



MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

US ANNUAL REPORT

2015



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DEMOCRATIC REPUBLIC OF CONGO

MSF staff at the General Hospital in Rutshuru, treating children with malaria. © Leonora Baumann



Doctors Without Borders/Médecins Sans Frontières (MSF)

is an international independent medical humanitarian organization that delivered emergency aid to people affected by armed conflict, epidemics, malnutrition, natural disasters, and exclusion from health care in 69 countries in 2015.

On any given day, thousands of 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.

Dear Friends,

**Kunduz. Haydan. Idlib. Boguila. Malakal.
And more.**

The list of places where MSF-run or MSF-supported facilities were bombed, shelled, or otherwise attacked in 2015 is frighteningly long. In that regard, it was a year unlike any other for the organization, with repeated incidents both causing immediate casualties and damage while also, in the aftermath, depriving people of vital medical care at the precise moment they needed it most.



This speaks to an existential threat to the practice of humanitarian action. This threat was present from the start of MSF's work in conflict zones and will persist into the future. That is true. But last year was beyond extreme, highlighting like never before the challenges inherent in our efforts to establish safe medical spaces for our beneficiaries and staff.

Without a safe medical space, we cannot have confidence that our staff and patients are not assuming excessive risk in order to provide or receive care. We cannot plausibly claim that our work is independent, neutral, and impartial—core tenets of our organization. We cannot be sufficiently certain that our work will not be co-opted for the political or military purposes of another group.

This is something we must reaffirm every time we open a new project, or when the context changes around an existing one. Mostly, we accomplish this by negotiating with all parties to a given situation, particularly when that situation is a conflict zone.

First, small exploratory teams assess the medical needs and the practicality of setting up a project. Then, team leaders meet government representatives, community leaders, military commanders and others to describe what MSF is and does. They talk about the services we provide and the assurances we need if we are, in fact, going to set up a project. We need to know, for instance, that all parties will respect our “no weapons” policy and that they won't prevent our staff from providing care based solely on medical needs.

These conversations are not endorsements and do not suggest any sort of affinity with one group or another. They are a means to an end—an avenue through which we can establish safe humanitarian spaces and provide people in need with the care they deserve.

Is it foolproof? No. We've had hospitals and clinics attacked and robbed throughout our history. We've had staff mem-

bers kidnapped and even killed. Each of these incidents is a profound tragedy felt deeply throughout the organization. And after each, we try to understand what happened so that we can learn and adapt as needed.

But in 2015, the scale and nature of attacks against medical facilities was astonishing. Even our most experienced aid workers were taken aback.

We had to find the best operational, communications, and advocacy responses to these incidents, each of which differs in important ways. The attack on our hospital in the Afghan city of Kunduz last October that killed 42 patients and staff was particularly fraught, given the involvement of the United States military. But in all cases, we demand that combatants uphold their obligations under international humanitarian law and the Geneva Conventions, and take every conceivable measure not to inflict damage upon medical facilities. On our side, we do everything we can to prevent our projects from being used by anyone for any purpose other than humanitarian medical care.

These efforts continue. Speaking out, publishing op-eds in top-tier publications, negotiating bilaterally with states and others, and maintaining dialogues with everyone from low level militias to the largest militaries in the world—these are our tactics.

We also took a lead role in pushing a United Nations Security Council resolution through which states re-affirmed their commitment to the principles described above (it passed unanimously and with the co-sponsorship of 85 member states in May 2016). And we are doing the same regarding international conventions around refugees—crucial accords in this time of ever greater population movements—and other issues, such as drug and vaccine pricing.

We will keep informing you about what we are doing in this regard and why we are doing it. We also want to tell you what it meant in 2015. You can read all about it in this Annual Report. But we can say, in short, that your support—along with the groundwork and negotiations we carried out for our medical projects—allowed us to perform more than 8.1 million consultations, carry out more than 83,000 major surgical interventions, and assist more than 219,000 deliveries, among other services, in nearly 70 countries last year.

And we will continue to fight to establish and maintain safe medical space, for our field teams and for our patients, now and into the future.

Sincerely Yours,

Deane Marchbein, President, MSF-USA Board of Directors
Jason Cone, MSF-USA Executive Director

AFGHANISTAN: The charred insides of MSF's Kunduz Trauma Center after it was attacked from the air on October 3, 2015.
© Dan Sermand





The New York Times

OCTOBER 24, 2015

Doctors Without Hospitals

“We knowingly take the risks associated with working in active conflict areas. But this attack tore through the protections afforded to hospitals in war zones, protections on which we rely and must constantly reinforce in order to establish and maintain lifesaving medical projects across front lines.”



AFGHANISTAN: Doctors tend to a patient at MSF’s trauma center in Kunduz, in March 2015. © MSF

YEMEN: MSF emergency room staff care for badly wounded patients in Aden. © Guillaume Binet



PROTECTING HUMANITARIAN SPACES

In 2015, patients, medical facilities, and medical staff came under fire far too many times, in far too many places.

During the month of October alone, MSF's trauma center in Kunduz, Afghanistan, was targeted by a sustained aerial attack that killed 42 staff and patients and completely destroyed the facility, an event that was unprecedented in MSF's history. A health center that MSF ran in Haydan, in northern Yemen, was likewise reduced to rubble in a bombing that left 200,000 people without any options for medical care. And a dozen hospitals were attacked in Syria, including six supported by MSF—part of a years-long pattern of attacks on medical work in the country that saw facilities MSF ran or supported bombed or shelled 94 times in 2015.

These attacks and the deaths they caused left us shocked, appalled, angry, and resolute. They were not the only threat medical workers and patients faced, though. Hospitals in Sudan were also bombed, and MSF facilities were robbed, ransacked, and pillaged in Honduras, Central African Republic, Myanmar, Lebanon, and elsewhere. Staff were kidnapped, assaulted, threatened, and harassed in a host of other locations as well—with national health workers almost always bearing the brunt. In some cases, teams had to be evacuated and projects suspended or closed.

South Sudan proved particularly dangerous for people seeking medical care. Between December 2013 and June 2015, 58 people were killed on hospital grounds in the country. This includes 25 patients who were killed in MSF project compounds in Bentiu, Bor, Leer, and Malakal. And the attacks continued in 2016: in March, MSF's hospital in Pibor was ransacked after fighting broke out around it; in April, a hospital MSF supported in Aleppo was bombed, killing 55, wounding many more, and destroying the building.

Only in a safe space can we offer our staff and patients the assurance that they can deliver or receive treatment without fear.

THE NEED FOR SAFE SPACE

As noted in the letter that opened this Annual Report, a safe medical space—or a safe humanitarian space, as it's sometimes called—is the *sine qua non* of our work.

Only in a safe space can we provide care based on medical needs alone, free of interference. Only in a safe space can we offer our staff and patients the assurance that they can deliver or receive treatment without fear. Only in a safe space can we uphold our obligations as a neutral and impartial humanitarian organization, as defined by our Charter, international humanitarian law, and the Geneva Conventions. And only in a safe space can we perform our work according to the medical ethics that guide us, which dictate that any sick or wounded individual who follows the regulations of our medical facilities—especially the “no weapons” policy—should get treatment solely on the basis of need.

When our staff, patients, and facilities are repeatedly threatened and attacked in a given location, we cannot in good conscience claim that we can carry out our mission as an organization. That's the big picture view. At the ground level, it simply means that we can't treat people who need treatment. It means pregnant women don't receive quality maternity care and thus face an increased risk of dying in childbirth. It means children don't get the vaccines they need to survive diseases that still claim too many young lives. It means treatable diseases like malaria, diarrhea, and cholera become fatal. And more generally, it means that hundreds, or thousands, or hundreds of thousands of people are denied access to care that just might save their lives.

There may be some irony in talking about safe spaces within conflict zones, which are by definition unsafe. But talk about it we must, because claiming safe spaces in areas of strife—and treating those who need treatment—is the very essence of humanitarian work. Even in the bloodiest of conflicts, we must at least try to establish some territory the bombs and bullets cannot reach. And in that space, we must do all we can to counteract the horrible toll of war. We must treat, we must heal, we must attend, and in so doing, we must let people know that their lives, and their futures, matter.

There will be individuals, armed forces, and even nations that have little time or patience for such arguments. That awful truth is what first spawned international humanitarian law and the Geneva Conventions,





theguardian

JANUARY 19, 2016

Bombing Hospitals and Schools Cannot Become the New Normal

“Today, sophisticated military weapons are being—purposely or mistakenly—aimed at hospitals and clinics. With total impunity, essential medical services are being destroyed as a military strategy, both by national armies and by international coalitions, in Afghanistan, in Syria, and in Yemen.”



SYRIA: A mother and her children in a displacement camp. © MSF

SOUTH SUDAN: A mother looks on as an MSF worker treats her daughter in Lankien. © Karel Prinsloo

TIME

JANUARY 29, 2016

Hospitals Are Under Fire in Yemen's War

"The warring parties and their international backers must honor international humanitarian law and be held accountable for violations. And the wounded and sick must be permitted access to health care."



YEMEN: MSF International President Dr. Joanne Liu talks to displaced people during a field visit. © Malak Shafer/MSF

SOUTH SUDAN: At MSF's project in Lankien relatives assist a man who is being treated for kala azar. © Karel Prinsloo



How do we create safe space? By negotiating. By talking. By establishing dialogue with all parties to a conflict...

compacts that make legal claim to safe space for people in need. And yes, this includes wounded combatants, whether they are considered “good guys” or “bad guys.” Assignations do not matter, because wounded combatants who lay down their arms when they seek care are no longer considered combatants. This is why American military medics treat “enemy” fighters on the battlefield; they, too, are duty bound to care for the wounded based on health status alone. To deny care or discriminate against patients because of their beliefs or affiliations is itself a violation of the laws of war and possibly a war crime.

And, on a practical level, if we treated one group but not another, we could never claim to be independent and impartial—and we would then never be able to work across frontlines the world over to provide emergency and often lifesaving medical services to hundreds of thousands, if not millions, of civilians in conflict zones.

CREATING AND PROTECTING SAFE SPACES

How do we create safe space? By negotiating. By talking. By establishing dialogue with all parties to a conflict—all relevant government representatives, all armed groups, all local leaders—and explaining over and over again who we are, what we do, how we do it, and why we do it that way.

We talk about being impartial, neutral, and independent. We talk about how we don’t use armed guards and that weapons are banned from our facilities. We talk about how we work across frontlines, and we ask for assurances that our teams, our projects, and our patients will not be targeted, that their right to provide and receive care unimpeded will be honored. If such assurances cannot be given, we will not open or maintain a project in that location.

Most importantly, our teams act according to these principles, at times caring for wounded men from opposing forces who had just been fighting each other on the battlefield.

And when that safe space is violated?

In some instances, encroachment can be addressed through additional conversations that help us understand whether something was a one-time incident or a sign of longer lasting and more disturbing developments. As that process plays out, we may need to move some or all team members out of a project while new assurances can be sought, new understandings forged. There have been times when a new party seizes power in a given area, as the Islamic State group did in Syria, and the prevailing trends shift radically. On occasion, fighting will erupt or intensify in places that had enjoyed a period of relative stability, as happened last year in Kunduz, Yemen, and South Sudan, or in years past in places such as the eastern Democratic Republic of Congo, Sri Lanka, or Central African Republic. Plans must then be adapted. Team leaders must gauge whether the environment is still viable for our projects.

These dynamics are particularly complex today, when multinational coalitions are fighting in Afghanistan, Syria, Yemen, and elsewhere, their members all hewing to





MAY 9, 2015

South Sudan: Imminent Attack Forces Evacuation of Hospital

“We must sound the alarm on the grim situation in southern Unity state... We cannot stand by and watch as civilians and medical facilities are attacked again. All warring parties must take immediate steps to ensure that civilians, as well as humanitarian staff and their facilities and vehicles, are not targeted in the fighting.”



SOUTH SUDAN: A young girl waits with her mother to be seen by a nurse at MSF's hospital in Leer, soon after it was looted, in May 2015. © Dominic Nahr

AFGHANISTAN: A father brings his daughter in for care at MSF's trauma center in Kunduz, in May 2015. © Andrew Quilty

...we must do all we can to counteract the horrible toll of war—we must treat, we must heal, we must attend, and in so doing, we must let people know that their lives, and their futures, matter.

their own rules of engagement and interpretations of the laws of war. We also have countries waging wars and launching military actions under the banner of counterterrorism seeking to extricate themselves from the bounds of international treaties and conventions. And we have non-state armed groups who almost seem to be competing with each other to carry out ever more savage forms of violence against whomever they target. The result is an environment wherein attacking medical facilities and medical personnel in conflict zones seems like some shockingly perverse new normal.

HOW WE ARE RESPONDING

Since its inception, MSF has spoken out about attacks on medical facilities, personnel, and patients. The particulars of our responses may vary, but the purpose is always the same: protecting our facilities so we can deliver life-saving care in places where the needs are immense and the options are few.

We tailor our responses to the circumstances of each incident, basing our statements and actions on the established facts at our disposal and taking into account the context where the violation occurred. For both Kunduz and Yemen, we called on UN member states to mobilize the International Humanitarian Fact-Finding Commission (IHFFC), which was created by the Additional Protocols to the Geneva Conventions to investigate breaches of international humanitarian law. Even though these calls went unheeded, we may well do likewise in the future, because the IHFFC, when activated, can pursue the matter in a way the US or the Saudi-led coalition fighting in Yemen (or any state involved in other conflicts) will not.

In April 2016, when the US released its report into the Kunduz attacks, we noted that the investigation was neither independent nor sufficient in terms of the accountability imposed for the deaths of our staff and patients. It's absurd to expect objectivity when perpetrators investigate themselves, after all, in this or any case. We also noted that this investigation was launched in the first place because the target was a well-known international humanitarian group and not a group of anonymous villagers in the hinterlands of some faraway country.

That said, few other nations or non-state groups have gone as far as the US did to document the innumerable errors and stunning displays of negligence that led to an attack on a fully functioning health care facility, in clear violation of the military's own rules of engagement in Afghanistan. Many just write off incidents as “collateral damage” or “the fog of war,” or seek

We will keep working to create safe spaces for our staff and patients in all our projects around the world... That's how we assert some sense of humanity in some of the world's worst places.

to justify them based on their own national and military interests. Some ignore international humanitarian law altogether, reserving the right to attack whomever and whenever they want. Or they say they didn't mean to hit a hospital, even though negligence or recklessness leading to strikes on medical facilities can also meet legal definitions of a war crime.

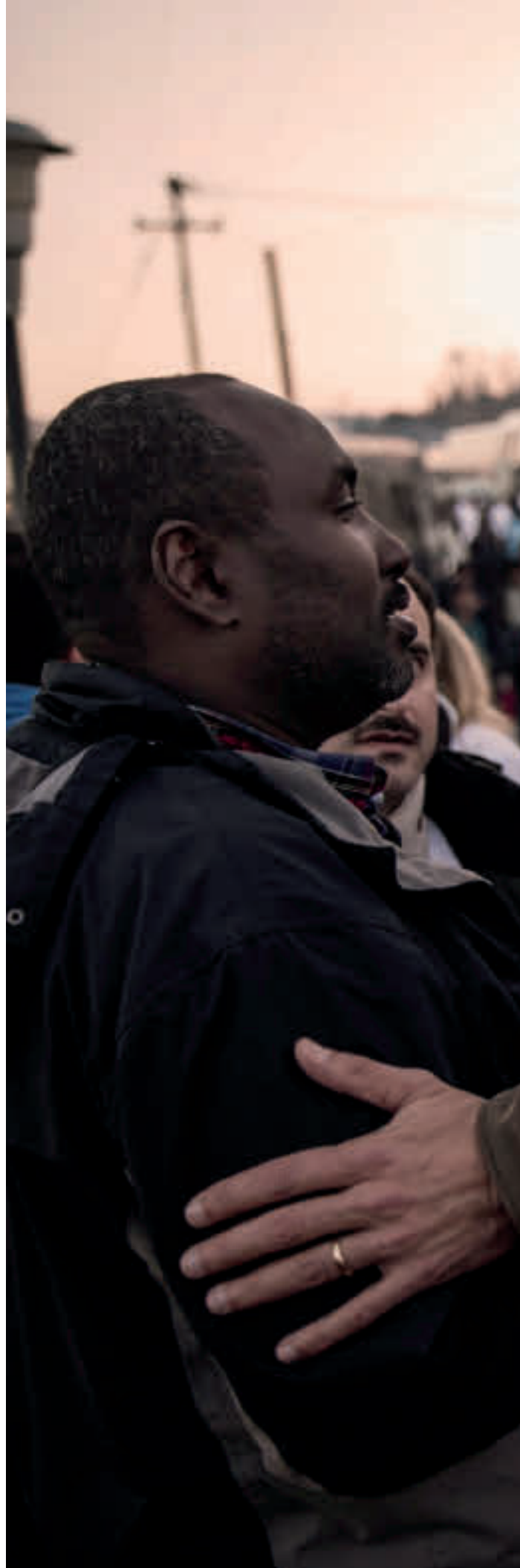
That needs to change. And in an effort to achieve that change, we not only denounced attacks on medical facilities whenever they occurred; we also backed a UN Security Council Resolution through which states reaffirmed their commitment to the protection of medical facilities and personnel.

Before the resolution passed by unanimous vote, co-sponsored by 85 member states, on May 3, 2016, we worked to make sure that it clearly recognized that a sick or wounded individual, even a combatant, has the prerogative to seek and receive care in conflicts; that it called on all warring factions—state and non-state forces alike—to uphold their obligations toward civilians and the medical mission as dictated by international law; that it called on governments and militaries to enshrine these principles in their national laws and codes of conduct; that attacks be catalogued, their frequency and perpetrators recorded; and that transgressors be held accountable, their actions investigated by an independent body empowered to report its findings at the highest levels.

Most of this was already law, and it was inconceivable that it had to be reaffirmed at all. But given the serial nature of attacks on medical facilities today, we needed to hear states assert that they will no longer condone acts that destroy medical facilities, kill medical workers and patients, and deprive medical care to populations in need.

We don't hold any illusions that the resolution will immediately halt these attacks, but it was an important message to send—all the more powerful because so many of world nations lent their support to it.

We will keep working to create safe spaces for our staff and patients in all our projects around the world, and we will keep working at every level to protect those spaces. This includes now holding UN member states to the pledge they made this past May. We have to, because that's how we work. That's how we assert some sense of humanity in some of the world's worst places. That's how we honor your support of our efforts. And that's how we reach children, women, and men who need emergency medical care.





APRIL 5, 2016

What Was Lost in the Kunduz Hospital Attack?

“I can’t help but think that every day the hospital is a burnt out shell is a day that could have seen dozens of lives saved and hundreds of patients treated. What will they all do—the survivors and future injured patients of Kunduz? What on earth will they do?”

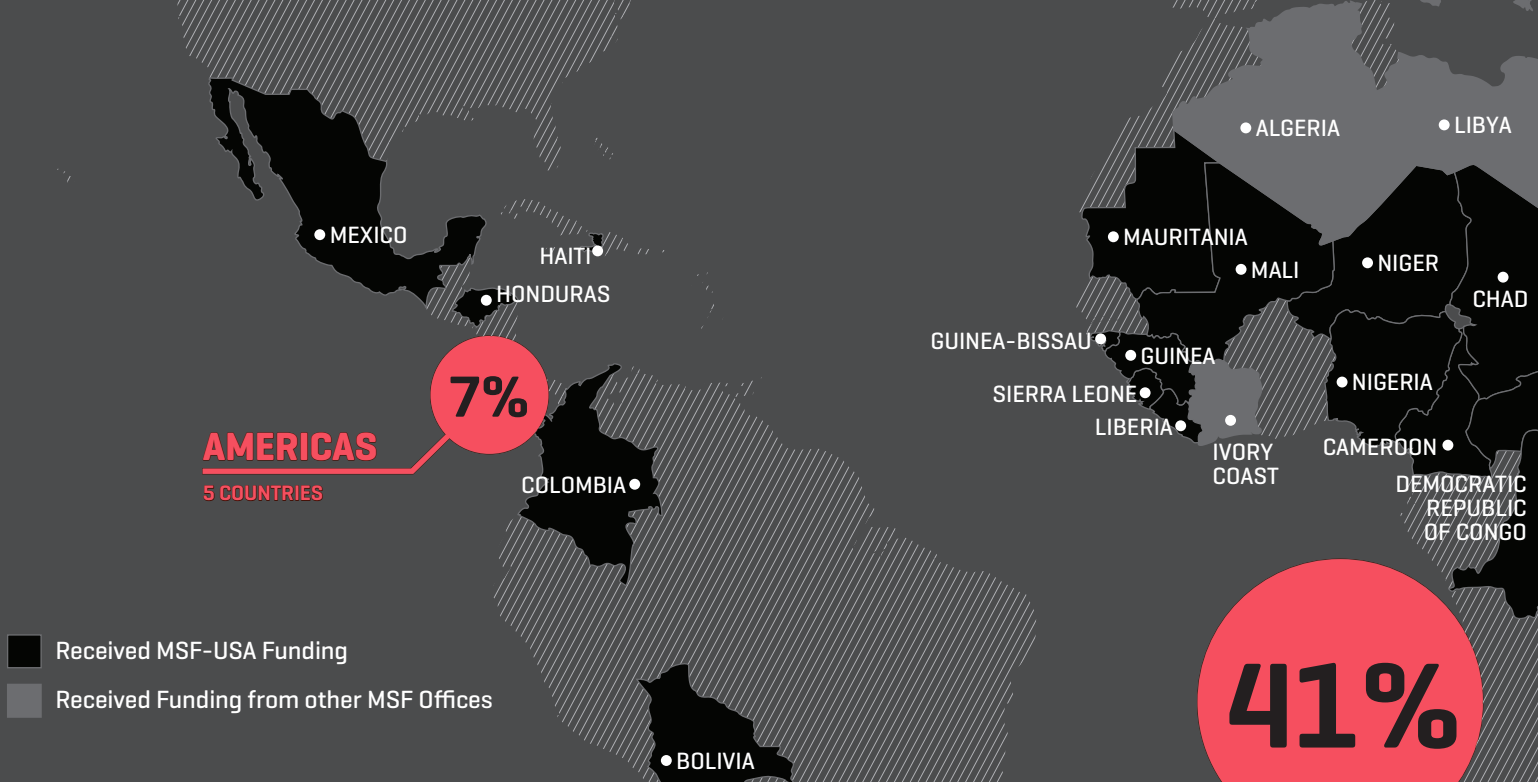


AFGHANISTAN: A man injured in a traffic accident is treated at MSF’s trauma center in Kunduz. © Andrew Quilty

GREECE: An MSF health promoter speaks with a Somali refugee outside MSF’s clinic in Idomeni. © Jodi Hilton

ACTIVITIES

In 2015, Doctors Without Borders/Médecins Sans Frontières (MSF) provided humanitarian assistance in 69 countries. MSF-USA supported work in 53 of these countries.



Largest Country Programs in 2015

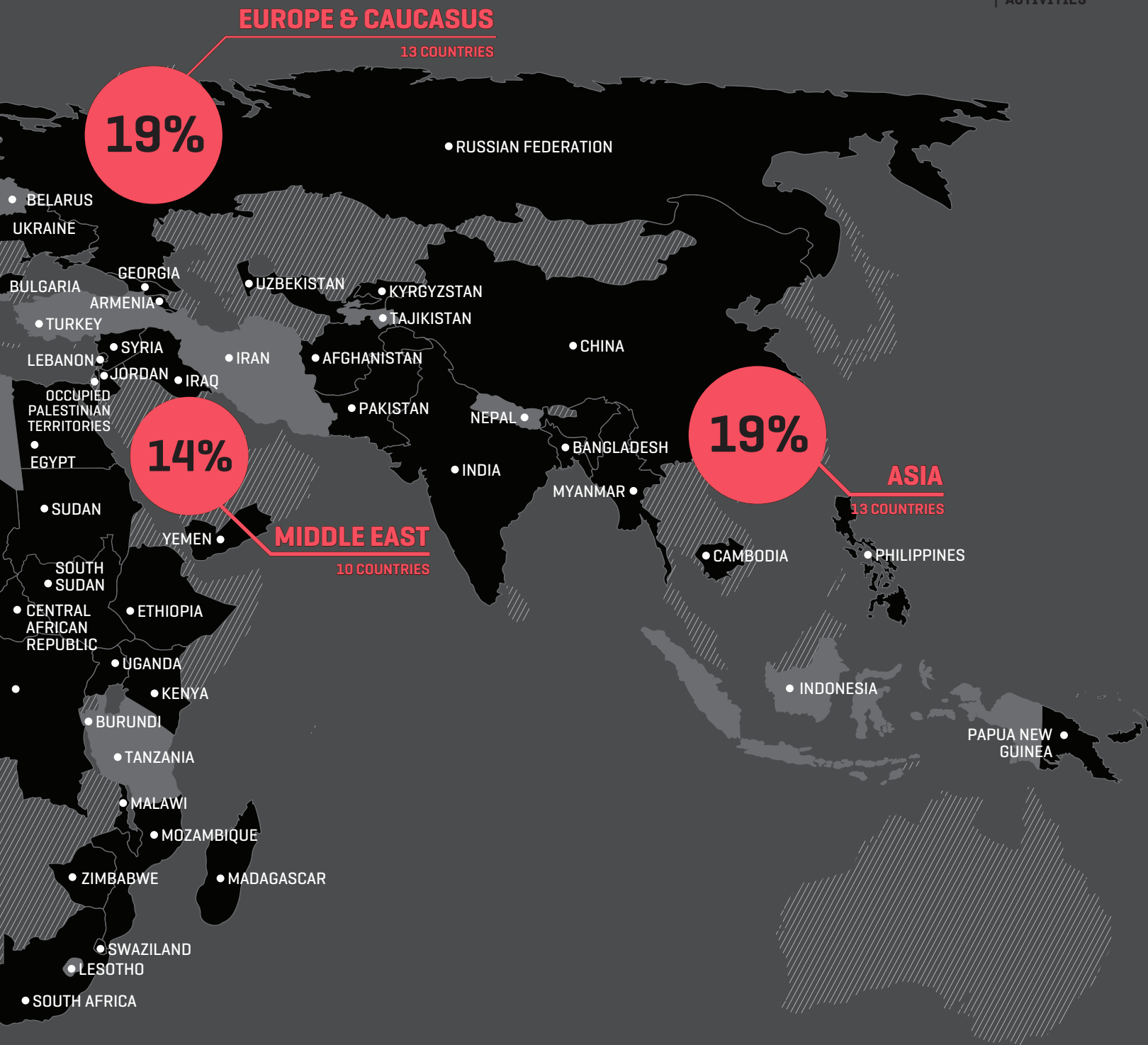
Based on 2015 expenditures from all MSF offices.

DEMOCRATIC REPUBLIC OF CONGO	\$111.3 million
SOUTH SUDAN	\$90.6 million
CENTRAL AFRICAN REPUBLIC	\$58.7 million
YEMEN	\$42.6 million
HAITI	\$35.6 million
IRAQ	\$34.4 million
NIGER	\$31.6 million
AFGHANISTAN	\$30.2 million
LEBANON	\$30.1 million
ETHIOPIA	\$29.5 million

Staff Numbers in 2015

Largest country programs based on the number of MSF staff in the field.

SOUTH SUDAN	3,322
DEMOCRATIC REPUBLIC OF CONGO	2,867
CENTRAL AFRICAN REPUBLIC	2,629
AFGHANISTAN	2,303
HAITI	1,835



Outpatient Consultations in 2015

Largest country programs according to number of outpatient consultations (not including specialist consultations).

DEMOCRATIC REPUBLIC OF CONGO	1,652,008	AFGHANISTAN	366,200
CENTRAL AFRICAN REPUBLIC	1,016,096	PAKISTAN	358,300
SOUTH SUDAN	915,934	LEBANON	342,100
ETHIOPIA	413,200	KENYA	281,100
NIGER	408,000	SUDAN	241,700



2015 BY THE NUMBERS

8,132,100 Outpatient consultations

594,900 Patients admitted

83,500 Major surgical interventions, including obstetric surgery

YEMEN: Surgeons at work in MSF's operating theater in Aden. © Benoit Finck



Births assisted, including Caesarean sections	219,300
People treated for cholera	32,600
People living with HIV/AIDS provided with care	333,900
People provided with antiretroviral treatment	230,400
People treated for malaria	2,299,200
Malnourished children admitted to inpatient or outpatient programs	181,600
People treated for measles	45,600
People vaccinated in response to meningitis outbreaks	326,100
Staff-held individual and group mental health sessions	223,900
Migrants and refugees rescued and assisted, Mediterranean Sea	23,700
Relief kits distributed	132,300
Patients treated (medically) for sexual-violence related injuries	11,100
Patients on first-line or second-line tuberculosis treatment	20,100
Routine vaccinations conducted	258,800

PROJECT SUPPORT

SOUTH SUDAN: MSF staff offering malaria testing in residential areas of the “protection of civilians” site set up by the UN in Bentiu.
© Brendan Bannon



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 2015 International Activity Report (www.doctorswithoutborders.org/our-work/publications/annual-reports).

AFRICA

CAMEROON \$4,500,000

MSF opened an emergency program in northern Cameroon to provide assistance to people fleeing violence in Nigeria, offering medical care, maternal services, and nutritional support in the UNHCR-administered Minawao Refugee Camp. MSF also carried out water and sanitation activities.

In August, a preventive immunization campaign vaccinated some 58,000 refugees and local residents against cholera and tetanus. MSF staff in Mokolo and Mora working with displaced and local populations carried out 12,921 consultations, provided specialized nutritional and pediatric care, and admitted 5,000 children for treatment.

In June, MSF began supporting the surgical ward in Kousseri, performing emergency interventions and Caesarean sections. In July, MSF helped treat patients wounded in two suicide attacks in Maroua.

In the east, MSF assisted refugees fleeing violence in Central African Republic, supporting the Ministry of Public Health by providing medical, nutritional, and psychological care to refugee and host communities in Garoua-Boulai, Gbiti, and Batouri. Medical activities at Protestant Hospital in Garoua-Boulai were handed over to the French Red Cross.

In the border town of Gbiti, MSF's therapeutic feeding center provided primary health care consultations and referred severely ill patients to the Batouri District Hospital, where MSF also supported complicated malnutrition treatment, particularly for young children.

CENTRAL AFRICAN REPUBLIC (CAR) \$21,603,056

MSF continued to provide basic and emergency health care in hospitals and public health facilities in 13 prefectures and 15 localities in CAR. This included carrying out vaccination campaigns; operating mobile clinics; and providing emergency surgery and maternity services, specialized care for victims of sexual violence, and treatment for malnutrition, HIV, and tuberculosis [TB].

In Bangui, MSF carried out 4,100 surgical interventions and provided medical and psychological care to 675 victims of sexual violence at the General Hospital; conducted 37,000 consultations in the PK5 enclave; carried out 400 consultations daily at M'poko Hospital, while treating or referring 15,400 emergency cases; and assisted over 7,400 births, admitted 10,500 patients, and tended to 275 victims of sexual violence at Castor Health Center.

Elsewhere, MSF provided comprehensive inpatient and outpatient care to residents and displaced people in Kabo, Boguila, Paoua, Carnot, and Ndélé. In Batangafo and Bossangoa, MSF provided basic and specialist health care. In Berbérati, MSF supported the regional hospital, where it admitted around 6,000 children, and four health centers, where staff carried out 20,000 outpatient consultations. Staff also vaccinated 28,000 children against measles in Berbérati and Mbako, and provided care to residents and around 80,000 displaced people in Bambari.

In Bria, MSF provided health care to children under 15 and vaccinated 16,600 children

against measles. In Zémio, teams offered basic and specialist care in the hospital and supported peripheral health posts and malaria treatment points. What's more, MSF supported maternity, pediatric, and surgical services in Bangassou, health centers in Niakari and Yongofongo, and measles vaccination campaigns in Rafaï and Bangassou.

In addition, since malaria remains the biggest killer of children under five, MSF administered three rounds of preventive malaria treatment in Ndélé, Kabo, and Batangafo, reaching around 14,000 children, and launched a year-long campaign across 13 prefectures, targeting 220,000 children under five.

CHAD \$3,258,719

As conflict in Nigeria spilled over into Chad, MSF teams in Baga Sola, where 7,000 refugees had gathered at Dar es Salam Camp, carried out over 33,400 medical consultations and nearly 900 mental health consultations and distributed more than 2,000 hygiene kits and 660 water-purifying kits. In Bol, mobile clinics conducted over 2,700 consultations and distributed 350 hygiene kits and 264 water purifying kits. MSF also worked at Bol Regional Hospital.

In Bokoro, Hadjer Lamis region, MSF treated malnourished children; supported immunizations; treated malaria, diarrhea, and acute respiratory tract infections; ensured access to safe water; and ran community health promotion activities.

In Am Timan, Salamat region, MSF supported the public hospital's pediatric and maternity wards, TB and HIV care, a nutrition program, and three mobile clinics. Teams carried out more than 24,400 outpatient and 4,400 antenatal consultations, treated 8,100 children for malaria, and assisted 2,100 deliveries.

In Moissala, Mandoul region, MSF focused on pregnant women and young children and ran a prevention, detection, and treatment program for pediatric malaria. Staff administered four rounds of seasonal malaria chemoprevention [SMC], reaching around 100,000 children with each; polio vaccinations for 28,800 infants; pentavalent vaccines for 14,000 more; and measles vaccinations for more than 48,000. MSF also vaccinated 80,000 children against measles in Goz Beida, Dar Sila region.

In Abéché, Ouaddaï region, MSF performed 928 surgical interventions. Staff also provided materials and mass casualty management training at one hospital in Abéché and two in N'Djamena.

DEMOCRATIC REPUBLIC OF CONGO \$23,423,844

In Katanga, MSF vaccinated more than 962,000 children and supported treatment for more than 30,000 during a massive measles outbreak. Mobile clinics in Nyunzu and Kabalo treated malnutrition and malaria and vaccinated children. Staff treated diarrhea, provided oral cholera vaccinations, and improved the water supply infrastructure in Kalemie and in Kituku, Undugu, and Kitaki health zones. Teams also treated 30,100 people for malaria in Kikondja and provided measles vaccinations in Kikondja, Bukama, Haut Lomami, and Kiambi. And MSF supported health centers and the main hospital in Shamwana, primarily treating malaria, malnutrition, and diarrheal diseases.

In North Kivu, MSF provided comprehensive care for displaced people at hospitals and health centers in Mweso, carrying out over 185,000 outpatient consultations—a quarter of them for malaria—and 13,200 mental health sessions, while treating 4,000-plus children for malnutrition and assisting 6,500 births. Teams in Walikale conducted 133,000 consultations, nearly half for malaria. Staff at Masisi Hospital tended to women with high-risk pregnancies, while mobile clinics provided 168,801 outpatient consultations at displacement camps and remote villages. And teams at Rutshuru General Hospital provided over 33,300 emergency consultations and admitted over 3,700 patients for surgery. Staff in Goma screened for and treated HIV as well.

In South Kivu, MSF supported the general hospital and six health centers in Lulingu, as well as the Numbi reference health center, providing some 124,000 outpatient consultations, 37,000 reproductive health consultations, and vaccinations for 35,700 children. Staff supported Shabunda General Hospital, Matili Hospital, and seven health centers.

As rampant malaria overwhelmed MSF-supported Baraka Hospital, teams built an additional facility and supported community-based treatment, conducting 287,000 outpatient consultations. Teams at Kimbi Hospital and area health centers provided 149,500 outpatient consultations and treated 125,600 patients for malaria. MSF's provincial emergency team launched seven interventions to tackle epidemics and address the needs of displaced people.

In Maniema, MSF's project in Bikenge focused on pregnant women, children, victims of sexual violence, and surgical emergencies, carrying out around 24,710 consultations. In Ituri, Haut-Uélé, and Bas-Uélé, teams offered reproductive and emergency care at Boga General Regional Hospital and Rubingo Health Center; provided emergency, maternity, and

pediatric care at Gety Regional General Hospital; and responded to cholera, meningitis, and measles outbreaks.

ETHIOPIA \$6,193,621

In Gambella, MSF clinics provided comprehensive services in camps inhabited by South Sudanese refugees, providing 19,600 outpatient consultations and emergency and maternity services. MSF's 55-bed Itang Health Center, near Kule and Tierkidi camps, provided over 200,000 consultations and treated 70,000 for malaria. A meningitis vaccination campaign reached 29,196 people in Kule and 29,317 in Tierkidi.

In November, MSF started providing basic and specialist care, including malnutrition, HIV, and TB treatment, at the Pugnido camps. A targeted campaign for refugee children vaccinated 13,862 against pneumococcal disease and 3,376 against diphtheria, whooping cough, tetanus, and hepatitis B.

In the Somali region, MSF provides nutritional care, antenatal consultations, TB care, and other services to Somali refugees at Dolo Ado Reception Center and Buramino and Hiloweyn camps. In Jerar Zone, MSF supported a hospital, health centers, and mobile clinics across Degehabur, Birqod, Ararso, and Yocale. Teams provided specialist services in Degehabur and nutritional support to acutely malnourished children in Jehrar.

A team supported nutritional care in Nogob Zone, while others focused on child care, maternal health, malnutrition, and care for victims of sexual violence in Wardher Zone and at Yucub Health Center. Late in the year, MSF launched an emergency malnutrition intervention in Siti Zone as well, akin to similar efforts launched earlier in Gewane and Bidu.

In Adburafi, staff treated 325 patients for kala azar, 249 for severe acute malnutrition, and 325 for snakebites. Staff also ran outpatient psychosocial and psychiatric services for Eritrean refugees in Tigray Region.

GUINEA \$9,024,895

One year into the outbreak, MSF continued to respond to Ebola in Guinea, supporting Ebola treatment centers (ETCs) and assisting with safe burials, health promotion, community surveillance, and contact tracing, in addition to participating in related trials and studies.

An MSF rapid-response mobile team was deployed to Faranah and Kissidougou to analyze needs and propose a course of action. In April, MSF supported the transfer of patients from the Guéckédou ETC to a new facility in Forécariah and the ongoing work of identifying new cases and carrying out outreach activities. In July, MSF opened new ETCs in Nongo, an area of Conakry, and in Boké. The

Nongo center had a 72-bed capacity and assumed the activities that were taking place at Donka Hospital. Last December, Guinea was declared Ebola-free, although new cases were detected in March 2016.

In 2014, many people living with HIV/AIDS abandoned treatment because they feared contracting Ebola in health facilities. In response, MSF implemented a six-month refill strategy (R6M), enabling patients to pick up their medicine twice a year. Over 90 percent of patients who took advantage of the program were still under treatment as of March 2015. MSF also managed a medical facility in Matam and supported six health centers where HIV care was offered along with basic health services.

IVORY COAST \$2,293,643

In 2015, MSF worked with the Ministry of Health (MoH) to address rising maternal mortality rates. In Hambol Region, at Katiola's Central Regional Hospital, MSF managed the 20-bed maternity department, three intensive care beds, two operating theaters, and 10 neonatal beds. The facility served as a referral hospital for 98,000 women, 14,800 pregnant women, and 14,000 newborns. Staff managed 755 obstetric emergencies, high-risk pregnancies and complicated births; responded to 600 gynecological emergencies; and assisted 2,600 births, 374 of which required Caesarean sections.

MSF also supported and improved basic emergency obstetric and neonatal care units in outlying areas, and improved management of deliveries and referrals to Katiola. MSF staff in two outlying health centers treated 106 women during obstetric emergencies, high-risk pregnancies, or complicated births, as well as 28 gynecological emergencies. They assisted over 400 births and referred some 50 patients to Katiola.

KENYA \$7,286,098

Located in northeastern Kenya, Dadaab, the world's largest long-term refugee settlement, is home to some 345,000 refugees, mostly Somalis. Somali refugees are being pressured to return home, however, as funding for humanitarian assistance decreases. MSF staff at the 100-bed hospital in Dagahaley Camp and four health posts provide outpatient and mental health consultations, surgery, and antenatal, HIV and TB care. In May, however, insecurity forced MSF to evacuate some staff and close two health posts. Overall in 2015, teams carried out 182,351 outpatient consultations and admitted 11,560 patients.

In Ndihiwa, MSF started a new HIV treatment and prevention program. In December, MSF handed over its HIV and TB program in Homa



ETHIOPIA: An MSF staffer tends to a boy in the emergency room of MSF's project in Dolo.
© Matthias Steinbach

Bay to the MoH, having enrolled more than 7,300 people for ARV treatment by year's end.

In Nairobi's Eastlands slum, MSF's Lavender House clinic treated and supported victims of sexual and gender-based violence; more than half of the 2,429 people treated were aged under 18. MSF also runs the Lavender House trauma room and supports the emergency department of Mama Lucy Kibaki Hospital.

The Green House clinic, also in Eastlands, diagnosed and cared for DR-TB patients. And in Kibera, Nairobi's largest slum, MSF provides comprehensive care, HIV and TB treatment, and non-communicable disease care. Staff carried out 132,500 consultations and assisted 2,469 deliveries in the maternity ward in Kibera South as well. And teams also supported the MoH's response to a massive cholera outbreak.

In April, Al Shabab militants stormed a university in Garissa, killing more than 100 people. MSF treated survivors and provided medical consultations, food, and water at Garissa airport, where evacuated students spent the night.

LESOTHO \$807,607

After nearly a decade of working in Lesotho, MSF handed over all projects to the government in November 2015. During its time in the country, MSF prioritized free maternal care, family planning, and HIV care.

MSF supported St. Joseph's District Hospital in Roma with family planning services and ante- and postnatal care, and also ran six health clinics in the lowlands and three in remote Semonkong. During 2015, teams delivered an average of 130 babies at St. Joseph's each month. [UNICEF took over the free maternal care at St. Joseph's; MSF continues to advocate for a national rollout of free maternal care.]

MSF also trained and mentored local staff to provide integrated care for people with HIV and TB. Viral load monitoring was expanded, and lay counselors were trained to deliver adherence counseling. By the time MSF left, over 80 percent of first-line ARV patients had attained virological suppression.

LIBERIA \$2,494,811

In 2015, Liberia passed the acute phase of the prior year's Ebola outbreak, but traces of it—and profound aftereffects—remained. In March and May, respectively, MSF handed over an Ebola transit unit in Monrovia to the International Rescue Committee and an Ebola treatment center to the MoH. A transit unit triaged 81 patients and diagnosed seven with Ebola. The country was declared Ebola-free in May but new cases were reported in July and November, and MSF provided Ebola training sessions and helped augment infection prevention and control measures in Monrovia.

The damage done was readily apparent, though. Numerous hospitals closed in 2014. An estimated 8 percent of Liberia's health workers died from the virus, while others never returned to work. Many survivors suffered a host of maladies, including joint pain and eye problems, not to mention ostracism.

MSF began outpatient care and mental health consultations to Ebola survivors in Monrovia. MSF also opened the 74-bed Bardnesville Junction Pediatric Hospital to provide



SIERRA LEONE: An MSF outreach worker talks about health issues with people in Kurumbai, in March 2015. © Tommy Trenchard

specialized care for children, later increasing its capacity to 91 beds.

When measles hit in Monrovia in early 2015, MSF organized a vaccination campaign in Peace Island District, reaching 542 children. MSF later supported the MoH's countrywide vaccination campaign.

MALAWI \$2,333,794

Severe floods in Malawi killed 176 people and displaced more than 200,000 in 2015. MSF mobile clinics provided 40,000 outpatient consultations in the aftermath and teams distributed relief items and drinking water, which helped contain a cholera epidemic.

Meanwhile, MSF continued with plans to hand over HIV projects in Chiradzulu (by 2018) and in Thyolo (by this past December). Despite progress, HIV remains a pressing issue. Some one million Malawians are living with it; only half receive treatment.

Health authorities stepped up treatment and prevention efforts, building on MSF's work supporting more than 33,000 HIV patients, facilitating rapid access to viral load measures

In Nsanje, MSF helped implement the policy to put all HIV-positive pregnant and breastfeeding women on ARVs, regardless of

clinical status, to prevent transmission. The MoH requested MSF's support for community ARV groups, too.

MSF also worked in prisons in Lilongwe and Blantyre to reduce HIV and TB transmission. Teams also offered HIV and other testing to truck drivers and sex workers in Mwanza and Zalewa. And following spasms of xenophobic violence in South Africa, MSF offered medical and psychological care to 3,831 Malawians. Three months later, MSF organized mobile clinics in Kapise for Mozambicans fleeing violence in Tete Province.

MALI \$7,342,078

Ongoing fighting in the north impeded humanitarian access, and a lack of supplies and personnel left people with little or no health care. Insurgent attacks in the south sowed insecurity there as well.

In Gao, MSF managed outpatient services, maternal health, nutrition, and surgery at Ansongo District Hospital. Staff also arranged referrals from health centers. MSF provided care to pregnant women and children among pastoralist populations and antimalarial treatment—along with a slate of immunizations—to more than 46,000 children during

the seasonal peak. A team supported two health centers in the Kidal Region as well.

In Timbuktu, MSF staff at the 86-bed regional hospital admitted some 390 inpatients and assisted 80 deliveries each month. Teams also consulted on chronic diseases at the referral health facility. As security allowed, mobile teams offered basic care, vaccinations, maternal care, and malnutrition screening at three peripheral health centers.

With malaria the main cause of child mortality in the south, MSF focused on child health and malnutrition in Koutiala, Sikasso Region, supporting the Koutiala referral health facility's pediatric unit and five district health centers. MSF also delivered antimalarial treatments to 190,067 children through its SMC program, and teams provided preventive pediatric care, including vaccinations, in the Konségouéla area.

MOZAMBIQUE \$700,000

Working with the MoH, MSF teams in Mozambique battled HIV/AIDS and TB and responded to cholera epidemics. More than 1 in 10 people in the country has HIV, a situation exacerbated by shortages of staff and medicines. MSF provided technical and specialized care and programs enabling easier access to medicines.

In Maputo, MSF focused on specialized care for HIV/AIDS patients, including people co-infected with MDR-TB, viral hepatitis, or Kaposi's sarcoma. Teams also provided comprehensive care to MDR-TB patients and HIV-infected women and children. And MSF's "corridor project" offered HIV and STI testing to truck drivers and sex workers along the commercial route between Beira Harbour and Tete Province.

MSF teams in Tete and Zambezia Provinces also treated 416 patients for cholera during outbreaks.

NIGER \$7,012,656

Waves of Nigerians fleeing Boko Haram attacks arrived in Niger's Diffa Region throughout 2015. Diffa itself was also attacked, and the military response caused further displacement. MSF worked with the MoH in the main maternal and pediatric health center in Diffa City, the district hospital in Nguigmi, and health centers in Diffa, Nguigmi, and Bosso districts. MSF also provided medical care, vaccinations, and water and sanitation activities in Assaga Camp and Yebi, and distributed relief kits in Gueskerou, Bosso, Chetimari, Gagamari, Assaga, Diffa, Damasak, and Djamea.

When a severe meningitis outbreak occurred, MSF vaccinated more than 101,500 children aged between two and 14 in Dosso region. Staff also treated 4,800 patients in a hospital and 10 clinics in Niamey, while also working in the Oullam and Filingué district hospitals.

MSF runs medical and nutrition projects in several locations in Madarounfa and Guidan Roundji departments, providing support for children with severe malnutrition, pediatrics, neonatal care, and malaria treatment and prevention efforts. In Madarounfa, MSF supported four health centers in Dan Issa during the height of malaria season, carrying out almost 10,000 consultations and treating children with severe complicated malaria. Staff also supported a health center, laboratory, and blood bank in Guidan Roundji.

In Madaoua and Bouza Departments, MSF supports 11 outpatient feeding centers, inpatient feeding centers, and hospital pediatric units. Community volunteers in Madaoua screened children in 80 villages for severe acute malnutrition and HIV.

In Magaria, MSF supported the district hospital's inpatient feeding center and pediatric unit, along with and seven outpatient feeding centers. MSF also provided vaccinations and SMC in seven health zones. In Zinder city, MSF supported the national hospital's pediatric unit and an inpatient feeding center.

NIGERIA \$7,240,120

Boko Haram violence and the military response have displaced more than two million and devastated communities throughout northeastern Nigeria. The population of Maiduguri, in Borno State, more than doubled even as it was targeted in suicide attacks.

MSF provided health care to residents and people displaced by violence, carrying out around 10,000 outpatient consultations across four sites each month. Staff later launched maternal health activities as well.

In Kukurita Camp in Yobe State, an MSF team provided antenatal care, referred complicated cases, and provided six million liters of clean drinking water. MSF rehabilitated a health care center in Kukurita as well.

In Zamfara State, where MSF has responded to lead poisoning since 2010, staff monitored lead levels and provided chelation for children who needed it. The project also provides health care to children under the age of five in five villages, focusing on malaria, respiratory tract infections, malnutrition, diarrhea, and vaccinations.

A new program in Niger State addressed lead exposure in children and provided relevant training to Kagara hospital staff. And MSF supported the MoH at Magiru clinic to ensure children under five received quality care for common childhood diseases. In Kebbi, MSF ran three mobile clinics, a health center, and a malaria clinic.

Staff in Sokoto operated on 25 children suffering from noma, cleft palate, cleft lip, and other facial disfigurements, ensuring pre- and post-operative care, along with nutritional and psychosocial support for families. Over 300 children were admitted to the therapeutic feeding center as well.

Staff in Port Harcourt provided care for victims of sexual and gender-based violence, while teams in the Jigawa State town of Jahun ran emergency obstetrics at the government hospital and admitted an average of 900 patients per month. Staff also cared for 116 babies, and surgeons carried out approximately 2,400 interventions, including 300 for obstetric fistula. An early warning surveillance system based in Sokoto facilitated rapid response to other emergencies as well.

SIERRA LEONE \$1,978,478

MSF continued its Ebola response in Sierra Leone even as cases waned. The 100-bed Prince of Wales School Ebola Treatment Center in Freetown provided medical and psychological care until February. Of the 400 patients admitted, 170 were confirmed with the virus. The team performed triage, isolated and tested patients, and ran health promotion activities.

In January, MSF opened a specialized unit for pregnant women with Ebola in Freetown. In February, MSF opened a survivor clinic, offering medical and psychological support, referrals, and free access to ophthalmic care. In July, MSF mobile clinics began providing survivor support in Tonkolili and medical consultations and referrals in Kailahun.

In addition, MSF surveillance teams supported MoH follow ups on Ebola alerts and accompanied decontamination outreach teams in Freetown. Teams also distributed hygiene items and provided personal protective gear to healthcare workers.

MSF closed the Kailahun treatment center after building an isolation ward and training MoH staff in biosafety, isolation protocols, referrals, and surveillance. Centers in Magburaka and Bo were also closed. A lack of vaccinations during the outbreak led to a resurgence of preventable diseases. MSF therefore responded to a measles outbreak in Freetown and trained staff, supervised case management, and donated medication at 10 health centers. MSF also distributed antimalarials to more than 1.8 million people in Western Province.

SOUTH AFRICA \$2,459,204

In July, MSF began providing emergency medical and psychosocial care to sexual violence victims in Rustenburg, a town in South Africa's "Platinum Belt" mining area where sexual violence seems almost endemic. Teams provided treatment, conducted outreach activities—speaking to more than 25,000 adults and students about sexual and gender-based violence—and advocated for a primary care-level response run by nurses and psychologists.

In April, an emergency team provided medical care, psychosocial counseling, and water and sanitation logistics after xenophobic violence in Durban drove some 7,000 migrants from Malawi, Zimbabwe, Mozambique, DRC, and Burundi into hastily erected displacement camps.

MSF's Stop Stock Outs Project worked with civil society organizations to monitor essential drugs in clinics and sought quick resolutions to shortages. One in four clinics surveyed experienced shortages, MSF research found, representing a threat to public health that could undermine South Africa's ARV programs, among other initiatives.

In Khayelitsha, MSF provided specialized treatment for children with HIV/AIDS and supported HIV-positive young people and pregnant women. Teams broadened their operational research on the diagnosis and treatment of HIV-infected infants and worked to assist people co-infected with HIV and TB. MSF ran a full-service HIV-TB treatment and prevention program in KwaZulu-Natal as well.

SOUTH SUDAN \$26,410,137

Two years of sustained conflict has killed tens of thousands, displaced more than a million, and driven many beyond the reach of humanitarian assistance. MSF scaled up programs but access was disrupted repeatedly by fighting, attacks on medical facilities and other civilian centers, and drug shortages, leading to gaps in care and huge spikes in malaria. In fact, MSF treated 295,000 patients for malaria in 2015, nearly ten times as many as in 2014.

In Unity State, where escalating violence drove hundreds of thousands from their homes—and often into the bush or swamps—MSF received reports of executions, mass rapes, abductions and entire villages being razed. Five South Sudanese MSF staff were themselves killed; 13 remain unaccounted for. MSF temporarily evacuated from Nyal, in May, and twice from Leer. Staff ran the only hospital in the UN protection of civilians (PoC) site in Bentiu and expanded capacity to meet enormous needs.

MSF also operated mobile clinics and therapeutic feeding programs in southern Unity State and Bentiu Town when possible. Many patients with severe injuries were referred to MSF's hospital in Lankien. MSF also provided care in a health center and mobile clinics in Old Fangak, and opened a clinic in Mayom, in northern Unity State. Teams also responded to measles, malaria, and meningitis outbreaks in the refugee camp in Yida.

MSF provided care in Malakal, Wau Shilluk, and Melut in Upper Nile State, where access to care was severely limited. MSF ran the only hospital in the Malakal PoC site and responded to outbreaks. In Wau Shilluk, MSF expanded capacity of its health care center to include secondary care. MSF also provided assistance in Doro Refugee Camp.

Rampant malaria posed a huge threat and challenge given severe shortages and drug stockouts. MSF projects in Agok, Aweil, Bentiu, Doro, Gogrial, Mayom, and Yida saw malaria spikes and increased treatment and bed capacity. Cholera hit, too, and MSF provided treatment and support in Bor Hospital in Jonglei State. A cholera treatment center in Juba vaccinated over 160,000 people. In Western Equatoria, MSF ran mobile clinics and donated supplies for conflict-affected communities. MSF also continued its HIV "test and treat" program in Yambio.

SUDAN \$2,200,000

MSF provides assistance in some of the most remote, challenging environments in Sudan, but access to those most affected by conflict is severely limited. Access was restricted in Blue Nile State and East and South Darfur, for

example, greatly curtailing activities. In North Darfur, however, MSF offered basic care, reproductive services, and emergency surgery at the hospital in El Sireaf. Two additional clinics provided basic health care to displaced people. Staff carried out 54,000 outpatient consultations overall.

MSF's clinic in Tawila, the only health facility in Jebel Marra, conducted over 59,000 outpatient consultations, provided 16,700 children with routine vaccinations, and treated 1,300 for malnutrition. In Dar Zaghawa, teams carried out 54,200 consultations for people from Um Baru, Furawiya, and Jurajeem.

MSF and the MoH collaborated on a measles vaccination campaign in March that reached 80,000 people in North Darfur's El Sireaf locality and another in June that reached more than 55,000 children in the Zam Zam and Korma camps. In Kerenek locality, MSF teams supported clinics in Hajar Tama, Goderni, and Kongi, and a bi-weekly mobile clinic in Watsani, carrying out more than 33,800 outpatient consultations.

MSF established an isolation ward in Al-Geneina Hospital and two mobile clinics following a viral hemorrhagic fever outbreak and responded to measles outbreaks in West Darfur by vaccinating children aged between six months and 15 years. MSF treated 359 patients for kala azar in Tabarak Allah Government Rural Hospital in Al Gedaref State as well, while also supporting reproductive health services, assisting births, and referring women with obstetric fistula to Kassala fistula treatment center.

In White Nile State's Elsalam Locality, MSF conducted more than 44,300 outpatient consultations for South Sudanese refugees.

SWAZILAND \$1,350,000

Swaziland has the world's highest incidence of TB, and 80 percent of people with TB are co-infected with HIV. MSF collaborated with the MoH to expand diagnostics and treatment for both through integrated, decentralized models of care. MSF also advocated to use bedaquiline and delamanid, and were treating 22 XDR-TB patients with them in combination with repurposed drugs by year's end.

MSF teams in Shiselweni supported integrated HIV/TB care in 22 community-based health clinics, operating 20 point-of-care labs that carried out 47,842 biochemistry tests, 19,340 CD4 tests, and 30,726 viral load tests. To improve adherence, MSF trained people living with HIV to work with patients and piloted community ARV groups and medication delivery services in Shiselweni.

The test-and-treat approach was adopted as the standard in Nhlngano due to its high acceptance rate; 84 percent of people [and 96 percent of women] agreed to start ARV

treatment. And MSF continued research on thin layer agar, a drug sensitivity test for MDR-TB treatments.

In Matsapha, MSF offered comprehensive health care and integrated HIV/TB services. Teams carried out 34,101 consultations, ranging from maternity care, infant immunizations, family planning, and care for victims of sexual violence. MSF supported the National TB Reference Laboratory and the National TB hospital in Moneni as well.

TANZANIA \$800,000

MSF teams in Tanzania focused on delivering care among the country's roughly 200,000 refugees, most of whom come from Burundi and DRC. Unhygienic conditions put people at risk of cholera and other diseases. MSF set up a CTC in Kigoma and another in Kagunga, where staff also carried out health promotion activities and provided water and sanitation.

In May, MSF started working in Nyarugusu Camp and set up a CTC. The next month, nearly 1,000 people were arriving every day, and NGOs struggled to provide water, food, shelter, and medical services. MSF ran mobile clinics and nutrition programs, and supported the Tanzanian Red Cross Hospital. Teams also distributed around 90 million liters of water.

MSF, with the MoH, the WHO, and the UNHCR, supported an oral cholera vaccination campaign, administering 232,997 doses of

SOUTH SUDAN: An MSF midwife conducts a medical check-up on a pregnant woman in Northern Bahr el Ghazal State. © Matthias Steinbach



the vaccine. Teams treated 18,836 people in Nyarugusu as well—mostly for malaria, diarrhea, or respiratory tract infections—and later carried out around 600 mental health consultations per week.

In October, MSF's 100-bed hospital in Nduta Refugee Camp started providing care for malnutrition, reproductive health, and sexual violence. Teams also ran mobile clinics, donated 3,500 tents, distributed more than 1.5 million liters of water, and carried out 17,591 outpatient consultations.

UGANDA \$1,618,536

MSF opened a project in southwestern Uganda's Kasese District focused on access to health care and HIV/STI treatment in fishing communities on Lake George and Lake Edward. MSF also continued its support for the HIV laboratory in Arua, introducing devices to measure CD4 and viral load count as part of a UNAIDS-funded project, offering early infant diagnosis, and supporting genotyping tests to identify resistance to second-line ARVs.

During a malaria outbreak, MSF did epidemiological assessments in Apach, Oyam, and Kole districts, where drug donations and case management guidance was also provided. Teams ran mobile clinics, offered patient referrals, and treated 63,000 patients with malaria as well.

In July, after carrying out more than 48,000 consultations, MSF handed over its project for South Sudanese refugees in Adjumani District to Medical Teams International.

ZIMBABWE \$60,000

HIV prevalence has been roughly halved in Zimbabwe since 2000 but gaps in treatment remain. MSF supports the MoH to achieve UNAIDS 90-90-90 targets. Community-based models of care in Gutu, Buhera, Chikomba, Epworth, Makoni, Mutare, Mutasa and Nyanga now include more than 5,040 patients, and MSF provided viral load monitoring for 58,434.

MSF also focused on pediatric and adolescent HIV care with ARV adherence counseling and support group sessions. Teams provided second-line ARV therapy to patients whose first-line treatment failed. And MSF provided community-based MDR-TB treatment in Epworth, Buhera, and Gutu, along with cervical cancer screening in Epworth and Gutu.

In Mbarara and Epworth, MSF provided treatment and psychosocial support to victims of sexual violence, emphasizing the importance of seeking care within 72 hours of abuse. The Mbarara team carried out 2,325 consultations. MSF also carried out 1,615 mental health consultations at Chikurubi Maximum Security Prison and Chikurubi Female Prison in Harare, and started mental health care in Harare Central Hospital.

Additionally, MSF rehabilitated boreholes and collaborated with organizations like Africa AHEAD to provide clean water and sanitation for some 30,000 people in Harare suburbs.

AMERICAS

BOLIVIA \$150,000

In Bolivia, MSF and the MoH are pursuing an integrated strategy for Chagas, training staff to recognize signs of the disease and facilitating treatment for patients with related complications.

In Chuquisaca Department, where some 70 percent of the population may have Chagas, MSF recruits and trains health staff for the area's 17 health facilities and offers free diagnosis and treatment; 3,286 people have been screened, 1,186 confirmed with the disease, and 224 started treatment.

MSF is also augmenting community surveillance by training local volunteers and spraying houses to kill the vinchuca bugs that transmit Chagas. MSF also tested EMOCHA, an e-mobile surveillance application that allows community volunteers to send word of vinchuca infestations via SMS and call on vector control teams. EMOCHA will soon be implemented in Aiquile, Omereque, and Pasorapa in Narciso Campero Province.

COLOMBIA \$2,100,000

MSF teams in Nariño's Tumaco municipality offered mental health support to over 1,500 people affected by violence and offered comprehensive care to 240 victims of sexual violence. In Buenaventura, a new project offered free, around-the-clock phone counseling for victims of violence and sexual violence; nearly 1,100 people used the service over the course of the year.

Mobile clinics and health posts in Cauca Pacífico closed in December, and the mental health program supporting victims of violence, including sexual violence, in Cauca Cordillera will close in 2016. An MSF emergency response team will intervene when needed in Nariño, Norte de Santander, and Uraba, as they did throughout 2015.

HAITI \$10,286,724

Haiti's health care system struggles to meet basic needs, such as trauma treatment and maternal health care. MSF runs a burn unit in Drouillard Hospital, where staff provided more than 3,550 surgical interventions, 12,100 physiotherapy sessions, and 1,600 mental health consultations.



In Tabarre, staff at MSF's 122-bed Nap Kenbe Hospital provided surgery and trauma-related care, attending to over 13,000 emergency patients and performing over 6,400 surgical interventions, along with physiotherapy and social and mental health support. Staff at MSF's emergency and stabilization center in Martissant, which offers around-the-clock services, attended to 50,000 patients.

Sexual and gender-based violence is an overlooked emergency in Haiti. In May, MSF opened the Pran Men'm Clinic, offering the emergency medical assistance required during the 72 hours following an assault, along with longer-term medical care and psychological support.

In Port-au-Prince's Delmas 33 neighborhood, MSF's team at the 148-bed Centre de Référence des Urgences en Obstétrique provided care to pregnant women experiencing serious and life-threatening complications, carrying out more than 18,300 consultations, assisting over 6,000 births, and admitting 2,500 babies to the neonatal ward. In 2015, staff admitted more than 2,300 patients to the 55-bed Diquini CTC in Delmas, which MSF

provided 1,100 mental health consultations in Ixtepec, Tenosique, San Luis Potosí, Apaxco, Lechería, Huehuetoca, and Bojay.

In Acapulco, MSF offered mental health support to victims of violence and carried out over 3,000 consultations. In Tamaulipas, MSF handed over its Nuevo Laredo project but continued to work in Reynosa and smaller hospitals along the US border to provide training, mental health services, and care for victims of sexual violence.

MSF worked with health authorities to respond to Chagas in Oaxaca's San Pedro Pochutla Municipality as well. And staff provided psychological support to the parents of 43 students who disappeared in Guerrero State. MSF also supported emergency obstetric services in Arcelia Hospital, in Tierra Caliente, after violence forced several rural health posts to close.

ASIA

AFGHANISTAN \$7,629,552

While MSF provided a wide range of emergency medical services across Afghanistan in 2015, its work was largely overshadowed by the October 3 aerial attack on the Kunduz Trauma Center that killed 42 people, including 14 MSF staff, and completely destroyed the only facility of its kind in northern Afghanistan. In the days and months that followed, MSF looked to support the families of the deceased and wounded, while also repeatedly denouncing one of the worst atrocities to befall an MSF project in decades. The US military took responsibility for the attack, attributing it to a cascade of human and electronic errors, but handed out only administrative punishments for those who were involved. (For more, see the opening essay on p. 5)

Since opening in 2011, the 84-bed trauma center had provided free, high-quality surgical care to victims of general trauma, including conflict-related injuries. It had an emergency room, an intensive care unit, three operating theaters, outpatient and inpatient departments, a physiotherapy department, a laboratory, an X-ray room, and a pharmacy. Between January and August 2015, staff admitted more than 2,400 patients and carried out 18,088 outpatient consultations and 4,667 surgical interventions. MSF also ran a stabilization clinic in Chahardara, outside Kunduz, for people who couldn't reach the trauma center due to fighting or road blocks.

At Ahmad Shah Baba Hospital in eastern Kabul, MSF upgraded the facility, increasing capacity and offering free, high-quality emergency services, pediatrics, malnutrition care, and vaccinations. The maternity department

provided 16,654 antenatal consultations and assisted some 1,400 deliveries each month. Teams ran mobile clinics as well.

MSF's maternity department at Dasht-e-Barchi Hospital, in western Kabul, tended to complicated deliveries and provided emergency neonatal and obstetric services, assisting 10,727 deliveries, performing 558 Caesarean sections, and admitting 1,303 babies to the neonatal unit. At year's end, staff were admitting up to 300 women weekly and delivering 40 babies daily.

MSF's maternity hospital in Khost likewise offered maternal and neonatal care in a place few women could previously access it. By year's end, teams were delivering some 58 babies each day and running two operating theaters, a neonatal unit, and a dedicated women's health clinic. MSF also continued supporting Boost Hospital in Lashkargah, Helmand Province, with surgery, internal medicine, emergency services, intensive care, malnutrition care, and TB care. Teams built a new maternity ward and neonatal and pediatric intensive care units as well.

BANGLADESH \$250,000

MSF provided essential care to vulnerable groups, including undocumented refugees, young women, and people living in remote areas and urban slums. Close to the Kutupalong makeshift camp in Cox's Bazar, an MSF clinic provides comprehensive care to ethnic Rohingya men, women, and children who fled violence and persecution in Myanmar, carrying out around 93,000 outpatient, 2,700 inpatient, and 3,300 mental health consultations. Around 16,000 antenatal and 5,000 postnatal consultations were performed overall.

In Kamrangirchar and Hazaribagh, teams conducted 8,000-plus outpatient consultations in factories and tanneries where many workers are repeatedly exposed to hazardous conditions. MSF also scaled up its sexual and intimate partner violence program in Kamrangirchar, providing care and support to nearly 400 people who had been raped and more than 700 victims of intimate partner violence. MSF supported the burns unit in Dhaka Medical College Hospital for four months as well, offering psychological support during a period of political unrest.

CAMBODIA \$1,227,015

MSF screens for and treats artemisinin-resistant malaria in Cambodia's Preah Vihear Province, a remote border region with little health care. Teams target the most at-risk people while studying transmission patterns in order to evaluate potentially effective strategies. Staff also collaborate with the MoH and



KYRGYZSTAN: Staff at an MSF tuberculosis treatment program. © Pierre-Yves Bernard

runs with the MoH, while staff at the Delmas Figaro CTC admitted some 750 patients.

In August, MSF closed Chatuley Hospital in Léogâne, which was set up in 2010 as an expansion of the initial earthquake response.

MEXICO \$1,978,500

MSF provides migrants in Mexico with psychosocial support, referrals, and follow-up for emergency cases. During the first eight months of the year, some 19,000 people were registered in shelters where MSF works; nearly 50 percent received some form of support. Staff carried out more than 900 medical and

local communities to increase awareness and case detection.

MSF handed over its last TB program in Kampong Cham Province to Cambodian health authorities and other organizations, providing resources needed for screening, detection, treatment, and follow-up. MSF also carried out three rounds of active TB case-finding in Tboung Khmum and Krouch Chhmar Districts and will open a hepatitis C program in 2016.

INDIA \$2,030,000

MSF provided free basic health care in southern Chhattisgarh and to displaced people in Andhra Pradesh and Telangana, sites of ongoing strife. A mother-and-child health center in Chhattisgarh's Bijapur District provided obstetric, neonatal, and pediatric care, joining with mobile clinics to carry out more than 56,400 consultations and treat over 13,800 patients for malaria.

In Mumbai, MSF medical and psychosocial teams provided care to patients with HIV, DR-TB, and hepatitis B and C. The team also supported DR-TB infection control activities and worked with the Sewri TB hospital and the Revised National Tuberculosis Control Program to increase diagnostic and treatment capacity.

Teams in Manipur treated HIV patients co-infected with hepatitis C, while staff provided comprehensive HIV and TB care in Churachandpur, Chakpikarong, and Moreh as well. MSF also supported a local NGO with oral substitution therapy for intravenous drug users.

In Kashmir, MSF ran mental health programs in six districts and, with Kashmir University, conducted a mental health survey gauging the prevalence of depression, anxiety, PTSD, and other mental health issues stemming from years of conflict.

In November, MSF opened a 24-hour treatment center in Delhi for victims of sexual and gender-based violence; staff treat injuries, provide post-exposure prophylaxis, and offer counseling and pregnancy tests.

Staff in Bihar's Vaishali District treated 582 patients for kala azar and staff in West Bengal's Asansol District treated 178 children for acute fevers (often caused by dengue and chikungunya). And when flooding hit Chennai in December, MSF distributed 500 hygiene kits and 1,000 mosquito nets.

KYRGYZSTAN \$700,000

MSF teams in Kara-Suu District in Osh Province provided outpatient TB care to limit hospital stays, which reduces risk of infection and improves treatment adherence. MSF also provided comprehensive DR-TB services in Kara-Suu, including treatment, monthly consultations, and psychosocial support; in

2015, 127 DR-TB patients were enrolled in treatment. Staff works in three district TB clinics as well.

MSF continues to support diagnosis and treatment of DR-TB in Kara-Suu Hospital and assists with the hospital's waste management and infection control. Teams also carry

In Wa Special Region 2, after confirming shortages of basic and secondary health care, vaccination, and maternal health services, MSF opened a new clinic in Lin Haw, where teams ran weekly mobile clinics. MSF also provided HIV care for more than 35,000 patients in Yangon and Tanintharyi Regions and



NEPAL: MSF staff carry a patient who'd been injured during the April 2015 earthquake. © Brian Sokol

out around 20 home visits per month for patients unable to reach clinics. MSF is planning to introduce bedaquiline and delamanid in Kyrgyzstan in 2016 to shorten and simplify treatment regimens.

MYANMAR \$3,100,000

After cyclone Komen, MSF teams distributed water and hygiene kits and bed nets in Kalay and Tamu Townships in the Sagaing area, and in Minbya and Maungdaw Townships in Rakhine State. In Monywa, Kalay, and Tamu, MSF trained MoH staff to clean up mosquito breeding sites and provided door-to-door advice on dengue prevention measures. Teams also ran mobile health clinics in temporary shelters.

More broadly, MSF continued to re-establish activities in Rakhine that authorities shut down the year before. This included supporting mobile clinics for IDPs in Pauktaw and Sittwe and medical activities in Maungdaw. Staff conducted 84,689 outpatient consultations, supported measles and polio vaccinations, and provided over 900 referrals. Access to care remained unacceptably limited, however, due to severe restrictions on movement and the absence of other humanitarian organizations.

Shan and Kachin states. MSF supported the National AIDS Program's efforts to make care more widely available as well.

Teams also offered medical and psychosocial care to more than 700 people detained after being rescued from abandoned smuggling boats in the Bay of Bengal. And MSF also provided mental health care for Rohingya refugees in Banda Aceh, Indonesia.

NEPAL \$1,653,720

After April and May earthquakes killed some 8,500 people and injured 20,000, MSF responded quickly, running "helicopter clinics" to remote mountainous areas to provide emergency care and referrals. Staff also ran clinics in Gorkha, Dhading, Nuwakot, Rasuwa, Sindhupalchowk, and Dolakha Districts, focusing on children, pregnant women, and mental health care.

In Arughat, Gorkha District, staff at MSF's inflatable hospital offered emergency, maternity, and surgical services. MSF's temporary clinic in Chhapchet, Dhading District, offered basic care and minor surgical interventions.

When monsoons approached, MSF transported 6,000 tents and 3,000 reconstruction kits into the mountains, helping almost 10,000 households find shelter.

Between April and July, MSF provided more than 2,500 consultations and psychological support to more than 7,000 people. Staff also treated 240 patients and carried out over 1,200 physiotherapy sessions in Kathmandu's Orthopedic Hospital, and distributed food, shelter materials, water, and cooking and hygiene items to almost 15,000 households.

Following the immediate emergency, MSF continued providing physiotherapy, dressings, medical follow-up, and mental health care for post-operative patients at Sangha's Spinal Injury Rehabilitation Center. Staff also worked in the emergency room, inpatient department, and operating theater of an MoH primary health care center in Dolakha District.

Tragically, we lost three colleagues on June 2 when a helicopter crash claimed the lives of Sandeep Mahat, Jessica Wilford, and Sher Bahadur Karki, as well as the pilot, Subek Shrestha. They are deeply missed.

PAKISTAN \$5,060,273

MSF responded to urgent needs in Pakistan, focusing on women, children, and vulnerable communities. Teams in MSF's 67-bed pediatric hospital in Quetta, Balochistan's provincial capital, managed a neonatal ward and a children's inpatient therapeutic feeding center, admitting 1,300 patients, treating more than 1,900 severely malnourished children, and holding 4,000-plus mental health consultations.

MSF's mother-and-child health center in Kuchlak offered outpatient treatment, emergency obstetrics, vaccinations, and nutritional support for children. Staff in Kuchlak and Marriabad also treated over 1,700 patients for cutaneous leishmaniasis.

Teams worked with health authorities at Qila Abdullah Hospital in Chaman, offering free health care to residents and Afghan refugees, carrying out 10,900 antenatal consultations, assisting 4,400 births, attending to 5,800 emergency trauma patients, and treating more than 1,500 severely malnourished children. In Dera Murad Jamali, MSF supported an inpatient therapeutic feeding center, pediatrics, and neonatal care.

Staff in Bajaur Agency offered pediatric services, vaccinations, and therapeutic feeding for malnourished children, conducting 43,000 outpatient and 30,000 emergency consultations. At Sadda Tehsil Hospital in Kurram Agency, MSF provided inpatient care for children, carried out 600 weekly consultations, treated cutaneous leishmaniasis, and managed obstetric and general emergency referrals.

Around 100 pediatric consultations were carried out weekly at Alizai Hospital as well.

At Peshawar Women's Hospital, MSF offered emergency obstetric services for women from the Federally Administered Tribal Areas, Afghan refugees, and other displaced women. The team admitted 5,200 patients, delivered 4,700 babies, and trained local staff on high-risk obstetrics and maternity care.

MSF also treated complicated obstetric cases, assisted 8,395 births, and carried out 4,500 mental health consultations at Timurgara District Headquarters Hospital. A surgical project in Hangu carried out 15,000 emergency room consultations, performed 800 surgical interventions, and assisted 3,202 births.

Working with a local NGO, MSF provided over 102,000 consultations in Karachi's Machar Colony slum, vaccinated 31,000 children against measles, started a hepatitis C project, and ran health promotion outreach as well.

PAPUA NEW GUINEA \$2,575,943

In March 2015, MSF began supporting Port Moresby's Gerehu Hospital with TB screening, diagnosis, and treatment. The next step will be to set up a dedicated TB unit, a priority given that roughly 25 percent of PNG's TB patients live in the capital, and that Gerehu sees around 1,500 TB patients annually.

MSF also expanded its TB program in Gulf Province, conducting more than 2,800 outpatient consultations and screening 2,347 people for TB at Kerema General Hospital and two health centers. Concerned about the lack of follow-up care, MSF works with health authorities to develop decentralized models of care more conducive to adherence.

MSF treated victims of sexual violence in several locations but handed over its Regional Treatment and Training project to the National Department of Health and began the gradual handover of its full-service program in Tari, which provincial health authorities will manage going forward.

PHILIPPINES \$1,511,807

By June 2015, the response and recovery activities launched after typhoon Haiyan were all closed. These included maternal and child health activities in Leyte Provincial Hospital and the rehabilitation of three hospitals on Leyte and Samar islands.

After additional assessments were done, MSF made plans to open a sexual and reproductive health program in Manila in collaboration with Likhaan, a national organization. Services will include early screening and vaccination against the human papilloma virus to prevent cervical cancer.

MEDITERRANEAN SEA: Rescued Eritrean migrants about to board the *Bourbon Argos*.

© Paolo Pellegrin



TAJIKISTAN \$400,000

MSF started treating five TB patients with bedaquiline, one of the first new drugs for the disease in 50 years. A team at Dushanbe Hospital worked with the MoH to support comprehensive care for young people with TB and their families. MSF also used drug compounding to make formulations suitable for children with MDR-TB; 16 started treatment this year. The program includes nutritional and psychosocial support.

Diagnostic tools such as sputum induction and gastric lavage are now being used and the team hopes to introduce more new methods, including stool sampling and a rapid drug sensitivity test with GeneXpert. The pediatric TB protocol MSF developed is now the national guideline. MSF also opened a new project in Kulob, southern Tajikistan, treating pediatric HIV and TB.

UZBEKISTAN \$1,110,000

MSF is implementing and evaluating a shorter—nine months instead of two years—MDR-TB treatment regimen in Uzbekistan; outcomes were slated to be published in 2016. MSF also hopes to start a clinical trial



GEORGIA \$497,426

In Georgia, where MDR-TB rates are also extremely high, MSF supported the MoH with the introduction of bedaquiline and delamanid as part of UNITAID's endTB program. Between July 2014 and December 2015, 146 patients were put on bedaquiline and 11 on delamanid. MSF is leading preparations for a clinical trial in Georgia aimed at identifying new, shorter, less toxic regimens for MDR-TB patients based on these two drugs.

MSF supported the Abkhazia national TB program by transporting more than 500 sputum samples from Gulripsh TB Hospital to Tbilisi Referral TB Laboratory. MSF also provides financial assistance to AMRA, a local NGO that works with elderly and vulnerable people and provides adherence support to MDR-TB patients.

GREECE \$531,250

MSF provided services among the more than 856,000 refugees and migrants who arrived by sea or land in Greece in 2015, the majority from Syria, Afghanistan, Iraq, and Somalia. In July, MSF opened clinics in Lesbos' main port and the Moria and Kara Tepe camps. MSF improved water and sanitation facilities, provided waste management, and installed chemical toilets and water points; organized buses to transport new arrivals to registration centers and provide referrals; and assisted with shelter, food, blankets, and communications. Teams carried out 16,100 medical and 3,000 mental health consultations.

Teams launched similar services on Samos—providing medical consultations, distributing relief items, and serving an average 540 meals per day—and on Agathonisi. On Kos, MSF provided shelter, food, and medical screening as well. Staff ran mobile clinics on Leros, Simi, Tilos, and Kalymnos islands, too, carrying out more than 14,000 medical consultations and providing mental health support to 6,000 people on Kos and Leros alone. MSF also distributed 35,358 relief kits.

In Athens, MSF conducted 708 medical consultations at Eleonas Transit Center. And in Idomeni Transit Camp, a mobile clinic offered basic health care, mental health support, and relief items, performing 13,000 consultations. Teams also built shelters, showers, and latrines for more than 1,500 people, while maintaining the electricity grid and sanitation services as well. In addition, mental health teams counseled more than 14,000, and other staff organized shelter, medical services, and food and water distributions at ad hoc congregation points when the camp was closed.

combining new TB drugs with existing drugs to treat DR-TB.

In the Autonomous Republic of Karakalpakstan, MSF's "comprehensive TB care for all" provided outpatient care, rapid diagnostic tests, education, psychosocial support, and food assistance to ensure treatment adherence, help patients manage side effects, and prevent the spread of the disease.

In Tashkent, MSF supported the Tashkent City AIDS Center to increase diagnostic and treatment capacity. Staff started over 700 patients on ARV treatment and offered counseling and screening for opportunistic infections. In 2016, the project will treat patients co-infected with hepatitis C as well.

OTHER ASIA PROGRAMS \$150,000

EUROPE & THE CAUCASUS

ARMENIA \$1,270,270

In Armenia, which has one of the world's highest rates of MDR-TB, MSF continued supporting the National Tuberculosis Control Center (NTCC) by treating patients with TB, MDR-TB, and DR-TB in seven regions of the country and in prisons. At year's end, MSF-supported facilities had 226 DR-TB patients in treatment. MSF supported NTCC efforts to re-establish thoracic surgery at the Central Hospital for TB patients as well.

MSF also helped the MoH introduce two new TB drugs, bedaquiline and delamanid, to better fight MDR-TB and XDR-TB. Between April 2013 and December 2015, 81 MDR-TB and XDR-TB patients were started on these drugs. As the NTCC increases its capacity, MSF will shift away from support for "conventional" MDR-TB treatments towards management of MDR-TB and XDR-TB patients receiving the new drugs as part of the UNITAID-funded endTB partnership.

ITALY \$1,425,000

Long a landing point for migrants and refugees, Italy saw 153,000 people arrive by sea in 2015, mainly from Eritrea, Nigeria, Somalia, Sudan, and Syria. MSF provided services in Sicily's Ragusa Provincial Health Agency and inside Pozzallo's first reception center, carrying out more than 3,000 consultations by year's end. MSF launched mental health care programs in 16 reception centers in Ragusa as well, carrying out more than 1,100 individual and group consultations. MSF also lobbied the Italian government, hoping to spur to change in Italy's reception system.

In Rome, MSF provided psychological first aid and launched a project for asylum seekers who have been the victims of torture, offering medical, psychological, and socio-legal assistance. In Gorizia, near the Slovenia border, a team provided medical care, shelter, and assistance to hundreds of refugees who had been sleeping outdoors next to a river.

RUSSIAN FEDERATION \$1,785,337

In Chechnya, MSF handed over management of MDR-TB patients to the MoH in 2015 and now focuses on XDR-TB, providing medications for patients, including newly available treatments. MSF's program also includes laboratory support, health promotion, blood sugar monitoring—up to 20 percent of XDR-TB patients suffer from diabetes—and psychosocial assistance for patients and families.

MSF also provides mental health care in Grozny and mountainous districts of Chechnya still affected by violence. And teams continued to support Grozny's Republican Emergency Hospital as well, donating medicines and equipment, providing case management advice, and organizing coronarography and angioplasty training.

In Moscow, a team offered basic health care to migrants from former Soviet Union republics and other countries who had limited or no access to medical services.

UKRAINE \$6,476,961

In early 2015, as fighting between the Ukrainian army and the self-proclaimed Donetsk and Luhansk People's Republics took a severe toll on civilians, MSF expanded support to hospitals across the frontline. Until a late-February ceasefire, battles restricted access to the hardest-hit areas, and medical facilities were regularly shelled, forcing staff to flee and depriving thousands of care.

Throughout 2015, MSF donated medicines and equipment to 350-plus health facilities on both sides of the frontline, enabling treatment for nearly 10,000 patients with

conflict-related injuries, 61,000 with chronic diseases, and 5,100 women who delivered babies. Teams also worked with the MoH to conduct some 159,900 basic consultations and 12,000 mental health consultations.

Significant needs remained after the ceasefire because drug supplies had been disrupted. MSF supplied medicines for chronic diseases to hospitals, health centers, and homes for elderly and disabled people in the east. Teams provided insulin to more 5,000 diabetic patients and hemodialysis supplies for patients with advanced kidney failure. Staff also ran mobile clinics in 80 towns and villages, and psychologists provided individual and group counseling sessions. Staff also opened first aid and water points to assist people waiting to cross the frontline at checkpoints located at Artemovsk–Gorlovka, Volnavakha–Donetsk, and Mayorsk.

MSF managed its MDR-TB program in Donetsk prisons and even expanded it to cover Mariupol, Artemovsk, Dnepropetrovsk, and Zhdanivka penitentiaries. But in late 2015, the self-proclaimed Luhansk People's Republic and the self-proclaimed Donetsk People's Republic withdrew MSF's authorization to work in their territory, forcing projects to close and leaving thousands without access to care.

MIDDLE EAST

IRAQ \$2,117,660

MSF expanded efforts to provide care and relief to some of the 3.2 millions Iraqis displaced by conflict, impoverished host communities, and Syrian refugees. In Karbala, Najaf, and Babil governorates, MSF provided more than 10,700 individual and group mental health counseling sessions, and in Erbil, MSF provided mental health support to Syrian refugees in three camps. MSF also responded to cholera in Dohuk, Kirkuk, Erbil, Baghdad, Diyala, Najaf, Diwaniya, and Babil governorates.

MSF provided 21,775 consultations for displaced people in Dohuk, while mobile teams in Ninewa conducted 19,505 medical and mental health consultations. MSF also ran mobile clinics in towns between Mosul and Erbil and established an emergency field surgical unit for the area.

Mobile teams provided nearly 50,000 medical and mental health consultations in and around Kirkuk. In Baghdad, MSF worked in Abu-Ghraib and Al-Salam camps. MSF assisted residents and displaced people in north Garmian District and Diyala Governorate as well. And teams provided mental health services in three camps in Khannaqin, Diyala.

In the Domiz Camp, MSF handed over general medical services to the Directorate of Health but continued offering chronic disease, sexual and reproductive health, and mental health services, along with general health promotion activities. In Sulaymaniyah and Arabat camps, MSF ran water, sanitation, and hygiene activities.

As they have since 2006, a network of Iraqi doctors referred patients to MSF's reconstructive surgery hospital in Jordan. MSF also provided training for Iraqi doctors and supported the Baghdad-based Poisoning Control Center.

JORDAN \$12,403,101

With the count of just the registered Syrian refugees in Jordan at 600,000, MSF expanded services for Syrian refugees and vulnerable Jordanians to include non-communicable disease care. Teams in Irbid Governorate worked at the MoH's Ibn Sina Primary Health Clinic and, with a local NGO, opened the Ibn Rushd Clinic, too, conducting more than 20,000 consultations at the two facilities in 2015.

MSF's maternity and neonatal project admitted more than 3,900 women and assisted 3,400 deliveries, providing emergency Cesarean sections when needed. The neonatal intensive care unit admitted 498 babies as well, and 274 patients received mental health care.

Working with the MoH, staff at Ar Ramtha Government Hospital provided emergency trauma surgery for war-wounded Syrians, general inpatient care, physiotherapy, and psychosocial support. The emergency room team attended to 863 wounded patients, 315 of whom were admitted for surgery, and carried out 1,600 counseling sessions.

Patients from Ar Ramtha and elsewhere were often transferred to MSF's 40-bed post-operative facility in Zaatari refugee camp for rehabilitative, convalescent, and psychosocial care. And MSF's reconstructive surgery project in Amman offered orthopedic, plastic, and maxillofacial surgery, along with physiotherapy and mental health support, to war-wounded patients from neighboring countries. MSF also opened a full service microbiology laboratory to improve the quality of care for patients with infections resulting from their injuries.

LEBANON \$800,000

As Lebanon struggles to cope with an estimated 1.5 million Syrian refugees and Palestinian refugees from Syria, MSF provides free health care to those in need. With no official camps, families usually crowd into garages, farms, or unfinished buildings, leading to poor health outcomes.



UKRAINE: An MSF doctor visits a patient in her home in Debaltseve, in April 2015. © Jon Levy

In the Bekaa Valley, staff at clinics in Baalbek, Majdal Anjar, Aarsal, and Hermel offered basic and reproductive health care, mental health counseling, and chronic disease treatment, carrying out 126,000 outpatient consultations and assisting 768 deliveries.

In Beirut, MSF works in Shatila Camp, a Palestinian refugee settlement, offering basic health care for children under 15, chronic disease care, mental health support, women's health services, and referrals for high-risk pregnancies. In Tripoli, MSF provides reproductive health services, acute and chronic disease treatment, vaccinations and counseling in the neighborhood of Abu Samra, and similar services in Jabal Mohsen and Bab el Tabbaneh districts, where intercommunal fighting has intensified.

In January, MSF distributed stoves, fuel, or blankets to 900 Syrian families in Akkar District, in the mountainous northeast. Staff treated acute and chronic disease and provided ante- and postnatal care in El Abdeh

as well. And while MSF handed over its mental health program for Palestinians in Sidon, staff supported three health centers to provide Palestinians from Lebanon, Palestinian refugees newly arrived from Syria, and Syrians with acute and chronic disease care, mental health care, reproductive and maternal health services, and specialist referrals.

LIBYA \$1,893,619

Amidst worsening conflict, Libya features two competing governments, one in Tobruk, the other in Tripoli. Additionally, the Islamic State group took control of Sirte and has a presence in other cities. As a result, maintaining medical and drug supplies has become very difficult, foreign health workers have fled, and many hospitals and clinics cannot function properly.

MSF donated drugs and vaccines to hospitals in Al-Beyda and Al-Marj, and also improved hygiene conditions at Al-Qubba

Hospital in the east. MSF also donated equipment—chlorine, masks, gloves—to the crisis committee at Al-Marj, near the Mediterranean coast, to cope with the bodies of people who drowned attempting to cross the sea.

As conflict continued in Benghazi, MSF increased the capacity of Al-Abyar Field Hospital, about 35 miles from the city, and provided emergency care training in Al-Abyar and Al-Marj. MSF also donated drugs to Benghazi hospitals and worked with a Libyan NGO to distribute food to 2,400 displaced families. And in November, MSF started supporting Zuwara Hospital in western Libya with drugs, medical supplies, training, and staff.

OCCUPIED PALESTINIAN TERRITORIES \$2,297,015

As violence and tension rose in the West Bank, MSF provided psychological and social support to victims of political violence in Hebron, Nablus, Qalqilya, and East Jerusalem,

YEMEN: An MSF physiotherapist works with a patient at MSF's emergency surgical unit in Aden. © Benoit Finck



carrying out 5,522 individual and group consultations. More than half were in Hebron, where clashes, particularly in the H2 area, led to a significant increase in activities. MSF also ran psycho-education sessions and trainings for medical staff, teachers, and counselors.

In Gaza, MSF's burn and trauma centers in Gaza City and Khan Younis treated more than 2,500 patients, mostly children. Staff conducted more than 35,000 physiotherapy and 1,000 occupational therapy sessions. Since most patients were burned in domestic accidents in conflict-damaged homes, MSF ran burn safety awareness campaigns for more than 35,500 children in schools and nurseries.

Working with the MoH, MSF ran surgical programs in Gaza's Al Shifa and Nasser Hospitals and performed surgical interventions. Complex cases that cannot be handled in Gaza are referred to MSF's reconstructive surgery hospital in Jordan. Administrative delays meant only six out of 67 patients were successfully referred, however.

The MoH ordered MSF to suspend mental health activities in Gaza, which are sorely needed; efforts to restart them have thus far been unsuccessful.

SYRIA \$2,980,308

Syria's catastrophic war has killed hundreds of thousands of people, driven at least 4.3 million from the country, and displaced some 6.6 million internally. Civilian areas and hospitals are bombed routinely, usually by government forces or their allies, and the provision of even basic aid is severely restricted by administrative obstacles, insecurity, and outright threats.

MSF was unable to work in areas controlled by the Syrian government or the Islamic State group, and, in most cases, could not send international staff into the country for extended periods of time. MSF did manage to operate six medical facilities across northern Syria, however, witnessing the toll of the war up close and seeing ever more people with medical complications caused by delayed care and medication shortages.

MSF also supported around 70 health facilities run by Syrian doctors, particularly in besieged areas, providing technical advice, medical supplies, salaries, fuel, and reconstruction assistance. MSF also gives ad hoc support to around 80 other medical facilities. In 2015, 23 MSF-supported Syrian health staff

were killed and 58 wounded. Furthermore, 63 MSF-supported hospitals and clinics were bombed or shelled on 94 separate occasions; 12 were completely destroyed.

In Aleppo Governorate, MSF's 28-bed hospital in Azaz conducted over 32,500 outpatient and 17,000 emergency consultations, performed 1,200 surgical interventions, and delivered 409 babies. Hospitals repeatedly came under fire in Aleppo, however, and MSF had to close its hospital in Maskan in June. Late in the year, teams distributed winter kits containing warm clothes, blankets, and soap. MSF also built an interim hospital in Kobane in the spring but it was destroyed a few months later.

In Hassakeh Governorate, MSF worked in a maternity hospital, where staff assisted 1,559 births, and three clinics that provided more than 35,000 outpatient medical consultations to displaced people and the local population. In Idlib, MSF teams at the Atmeh Burn Unit conducted over 6,800 medical consultations, 5,500 surgical interventions, and vaccinated more than 7,000 children against measles and over 3,500 newborns against hepatitis B.

In Dara'a, MSF provided medical donations, relief items, and technical support to six hos-

pitals and health posts, helping Syrian medical networks undertake 118,000 outpatient consultations, treat 8,000 victims of violence, admit 5,800 patients, and assist more than 2,000 deliveries.

An MSF report showed that MSF-supported hospitals and clinics in northwestern, western, and central Syria treated 154,647 war-wounded patients, up to 40 percent of whom were women or children.

YEMEN **\$18,425,720**

Armed conflict escalated into a full-scale war between Houthi militias and a coalition of states led by Saudi Arabia, exacerbating already massive medical and humanitarian needs.

In Saada Governorate, MSF started supporting Haydan Hospital's emergency room and maternity services in April but suspended activities after an October airstrike destroyed most of the facility, resuming only in December in a preserved part of the building. In May, a team started working in Al Joumhour Hospital in Saada City, providing emergency, inpatient and intensive care, along with maternity and mental health services. Another team supported Shiara Hospital in Razeh District, assisting more than 100 births every week and tending to more than 1,000 patients in the emergency room. Staff also assisted in Majz and Nushur hospitals.

In Ad Dhale Governorate, MSF expanded support in MoH hospitals and clinics, carrying out more than 60,000 outpatient and emergency consultations and performing over 700 surgical procedures. In Aden, MSF ran an emergency trauma center, carrying out 7,778 emergency consultations and 4,300 surgical interventions; offering physiotherapy and mental health services; and responding to mass casualty incidents.

Taiz was besieged for much of the year, severely restricting access to care and supplies. MSF supported hospitals on both sides of the frontline, including the military hospital, Yemeni International, and Al-Risalah on the Al-Houban side, and, inside the enclave, Al-Thawra and Al-Rawda hospitals. Altogether, MSF provided more than 15,400 emergency room consultations, 6,800 consultations for people with war wounds, 1,100 surgical interventions, and 10,900 wound dressings. In November, MSF opened a mother and child hospital in the Al-Houban neighborhood, providing emergency services and reproductive health care, and an outpatient department for children under 10. In December, one of MSF's clinics was destroyed by an attack.

MSF's project at Amran's Al-Salam Hospital provided emergency, maternity, inpatient, and outpatient services, carrying out 3,000 surgical interventions and 28,200 emergency consulta-

tions, admitting 5,500 patients to hospital, and delivering more than 2,900 babies. MSF also supported the health center in Huth and ran mobile clinics in Khamir and Huth.

MSF supported Beni Hassan Health Center and offered medical aid to 15,000 internally displaced people through mobile clinics, then moved its program to Abs Hospital to provide a greater range of services. MSF also supported Al Joumhour Hospital in Hajjah City by responding to emergencies, treating war injuries, performing surgery, and assisting the inpatient department.

In Sana'a, MSF continued its HIV program at Al Joumhour Hospital. And MSF set up a mobile clinic in Hadramout after cyclones hit in November.

OTHER PROGRAM SUPPORT

ACCESS CAMPAIGN **\$1,060,913**

MSF's Access Campaign was created to push for access to, and the development of, affordable and adapted medicines for patients in MSF projects and beyond. Through technical and advocacy work directed toward governments, pharmaceutical companies, other humanitarian organizations, and policy makers, the Access Campaign aims to ensure, protect, or maintain access to urgently needed and often lifesaving drugs, vaccines, and diagnostic devices, while also challenging today's global research and development system to prioritize patient's needs. In 2015, its work included sustained and outspoken opposition to sections of the proposed Trans-Pacific Partnership trade agreement that would limit access to affordable drugs and patient-driven innovation; continued calls for pharmaceutical companies to make vaccines (and the pneumococcal vaccine in particular) more affordable for low and middle income countries and crisis affected populations; asking the Indian government to withstand external pressure—especially from the US—to change its laws and in so doing impede generic medicines development; congressional advocacy to improve incentives for innovation, especially the Food and Drug Administration's priority review voucher (PRV) for neglected diseases; pushing governments and the international community to continue the battle against HIV/AIDS, particularly in neglected contexts like West and Central Africa; and calling for more affordable prices and adaptability for new and improved treatments for DR-TB and hepatitis C.

DRUGS FOR NEGLECTED DISEASE INITIATIVE (DNDI) **\$950,484**

A not-for-profit, patient needs-driven research and development (R&D) organization that was co-founded by MSF in 2003, DNDi unveiled a new business plan in 2015 that aims to deliver 16 to 18 treatments for \$720 million by 2023. This will expand DNDi's alternative R&D model to new disease areas, including hepatitis C, antimicrobial resistance, and mycetoma. Another important landmark was the launch of DNDi's "Drug Discovery Booster," which aims to accelerate and cut the cost of early stage drug discovery for neglected tropical diseases.

Four companies joined this effort, which circumvents early commercial barriers. In September, DNDi announced the successful completion of Phase I human clinical trials for SCYX-7158 (AN5568), the first oral drug candidate specifically developed from the earliest drug discovery stage to combat human African trypanosomiasis (sleeping sickness). Finally, in the run-up to the 2015 World Health Assembly, DNDi and MSF joined a group of renowned health experts in calling for a global health R&D fund and mechanism to address critical gaps in innovation for a wide range of diseases for which the pharmaceutical market is not delivering.

INTERNATIONAL OFFICE **\$2,811,003**

MSF's International Office coordinates common projects on behalf of MSF's 21 sections worldwide and supports MSF's advocacy efforts with the United Nations and other international bodies.

MSF INTERNATIONAL FUND FOR INNOVATION AND OPERATIONAL RESEARCH **\$124,657**

The International Fund for Innovation and Operational Research promotes improvements in effectiveness and quality of care by financing MSF projects that undertake innovative operational, medical, and/or non-medical approaches.

TOTAL: \$242,155,557

FIELD STAFF



SOUTH SUDAN: Staff visit with a young mother and her baby at MSF's malnutrition program in Leer.
© Petterik Wiggers

With the Ebola outbreak largely under control, one might have thought that the pace would slow for us in 2015. But, as is always the case, several other emergencies unfolded throughout the year and we worked every day to place volunteers in projects where they could help carry out MSF's response. The total number of departures was 445 in 2015, just as it was in 2014.

The operational contexts we work in are becoming more complex, and we are adapting our recruitment accordingly, across the whole organization. We are fortunate in the US to have such a strong and diverse population to recruit from; this allows us to carry out targeted outreach efforts for people we think can help our programs. For example, we sought out more French and Arabic speakers, among others, who can bolster field teams in ways we have not always been able to do.

The outreach is working, I am happy to report. Our pool is now more diverse, which allows us to better fill specific needs that field programs have. And combined with our ongoing emphasis on field management training, we are developing a deeper network of field staff who can serve in coordinator and leadership positions in the future.

We have also continued to put more resources into our Psychosocial Care Unit (PSCU), which provides assistance to MSF-USA field staff before, during, and after their assignments. Dorothy Morgos, the head of our PSCU, also traveled to Yemen in 2015 to give direct support to our field teams there, national and international staff alike. This work can be crucial. Our teams have difficult jobs. Giving them the support they need helps them perform at the highest possible level.

On a personal note: I remain in awe of the commitment and competencies of our field staff—and also of our Field HR team here in the US—who work so hard to support our operations.

— **Kate Mort**, *Director of Field Human Resources, MSF-USA*

AFGHANISTAN

Sergio Borrego, FL, Anesthesiologist
Pavlos Kolovos, CO, Project Coordinator
Roshan Kumarasamy, CA, Project Coordinator/Head of Mission
Mark Leirer, CA, Nursing Team Supervisor
Linda Tetreault, MA, Logistics Specialist

ARMENIA

Sherri Stiles, UT, Mental Health Activities Manager
Rebekah Varela, CA, Finance and HR Coordinator

BANGLADESH

James Bengtson, MI, Medical Doctor
David Beversluis, MI, Medical Doctor
Mary Briggeman, PA, Nursing Team Supervisor
Cristin King, WA, Mental Health Supervisor
Helen Lee, WA, Project Administration Manager
David Maene, DC, Logistics Coordinator
Jon Martinson, NH, Project Coordinator

BELARUS

Mary Briggeman, PA, Nursing Activities Manager

BURUNDI

Brian D'Cruz, VA, Medical Doctor
Deane Marchbein, MA, Anesthesiologist

CAMBODIA

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CAMEROON

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Tricia Vannatter, CA, IECHP Activity Manager

CENTRAL AFRICAN REPUBLIC

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Lexie Cole, CA, Project Administration Manager
Henry Debusmann, IL, Project Coordinator
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Will Harper, DC, Project Coordinator
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Carolyn Johnson, WA, Nursing Team Supervisor
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John Lyons, CA, Logistics Supervisor
Rohan Mahy, CA, Logistics Manager
Alice Maitland, NH, Nurse
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Samuel Stern, FL, Logistician

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Ante Wind, FL, Project Medical Referent

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INDIA: A nurse with patients at a kala azar project in India's Bihar State. © Matthew Smeal

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Jordan Wiley, OR, Head of Mission

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Cecelia de la Vallee, NM,
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Samer Attar, IL,
Orthopedic Surgeon
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Coordinator

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Logistician
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Activities Manager
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Surgeon
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Deputy Logistics
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OH, Flight Manager
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NY, Project Administration
Manager

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Logistics Manager
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Midwife Activities
Manager

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Activity Manager

NIGERIA

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TN, Nursing Activities
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Coordinator
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Nursing Activities
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Ifeanyi Nwude, TX,
Medical Activities
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Gynecologist/Obstetrician
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Mission
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Medical Referent
Christopher Shepherd,
OH, Flight Manager
Matthew Stearns, MA,
Logistician
Humphrey Tirima, ID,
Project Coordinator

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TERRITORIES**

Jenifer Haner, OR,
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Nandakumaran
Ponthenkandath, CA,
Doctor Anaesthetist
Athena Viscusi, DC,
Mental Health Activities
Manager

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Celeste Thompson, CA, Finance Coordinator

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Aerlyn Pfeil, WA, Project Medical Referent
Margaret Quan, WA, Finance and HR Coordinator
Cynthia Scott, CA, Mental Health Supervisor
Jean Stowell, NC, Project Coordinator
Janaki Varadhan, MA, Surgeon

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Jordan Wiley, OR, Head of Mission

RUSSIAN FEDERATION

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Debra George, NY, Logistics Coordinator

Peter Lundgren, RI, Logistics Coordinator
Sabreen Shaig, CA, Mental Health Activities Manager

SERBIA

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Jane Boggini, CT, Nursing Activities Manager
Benjamin Bristow, CA, Field Epidemiologist
Paul Brockmann, CA, Project Coordinator
Gillian Burkhardt, CT, Gynecologist/Obstetrician
Patricia Carrick, MT, Nursing Activities Manager
Keri Cohn, MA, Medical Doctor
William Conk, NH, Finance/HR Manager
Earl Cuarteros, MI, Supply and Logistics Manager
Francis Dorbor, PA, Finance Coordinator/Project Administration Manager
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Maureen Foley, WA, Nursing Activities Manager
Mary Jo Frawley, CA, Nursing Activities Manager
Eyita Gaga, CA, Nursing Activities Manager

Jerry Harpole, WA, Construction Manager
Sydney Hubbard, PA, Field Epidemiologist
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Celeste Thompson, CA, Finance/HR Manager
Tudor Tiedemann, TX, Logistics Manager
Emily Veltus, WI, IECHP Activity Manager
Athena Viscusi, DC, Mental Health Supervisor
Ella Watson-Stryker, NY, IECHP Activity Manager
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SOUTH AFRICA

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Tsion Solomon, MD, Epidemiological Researcher

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MSF is looking for French-speaking staff to provide assistance in countries such as the Democratic Republic of Congo, Chad, and Haiti, where some of MSF's largest projects are located. MSF is also looking for Arabic speakers to work in countries where Arabic is the primary language. "Successful applicants who speak French or Arabic are likely to be matched with an assignment sooner," notes MSF-USA Field Human Resources Director Kate Mort. If you are interested in contributing your professional—and French or Arabic—skills to MSF's medical humanitarian work, please visit doctorswithoutborders.org/work-with-us/work-in-the-field for more information about MSF recruitment.

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Lisa Umphrey, CO, Medical Activities Manager
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Aditi Jani, IL, Laboratory Manager
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DRC: A young boy outside MSF's hospital in Rutshuru. © Gwen Dubourthoumieu

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AFGHANISTAN: MSF International President Dr. Joanne Liu visiting staff and patients in Kunduz, in February 2015, eight months before the center was attacked and destroyed. © Kim Clausen

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Individuals	85%	\$286,246,067
Foundations, including Pledged	8%	\$27,975,213
Corporations	7%	\$21,559,457

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SOUTH SUDAN: A nurse sits with a child in the intensive care unit of an MSF project.
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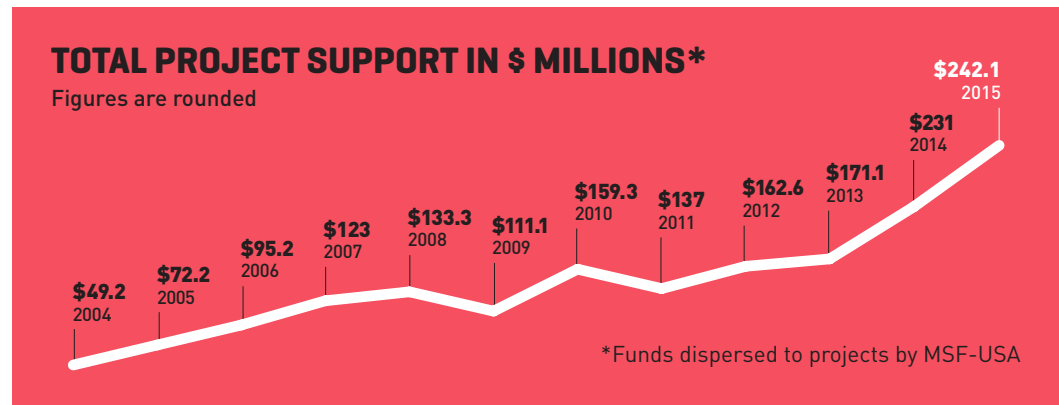
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DRC: An MSF doctor consults a women suffering from severe malaria in Remeka. © Sandra Smiley

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CAR: Staff tends to a boy at MSF's project in Bambari.
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DRC: A nurse checks a child for malnutrition in the Bikenge Health Center. © Sandra Smiley/MSF

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AFGHANISTAN: MSF staff at the Kunduz Trauma Center treating people wounded in fighting just days before the center was destroyed during aerial attacks that killed 42 people inside. © MSF

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FINANCIAL SUPPORT



SOUTH SUDAN: Patients receive malaria medication in Aweil. © Diana Zeyneb Alhindawi

Once again, our ability to respond promptly and robustly to emergencies was sustained by the hundreds of thousands of individual donors who support MSF-USA. Our sincere thanks to all those who helped make this work possible.

In 2015, MSF-USA maintained and consolidated the extraordinary volume of support we got in 2014. The high profile of MSF's humanitarian response to the migrant crisis in Europe and other parts of the world, along with the outpouring of support in response to the Kunduz Hospital bombing, boosted engagement significantly. Simultaneously, we increased our support for MSF programs by 4.7 percent. Our largest expenditures went to programs in South Sudan [\$26.4 million], Democratic Republic of Congo [\$23.4 million], and the Central African Republic [\$21.6 million].

Expenses allocated to management and fundraising increased by less than 3 percent and total expenses increased by 4.5 percent, but this increase remained below our total revenue figure. We therefore generated a \$49.8 million surplus, bringing our total net assets (or reserves) to \$277.9 million.

STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS

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

REVENUES	2015	2014
PUBLIC SUPPORT (total)	335,780,737	332,209,806
OTHER REVENUE		
Investment Income [loss]	-2,284,658	239,446
Gain [loss] on Investments and Actuarial Gain [loss] on Annuities	-1,541,402	177,142
Other Revenue	223,292	5,220
Grants from Affiliates:		
MSF Network Grants	3,814,732	2,826,795
Seconded field staff grants	8,998,978	9,405,720
Total Other Revenue	9,210,942	12,654,323
Total Revenue excluding gifts In-kind	344,991,679	344,864,129
Gifts In-kind	2,552,830	920,417
Total Revenues and Gifts In-kind	347,544,509	345,784,546

EXPENSES	2015	2014
PROGRAM SERVICES (total)	262,547,920	250,642,551
SUPPORTING SERVICES (total)	32,970,975	32,040,010
Total Expenses excluding Gifts In-kind	295,518,895	282,682,561
Gifts In-kind	2,213,820	870,297
Total Expenses and Gifts In-kind	297,732,715	283,552,858
Increase in Net assets	49,811,794	62,231,688

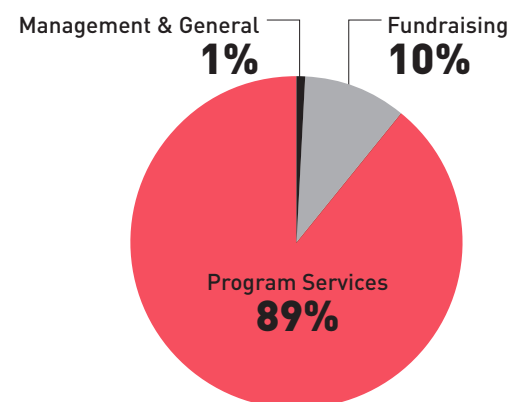
NET ASSETS	2015	2014
NET ASSETS		
Net assets at the beginning of the year	228,108,288	165,876,600
Increase in Net assets	49,811,794	62,231,688
Net assets at year end	277,920,082	228,108,288

STATEMENT OF FINANCIAL POSITION 2015

ASSETS	2015	2014
Cash & Equivalents and Short Term Investments	223,154,594	236,404,735
Receivables	44,813,268	35,334,225
Other Assets	26,259,972	23,582,112
Total Assets	294,227,834	295,321,072

LIABILITIES AND NET ASSETS	2015	2014
Grants Payables	450,630	53,858,002
Other payables	4,237,105	4,505,273
Other Liabilities	11,620,017	8,849,509
Total Liabilities	16,307,752	67,212,784
Unrestricted Net Assets	259,552,396	201,269,908
Temporarily Restricted Net Assets	17,694,964	26,204,363
Permanently Restricted Net Assets	672,722	634,017
Total Net assets	277,920,082	228,108,288
Total Liabilities and Net assets	294,227,834	295,321,072

2015 EXPENSES



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. For more details or a full presentation of MSF-USA's audited financial statements, please visit www.doctorswithoutborders.org/about-us/financial-information.

HOW YOUR SUPPORT

Whether it's because of its extremely literal name, its location next to larger, better-known neighbors, or some other factor, the Central African Republic (CAR) garners little attention, even while teetering on the brink of collapse.

That's been the case since 2013, when internecine warfare spread throughout the country, killing thousands, displacing more than a quarter of the population, and driving already alarming health indicators even further down.

MSF has worked in CAR since 1997 and has become the country's de-facto primary health care provider. Even before the violence broke out, CAR existed in a state of chronic medical emergency. The absence of a functioning health system, holoendemic malaria, and a massive prevalence of preventable and treatable diseases contributed to shocking levels of mortality. When the fighting began, MSF expanded its programs to respond to the massive needs. MSF's programs in CAR are now among its largest in terms of staffing, expenses, and patients treated.

Violence in 2015 forced multiple suspensions of mobile clinics, and vaccination campaigns in the areas of Kabo, Bambari, and

Boguila. Additionally, MSF and other NGO facilities were robbed, attacked, and looted in a number of locations.

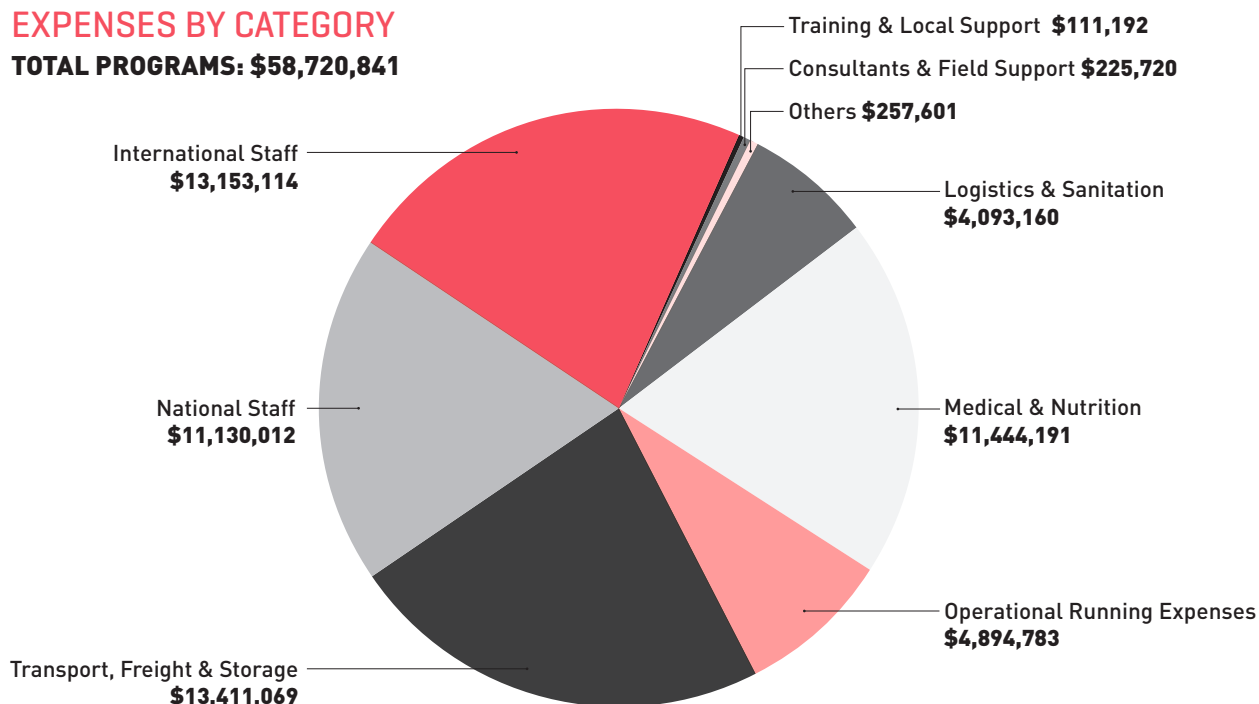
Despite such incidents, MSF managed to operate substantial basic and emergency projects across 13 prefectures and 15 localities, in both MSF hospitals and public health facilities. Teams carried out vaccination campaigns, operated mobile clinics, and provided emergency surgery, maternity services, specialized care for victims of sexual violence, and treatment for malnutrition, HIV, and tuberculosis [TB].

In 2015, MSF teams in CAR conducted one million medical consultations, assisted 18,000 deliveries, performed 7,100 surgical interventions, and supported 10,200 malnourished children through therapeutic feeding programs.

The table below describes where and how funds were allocated in 2015.

EXPENSES BY CATEGORY

TOTAL PROGRAMS: \$58,720,841



SAVES LIVES



CAR: An MSF nurse checks a child for malnutrition in Bangui. © Andre Quillien

BOARD OF DIRECTORS

DEANE MARCHBEIN, MD, PRESIDENT

Dr. Deane Marchbein joined MSF in 2006 to work as an anesthesiologist in MSF's surgical program in Ivory Coast. She later worked as an anesthesiologist with MSF in Democratic Republic of Congo, Haiti, Libya, Nigeria, South Sudan, Afghanistan, Syria, and Burundi, and as a medical doctor in Libya, deputy head of mission in Guinea, and medical referent in Lebanon and South Sudan. She was formerly the business manager and chairperson of the anesthesia department at Lawrence General Hospital in Lawrence, Massachusetts, where she also served as the director of the intensive care unit. Dr. Marchbein most recently worked for Massachusetts General Hospital and the Cambridge Health Alliance. She is now retired and plans to continue her work in the field with MSF.

JOHN LAWRENCE, VICE-PRESIDENT

John Lawrence, a native of Illinois, attended Dartmouth College and Dartmouth Medical School, then completed a family practice internship and worked as a general medical officer in Tuba City, on the Navajo Reservation, in northern Arizona. He later returned to residency and completed training in general surgery in Rochester, New York, and then in pediatric surgery at St. Christopher's Hospital in Philadelphia. For the past 20 years, he has been a practicing pediatric surgeon, primarily in academic settings, and he is currently a staff pediatric surgeon at Maimonides Medical Center in Brooklyn, New York. Owing in part to a longstanding interest in global health, Lawrence has completed eight missions with MSF since 2009 and is pursuing an MPH degree through the Bloomberg School of Public Health at Johns Hopkins University.

GENE WOLFSON, 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. 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, while also working on special projects related to investment opportunities and acquisitions. Wolfson 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.

DAVID A. SHEVLIN, ESQ., SECRETARY

David Shevlin is an attorney at Simpson Thacher & Bartlett LLP, where he is a partner and 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

Nabil Al-Tikriti, who was first elected to the US Board of Directors in 2011, has worked with MSF since 1993 as a field administrator, logistician, context analyst, cultural facilitator, and deputy head of mission in Somalia, Albania, Iran, Turkey, Jordan, Syria, and the Mediterranean Sea. He has also served as a consultant and election monitor in Europe, Asia, and Africa. An expert on the modern Middle East, Iraq, and Turkey, Dr. Al-Tikriti is currently associate professor of Middle East

history at the University of Mary Washington. He holds a bachelor's degree in Arab studies from Georgetown University, a master's in international affairs from Columbia University, and a doctorate in Ottoman history from the University of Chicago. He has also studied at Bogaziçi Üniversitesi in Istanbul, the Center for Arabic Studies Abroad in Cairo, and the American University in Cairo, and he has been awarded two Fulbright scholarships, a United States Institute of Peace fellowship, and a National Endowment for the Humanities/American Research Institute grant for fieldwork in Turkey.

SUERIE MOON, MPA, PHD

Suerie Moon is a lecturer at the Harvard School of Public Health, as well as an associate fellow in the Sustainability Science Program at Harvard's Kennedy School of Government. She is also research director of the Forum on Global Governance for Health at the Harvard Global Health Institute. Previously, she worked for MSF's Access Campaign and for MSF offices and missions in New York, Geneva, Paris, 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.

KELLY S. GRIMSHAW, RN, MSN, APRN, CCRN

Kelly Grimshaw joined MSF in 1999, establishing a tuberculosis program in Turkmenistan. She has since worked as a nurse practitioner and project coordinator in China, Sierra Leone, Indonesia, and Zambia, assisting people affected by civil and ethnic conflicts, as well as the HIV pandemic. Kelly also provided assistance and program oversight as medical coordinator for projects in Angola, Liberia, Ivory Coast, and Nigeria that responded to cholera, Marburg hemorrhagic fever, meningitis, and measles outbreaks. In the US, she has volunteered her services to MSF-USA's Speaker's Bureau throughout the country and Refugee Camp in the Heart of the City exhibits. She currently works in nursing education.

KASSIA ECHAVARRI-QUEEN

Kassia Echavarrí-Queen began her field work with MSF in 2007 as a supply manager in Sierra Leone, having previously worked in marketing and strategy for technology companies, start-ups, and the Fritz Institute, which focuses on disaster response and recovery. In the years that followed, Echavarrí-Queen worked extensively in the field with MSF as program coordinator and head of mission in Guatemala, Kenya, South Sudan, Sri Lanka, and Syria. Her two most recent missions were an Ebola response program in Liberia and a project in Nepal following the earthquake there in April 2015. All told, Echavarrí-Queen has more than 14 years of international program management experience. Now living in her native San Francisco, Echavarrí-Queen holds a BA in international relations from Alliant University and an MA in international economics and management from SDA Bocconi.

RAMIN ASGARY, MD, MPH

Ramin Asgary started with MSF in 1997. His international experience has focused on the management of complex humanitarian emergencies and refugee health, and he's worked in projects in Eurasia, Africa, and Central and South America. His international health research relates to cancer screening, HIV and other sexually transmitted infections, women's health, and chronic disease management. Domestically, Ramin has founded programs for and worked with refugees and asylum seekers, immigrants, and the homeless. He has also developed training curricula in global health for practitioners and students. He is a graduate of Columbia University, Albert Einstein College of Medicine, Johns Hopkins University, Mount Sinai School of Medicine, and New York University.

JANE COYNE

Jane Coyne spent 15 years working in a variety of analytical and project management positions, with an emphasis on supply-chain optimization, for companies such as HP, Nike, Dell, and others before leaving the corporate world in 2003 and joining MSF as a field logistician. She has since worked in Uganda, Sri Lanka, Nigeria, Central African Republic, Democratic Republic of Congo, and Sudan. Initially her work focused on logistics, but eventually her role transitioned to project and program management. In July 2009, she was appointed as program manager for MSF France, where she managed 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 master's in business administration from the Kellogg School at Northwestern. She now lives in San Francisco.

MEGO TERZIAN, PRESIDENT, MSF-FRANCE

Dr. Mego Terzian is the president of MSF in 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 through 2002, he worked 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. He later served as deputy director and then as director of MSF's emergency programming at MSF in France, before assuming his current role.

DR. SUSAN SHEPHERD

Dr. Susan Shepherd is a pediatrician who earned her medical degree at the Université Libre de Bruxelles and completed a residency in general pediatrics at the University of Chicago. When she joined MSF in 2003, she was practicing at the Butte Community Health Center in rural Montana. Dr. Shepherd has undertaken field assignments in Uganda, Chad, Niger, and Kenya. She became deeply involved in MSF's efforts to combat childhood malnutrition, working for MSF's Access Campaign, coordinating the MSF Nutrition Working Group, and holding a position in the MSF France Department of Operations. Since leaving MSF in 2013, Dr. Shepherd has worked with the World Food Program in Central African Republic and Cameroon. Currently she works for a small French medical NGO, the Alliance for International Medical Action [ALIMA], where she focuses on developing strategies to improve service delivery and quality of medical care for children in Sub-Saharan Africa.

JEAN-MARIE KINDERMANS, MD

Dr. Jean-Marie Kindermans first worked for MSF in Thailand in 1980, later going on to work in programs in Chad, Afghanistan, and other countries. A specialist in public health and tropical medicine, Kindermans left MSF in 1984 to become a public health consultant and then the director of AEDES, the European Association for Development and Health. In 1995, Kindermans 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 acted as an International Board member. Today, he works on malaria for various international organizations and is a consultant in medical management of French hospitals. He currently leads the AEDES Foundation and lives in France. He was appointed to the Board of MSF-USA in September 2013.

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GREECE: A group of Syrian refugees head towards the Macedonian border in June 2015. © Alessandro Penso

INDEPENDENCE. IMPARTIALITY. INNOVATION. FROM 1971 TO TODAY.

YEMEN: A staff member clears debris off the roof of MSF's hospital in Haydan after it was hit by an airstrike days earlier. © Rawan Shaif

FRONT COVER: GREECE: An MSF nurse assists an elderly refugee struggling to get ashore from the overcrowded boat that carried her and many others from Turkey to the island of Samos. © Aurelie Baumel



Doctors Without Borders

333 Seventh Avenue, 2nd Floor
New York, NY 10001-5004

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