERS:** The MapSwipe app means that in a matter of minutes you can contribute to the work being done around the world by MSF from the comfort of your own phone.

In a humanitarian crisis, the location of the most vulnerable people is fundamental information for delivering food, shelter, medical care, and other services where they are most needed. And, although it may be hard to believe, millions of people around the world are not represented on any accessible map.

Developed as part of the Missing Maps project (learn more about Missing Maps at www.missingmaps.org), MapSwipe enables anyone with a smartphone to contribute to the mapping of these vulnerable communities. Download the app, choose a mission, and download imagery for offline MapSwiping on an underground train or plane.

Now, with MapSwipe, we can give vaccination campaign coordinators a super-fast snapshot of population clusters, helping them to send their teams to the locations where they are most needed to achieve maximum vaccination coverage. By using MapSwipe to identify where communities are located, you’re helping us map the towns and villages without having to search through miles of land to find them, saving time and helping to put valuable data into the hands of our medical teams even faster. Learn more and download the app at www.mapswipe.org.
HOW IS MSF ADAPTING ITS PROGRAMS TO ADDRESS NONCOMMUNICABLE DISEASES?

Jeffrey K. Edwards, MD, MPH, is an MSF noncommunicable diseases mobile implementation officer and an operational research fellow.

MSF’s work is often associated with infectious diseases—malaria, cholera, TB, HIV/AIDS, and other bacterial, parasitic, or viral infections. Noncommunicable diseases (NCDs)—diseases that cannot be transferred from person to person such as hypertension and diabetes—have not historically been recognized as a medical priority in the contexts where we work.

However, NCDs account for at least 38 million deaths each year, and 75 percent of these occur in low- and middle-income countries such as Kenya, Zimbabwe, Cambodia, and Jordan. MSF is present in many of these places and we have witnessed the transition of disease burden from infectious diseases to NCDs. NCDs are now beginning to overwhelm health systems and generally receive little, if any, international support, frequently contributing to the cycle of poverty.

In 2002, we initiated our first program to care for patients with hypertension and diabetes. Understanding the similarities between managing NCDs and other chronic conditions such as HIV/AIDS, MSF established a novel integrated chronic disease clinic, offering care for HIV/AIDS, TB, diabetes, and hypertension. In the first five years, we treated more than 2,700 patients for diabetes, proving the feasibility of adding NCDs into the scope of our work.

This model of care has been replicated and integrated successfully over recent years. In Kenya, NCDs are responsible for over 50 percent of all hospital admissions and deaths, and are on their way to exceeding infectious diseases as the leading cause of mortality within the next 10 years. MSF operates a primary care program in Kibera—the largest slum in Nairobi—providing treatment for HIV, TB, and NCDs. In this project we currently have an active cohort of about

NONCOMMUNICABLE DISEASE DEATHS

38 MILLION
Deaths per year, worldwide

TOP 4 NONCOMMUNICABLE DISEASES

<table>
<thead>
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<th>Disease</th>
<th>% of Deaths</th>
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<tr>
<td>Chronic Respiratory Diseases</td>
<td>75%</td>
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<tr>
<td>Diabetes</td>
<td>75%</td>
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<tr>
<td>Cardiovascular Diseases</td>
<td>75%</td>
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<tr>
<td>Cancers</td>
<td>75%</td>
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75 PERCENT of these deaths occur in low- and middle-income countries such as:

Jordan, Kenya, Cambodia, Zimbabwe

HOW MSF WORKS: YOUR QUESTIONS ON FUNDRAISING, AND OUR ANSWERS

We regularly receive questions about fundraising from both donors and the public at large. In this section of Alert, we answer some of the most common questions we see. We’ll continue to address your questions about our fundraising practices in upcoming editions of Alert, so if you have a question that is not addressed here, please do not hesitate to contact us at donations@newyork.msf.org.

Can I earmark my gift?
We appreciate every contribution to our medical assistance of populations in distress. As an organization that needs to be responsive to emergencies, we prefer to receive un-restricted donations. This allows us to remain flexible and to allocate the resources most efficiently and to where the needs are greatest. However, we honor the wish of a donor to make an earmarked gift, under the condition that your gift is directed toward a specific program or country where we are currently working.

Can I send medications or other supplies to you?
MSF is unable to accept donations of supplies. Because the key to saving lives in an emergency is speed, it is our practice to have prepared, specialized, and uniform kits and other materials ready to go in the event of an emergency. MSF pharmacists and logistic specialists ensure the quality of our medical and non-medical materials. MSF does all of the purchasing for these kits in advance, and therefore cannot accept in-kind gifts such as medical equipment, drugs, food, or other materials for its operations.

For information on suitable charities that accept gifts in-kind, we recommend visiting www.guidestar.org.

If I give to a telemarketer over the phone, how much of that money do you get?
MSF uses very limited telemarketing, and if you receive a solicitation call from us it is most likely that we will be asking you to become a monthly donor. Monthly giving is extremely valuable for us as an organization, as it provides ongoing support to our field mission, helps us plan our interventions, and keeps us prepared for any upcoming emergency. We pay our telemarketing firms a flat rate of $4.80/hour. Generally, 10 calls can be completed per hour, so each call (regardless of results) costs around $4.80. Payment data collected by telemarketers is passed directly to MSF, and all charges are processed by us, so we receive 100 percent of the proceeds.

Why do you have a New York address and a Maryland address?
MSF’s USA offices are in New York City. Our staff and field project management are located in this main US office. We receive tens of thousands of pieces of mail a year and strive to keep full-time staff costs low, so we contract with a “caging house” in Maryland, where much of our incoming mail is opened and checks are deposited.
2,200 NCD patients and 5,500 HIV patients, carrying out almost 8,000 consultations per month.

Those displaced by conflict often find it impossible to continue treatment for chronic conditions such as diabetes. MSF’s projects for Syrian refugees have a strong focus on NCDs. In Jordan’s Irbid Governorate, MSF manages two clinics that currently treat almost 4,000 patients—mostly Syrian refugees—for diseases such as diabetes, hypertension, asthma, and cardiovascular diseases, which are among the most common causes of death in Jordan and the surrounding region.

With regular treatment, chronic diseases are manageable and not life-threatening, but there are many associated challenges: it is difficult for patients to access care; care is not often free; and NCD medications can be expensive. Additionally, populations are often mobile, treatment is long-term, and more than 50 percent of cases in some countries remain undiagnosed, so it is hard to get the full picture. Over the years MSF has found ways to treat NCDs in the most difficult of circumstances and we will continue to adapt and expand our response to meet this new, rapidly increasing burden.

**HOW IS MSF ADDRESSING ANTIMICROBIAL RESISTANCE IN ITS PROJECTS?**

Rupa Kanapathipillai is an MSF infectious disease physician.

AMR stands for antimicrobial resistance. That basically means that bacteria, viruses, and parasites are becoming resistant to commonly used treatments like antibiotics, tuberculosis drugs, antimalarials, and anti-HIV drugs. This is an increasingly urgent problem—in 2014 the World Health Organization released a report that showed rates of resistance were much higher than expected around the world. Our own studies have borne those results out: every time MSF has looked for antibiotic resistance in our own projects we have found it, often at levels that are much higher than expected.

Consequently, MSF has begun to adapt its operations to work around antibiotic resistance. A key element in this new approach is the use of microbiology laboratories. Findings from microbiology laboratories help us to customize medical care to meet every patient’s needs effectively. These labs help us to identify bacteria and figure out which antibiotics the bacteria is sensitive or resistant to. Based on that data we adjust our treatment plan accordingly—often by moving to second or third-line antibiotics. When working in the field, we often rely on preexisting microbiology laboratories, but in certain settings, MSF has built its own microbiology laboratories—in Amman, Jordan, for example, and in Koutiala, Mali.

The laboratories are also useful for health surveillance—in other words, identifying the magnitude and type of the problem at a population level. Labs help us to understand the rates and types of specific resistances that we see in our projects. We are diligent about collecting microbiological data wherever we have access to labs and using it to continuously evaluate our treatment guidelines and tailor antibiotic therapy for individual patients, a process known as antimicrobial stewardship. Another key element of antimicrobial stewardship is improving infection control and hygiene in our hospital structures to prevent the transmission of resistant bacterial infections.

While the drug development pipeline for new antibiotics is pretty dry, some gains have been made regarding new antimicrobial drugs for drug-resistant TB; MSF is currently participating in clinical field trials assessing shorter clinical regimens of these drugs. MSF will continue to actively campaign for more support for the research and development of new antimicrobial drugs, vaccines, and diagnostics to combat AMR.

BETWEEN: An MSF health worker examines a patient suffering from diabetes at a mobile clinic in Makhmour, Iraq. © Monique Jacques

How MSF Works: Questions Answered, Explored, and Raised | 13
Supporting MSF Through Socks
A Conversation with Blue Q co-founder Mitch Nash

On any given day at MSF’s New York office you might notice staff wearing brightly colored socks featuring sassy sayings. Those socks are courtesy of Blue Q, a novelty gift manufacturer that donates 1 percent of proceeds from sales of their socks to MSF. Here, Blue Q co-founder Mitch Nash discusses why his company chose to give to MSF, and why they continue to give.

What is Blue Q?
Blue Q is a gift manufacturer based in Pittsfield, MA, founded in 1988. We design and make curious and fun gift items. Our first gift to MSF was made 14 years ago in 2003 for $75. Over the past three years, through 1 percent of the sales of our socks, we’ve been able to donate $249,726.08.

Why did you decide to give a percentage of your sock proceeds to MSF?
We decided to support MSF during a product development brainstorm. We were discussing organizations who have strong track records of humanitarian work. Katie, our product development manager, suggested MSF, and really the conversation ended there! We knew it was going to be a long-term relationship, so we wanted to make sure the organization we chose would continue to do great work. As a company we want to be well-rounded, good to our employees and customers, and support a cause. Making a difference means just as much as creating beautiful products. At Blue Q we believe there is a price to everything, including living in the world. This is one way we pay it back.

What part of MSF’s work resonates with Blue Q?
MSF is involved in real life-or-death emergencies and there is a sense of urgency. At Blue Q we are drawn to the idea of MSF not being patient but responding to emergencies immediately. You guys go to where you’re needed, regardless of politics. Your name says it all—there are no borders.

How do your employees feel about Blue Q’s support of MSF?
Our employees are proud to support MSF, often sharing that their hearts “swell with pride” because they know that every sock we create benefits MSF. We don’t have nor do we need any analysis from the market, we’re not concerned with quantifying what supporting MSF does for us. We just like the idea of being a good steward of MSF’s message.

How does supporting MSF further your company’s mission?
Supporting MSF is an extension of Blue Q’s ethos. We have products that benefit the Nature Conservancy, we employ people with disabilities, and all of our employees benefit from our profits. MSF is a piece of the larger question of “who we are,” and is arguably the most beloved. This is not just a business for us, we are trying to redefine what a company can be. As with our employees, who share in the success of our company, we’re glad that MSF is able to share in our success as well.
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-USA 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) 763-5745.

THE MULTIYEAR INITIATIVE

MSF-USA would like to thank all of our donors who have made commitments towards the Multiyear 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 $49,813,325 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 doctorswithoutborders.org/multiyear.

MSF ON THE ROAD: A VOICE FROM THE FIELD

This March, “MSF On the Road: A Voice from the Field” continues, a program in which returned MSF field workers travel the country updating donors on our current work. Dr. Gerry Bashein, an anesthesiologist who has completed more than 15 missions with MSF, will visit 10 cities throughout Florida, discussing his experiences in the field and providing an in-person opportunity to find out more about MSF’s programs around the world. For more information, please call (212) 655-3759 or email OnTheRoad@msf.org.

APPLE PAY AND PAYPAL

Supporting MSF just got easier. In addition to major credit cards, we now accept quick, secure donations through PayPal and Apple Pay. If you’re using an Apple Pay-capable device, you have the option to donate with a just single click.

Visit donate.doctorswithoutborders.org today and see how easy it is to become a part of our movement.

STOCK DONATIONS

Did you know you can donate gifts of securities to MSF-USA? 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-USA 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-give. You can also call (212) 679-6800 and ask to speak to our donor services department, or call (212) 679-6800 and ask for Donor Services.

If you have any questions or comments, contact our Donor Services team toll free at (888) 392-0392, at (212) 763-5797 or email donations@newyork.msf.org.
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.