DOCTORS WITHOUT BORDERS/MEDECINS SANS FRONTIERES (MSF) is an international independent medical humanitarian organization that delivers emergency aid to people affected by armed conflict, epidemics, malnutrition, natural disasters, and exclusion from health care in nearly 70 countries. On any one day, more than 30,000 individuals representing dozens of nationalities can be found providing assistance to people caught in crises around the world. They are doctors, nurses, logistics experts, administrators, epidemiologists, laboratory technicians, mental health professionals, and others who work together in accordance with MSF's guiding principles of humanitarian action and medical ethics. The organization received the Nobel Peace Prize in 1999.
Friends, at any given time, great numbers of people are on the move. It would be wonderful if they were all visiting family or conducting business or taking a holiday—if their journeys were their choice, that is. But we know that’s not the case.

This past year, 2013, provided numerous reminders of just how often people are forced from their homes and homelands by circumstances—armed men, natural disasters, repression, privation, and more—beyond their control. In places such as Central African Republic, South Sudan, and Syria, we saw millions take flight in the face of conflict and violence. In the Philippines, a typhoon destroyed whole towns and cities, sending their former occupants looking for shelter or neighbors with houses still intact. In other countries, it was the search for economic survival that drove people, or the need to access services they were being denied.

As an emergency medical organization, Doctors Without Borders/Médecins Sans Frontières (MSF) knows from experience that we have to be ready to respond to these sorts of situations, and we have to be ready for the particular set of needs that arise among refugees and those displaced within their own countries. Being uprooted from one’s home is traumatic enough by itself, but due to the often-grueling nature of the journey to the next point and the conditions that await there, the risk of injury, disease, malnutrition, and trauma also rises. We know that vaccinations and chronic disease care get interrupted, at great cost. We know that women and children require special attention and that physical and psychological burdens increase over time—it gets harder, not easier—for those unable to return home.

To put it simply, people are on the move, so we have to stay on the move as well. In practice, this means mobilizing staff and resources and getting them where they have to be. It means negotiating access to the populations in need and remaining constantly aware of the dynamics on the ground, so we can be as efficient as possible while keeping our personnel and our patients as safe as can be. It can mean crossing frontlines or borders or rivers and mountains to reach them.

In this year’s annual report, we are highlighting populations that were on the move en masse in 2013, along with MSF’s responses in these situations. Case studies look into specific contexts more closely, while our facts and figures, our financial case study, and our roster of US-based staff who left for missions last year all show the perpetually active and necessarily responsive nature of our work.
The challenges inherent in these efforts were underscored yet again in 2013. While we were able to celebrate the release of our colleagues Montserrat Serra and Blanca Thiebault from captivity in Somalia, we also had colleagues who went missing in Democratic Republic of Congo and others abducted in Syria, as well as numerous security incidents. Furthermore, we were forced to close our programs in Somalia after nearly two decades due to deteriorating security conditions and our realization that local communities and leaders would not or could not provide the bulwark against various threats that we rely on to operate in conflict situations.

But we can fairly say that we accomplished a great deal. MSF’s US office sent 400 people to various field missions around the world, a very significant contribution to the overall work of the organization. Our teams carried out more than 9 million consultations and 77,346 surgeries, while also assisting more than 180,000 births (a full run down of the year in numbers can be found on pages 14 and 15). Our advocacy teams and Access Campaign also fought diligently to help remove barriers that prevent patients from getting the medications they need and to push the international community to uphold its responsibilities to populations in crisis.

Many are involved in this work, and we were deeply saddened by the loss of two people integral to the founding and development of MSF-USA, Garrick Utley and Dr. Richard Rockefeller. We are forever grateful for their assistance and counsel, and thank them, as we thank all of those who help us deliver emergency care to people who need it most, wherever they may be.

Sincerely yours,

Deane Marchbein
President, MSF-USA Board of Directors

Sophie Delaunay
Executive Director, MSF-USA
At present, there are more than 51 million people in the world who have been forcibly displaced from their homes, according to the United Nations High Commission for Refugees. Some were displaced recently, others years ago. Some are still located within the borders of their countries of origin, while others crossed into different nations in search of sanctuary or opportunity. Some have been displaced many times over. Almost half are women and girls.

However you divide it, an enormous number of people—more than the populations of New York, Hong Kong, Mumbai, Cairo, and Rio combined—have been set in motion by conflict, natural disasters, privation, a lack of opportunity, or some other factor beyond their control. Their departures are usually frantic, hurried affairs. They can do little planning. They often can take no more than what they can carry and often have to leave before they can gather their families together.
Displacement can have a devastating impact on an individual's health, and the conditions that drive people to take flight can have a devastating effect on health systems. Facilities can be destroyed and health workers killed, injured, or displaced themselves, creating a huge burden on those who remain behind. Those in transit may struggle to find care along their route or once they arrive in their supposed sanctuary. Existing health issues are exacerbated, and new ones arise, often sooner than a commensurate response can be readied to meet them.

MSF first responded to a refugee situation in 1975, when hundreds of thousands of Cambodians fled the Khmer Rouge. MSF teams have subsequently provided care in some of the largest and longest-running displacement situations of the modern age—in Afghanistan, Rwanda, Democratic Republic of Congo, Thailand, and Colombia, to name just a few.

Today, MSF runs projects for IDPs and refugees in more than 30 countries around the globe, and four of last year’s highest-profile emergencies—in and around Syria, South Sudan, Central African Republic, and the Philippines—were characterized by huge and chaotic population movements that came with immense health needs.

That is why we are focusing on “people on the move” in this year’s annual report. To some extent, this theme could include MSF staff members who were themselves on the move, leaving their homes to work in faraway nations or elsewhere in their own countries. It could also include the millions moving from countrysides to cities, and, in many cases, winding up in overcrowded and unhygienic slums. But for the most part, we are thinking of those 51 million people who've been uprooted without their consent or control, who've been pitched into an unknown future where MSF has a role to play by providing emergency medical care that might help them survive today and perhaps reach a better tomorrow.

Recurrent violence in Democratic Republic of Congo has displaced millions of people. MSF, which has worked in the country since 1981, treated hundreds of thousands of people in DRC in 2013, providing vaccinations, surgery, maternal and child care, emergency obstetrics, treatment for victims of sexual violence, and more.
In 2013, as Syria entered its third year of brutal war and violence erupted anew in CAR and South Sudan, MSF teams worked diligently to tend to people displaced by these conflicts. In each country, and in the countries surrounding them—particularly Jordan, Iraq, and Lebanon; Chad and Cameroon; and Ethiopia and Uganda—the particular toll that fighting takes on displaced people was readily apparent.

On a daily basis, staff tended to war wounds caused by gunshots, shrapnel, machetes, and other weapons; to respiratory and gastrointestinal ailments linked to awful living conditions; to chronic illnesses that worsened when treatment was interrupted; and to depression and anxiety that so often affect people uprooted from all they know. They provided the specialized care required by children and women (see p. 10) in displacement settings and nutritional assistance when the need arose.

Before they started to work, they labored to determine where our intervention would be of most value and then to negotiate access to populations in need. After projects were established, they did all they could to keep MSF facilities, patients, and staff as safe and secure as could be. They were not always successful, but over the course of the year, MSF reaffirmed its willingness to work in places others would not and to find ways to assist those for whom no other assistance was available, even in war.
For time immemorial, people have taken to the road in an attempt to improve their circumstances, to find the sustenance and resources—or the political freedom—that would allow them and their children to have a better life, or simply to survive. This continues, even in our modern age (perhaps because of it, in many instances).

There is a choice involved, to some extent, but it still means that people have to leave behind everything they know and subject themselves to different laws, different policies, different prejudices. It can also land them in places where they have little access to medical care.

MSF has intervened in several of these contexts, providing medical care for migrants from Central Asia and North Africa who were being detained in Greece or Italy and from East and West Africa as they tried to move through Morocco and Yemen. Our teams have also assisted Zimbabweans who crossed over into South Africa, ethnic Rohingyas in Bangladesh, and people from various Central American countries moving through Mexico.

There is often a tangle of legal and political issues that have to be sorted out before people in these sorts of situations can move on or be free, but as that all plays out (or doesn’t, as the case may be), there will almost certainly be medical issues linked to their passage and their circumstances that need attention.
When a massive typhoon struck the central Philippines in late 2013, MSF teams responded as quickly as they could, and, within a few days, were moving around the islands by land, sea, and air in an effort to reach people in need. Natural disasters on this scale can completely wipe out health facilities and drastically limit the ability of local medical staff to treat survivors (if they themselves survived). That’s what happened in Haiti following the enormous earthquake that hit the island in 2010, after which MSF launched its largest-ever emergency response, hiring thousands of new staff and treating more than 350,000 patients in the 10 months that followed.

Many of the challenges then—as in the Philippines and after other natural disasters—were logistical. When roads are out, fuel short, airports clogged, and buildings reduced to rubble, where do you treat patients, and how do you get supplies where they need to be? Doing so requires a huge and holistic logistical effort that MSF has undertaken in several places in recent years. In the
In November 2013, Typhoon Haiyan killed around 6,000 and left millions without a home. MSF intervened to provide emergency relief to the victims and re-establish hospital facilities for the population, especially pregnant women, newborns, and young children.

Philippines, as in Haiti and in Pakistan following an earthquake there in 2005, this included erecting an inflatable hospital where medical activities could be carried out.

From November 8, 2013, through February 28, 2014, MSF teams in the Philippines treated 96,611 outpatients, admitted 2,229 patients to hospital, performed 6,391 emergency room consultations, and carried out 3,756 surgical procedures. Natural disaster responses often last far beyond the immediate crisis, however. The emergency phase, in fact, can be relatively short. In the long term, it’s crucial that programs anticipate and address the medical needs that later emerge—infec
tious diseases, mental health issues, sexual violence, and more—while also working to aid the re-establishment of health care systems that were damaged.
For women, displacement comes with a host of additional medical risks. Once they leave home, it often becomes far more difficult to access medical care of any kind, particularly emergency obstetric care. This can put their lives in jeopardy, since some 15 percent of deliveries involve life-threatening complications that need urgent attention. In fact, research has shown that more Caesarean sections are performed in and after conflicts and natural disasters than any other major surgery, including surgery for war-wounded patients.

There is also an increased threat of violence and sexual violence in instances where families have been split up, social bonds have been shredded, and there is little or no rule of law. Women in transit on their own or alone with children are also often extremely vulnerable to predation from thieves, militia men, border guards, and human traffickers. In camps, basic acts like collecting firewood or going to the bathroom can place women in terrifying situations where they have no protection to call on.

Mental health is another area of concern. Women must contend with the impact of having been exposed to a range of traumas—from losing loved ones to witnessing or being a victim of extreme violence—and with the uncertainty of life as a refugee. This can lead to depression, anxiety, or post-traumatic stress disorder that manifests in a variety of ways that have significant health consequences.

In displacement settings, therefore, MSF makes it a priority to provide services that address these critical medical issues. Emergency obstetric care and response to sexual violence are both part of the Minimum Initial Service Package for Reproductive Health in Crises, a set of priority activities defined by international agencies that are designed to minimize mortality and morbidity. MSF teams aim to address the four greatest causes of maternal mortality—post-partum...
hemorrhage, pre-eclampsia and eclampsia, sepsis, and the consequences of unsafe abortion—by establishing emergency obstetric care centers that have the capacity to perform blood transfusions and Caesarean sections. Specialized programs for the treatment of victims of sexual violence are implemented as well. And teams make sure to have female doctors on hand in locations where women will not feel comfortable seeking care from men.

Once these services are assured, MSF turns to other medical issues facing displaced women, such as access to family planning and newborn care, wound care, vaccinations and pediatric care, and psychological and mental health care.

The humanitarian crisis in Central African Republic has worsened since the level of violence escalated in early December. Targeted massacres provoked massive displacement of population. In response, MSF has drastically expanded its operations across the country, including maternal health and surgical projects. Other MSF teams work with refugees in Chad and Cameroon.

**CENTRAL AFRICAN REPUBLIC**

**715,000 internally displaced**

245,000 refugees in neighboring countries
In 2013, Doctors Without Borders/Médecins Sans Frontières (MSF) provided humanitarian assistance in 67 countries. MSF-USA supported work in 47 of these countries. Names are indicated solely for those countries and territories in which MSF ran projects in 2013.

<table>
<thead>
<tr>
<th>Region</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americas</td>
<td>6</td>
</tr>
<tr>
<td>Europe</td>
<td>5</td>
</tr>
<tr>
<td>Africa</td>
<td>31</td>
</tr>
</tbody>
</table>

Countries in **red** received MSF-USA funding
Countries in **gray** received funding from other MSF offices
A patient in Kyrgyzstan. A girl awaits treatment in Myanmar’s Rakhine state.

An MSF staff member speaks with a Syrian refugee in Jordan’s Zaatari camp.
Patients await care at a kala azar program in South Sudan.
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Consultations</td>
<td>9,029,071</td>
</tr>
<tr>
<td>Admitted Patients</td>
<td>477,666</td>
</tr>
<tr>
<td>Malaria, Cases Treated</td>
<td>1,871,202</td>
</tr>
<tr>
<td>Severely Malnourished Children Admitted to Inpatient or Outpatient Feeding Programs</td>
<td>233,825</td>
</tr>
<tr>
<td>Moderately Malnourished Children Admitted to Supplementary Feeding Centers</td>
<td>17,082</td>
</tr>
<tr>
<td>HIV Patients Registered Under Care</td>
<td>341,645</td>
</tr>
<tr>
<td>Patients on First-Line Antiretroviral Treatment</td>
<td>325,532</td>
</tr>
<tr>
<td>Patients on Second-Line Antiretroviral Treatment</td>
<td>5,473</td>
</tr>
<tr>
<td>Pregnant Women with HIV who Received Prevention of Mother to Child Transmission of HIV (PMTCT) Treatment</td>
<td>18,489</td>
</tr>
<tr>
<td>Babies Born in 2013 who Received PMTCT Treatment</td>
<td>16,838</td>
</tr>
<tr>
<td>Women who Delivered Babies, Including Caesarean Sections</td>
<td>182,234</td>
</tr>
<tr>
<td>Major Surgical Procedures, Including Obstetric Surgery, Under General or Spinal Anesthesia</td>
<td>77,346</td>
</tr>
<tr>
<td>Patients Medically Treated for Sexual Violence</td>
<td>11,062</td>
</tr>
<tr>
<td>Patients Newly Started on First-Line TB Treatment</td>
<td>29,903</td>
</tr>
<tr>
<td>Patients Newly Started in Second-Line Treatment for Drug-Resistant TB</td>
<td>1,954</td>
</tr>
<tr>
<td>Individual and Group Mental Health Sessions</td>
<td>155,308</td>
</tr>
<tr>
<td>People Treated for Cholera</td>
<td>27,909</td>
</tr>
<tr>
<td>People Vaccinated Against Measles in Response to An Outbreak</td>
<td>2,497,255</td>
</tr>
<tr>
<td>People Treated for Measles</td>
<td>129,870</td>
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<tr>
<td>People Vaccinated Against Meningitis in Response to An Outbreak</td>
<td>162,414</td>
</tr>
<tr>
<td>People Treated for Meningitis</td>
<td>1,746</td>
</tr>
</tbody>
</table>

*These highlights do not give a complete overview of activities and are limited to where MSF staff have direct access to patients.*
Projects described in this section were made possible in part by generous contributions from individuals, foundations, and corporations in the United States. The great majority of funds MSF collects are unrestricted to any particular project, which is essential to MSF's ability to react to emergencies as they unfold. The dollar amounts here reflect the total MSF-USA funding directed by MSF to field programs in a given country. These amounts are part of total project costs presented by MSF International in its 2013 International Activity Report, which is available at www.doctorswithoutborders.org/our-work/publications/annual-reports.
In 2012, MSF launched an emergency response for refugees in Mali who had fled to Burkina Faso. Most were initially housed in the border province of Oudalan but later moved further inland. MSF thereafter scaled down its activities, though it ran mobile clinics for Malians who remained in the Dibissi camp and residents in Gandafabou health district. The team provided basic health care consultations, vaccinations—primarily for tetanus and measles—and referrals to the hospital in Dori.

Cameroon’s centralized medical system and fees exclude many from health services, particularly people with neglected diseases such as Buruli ulcer, which can cause permanent disability if not treated. MSF teams in the country run a program in Akonolinga hospital for Buruli patients that also offers HIV testing. In total, the team treated 188 people with chronic wounds resulting from Buruli, applied more than 15,800 surgical dressings, admitted 48 new patients, and carried out 78 surgical procedures. MSF also continued to assist health professionals with efforts to diagnose the disease.

Even before descending into all-out war, CAR had for years been in a state of political, military, and public health crisis featuring recurring displacement, conflict, and epidemics of preventable diseases. As the country’s main health care provider, MSF treated tens of thousands annually for a wide range of conditions at comprehensive projects in Batangafo, Boguila, Carnot, Kabo, Ndélé, Paoua, and Zémio. But it all got worse in 2013. After the Séléka rebel group staged a coup, armed self-defense groups called anti-balakas joined the fight. Both groups killed scores and committed grievous human rights violations. Unsurprisingly, health needs multiplied.

MSF launched an expansive emergency response, scaling up programs and resources exponentially. Teams provided free medical care to people wounded in attacks or displaced by violence; mobile clinics for people displaced or unable to reach medical facilities; and access to clean drinking water and hygiene services. Emergency projects were opened in Damara, Sibut, Bangui, Bouca, Bossangoa, Bria, and Gadzi, and emergency medical teams visited Yaloke and Bourar. Emergency surgery and basic health care were available for the wounded, and teams regularly treated patients for malaria, respiratory and skin infections, diarrheal diseases, and malnutrition.

Violence overwhelmed Bangui in December, driving hundreds of thousands from their homes. MSF tried to ensure basic standards of hygiene among 10,000 people at a makeshift camp at Bangui’s airport by building hundreds of latrines, trucking in water, and distributing relief supplies. The camp later grew four-fold in size. Medical staff provided trauma surgery and basic health consultations; at Castor health center, for instance, surgeons responded to 465 trauma cases in just three weeks.

By year’s end, MSF’s 250 international and 2,500 Central African staff had tended to approximately 600,000 people in seven hospitals, two health centers, and 40 health posts. Basic needs remained unmet, however, due to the insufficient mobilization of humanitarian services. MSF repeatedly called on parties to the conflict to allow access to care for the sick and wounded and urged the UN and other aid agencies to deploy more resources, especially outside the capital.

Chad struggles with high childhood mortality rates, poor vaccination coverage, recurrent refugee influxes, and epidemics. With malaria a primary cause of death for children under five, MSF supported numerous health and community centers in the Mandoul region and treated some 53,000 children through a strategy called seasonal malaria chemoprophylaxis, recording a 60 percent reduction of cases in the target area compared to the previous year.

Between July and December, staff at Massakory hospital in Hadjer Lamis region treated 36,600 patients during an acute peak of malaria and provided malnutrition care as well. From August to October, MSF responded to high levels of malaria in the Salamat region with an emergency intervention that included outreach to remote areas. Specialized care for women and children was provided in Am Timan hospital, along with reproductive health care, emergency obstetric care, nutrition, and tuberculosis (TB) and HIV treatment.

When clashes in Sudan’s Darfur region drove refugees into Tissi early in the year, MSF established an emergency room to treat victims of violence, a health center in Ab Gadam camp, and a health post in Um Doukhim, carrying out more than 52,000 outpatient consultations, treating 10,400 for malaria, providing clean drinking water, and building latrines. Teams offered similar services in Goz Beida as well, and did likewise for refugees from CAR in the Moyen-Chari region.

MSF also worked with the Ministry of Health (MoH) to expand vaccination coverage, running three measles vaccination campaigns that reached more than 400,000 children and a yellow fever response that reached 161,300 people.

MSF works to make care more widely available and responds to health emergencies in DRC, where the wholesale lack of basic health services again led to numerous outbreaks, while conflict in the east continued to kill, displace, and injure civilians. Regrettably, four Congolese MSF staff were abducted by an armed group in North Kivu; a dedicated team is still actively searching for them.

In North Kivu, teams carried out more than 41,800 consultations in the Mugunga III displacement camp and treated some 840
Among MSF’s wide-ranging programs in Ethiopia are a maternal and pediatric care project in Sidama, in the Southern Nations, Nationalities and People’s Region, involving two health centers and outreach activities in 15 locations through which teams provided 10,460 ante- and postnatal consultations, assisted 800 deliveries, and vaccinated 19,260 children in 2013.

In Abdurafi, Amhara region, MSF treats people with kala azar and HIV/AIDS, and those co-infected with TB, while offering nutritional support. In Degehabur, Somali region, where access to care is limited, MSF supported the regional hospital and ran mobile clinics, providing emergency obstetric services, mental health care, and treatment for malnutrition and TB.

At Wardher hospital, MSF focused on severely ill or malnourished children, maternity services, and TB treatment. Teams also supported the Yucub health post and two other health centers, while running regular mobile clinics, providing antenatal care, therapeutic feeding, immunizations, and a free ambulance service. MSF also provided inpatient care, nutritional support, and emergency obstetric surgery for Somali refugees.

In the Benishangul-Gumuz region, staff conducted 23,170 consultations for Sudanese refugees in three camps and admitted 21,025 children to supplementary feeding programs. Teams aided South Sudanese refugees in the Gambella region as well.

Amidst a brutal drought, MSF set up a feeding program and inpatient unit in the remote Afar region that assisted 1,880 children. MSF also provided psychosocial support to more than 15,000 Ethiopians deported from Saudi Arabia. Additionally, MSF worked with the government to treat TB patients in Dire Dawa before handing the program over to the Bureau of Health, as it also did with clinics in East Imey, Somali region, and a full service health center in Mattar.
MSF works with Guinea’s MoH in Guéckédou to treat and prevent malaria, a leading cause of death in the country, supporting a district hospital, 7 health centers, and 12 health posts, while also training community health workers to screen and treat uncomplicated cases.

Teams also run an HIV program in Conakry through an ambulatory treatment center and five health centers that offer free, comprehensive health care, including psychosocial care, TB treatment for co-infected patients, and prevention of mother-to-child transmission (PMTCT) services. A similar program in Guéckédou was handed over to the MoH, as was a maternal health program in Matam.

An MSF team treated 132 patients during a May meningitis outbreak and 80 more the next month during a cholera outbreak.

Despite instability on Kenya’s border with Somalia, MSF manages a 100-bed hospital in the Dagahaley refugee camp for Somalis in Dadaab and four additional health posts in the area, providing adult and pediatric care, maternity services, emergency surgery, HIV/AIDS and TB treatment, and mental health support. Teams carried out roughly 18,000 monthly outpatient consultations and, throughout the year, delivered 2,580 babies and treated some 4,100 children in outpatient and inpatient feeding programs.

Three MSF clinics in Nairobi’s Kibera slum provided free basic health care, services for victims of sexual violence, and integrated treatment of HIV/AIDS, TB, and chronic non-communicable diseases. Overall, teams in Kibera completed more than 142,000 outpatient consultations and provided antiretroviral (ARV) drugs to more than 4,300 HIV patients. A new clinic offering basic and maternity care was opened in February as well. Another clinic in Nairobi, in the Eastlands area, attended to roughly 150 victims of sexual violence each month and treated nearly 500 people for TB.

MSF handed over an HIV program at Homa Bay, where 25,000 people have received care since 2001, to the MoH, but will open a new project in Ndhiwa in 2014. Teams also ran an emergency intervention in the Tana Delta region for victims of intercommunal violence and expanded their efforts after heavy flooding displaced many communities. Staff provided medical and mental health support, built latrines, distributed relief items, and carried out water and sanitation services. An MSF team in Mandera likewise distributed relief items to people affected by violence and donated medical supplies and drugs to the local hospital.

MSF teams in Lesotho provide antenatal, postnatal, and emergency obstetric care at St. Joseph’s district hospital in Roma, six basic health care clinics in the lowland area, and three clinics in the remote Semonkong area. MSF also runs an ambulance service and a maternity lodge for expectant mothers.

Along with maternal and child health, integrated HIV and TB care is another area of focus. Teams have increasingly decentralized programs so nurses, village health workers, and lay counselors can provide specialized care to patients closer to their homes.

Staff also began putting all women who tested positive for HIV on ARV treatment to prevent the transmission of HIV to children they might have later, piloted a community adherence group, and installed CD4 testing machines, which indicate an HIV patient’s immunity level, in nine health centers. A rapid TB test called GeneXpert was introduced to MSF’s programs as well.

Access to health care has decreased in Madagascar due to budget cuts, a cruel blow to vulnerable and isolated communities. Since 2011, MSF has therefore worked to expand assistance in the remote Androy region, providing clinical care, inpatient services, and maternal care at Bekily hospital, while also training staff and conducting patient consultations at two health centers. MSF also works with national agencies to test and treat TB.

Additionally, after a cyclone hit the country in February, MSF ran mobile clinics in the cities of Tuléar and Morombe and donated drugs to hospitals and health centers in affected areas. An MSF team also helped health authorities respond to a spike in malaria infections in Tuléar, Morombe, and Betioy. A total of 5,761 consultations were carried out.
Given Malawi’s high HIV rates and its chronically underfunded health care system, MSF works to deliver high-quality care for patients while providing training and technical support at the national level. At MSF’s HIV program in Chiradzulu, for instance, more than 28,000 patients were receiving ARV treatment this year and new infection levels were shown to be very low. MSF began using the first point-of-care viral load test to be installed in a rural health center, thanks to a UNITAID grant.

MSF withdrew from Chikhwawa district and expanded efforts in Nsanje, focusing on HIV care and PMTCT in 14 health clinics. Fifty health workers were mentored in 14 sites, with 88 percent completing the program. This complements an MSF scholarship initiative that enrolled 49 local students in the Thyolo, Nsanje, and Chikhwawa districts into a training program for health workers, provided they agree to work in their home areas for at least five years.

While teams handed over some programs in Thyolo, MSF continues to conduct operational research, expand community ARV groups, and provide technical and clinical services in the area.

When sporadic fighting around Gao drove residents and health workers from their homes, MSF provided basic health care at clinics in Chabaria, Wabaria, Sossokoa, and Bazai Haoussa. A team also worked in Ansongo hospital, south of Gao, vaccinating more than 8,500 children and providing outpatient and inpatient services, reproductive health care, and emergency surgery.

In Timbuktu, insecurity likewise reduced access to care. MSF worked in all departments of Timbuktu hospital, Naifunké hospital, and five outlying health centers, conducting 91,975 consultations primarily related to malaria, complicated pregnancies, respiratory infections, and chronic diseases.

In the south, MSF worked with the MoH in Koutiala, Sikasso state, to offer care aimed at ensuring children’s growth and development. Staff admitted more than 5,300 patients to Koutiala hospital, the vast majority of them malnourished children, and provided basic health care in five health centers, conducting some 82,000 consultations, more than a third involving malaria.

Teams in Konseguela provided preventative and curative pediatric care, including a full package of vaccinations and malnutrition treatment. MSF also implemented seasonal malaria chemoprophylaxis during the high transmission period, treating an average of 163,000 children in each of four rounds and reaching approximately 87 percent of children for at least three of the four distributions, after which the number of children suffering from uncomplicated malaria dropped 31 percent from the previous year.

In the Mopti region, MSF handed over a nutritional project to Save the Children and medical programs in Mopti, Douentza, Konna, Boré, Douentza, Hombori, and Boni—opened during fighting in Mali in 2012—to the MoH.

Violence in Mali drove some 59,000 people into Mauritania. MSF supported a health post on the border that screened children under five for malnutrition, along with three health centers in Mbera camp, carrying out some 1,800 consultations per week, collectively, and treating 300 severely malnourished children each month in Mbera alone. MSF also publically called on aid organizations to do more to meet the basic needs of the refugees.

In a country still struggling greatly with HIV/AIDS, MSF teams in the Chamanculo and Mavalane districts of Maputo and Tete provide comprehensive care for patients co-infected with TB and specialized care for people not responding to first-line treatment or with more complex conditions, such as Kaposi’s sarcoma or cervical cancer.

In Chamanculo, MSF treated complex HIV/AIDS cases in five MoH health centers and one referral center, and supported the Mavalane project, which worked with four health centers and one health post. MSF also supported the Primeiro de Maio health center for adolescents, trained MoH health workers, and introduced viral load technology in Maputo and Changara districts.

Following flooding in Gaza province, MSF supported the MoH response with staff and medical supplies, carrying out more than 23,000 medical consultations, almost half of which were related to HIV/AIDS and TB, and the rest of which involved respiratory infections, diarrhea, and malaria.

When the “hunger gap” between harvests hits concurrently with the rainy season, during which mosquitoes proliferate, children in Niger face a dual threat of malnutrition and malaria. MSF expanded preventative activities by implementing seasonal malaria chemoprophylaxis for some 225,000 children in Guidan Roumdji, Madarounfa, Bouza, Madaoua, and Magaria, while providing bed nets and other tools to stem malaria’s spread. Simultaneously, malnutrition programs offered mobile screening, treatment, and hospitalization for severely malnourished children.

To expand the reach of the programs, teams conducted home-based malaria diagnoses and treatment for pregnant women and children at 111 health posts in Tahoua region, where MSF-trained community health workers diagnosed malaria and treated simple cases while also examining children’s nutritional and vaccination status. Additionally, a measles vaccination campaign following an outbreak in Madaoua and Sabon Guida reached 84,460 children, and, in a new initiative, peer networks of mothers in the Tahoua region were given nutrition training they could share with their communities.

Teams in the Madarounfa district worked with FORSANI, a national NGO, to provide pediatric care and ran malaria prevention programs for children, distributing nutritional supplements, mosquito nets, and routine immunizations. MSF also handed out malaria prevention kits, soap, and blankets following heavy rains in Madarounfa in July.
In Zinder, MSF decentralized malnutrition care by holding at-home consultations and setting up treatment and observation posts at health centers in Magaria, Dungass, and Bangaza. MSF also carried out 57,500 consultations for Malian refugees and local residents in the Tilabéri region and treated 1,500 patients during a cholera outbreak in May. Staff provided basic and specialist care to 14,000 refugees in the Abala camp as well, along with 33,000 local residents.

Niger $4,600,000

An upsurge in violence made accessing healthcare even more difficult in Nigeria; where possible, MSF continued to deliver specialized care to vulnerable communities and respond to outbreaks of disease.

The rising price of gold triggered a surge of unsafe mining in Zamfara state, where MSF has responded to severe lead poisoning in recent years. Teams screened more than 1,570 children and provided some 10,800 basic health consultations for children under five in 2013, while lobbying the government to remediate affected villages.

In Jigawa state, where maternity services are few and maternal mortality rates high, MSF admitted more than 8,390 women to the obstetrics unit in Jahun and provided fistula surgery for 370 women. MSF also ran a maternal and child health program in Sokoto state until insecurity forced its closure. And teams provided care to 3,750 displaced people in Baga and Chibok in the strife-afflicted northeast until it, too, grew to insecure to continue.

MSF supported 300 health clinics in Katsina state during a measles outbreak, donating medicine, treating 14,290, and vaccinating 217,490 children in Bakori, Sabuwa, Funtua, Dandume, and Faskari. Teams treated 47,585 people during a separate measles outbreak in Kebbi, Sokoto, and Zamfara states as well. Some 2,000 people were treated for cholera in Rini and Gusau, too.

Republic of Congo $500,000

MSF had been running emergency programs for refugees from DRC in Bétou district since 2009. From November 2012 to May 2013, staff treated 9,800 people for malaria alone. MSF also had 13 teams that provided nearly 100,000 vaccinations in that same time frame and worked with authorities to improve national control programs against TB, HIV, leprosy, and yaws. In April 2013, however, more than 36,000 refugees were repatriated to DRC; MSF closed its Bétou project two months later.

Teams in Bétou and the northern Congo rainforest carried out a second round of treatment for people with yaws, a bacterial infection that causes lesions and can lead to disfigurement and disability, targeting Aka pygmies in remote areas.

Sierra Leone $3,000,000

More than a decade after the end of the civil war, Sierra Leone still has systemic gaps in its medical system, and while the government's offer of free health care to pregnant women and children is improving access, many still die from treatable diseases such as malaria, measles, and Lassa fever.

In Bo district, MSF runs the Gondama referral center, a 220-bed hospital offering emergency pediatric and obstetric services. In
In August, MSF closed all projects in Somalia after 22 years of continuous operations. The wrenching decision was unavoidable given that violent attacks on MSF personnel occurred with the tacit acceptance or active complicity of armed groups and civilian authorities. Unable to get even minimal assurances of safety, MSF handed over its operations to government entities and humanitarian organizations. Sadly, the humanitarian situation remains dire and access to care is still extremely limited.

Among the projects MSF had to leave behind were a 60-bed hospital in Daynile, outside Mogadishu, with an emergency room, operating theater, intensive care unit, pediatric unit, feeding center, and maternity facilities. MSF’s 40-bed hospital in Mogadishu’s Jazziya district carried out some 25,700 consultations and 2,200 hospital admissions, most of them for displaced people. In Hamar Weyne, MSF ran Mogadishu’s only pediatric hospital, treating measles, acute watery diarrhea, and malnutrition. MSF also ran clinics in the Wadajir, Dharkenley, and Yaaqshid districts that focused on maternal and child health and were able to respond to sudden outbreaks of disease, treat peaks of malnutrition, and participate in mass vaccinations against resurgent polio. More than 100,000 consultations were carried out at these facilities.

In Bay region, teams had supported the 60-bed Dinsoor hospital since 2002, providing maternity services and treating malnutrition, TB, and kala azar. At the Afgooye district hospital, teams offered displaced people and residents inpatient and outpatient services, maternity care, and therapeutic nourishment. In 2013, the hospital conducted 11,408 medical consultations and assisted the delivery of 953 babies before MSF handed the project over to the Qatar Red Crescent Society.

MSF provided outpatient care, maternal and child health services, vaccinations, and nutritional support at the Jowhar maternity hospital and health centers in Kulmis, Bulo Sheik, Gololey, Balcad, and Mahaday. In the divided city of Galkayo, teams in two referral hospitals offered surgery, pediatric outpatient and inpatient care, maternal and child health services, feeding programs, immunizations, and TB treatment, reaching well over 75,000 patients.

MSF’s hospital in Marere provided basic and specialist health care, TB treatment, nutritional services, and emergency obstetric care to the populations of several large regions. Mobile teams delivered basic and nutritional care to children, while a clinic in Jilib treated malnutrition, measles, and cholera. Additionally, MSF’s team in Kismayo ran an inpatient nutrition program for children.

In Somaliland, MSF supported the inpatient, maternity, and surgical facilities of Burao hospital in the Togdheer region, conducting 775 surgical interventions, admitting 1,602 people, and assisting in 720 births before its departure. MSF also carried out consultations and improved water and sanitation facilities in three prisons in Somaliland.

> SOMALIA $6,511,792
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> SOUTH AFRICA $1,600,000
MSF pushes innovative care models in South Africa to support the treatment and empowerment of people living with HIV. In Khayelitsha, on Cape Town’s outskirts, MSF promoted ARV adherence clubs that offer people living with HIV the opportunity to combine peer support with check-ups and drug refills at bi-monthly meetings. Some 231 ARV clubs composed of 7,733 patients have been established at 10 Khayelitsha health facilities.

Research has found that 97 percent of adherence club members continued treatment; members were also 67 percent less likely to experience treatment failure. The model, now run by local health authorities, will use a $15 million Global Fund grant to expand.

In KwaZulu Natal, which is the epicenter of South Africa’s HIV epidemic and has the country’s highest TB rates, TB remains the leading cause of death for people with HIV. Several strategies aim to address this, including the rapid expansion of community-based testing, greater continuity of ARV and TB treatment, faster TB and drug-resistant tuberculosis (DR-TB) diagnosis and treatment, and the promotion of prevention methods such as voluntary male circumcision and earlier HIV treatment.

Mobile one-stop shops offering rapid HIV testing and treatment in a single location are integral to the effort, and MSF started outreach programs with testing and health promotion around Eshowe and Mbongolwane. Viral load monitoring has also been emphasized. MSF’s South Africa office remains actively involved in efforts to facilitate patent law reform to ease the production and/or importation of generic drugs, making them more affordable.

> SOUTH SUDAN $11,675,207
South Sudan drifted towards chaos in 2013 and erupted into conflict at year’s end, damaging people’s ability to access care and MSF’s ability to operate. In April, for example, MSF suspended activities at Pibor hospital, in Jonglei state, amid clashes and threats. The hospital was later ransacked, and area residents fled into the bush without access to safe water or food. Thousands later arrived at MSF’s nearby clinic in Gumuruk, where staff carried out more than 100 consultations per day and performed 49 surgical procedures. A second clinic opened in Dorein. In Bor, to the south, 177 patients received emergency care during later outbreaks of violence.

MSF also provided basic and specialist health care, ran nutrition centers, and provided water and sanitation services for 180,000 Sudanese refugees in Yida camp, Unity state, and Maban county, Upper Nile state. Teams worked with the MoH to vaccinate 132,500 Sudanese refugees in Yida camp, Unity state, and Maban county, Upper Nile state. Teams worked with the MoH to vaccinate 132,500 people against cholera as well. Additional Sudanese refugees in northern Bahr El Ghazal and Upper Nile state received basic and specialist health care and nutritional assistance.

MSF clinics and hospitals throughout the country continued to offer a full range of services. In Nasir, Upper Nile state, teams provided basic and specialist services, including HIV and TB treatment. In Jonglei, MSF’s Lankien hospital project provided more than 71,000
and carried out postnatal home visits. MSF had to manage its projects in Kaguro remotely because no international staff were permitted, but teams staged an emergency intervention—mobile clinics, feeding programs, and reproductive health care—after clashes displaced some 65,000 people, and MSF also worked with the MoH to launch the North Darfur Emergency Response program.

MSF started diagnosing and treating TB in five health centers in Jebel Awlia, a crowded slum on Khartoum’s outskirts, while also training MoH staff and working with patient groups to develop support systems. After August flooding hit Khartoum state, MSF provided 228,600 liters of clean water and ran mobile clinics in the Sharag Alniel locality.

In an effort to support MoH reproductive health activities and reduce maternal and neonatal mortality, MSF offered comprehensive emergency obstetric services, postnatal consultations, and family planning support. MSF also refurbished the maternity wing and operating theater in Quresha hospital.

Amidst concerns about yellow fever, MSF worked with the MoH to vaccinate 750,000 adults and children in four localities in Central Darfur state and treat 256 patients. In Al Gedaref state, teams vaccinated 306,400 people for measles and treated 468 for kala azar.

> **SUDAN $1,210,896**

In July, MSF started supporting the health center in El Serif displaced persons camp near Nyala in South Darfur, adding to a host of projects it runs in Sudan’s still-troubled Darfur region. In North Darfur, insecurity forced MSF teams in Tawila to limit their work to basic health care activities in the town and referrals. Staff in Dar Zaghawa also supported two health centers and two health posts and carried out postnatal home visits. MSF had to manage its projects in Kaguro remotely because no international staff were permitted, but teams staged an emergency intervention—mobile clinics, feeding programs, and reproductive health care—after clashes displaced some 65,000 people, and MSF also worked with the MoH to launch the North Darfur Emergency Response program.

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> **SWAZILAND $2,550,000**

MSF supports efforts to integrate TB and HIV services in Swaziland and to implement outpatient DR-TB care. Teams in Matsapha, Manzini region, provided comprehensive HIV and TB care, with psychosocial counseling, testing, diagnosis, and treatment, along with reproductive health care, ante- and postnatal care, and immunizations for children.
In Mankayane, MSF works with the MoH's HIV and TB department to improve diagnosis and treatment of HIV/DR-TB co-infected patients. MSF also worked to improve infection control and provided psychosocial support in Mankayane hospital and in community-based clinics, while training staff at the TB National Reference Laboratory in Mbabane as well.

In Shiselweni, MSF helped establish numerous new HIV and TB service points and provided treatment and psychosocial support for HIV and TB patients in 22 basic health clinics and three specialist facilities. As part of the effort to improve DR-TB diagnosis and care, MSF helped get rapid diagnostic technology distributed throughout the region; 20 primary clinics now have their own mini-labs, and community treatment supporters visit patients who cannot reach a facility for daily injections.

To prevent the spread of HIV, teams pushed a “test early/treat early” campaign designed to put everyone with HIV on ARV treatment, regardless of how far the virus has progressed. Routine viral load testing was implemented and a voluntary door-to-door HIV-testing campaign screened 6,452 people in August.

**Uganda $690,000**

In Uganda, where declining rates of HIV infection began rising again in 2010, MSF worked in the West Nile region, where roughly five percent of adults aged 15 to 49 have HIV. Assisting area residents and significant numbers of patients from DRC, MSF treats HIV and TB and offers PMTCT services through a program based at the Arua regional referral hospital.

After fighting in DRC’s North Kivu province drove up to 50,000 refugees into western Uganda, MSF worked among the roughly 22,000 people who settled in Bubukwanga transit camp—providing health care, trucking in water, and building latrines—while also conducting some 25,000 consultations in Kyangwali camp.

**Zimbabwe $4,129,238**

In Zimbabwe, where HIV is still widespread but treatment options are often limited and the TB burden is growing, MSF works with the MoH to expand and integrate care. To that end, MSF supported HIV and TB projects in Harare, Gokwe North, Tsholotsho, Beitbridge, Buhera, Nyanga, and Gutu/Chikomba.

Staff in Nyanga emphasized pediatric ARV care, integrating treatment into the district hospital and nine health clinics, while training nurses as well. MSF also assists with patient management and guidance for community ARV groups.

In Gokwe North, teams are decentralizing services through training and mentorship, integrating treatment for HIV and TB—and for victims of sexual violence—into two rural hospitals and 16 health centers. The Gutu/Chikomba program likewise decentralized care to 28 facilities in Gutu and 31 in Chikomba and established patient support groups. And in Harare, the capital, MSF pushed for the accreditation of seven health facilities as ARV treatment and follow-up sites, while also training nurses in HIV and TB care.

Staff implemented viral load monitoring in Buhera, Gutu, and Chikomba, and MSF trained laboratory technicians and scientists at three Harare hospitals. Backed by a UNITAID grant, MSF also installed the NUCLISENSE platform at the National Microbiology Reference Laboratory in Harare hospital to provide nationwide viral load analysis. Most MSF facilities also introduced new TB diagnostic technology, too.

Mental health teams provided psychiatric support in 10 prisons, including Harare maximum security prison, and staff provided free medical care, counseling, and referrals for psychological, psychosocial, and legal support for some 1,220 victims of sexual violence in Harare’s Mbare suburb. Awareness and outreach campaigns were carried out as well.

The HIV/TB program in Epworth was handed over to the MoH, as was the Tsholotsbo project, which had achieved 98.7 percent coverage of people in need of HIV care in the district. In December, MSF had to close its Beitbridge project when authorities denied the team permission to continue activities. The project had started 7,590 patients on ARV treatment and 853 patients on TB treatment, while providing counseling for 16,300.

**Colombia $1,000,000**

Years of conflict and strife have dramatically impacted public health in Colombia, especially in the south, where killings, extortion, and displacement have been far too common. In areas where access to care is limited, MSF has been managing health posts and conducting mobile clinics to provide basic, reproductive, and mental health care, among other services.

TB has become a major concern, particularly in Buenaventura, and almost one in ten new cases is drug-resistant. MSF, which works in two health facilities and oversees 15 medical stations, started 218 DR-TB patients on treatment in 2013, while also advocating to introduce a recently-approved drug (bedaquiline) as a treatment for patients with extremely resistant forms of the disease.

**Haiti $16,650,000**

Many Haitians still cannot access medical care, even as poor living conditions, particularly in camps for people displaced by the 2010 earthquake, continue to cause health problems. The post-earthquake cholera crisis persists, too, particularly during the rainy season. Since October 2010, MSF has treated one-third of the more than 700,000 people infected with cholera, and teams still run two cholera treatment centers in Port-au-Prince, distribute hygiene kits, and manage water chlorination points. Nearly 10,000 cholera patients were treated in 2013 as well.
In San Pedro Sula, MSF responded to an epidemic of dengue fever, treating more than 600 children and donating drugs and medical supplies to the hospital.

> **AFGHANISTAN** $5,500,000

In 2013, MSF expanded efforts to provide medical assistance to Afghans who struggle to access care despite some of the world's worst health indicators. In eastern Kabul, teams working at Ahmad Shah Baba hospital upgraded the facility, opened a new maternity ward, and trained MoH and MSF staff. Teams assisted 1,000 births per month and ran mobile vaccination and maternity programs.

In Kunduz, MSF's trauma center provided free surgical care to victims of traffic accidents and conflict-related injuries, while also admitting patients with moderate and severe head injuries. Staff treated 17,000 people, performed 4,500 surgical procedures, conducted more than 12,000 physiotherapy sessions, and offered mental health services as well.

In Khost, MSF ran the only maternity hospital in the area, providing a safe place for women to give birth. Staff assisted some 12,000 deliveries and helped more than 2,000 women who had complications during pregnancy.

> **HONDURAS** $600,000

Working to expand access to emergency health care for trauma, medical emergencies, and sexual violence, MSF's comprehensive program in Tegucigalpa, the capital, offers free treatment and follow-up to those in need. Staff also helped reorganize services in the university hospital Escuela, where the emergency room sees 260 patients per day.

Mobile MSF teams visited 25 sites around Tegucigalpa each week to identify medical, psychological, and social needs among the city's homeless population, who are particularly vulnerable to violence, caring for more than 1,040 victims of violence, including 725 victims of sexual violence.
MSF also supported the 250-bed Boost hospital in Helmand Province, one of two functioning referral hospitals in southern Afghanistan, with surgery, internal medicine, emergency services, and maternal, pediatric, and intensive care. Staff admitted roughly 1,300 patients per month, treated 66,000 patients in the emergency room, and performed 5,600 surgical procedures. Some 200 children were admitted monthly to the pediatric ward, and 3,200 malnourished children received therapeutic feeding care.

**Bangladesh $500,000**

MSF teams in Bangladesh provided care to vulnerable populations, including members of the Rohingya ethnic minority who fled severe discrimination and violence in Myanmar only to find additional discrimination in a new land. In Cox’s Bazar, MSF’s clinic provides comprehensive medical assistance for the host community and 30,000 unregistered Rohingya in a makeshift camp at Kutupalong. It has a stabilization unit for severely malnourished children, an inpatient department, and a diarrhea treatment center.

In Kamrangirchar, Dhaka’s largest slum, where water quality and hygiene conditions are poor, an MSF health center offers basic health care and sexual and reproductive health services to young women. MSF handed over its kala azar project in Fulbaria to the MoH, but staff also responded to specific emergencies, providing mental health support to 413 people who survived the collapse of an eight-story building housing several garment factories and psychological first aid to 28 people who suffered burns during pre-election violence.

**India $500,000**

MSF teams in India provide medical care to populations made vulnerable by conflict or privation. To that end, teams ran weekly mobile clinics in Chhattisgarh and Andhra Pradesh, where strife is ongoing; a mother and child health program in Bijapur, Chhattisgarh, with TB screening and diagnosis; and a basic health care project in Mallampeta, on the Andhra Pradesh-Chhattisgarh border. All told, MSF carried out nearly 52,600 consultations and treated approximately 8,465 people with malaria.

In Nagaland, where fighting has stunted development, MSF carried out more than 30,000 consultations and assisted more than 680 deliveries at Mon district hospital, while also upgrading key services and training staff in maternal health and TB care.

In Mumbai, MSF treated patients with HIV and co-infections excluded from government health services, while increasingly emphasizing DR-TB programs and hepatitis B and C. In Manipur, in the northeast, the state with India’s highest HIV prevalence, MSF cared for people with HIV, TB, and DR-TB in three clinics in Churanchandpur and Chandel districts.

Teams provided more than 2,500 mental health consultations at five locations in Kashmir, where decades of conflict have taken a significant psychological toll. MSF also provided counseling after deadly floods in Uttarakhand state.

In Bihar, MSF has treated more than 10,000 kala azar patients since 2007 and worked with the Drugs for Neglected Diseases initiative to run pilot programs for new treatments that have shown encouraging results. MSF has also treated more than 13,000 severely malnourished children since 2009 in Bihar’s Darbhanga district and built a malnutrition intensive care unit inside a teaching hospital as well.

**Myanmar $3,006,820**

Violence and segregation across Rakhine state displaced more than 100,000 people and consigned them to appalling conditions in camps almost entirely cut off from health care and other basic services, including clean water. With the ethnic Rohingya minority extremely vulnerable, MSF is striving to overcome significant challenges and obstacles to provide assistance to those most in need. MSF worked in fixed and mobile clinics in 24 displacement camps in 10 townships, offering basic health care, obstetric services, mental health care, and treatment for HIV/AIDS and TB. Teams also treated 10,816 malaria patients.

As the largest HIV/AIDS care provider in a country where only one of three people who need ARVs get them, MSF treated more than 33,000 patients in Kachin, Shan, and Rakhine states; Yangon, the capital; and Dawei in Tanintharyi region. An HIV project in Insein prison was closed after three years after providing counseling and testing to 1,400 prisoners and more than 15,000 outpatient consultations. Staff in Yangon also worked with the MoH to treat 58 patients with MDR-TB.
MSF provides care for people in areas where medical assistance, particularly for women and children, is hard to find. In Hangu district, which borders conflict-afflicted North Waziristan, Orakzai, and Kurram agencies, MSF managed emergency and surgical services in the Hangu Tehsil Headquarters hospital, admitting more than 25,000 emergency room patients and performing 1,407 surgeries. MSF midwives also supported the maternity unit. MSF's 32-bed women's hospital in Peshawar admitted 3,717 patients as well, and staff set up a referral network in rural health centers and displacement camps.

MSF treated more than 100,000 patients in the Timergara (Lower Dir) district hospital's emergency room and more than 22,000 in the resuscitation room. Staff also assisted 7,000 births and conducted more than 5,300 mental health consultations.

In restive Kurram Agency, where state-sponsored health care is very limited and insecurity severely impedes access, MSF provided pediatric services at hospitals in the Sunni enclave of Sadda and the Shia community of Alizai. In Bajaur Agency, MSF mobile clinics provided basic and disease care in Talai, Kotkay, and Derakai.

In remote Balochistan province, MSF supported Quetta pediatric hospital and treated malnourished children through ambulatory and inpatient feeding programs, while offering neonatology services as well. Teams in Kuchlak ran a mother-and-child health center with outpatient treatment, nutritional support, a birthing unit, psychosocial support, and screening and treatment for cutaneous leishmaniasis. Obstetric, neonatal, and emergency care was provided at Chaman District Headquarters Hospital, and, in Jaffarabad and Nasirabad, MSF ran maternal and child health programs in Dera Murad Jamali hospital and four health centers that treated 9,600 malnourished children and carried out 6,000 antenatal consultations.

In Machar Colony, a slum on Karachi's outskirts, MSF's clinic, run with SINA Health Education and Welfare Trust, provided free, basic, emergency, and obstetric services, conducting more than 35,000 basic consultations and screening 7,600 children for malnutrition. MSF worked with MoH staff to treat 110 people wounded by bomb blasts in Khyber Pakhtunkhwa and the Federally Administered Tribal Areas in May. Teams also responded to dengue and watery diarrhea outbreaks in Timergara and Swat, a measles outbreak in Upper Dir, and an earthquake in Balochistan's Mashkel district.

Typhoon Haiyan killed more than 6,000 people in the central Philippines, displaced more than four million, and destroyed numerous hospitals and clinics. MSF teams arrived the next day, and over the next two weeks, amid huge logistical obstacles, used trucks, boats, planes, and helicopters to reach outlying areas, assess needs, and set up medical activities.

In Tacloban, MSF erected a 60-bed inflatable hospital with an emergency room and outpatient department, and provided surgical, maternal, and mental health services. Mobile clinics tended to people who could not reach health centers. Teams distributed relief items to 3,000 families in Tanauan as well.

In Leyte, MSF provided staff, supplies, and water and waste disposal support to the district hospital, while also distributing relief supplies to 48,500 people and offering mental health support to 11,470.

Teams based on Panay island delivered aid to 21 smaller islands, rehabilitated 13 health facilities, and vaccinated 4,650 children against polio and 14,990 against measles. Staff distributed more than 11,000 relief kits, food for 11,000 families, and 1.2 million liters of chlorinated water.

MSF set up a 60-bed tent hospital in Guiuan, Samar island, with an operating theater, delivery room, and maternity unit. Teams worked in rural health centers on Samar, ran regular mobile clinics on smaller islands, offered psychosocial support to adults and children, and supplied clean water for 20,000 people each day. Tents, cooking
equipment, and shelter kits were distributed in isolated communities.

Many acute emergency activities were completed by January 2014, but MSF maintained a strong presence in areas where health services hadn’t yet recovered and continued to provide surgery, inpatient care, and psychological support out of inflatable medical hospitals.

Since 2005, MSF has worked to improve the diagnosis and treatment of DR-TB in Armenia, which has some of the world’s highest DR-TB rates. MSF treats patients, provides support to help them complete the arduous treatment regimen, helps implement infection control policies, and works with MoH TB and DR-TB programs throughout the country. MSF also supports the National Tuberculosis Program’s “compassionate use treatment” for patients with XDR-TB.

The MSF team aims to enhance the national program’s capacity to implement DR-TB response plans and gradually hand over activities.

MSF treats patients with MDR-TB in the autonomous republic of Abkhazia and assists with the development of the Abkhazian national program by consulting on training, protocols, lab support, and the supply of equipment and drugs. MSF is discussing clinical trials of two new MDR-TB drugs with Georgia’s MoH as well. Staff also offer eye care, home visits, and material support such as wheelchairs to around 50 mostly elderly and bedridden patients dealing with chronic diseases in Sukhumi, Abkhazia, and Tbilisi.

MSF treated prisoners with TB in Bishkek and also supported treatment for co-occurring illnesses. Screening and vaccination for hepatitis B was offered as well. MSF has also helped establish TB protocols and improve access to care, while supporting development of a new national reference laboratory.

In Osh province, MSF supported the Kara Suu hospital, which has 80 beds for TB and DR-TB patients and aims to be a model for other services for people living with HIV.

Given the high rate of heart disease in Chechnya, MSF supports the cardiac unit at the Republican Emergency Hospital in Grozny with training, equipment, and medicines for specialized treatment. MSF conducted further trainings on fibrinolysis and laboratory procedures as well. A team also counseled patients in Grozny and surrounding communities still experiencing the psychological effects of exposure to violence.

MSF has provided DR-TB treatment to prisoners and ex-prisoners in eastern Ukraine’s Donetsk region since 2012. Teams provide short course directly observed treatment in a special prison TB hospital and in three pre-trial detention centers, offering ARVs to patients co-infected with HIV.

Staff also provides counseling to assist people with the grueling treatment regimen, which can take up to two years and brings serious and painful side effects. Staff follows up with prisoners after they are released as well.

MSF laboratory services enable rapid, accurate TB diagnosis and guarantee an uninterrupted, quality-assured drug supply. MSF also lobbies for integrated TB/HIV services and multidisciplinary, patient-oriented TB case management in penal facilities.

In the TB program MSF has run with the MoH since 1997 in the Autonomous Republic of Karakalpakstan, staff enrolled 1,212 patients for first-line TB treatment and 677 for outpatent DR-TB care in 2013. In September, 16 MDR-TB patients were enrolled in a pilot project in which treatment that usually takes two years was compressed into nine months. MSF’s work expanded into Chimbay, Shumanay, and Kanlikul districts, while activities in the districts of Khodjeily and Takhiatash and Nukus region were handed over.

Teams worked both at Tashkent’s Republican AIDS Center and at the Tashkent City AIDS Center, providing psychosocial activities and other services for people living with HIV.

Amidst ongoing political upheaval, MSF’s mother-and-child program at the Abu Elian clinic on Cairo’s outskirts carried out an average of 1,700 monthly consultations—most for children with respiratory infections, intestinal parasites, skin diseases, and diarrhea—while also providing referrals and transport and covering hospital costs for pregnant women. MSF also offered mental health
For some patients suffering from traumatic injuries that required specialist care, MSF offered treatment in MSF’s reconstructive surgery program in Amman, Jordan. MSF psychologists also provided 775 mental health counseling sessions in Baghdad and Fallujah before the program was handed over to the MoH.

**Jordan** $8,129,272

At MSF’s regional reconstructive surgery program in Amman for gravely injured patients who need specialized care they can’t get elsewhere, surgeons performed 1,370 operations on patients from Syria, Iraq, Yemen, and Gaza in 2013. Many initially received treatment at other hospitals but later needed additional care. MSF also conducted around 300 medical and surgical monthly consultations for Syrian refugees at a special clinic within the compound.

In August, MSF opened an emergency trauma project in Ramtha, near the Syrian border, providing surgical and post-operative care to victims of bombings and shellings. The project admitted 181 patients and performed 336 major surgical procedures through the end of the year, and offered mental health and physiotherapy sessions as well.

In Irbid governorate, “home” to more than 120,000 Syrian refugees by the end of 2013, MSF opened a general and inpatient care program for refugees and people in host communities. It handed over its pediatrics program at Zaatar refugee camp in November to other health providers after the program had treated more than 17,500 patients.

care to migrants who’d been victims of violence and treatment for sexual violence at Cairo’s Nasr City mental health clinic. Additionally, during a harsh winter, teams in Cairo and Alexandria provided medical and psychiatric consultations to vulnerable families.

After two years of negotiations, MSF received permission to open a project south of Cairo in 2014 for people with hepatitis C, which affects an estimated 12 percent of Egyptians. MSF also trained volunteer Egyptian doctors in Cairo to respond to medical needs during demonstrations.

**Iraq** $3,254,861

As health facilities struggled to keep up with increasing violence, MSF tried to fill gaps, providing training and supervision in the neonatal care unit at Kirkuk general hospital, for instance, and training doctors and nurses, implementing protocols, and upgrading the management of Najaf’s Al-Zahra hospital, the area’s main referral hospital for obstetrics, gynecology, and pediatrics, where more than 23,000 deliveries were registered in 2013.

In Hawijah, teams performed more than 300 emergency surgical procedures each month at the district’s only specialist facility, while also surveying the capabilities of other area health centers.

With the influx of more than 200,000 Syrians into northern Iraq, MSF offered basic and mental health care at the Kawargosk camp in Erbil province, a mobile clinic in the smaller Qushtapa camp, and full-service capabilities in Domiz, the largest of the camps, where teams carried out 2,400 consultations every week. Targeted distributions of washing kits and water and sanitation activities were completed as well.
In Gaza, MSF works alongside Palestinian colleagues in the two main public hospitals to perform plastic surgery, reconstructive surgery, and hand surgery. Most patients are children with burns caused by domestic accidents; electricity shortages force people to find alternative and often dangerous means of cooking and heating their homes. MSF also runs a clinic offering post-operative care and physiotherapy to help patients rehabilitate. Teams supported the MoH with trainings on intensive care and technical support for medical and paramedical staff as well.

The grinding stress and violence in the region spawns many mental health issues among Palestinians. MSF teams therefore provided psychosocial support to victims of violence and others in Nablus, Hebron, and East Jerusalem. Almost half of the patients are under 18. Most suffer from anxiety-related conditions; depression, behavioral issues, and post-traumatic stress disorder are common.

> SYRIA $4,670,000

With Syria’s health care system decimated by war, MSF provided emergency and trauma surgery, basic and mental health care, maternal health services, and vaccinations. MSF also donated tons of medical and non-medical supplies to dozens of hospitals and clinics across seven governorates.

In Idlib governorate, MSF’s trauma unit for patients with shrapnel wounds, bullet wounds, and burns also provided physiotherapy, post-operative care, and mental health care. In an area displacement camp, MSF built 60 latrines and 40 showers and distributed tents, blankets, and plastic sheeting. Teams also vaccinated children against measles and polio and opened two outpatient clinics in November.

Teams in the Jabal Al-Akrad region ran a field hospital first in a cave, then on a converted farm, performing more than 520 surgical procedures and 15,550 emergency consultations. Teams ran mobile clinics when security allowed, distributed relief items, and opened two additional clinics, conducting more than 30,600 consultations overall.

MSF’s hospital in Aleppo governorate treated children and the wounded, performed surgical procedures, provided maternity and obstetric care, and treated patients with acute and chronic diseases. MSF opened another hospital in the governorate in May, where staff performed more than 1,300 surgical procedures and carried out 14,300 consultations. And in July, MSF opened a third hospital to provide care to patients with conflict-related injuries and others indirectly affected by the war. For the displaced, MSF donated tents and medicines, provided vaccinations, and supported both Syrian volunteers treating displaced people in Mambij and a pediatric ward at Al-Bab hospital.

MSF opened a basic health care clinic in Tal Abyad and supported the pediatric ward as well. Mobile teams provided emergency assistance to people living in empty school buildings, distributed non-medical items to displaced families, conducted more than 12,600 outpatient consultations, and vaccinated 27,000 children against measles. Staff also supported the trauma ward in a hospital in Al Hasakah and set up a health post to assist Syrians on the Iraqi border.

> TURKEY $961,463

Working with Turkish NGOs, the Helsinki Citizens’ Assembly (HCA) in particular, MSF assisted Syrian refugees in Turkey living with limited access to medical care. In Kilis, MSF and HCA supported a clinic that provided basic health care and mental health services to refugees living inside established camps and others living outside of them. MSF supported another HCA psychosocial project for migrant communities in Istanbul for a time as well.

> YEMEN $5,950,000

Insecurity affected MSF programs in Yemen, further limiting access to health care in the country. MSF continued to work amidst strife in Ad-Dali governorate, providing basic health care and emergency services, including surgery, for victims of violence and trauma at the Al Naser general hospital and in Al Azaraq and Qataba’a districts, carrying out 41,704 consultations in all.

In Aden, MSF’s emergency surgical unit performed more than 2,500 surgeries and provided 860 patients with post-operative care and physiotherapy. A weekly clinic for inmates at Aden central prison saw 80 patients each month. MSF also supported hospitals in Lawdar and Jaar in Abyan governorate with staffing, supplies, and training.

In the rural areas of Amran governorate, where there is very little health care available for most people, MSF works in the emergency, surgery, maternity, pediatric, inpatient and intensive care departments at Al-Salam hospital in Khamir, conducting 21,980 emergency consultations, performing nearly 2,000 surgeries, and admitting more than 4,000 to the hospital. Following a six-month suspension of activities due to security concerns, MSF resumed support of the Huth Health Center in March, providing emergency, maternity, and inpatient care, and then establishing stabilization and referral services. Teams also ran mobile clinics in the very remote Osman and Akhraf valleys, carrying out 5,350 consultations and treating 427 patients for malaria.

In Sana’a, MSF provided HIV care and opened a mental health program for migrants in detention. More than 150 Yemeni patients were also sent to MSF’s Reconstructive Surgery Project in Amman, Jordan.

> OTHERS $240,000

MSF-USA also contributed small amounts to programs in Cambodia, Ivory Coast, Lebanon, and elsewhere.
Epicentre $430,000

A nonprofit research center founded by MSF in 1987, Epicentre conducts epidemiological assessments and studies that allow MSF to better understand medical and nutritional needs, improve treatments, and develop high-quality health care initiatives in its field projects. Among other studies in 2013, its work in Chad showed that the tetanus toxoid vaccine remains efficacious in a controlled temperature chain, rendering the use of a traditional cold chain unnecessary. This discovery facilitates the vaccination of women living in hard-to-reach places, increasing protection from tetanus in vulnerable populations.

International Office $2,142,612

MSF’s International Office coordinates common projects on behalf of MSF’s 23 sections worldwide and supports MSF’s advocacy efforts with the United Nations and other international bodies.

Total $171,134,520
FIELD STAFF

An MSF staff member checks a child for malnutrition in Pakistan’s Sindh province.
“MSF is an emergency medical organization, and we were certainly reminded of that on an almost daily basis in 2013, as new emergencies emerged and older ones flared up again. This meant that the US office had to step up its efforts to supply our emergency responses with the personnel they needed to be as effective as possible. In fact, the majority of the 400 people we sent to the field in 2013 were sent to emergency settings, particularly those related to Central African Republic, South Sudan, Syria, and the Philippines. Thankfully, our roster of volunteers showed great flexibility and readiness and we were able to provide a great deal of support where it was most needed.

What's more, we saw the fruits of the investments we've made in recent years into career development and coordinator training; we had a host of extensively experienced professionals in our fold, and they were better prepared to fill managerial roles in different missions. We were also able to provide a great deal of support in other difficult contexts, such as Afghanistan, and in certain roles, such as surgeons and OB/GYNs.

As emergencies continue to arise and evolve, we will keep doing our utmost to keep pace, to attract and send out people who have the experience, the skills, and the temerity we need to fulfill the mission laid out in our charter—assisting vulnerable, at-risk populations who need high-quality medical care that they cannot find elsewhere.”—NICHOLAS LAWSON, DIRECTOR OF FIELD HUMAN RESOURCES

**INTERESTED IN JOINING MSF?**

MSF is always looking for motivated and skilled medical and non-medical professionals for our field projects around the world. MSF-USA also needs volunteers and interns to work in our New York office. For more information, please visit [doctorswithoutborders.org](http://doctorswithoutborders.org)
Sarah Ocwieja, MI, Logisticians-Water and Sanitation
Kate Redmond, CO, Logisticians
Teresa Scott, TX, Mental Health Officer
Shanna Snider, NY, HR Manager Officer
Athena Viscusi, DC, Mental Health Officer

The first baby born in Tacloban after Typhoon Haiyan struck the Philippines.
US Annual Report 2013

Doctors Without Borders / Médecins Sans Frontières (MSF)

**TREATING PEOPLE ON THE MOVE**

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

doctorswithoutborders.org/work-with-us/work-in-the-field

for more information about MSF recruitment.

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Sudanese refugees in Iraq.

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MSF is extremely grateful for the financial support it receives from individuals, foundations, and corporations. Your generosity allows MSF to respond to emergencies based on medical humanitarian needs and to operate independent of political, economic, or religious interests.

An MSF nurse and young patient in CAR.
Multiyear commitments 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. By the close of 2013, MSF had received 173 multiyear commitments toward this effort, totaling $33,699,945.

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Staff tending to a patient in South Sudan's Unity state.
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<td>Mr. &amp; Mrs. William A. Kimbrough</td>
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<td>Mr. &amp; Mrs. Kent Kime</td>
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2013 PRIVATE SUPPORT RECEIVED BY MSF-USA

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The Robert A. & Jane G. Friedman Charitable Trust
The Robert J. Bauer Family Foundation
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Ann S. Cleary
Mrs. Yvonne Franklin Clement
Ms. Clara Coen
Mrs. Bernard Cohen
Mr. & Mrs. Richard N. Cohen
Timothy & Mary Ellen Coleman
Alexis & David Colker
A young patient at MSF’s burn ward in Drouillard hospital, Port-au-Prince.
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Throughout the year, when I hear or see your organization mentioned, it gives me great pleasure to know I have helped your good work in some small way.

—PETER GERBIC OF THE EDWARD AND VERNA GERBIC FAMILY FOUNDATION

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 will face in the future. Each year, many of our loyal supporters join our Legacy Society by naming MSF in a will or trust or as a beneficiary of a retirement plan, or by setting up a charitable gift annuity or charitable trust. As a member of our Legacy Society, you will receive updates about our work around the world and be listed in our Annual Report.

For information about MSF’s planned giving program, please call our planned giving officer at 212-847-3153.
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Mr. Albert Podell
Ms. Mary Forsyth Poole
David and Gaylene Poretti
Ms. Nancy R. Posel
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Robert S. Powers
Peggy & Peter Pressman Foundation
Rachelle Piaris
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Mr. Peter A. Benson
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Ms. Belinda Stern
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David & Tamara Schoenbaum
Elizabeth Schrauder
Michael and Phyllis Schreiber
Mr. John Schreiner &
Ms. Heidi Wetzel
Ms. Susan Schrenzel
Ms. Jeanne D. Schwartz
Tori Schwartzman
Mr. Emanuel Schweid
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Schwerdt, MD
Margaret Sciacqua
Ms. Katherine S. Scott
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Ms. Nancy Shire
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Ms. June C. Starck
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Ms. Eugenia L. Staszewski
Mr. Abram & Mrs. Ruth Stavitsky
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Joseph Stokes
In 2013, despite worrisome initial projections, MSF-USA's total revenue increased by 10.3 percent vs. 2012, reaching a total of $221.6 million. This allowed MSF-USA to increase its direct field support to more than $171 million. Once again, the percentage of our expenses devoted to activities within our social mission exceeded 85 percent, while fundraising and general management expenses accounted for 12.6 percent of all expenditures. MSF-USA funded activities in 48 countries, with the greatest allotment of funds going to the Democratic Republic of Congo ($21.7 million), Haiti ($16.6 million), and South Sudan ($11.7 million). A total of $10.5 million was also raised to fund MSF's response to Typhoon Haiyan and ongoing assistance in the Philippines throughout 2014.

Once again, our significant and prompt response to emergencies has been made possible thanks to the hundreds of thousands of individual donors that support MSF-USA. MSF thanks all those who helped make this work possible.

On the next page you will find a summary from MSF-USA's audited financial statements.
The following summary was extracted from MSF-USA’s audited financial statements:

### Revenue

<table>
<thead>
<tr>
<th>Public Support</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions and private grants</td>
<td>206,993,170</td>
<td>184,147,094</td>
</tr>
<tr>
<td>Contributions pledged</td>
<td>1,993,347</td>
<td>5,158,361</td>
</tr>
<tr>
<td>Total Public Support</td>
<td>$208,986,517</td>
<td>$189,305,455</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Revenue</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Income</td>
<td>357,192</td>
<td>212,526</td>
</tr>
<tr>
<td>Gain (Loss) on Investments and Actuarial Gain (Loss) on Annuities</td>
<td>909,186</td>
<td>573,071</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>44,940</td>
<td>46,164</td>
</tr>
<tr>
<td>Grants from Affiliates</td>
<td>11,282,340</td>
<td>10,671,977</td>
</tr>
<tr>
<td>Total Other Revenue</td>
<td>12,593,658</td>
<td>11,503,738</td>
</tr>
<tr>
<td>Total Revenue excluding gifts in kind</td>
<td>$221,580,175</td>
<td>$200,809,193</td>
</tr>
</tbody>
</table>

### Expenses

#### Program Services

| Emergency and medical programs | 171,134,520 | 162,566,427 |
| Program Support and development | 5,915,520   | 5,363,430   |
| Field Staff                     | 8,637,536   | 8,304,843   |
| Communications                  | 3,572,066   | 3,600,491   |
| Total Program Services          | 189,259,642 | 179,835,191 |

#### Supporting Services

| Management and General         | 2,723,698   | 2,635,325   |
| Fundraising                    | 24,658,058  | 24,517,940  |
| Total Supporting Services      | 27,381,756  | 27,153,265  |
| Total Expenses excluding gifts in kind | 216,641,398 | 206,988,456 |
| Investment return in excess of designated amounts | 25,389 |
| Other Changes                  | 25,389      |            |
| Excess (deficit) in net assets | $4,964,166  | ($6,179,263) |

### Net Assets

| Net assets at the beginning of the year | 160,912,434 | 167,091,697 |
| Increase / (Decrease) in Net assets   | 4,964,166   | (6,179,263) |
| Net assets at year end                | $165,876,600 | $160,912,434 |

---

1. Receivables for 2013 and 2012 include 21,187,373 and 18,718,556 respectively, in contributions received as of year-end but deposited in the following month of January. For more details or a full presentation of MSF USA’s audited financial statements, please visit: https://www.doctorswithoutborders.org/sites/usa/files/doctors_without_borders_financial_statements_-_final_20140429.pdf

MSF-USA is recognized as tax-exempt under section 501 (c) (3) of the Internal Revenue Code. A copy of the most recent annual report filed by MSF-USA with the New York State Attorney General may be obtained, upon request, by contacting MSF-USA at 333 Seventh Avenue, 2nd Floor, New York, NY 10001-5004, or the Attorney General’s Charities Bureau at 120 Broadway, New York, NY 10271. A list of all of the MSF offices that received funds from MSF-USA is also available upon request. Audited Financial Statements are also available on MSF-USA website.
Typhoon Haiyan, which ripped through the central Philippines on November 8, 2013, was the worst natural disaster the country had experienced in more than a century.

More than 6,200 people were killed and whole communities were flattened. Bridges were destroyed, roads rendered impassable, and power and communications cut off. With fuel in short supply and no way to reach safe havens, survivors crammed into damaged schools, stadiums, and churches to wait for assistance. Within days, MSF began providing medical and humanitarian assistance in three of the most affected and isolated areas: around Guiuan in the east of Samar Island; around Tacloban, Ormoc, Santa Fe, and Burauen on Leyte Island; and around Estancia and on the northeastern archipelago of Panay Island.

MSF teams traveled by boat, truck, plane, and helicopter to assess needs and provide aid. The immediate priorities were addressing acute and immediate medical trauma needs; restoring basic medical services and facilities; providing shelter, reconstruction kits, and

**2013 EXPENSES** Total $24,383,947 (Amount in USD)

<table>
<thead>
<tr>
<th>Areas of Intervention</th>
<th>Amount (USD)</th>
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<tbody>
<tr>
<td>Tacloban and surrounding areas</td>
<td>$4,696,188</td>
</tr>
<tr>
<td>Guiuan and outlying islands</td>
<td>$11,299,225</td>
</tr>
<tr>
<td>Ormoc, Santa Fe, and surrounding areas</td>
<td>$1,406,766</td>
</tr>
<tr>
<td>Burauen</td>
<td>$3,793,639</td>
</tr>
<tr>
<td>Mainland Panay and outlying islands</td>
<td>$3,188,129</td>
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*DOCTORS WITHOUT BORDERS / MEDECINS SANS FRONTIERES (MSF)*

*US ANNUAL REPORT 2013*
water and sanitation facilities; and offering psychosocial support to both children and adults.

From November 8, 2013, through February 28, 2014, MSF teams treated 96,611 outpatients, admitted 2,229 patients to hospital, performed 6,391 emergency room consultations, and carried out 3,756 surgical procedures.

MSF operations in Philippines in 2013 cost $24,383,947, and MSF plans to spend another $20,948,092 on operations there in 2014–2016. The tables below provide breakdowns of how funds were—and will be—allocated, by region and category.

> RAISED FUNDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tr>
<td>Private Income restricted</td>
<td>$41,335,913</td>
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<tr>
<td>Institutional funds</td>
<td>$3,313,453</td>
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<tr>
<td>Total restricted income</td>
<td>$44,649,366</td>
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> EXPENDITURES

<table>
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<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Spent in November and December 2013</td>
<td>$24,383,947</td>
</tr>
<tr>
<td>Expenses foreseen in 2014</td>
<td>$11,294,392</td>
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<tr>
<td>Expenses allocated to 2015–2016</td>
<td>$9,653,700</td>
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<tr>
<td>Total expenses</td>
<td>$45,332,039</td>
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**BOARD OF DIRECTORS**

**PRESIDENT**

Dr. Deane Marchbein joined MSF in 2006 to work as an anesthesiologist in MSF’s surgical program in Ivory Coast. She has worked with MSF in Democratic Republic of Congo, Haiti, Libya, Nigeria, South Sudan, and Syria, and as a medical doctor in Libya and Lebanon. She was formerly the business manager and chairperson of the anesthesia department as well as the director of the intensive care unit at Lawrence General Hospital in Lawrence, Massachusetts. Dr. Marchbein now works for Massachusetts General Hospital and the Cambridge Health Alliance and serves on the board of directors of the Fanconi Anemia Research Fund.

**VICE PRESIDENT**

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

**TREASURER**

Gene Wolfson is currently a partner at Catalyst Investors, where he manages investor relations and firm business development and serves as a member of the investment committee. He also served on the board for Catalyst portfolio company Advantage Business Media. From 2006 to 2008, he was managing director at Citigroup, where he managed the micro-cap sales and trading desk and international broker/dealer relationships in addition to working on special projects related to investment opportunities and acquisitions. Gene has previously held management positions at TD Waterhouse Capital Markets, where he was president and founder; Allegiance Securities; TD Securities USA; and Gateway Capital Investment Group. He holds an MBA in finance from Pace University and a BS in marketing and management from Montclair State University.

**SECRETARY**

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

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

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

**JANE COYNE** recently returned to San Francisco after nearly a decade working with MSF, an experience that began in 2003, when she chose to leave the corporate world and became a field logistician. She has since worked in Uganda, Sri Lanka, Nigeria, Central African Republic, Democratic Republic of Congo, and Sudan, transitioning from her early logistics work to project and program management. In July 2009, she was appointed as Program Manager for MSF-France. She worked with a team in Paris to manage operations in South Sudan, Sudan, Central African Republic, Kenya, and Georgia. She is a graduate of Cornell’s College of Agriculture and Life Sciences and received a Masters in Business Administration from the Kellogg School at Northwestern. She worked for 15 years in a variety of analytical and project management positions for both small and large manufacturing companies (Hewlett Packard, Microsoft, Dell, etc) with an emphasis on supply chain optimization.

**KELLY GRIMSHAW** joined MSF in 1999, establishing a TB program in Turkmenistan. She has since worked as a nurse practitioner and project coordinator in China, Sierra Leone, Indonesia, and Zambia, assisting those affected by civil and ethnic conflicts as well as the HIV pandemic. Kelly also provided further assistance and program oversight as Medical Coordinator in Angola, Liberia, Ivory Coast and Nigeria with responses to cholera, Marburg Hemorrhagic Fever, meningitis, and measles outbreaks. In the US, she has volunteered her services to MSF-USAs Speaker’s Bureau throughout the country and Refugee Camp in the Heart of the City exhibits. She currently works in nursing education.
Martha (Carey) Huckabee began working for MSF in Somalia in 1992 as a food logistician. For the next ten years she worked primarily in emergency contexts in Africa, particularly in South Sudan and West Africa. This field experience was complemented by work at the MSF operational center in Brussels. Martha returned to the US in 2002 and earned an MPH and an MA while also starting her first stint on the MSF-USA board of directors. Her most recent field experience was in 2009, when she went to Malawi with her family to serve as head of mission. Currently living in Kalamazoo, Michigan, she is the executive director for a local nonprofit and is also working on her PhD, which examines the experience of being a beneficiary of MSF, including the experience of being photographed for advocacy campaigns.

Dr. Jean-Marie Kindermans first worked for MSF in Thailand in 1980 and worked in programs in Chad, Afghanistan, and other countries. A specialist in public health and tropical medicine, Jean-Marie also spent time as a public health consultant and as director of AEDES, the European Association for Development and Health. In 1995, Jean-Marie returned to MSF as Secretary General, managing the International Office for five years. Since 2000, he has worked for the Access Campaign, been a member of the board of MSF Switzerland, served as president of MSF Belgium from 2002 to 2010, and served on the International Board. Today, he lives in France where he leads the AEDES Foundation and works on malaria for various international organizations, while also consulting with French hospitals on medical management.

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

Dr. Michael D. Newman attended the University of Cincinnati Medical School in Ohio and completed his general surgery residency at Cottage Hospital in Santa Barbara, California. He began working with MSF in 2005 as a general surgeon in a project in Liberia and has completed multiple missions since then. A member of the American College of Surgeons and the Ohio State Medical Association, Dr. Newman practices general surgery at Ohio’s Fayette County Memorial Hospital, and his research work has been published in the New England Journal of Medicine and A Journal of Social Justice.

Dr. Megh Terzian was recently elected president of MSF-France. Born in Lebanon, he earned his medical degree in pediatrics from Yerevan State Medical University in Armenia in 1999. While still in medical school, he worked as a translator for MSF in Nagorno-Karabakh, and from 1999-2002, he worked for as an MSF field doctor in Sierra Leone, Afghanistan, Iran, and the Democratic Republic of Congo. In 2003, he became an emergency coordinator for MSF projects in Liberia, Ivory Coast, Niger, Pakistan, Central African Republic, Jordan, and other countries. From 2007 until he was chosen to lead MSF-France, he served first as Deputy and then as Director of MSF’s Emergency Programming in Paris.
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