



MSF ACTIVITY REPORT 2010

THE MÉDECINS SANS FRONTIÈRES CHARTER

Médecins Sans Frontières is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honour the following principles:

Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and to maintain complete independence from all political, economic or religious powers.

As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.

The country texts in this report provide descriptive overviews of MSF's operational activities throughout the world between January and December 2010. Staffing figures represent the total full-time equivalent positions per country in 2010.

Country summaries are representational and, owing to space considerations, may not be comprehensive. Some patients' names have been changed for reasons of confidentiality.

CONTENTS

2 MSF MISSIONS AROUND THE WORLD

4 THE YEAR IN REVIEW

Dr Unni Karunakara, International President
Kris Torgeson, Secretary General

8 OVERVIEW OF MSF OPERATIONS

10 GLOSSARY OF DISEASES AND MSF ACTIVITIES

14 MEDICAL AND PSYCHOLOGICAL CARE IN DETENTION

16 FORTY YEARS OF MEDICAL INNOVATION

18 INNOVATION IN ACTION: A TALE OF TWO VACCINES

MSF PROJECTS AROUND THE WORLD

21 Africa

59 Asia and the Caucasus

77 The Americas

87 Europe and the Middle East

99 MSF SPECIAL REPORTS 2010

100 HAITI: A YEAR OF CRISIS

104 FACTS AND FIGURES

108 CONTACT MSF



2 MSF Missions around the World



21 Africa



59 Asia and the Caucasus



77 The Americas



87 Europe and the Middle East

MSF MISSIONS AROUND THE WORLD





| | |
|---|---|
| 60 AFGHANISTAN | 95 LEBANON |
| 61 ARMENIA | 38 LESOTHO |
| 62 BANGLADESH | 39 LIBERIA |
| 78 BOLIVIA | 40 MALAWI |
| 79 BRAZIL | 41 MALI |
| 22 BURKINA FASO | 90 MALTA |
| 23 BURUNDI | 42 MOROCCO |
| 63 CAMBODIA | 43 MOZAMBIQUE |
| 28 CAMEROON | 69 MYANMAR |
| 24 CENTRAL AFRICAN REPUBLIC | 44 NIGER |
| 26 CHAD | 46 NIGERIA |
| 64 CHINA | 96 OCCUPIED PALESTINIAN TERRITORY |
| 80 COLOMBIA | 70 PAKISTAN |
| 29 CONGO, REPUBLIC OF THE | 72 PAPUA NEW GUINEA |
| 30 DEMOCRATIC REPUBLIC OF THE CONGO | 86 PARAGUAY |
| 32 DJIBOUTI | 73 PHILIPPINES |
| 33 EGYPT | 91 RUSSIAN FEDERATION |
| 34 ETHIOPIA | 50 SIERRA LEONE |
| 88 FRANCE | 48 SOMALIA |
| 65 GEORGIA | 51 SOUTH AFRICA |
| 89 GREECE | 74 SRI LANKA |
| 82 GUATEMALA | 52 SUDAN |
| 36 GUINEA | 54 SWAZILAND |
| 84 HAITI | 97 SYRIA |
| 83 HONDURAS | 75 THAILAND |
| 66 INDIA | 55 UGANDA |
| 94 IRAN | 76 UZBEKISTAN |
| 92 IRAQ | 98 YEMEN |
| 37 KENYA | 58 ZAMBIA |
| 68 KYRGYZSTAN | 56 ZIMBABWE |

THE YEAR IN REVIEW

Dr Unni Karunakara, International President,
Kris Torgeson, Secretary General

The earthquake that hit Haiti on 12 January killed an estimated 222,000 people, injured more than 300,000, and left 1.5 million people homeless. Efforts to support the survival and recovery of the Haitian people following this disaster tested Médecins Sans Frontières (MSF) and the aid system as a whole to their limits. More than 8,000 MSF staff were mobilised to treat more than 358,000 patients.



© Ron Haviv/VII

A patient is treated for cholera at MSF's clinic in Sarthe, Port-au-Prince, Haiti.



© Seb Geo

A doctor and interpreter speak with a malaria patient at MSF's clinic in Dera Murad Jamali, Balochistan province, Pakistan.

In October, a cholera epidemic took on overwhelming proportions. In less than three months, MSF treated more than 91,000 patients for the disease, around 60 per cent of all registered cases (see pages 84–85). The operating budget for MSF in Haiti in 2010 came to almost 106.1 million euros.

One year after the earthquake, however, significant needs were still not being met. As Stefano Zannini, Head of Mission for MSF in Haiti, said: “Our staff worked tirelessly over this last year, and in spite of that I feel uneasy and sort of uncomfortable about what is still a disaster situation for most of the population”. The aftermath of the earthquake in Haiti has exposed serious deficiencies in the wider aid system, deficiencies that have also been revealed in Afghanistan and Pakistan, raising the question of whether the international aid system in its current set-up is really meeting the needs of the people it claims to help.

A year of natural disasters

The Haitian earthquake was not the only major natural disaster MSF responded to in 2010. In Pakistan, MSF staff carried out more than 80,000 medical consultations, treated more than 4,500 children for malnutrition and distributed 1.8 million litres of clean water every day to people affected by flooding in the provinces of Khyber

Pakhtunkhwa, Balochistan, Punjab and Sindh. Parts of Chad, Nigeria and Somalia also experienced the worst flooding in more than a decade. MSF distributed blankets, tarpaulins, plastic sheeting and mosquito nets, and set up clean water supplies to help the hundreds of thousands of displaced people. In central Chile, a powerful earthquake killed several hundred people and displaced more than a million others. Nearly every region of Guatemala was affected when a violent tropical storm hit just hours after a volcanic eruption. MSF assisted victims of both of these emergencies from project bases in Central and South America.

Securing care during conflict

Elsewhere, millions of civilians living in conflict zones continued to suffer the effects of armed violence. In 2009, MSF returned to Afghanistan to respond to mounting humanitarian needs as conflict spread to almost every region of the country. MSF has worked hard to find the space to provide independent and impartial assistance in an environment where, as MSF's Afghanistan country representative Michiel Hofman said, “seeking help amounts to choosing sides in the war”. In 2010, MSF staff worked in hospitals in the Afghan cities of Kabul and Lashkargah, and we are continuing negotiations with all warring parties in order to extend our operations further.

In Pakistan, teams have been helping to improve the emergency response capacity of hospitals in conflict zones. On several occasions during the year, violent incidents resulted in massive numbers of casualties arriving at the District Headquarters hospital in Timurgara, near the border with Afghanistan.

Its independence, impartiality and needs-based approach have enabled MSF to reach and assist people living in conflict areas in Afghanistan, the Central African Republic, Kyrgyzstan, Pakistan and Somalia in 2010. Despite insecurity, MSF is generally able to assure the continuity of medical care. But incidents in parts of Sudan and the Democratic Republic of the Congo (DRC) have put MSF staff at unacceptable risk and restricted our ability to provide healthcare. Activities in Gumuruk in south Sudan had to be suspended after therapeutic food was stolen from the clinic and MSF staff were violently robbed while travelling to another health centre. In DRC, soldiers from the Congolese army entered a hospital in the South Kivu region and abducted four patients. The complete absence of respect for medical structures and access to medical care forced MSF to evacuate its surgical team from the hospital.

continued overleaf ➤

Mismanaged healthcare system

MSF was obliged to suspend activities in Turkmenistan in 2010 for very different reasons. Having worked in the country since 1999, MSF decided it could no longer provide effective assistance in a country where national health authorities hide the true state of public health and disseminate misinformation, and where the system prevents health workers from providing adequate care. MSF drew attention to the problems facing people in need of medical care in Turkmenistan in the report *Turkmenistan's Opaque Health System*.

Outbreaks new and old

Other countries where MSF works simply do not have the resources to provide adequate care. Measles is endemic in many developing countries, but in 2010 a number of countries that had seen a decline in cases were subjected to serious outbreaks of the disease: Malawi suffered its biggest epidemic in 13 years. MSF led a campaign that vaccinated 3.3 million children, and our staff provided care for 23,000 patients. Teams also provided assistance in responding to massive outbreaks of measles in Chad, DRC, Nigeria, South Africa, Swaziland, Yemen and Zimbabwe,



Medical staff at the operating theatre of Hangu hospital, Pakistan.

supporting the immunisation of more than 500,000 children and treating thousands of patients.

Measles is not the only disease recurring. Faced with a “new” disease, people may be afraid or unaware of how to respond, and local medical staff may lack experience in

treatment. Cholera had not been seen in Haiti for more than a century before the epidemic in 2010. Papua New Guinea also experienced its first cholera outbreak in 50 years; MSF treated thousands of patients and trained more than 1,000 health workers and volunteers in clinical management and infection control.



Devastation caused by the floods in Gulabad, Pakistan.

© Ton Koene



A patient with shrapnel wounds is transferred for post-operative care to Boost hospital, Lashkargah, Helmand, Afghanistan.

A global polio eradication campaign, begun in 1988, had met with significant success, and the disease remained endemic in only Afghanistan, India, Nigeria and Pakistan. However, in 2010 serious outbreaks have occurred in DRC, the Republic of the Congo and Tajikistan. MSF teams assisted with treatment and vaccination campaigns in DRC and the Republic of the Congo.

We faced new emergencies too. MSF treated almost 400 children for lead poisoning, after seven villages in northwestern Nigeria were found to be contaminated with lead from small-scale gold mining activities.

Access to new vaccines, affordable medicines and adequate nutrition

2010 saw the roll-out of a new vaccine that could prevent the worst meningitis epidemics in Africa. MSF took part in vaccination campaigns in Niger and Mali and is actively advocating for widespread use of the vaccine (see pages 18–20). And after campaigning for improved food aid for several years, we are at last seeing international donors start to review and adjust their food aid policies. (To see the effect of the improved policies, see the report on Niger, pages 44–45.) 2010 also saw the establishment of the Medicines Patent Pool, which will allow generic

manufacturers to produce patented medicines in exchange for royalty payments. For the mechanism to work, however, we need drug companies to step up and make their patents available.

Unfortunately, efforts to improve access to HIV/AIDS treatment are facing a setback. International donors are shifting their focus away from HIV/AIDS and funding is stagnating, while new evidence demonstrates that providing better treatment earlier prevents severe illness and helps reduce transmission. MSF is urging governments to create reliable funding mechanisms to ensure that the progress made over the last decade is not put at risk, and that more patients can be treated more effectively.

Reaching “invisible” populations

In recent years, more and more migrants have embarked on a long journey to escape violence, persecution or poverty, in search of a more secure life, only to find themselves in a prison cell. In 2010, the conditions in detention centres in Greece reached critical levels: undocumented migrants were being forced to live in converted warehouses or police cells crowded to three or four times their capacity. “No human being should be subjected to such treatment”, said Ioanna Pertsinidou, MSF’s emergency coordinator.

Appalling living conditions, police harassment, threats of xenophobic attacks and a lack of access to essential healthcare still define the desperate lives of thousands of these vulnerable people. In just two months, MSF staff in South Africa treated 71 Zimbabwean migrants who had been victims of sexual violence.

As 2010 comes to an end and MSF approaches its 40th year, it is clear that changing environments demand constant innovation, so that MSF can respond to the health needs of more people, more effectively. Thanks to our supporters and our dedicated staff, we are able to remain committed to assisting people in need of emergency humanitarian medical care.

Thank you.

OVERVIEW OF MSF OPERATIONS

Largest interventions based on project expenditure

| | |
|-------------------------------------|------------------------------|
| 1. Haiti | 6. Somalia |
| 2. Democratic Republic of the Congo | 7. Chad |
| 3. Sudan | 8. Zimbabwe |
| 4. Niger | 9. Nigeria |
| 5. Pakistan | 10. Central African Republic |

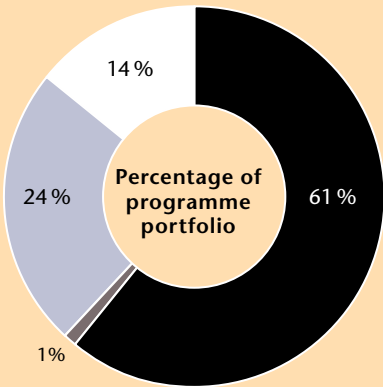
These 10 countries total a budget of 334 million euros, or **60 per cent** of MSF's operational budget.

Project locations

Number of projects

| | |
|----------|-----|
| Africa | 260 |
| Europe | 6 |
| Asia | 102 |
| Americas | 59 |

Asia includes the Middle East and the Caucasus



Staff numbers

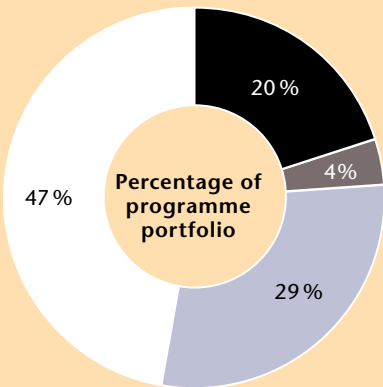
Largest country programmes based on the number of MSF staff in the field. Staff numbers measured in full-time equivalent units.

| | |
|-------------------------------------|-------|
| 1. Haiti | 2,918 |
| 2. Democratic Republic of the Congo | 2,766 |
| 3. Sudan | 2,226 |
| 4. Niger | 1,599 |
| 5. Somalia | 1,461 |

Context of interventions

Number of projects

| | |
|----------------------|-----|
| Armed conflict | 87 |
| Post-conflict | 16 |
| Internal instability | 125 |
| Stable | 199 |



Patients treated

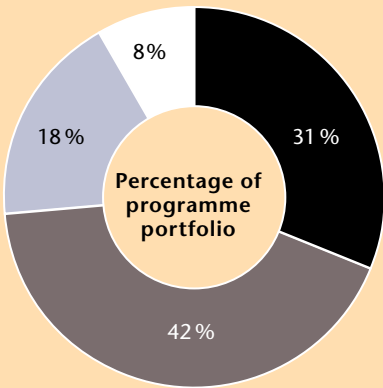
Largest country programmes according to the number of outpatient consultations held.

| | |
|-------------------------------------|-----------|
| 1. Democratic Republic of the Congo | 1,225,175 |
| 2. Central African Republic | 564,457 |
| 3. Somalia | 460,347 |
| 4. Niger | 468,477 |
| 5. Haiti | 468,156 |

Event triggering intervention

Number of projects

| | |
|------------------|-----|
| Armed conflict | 134 |
| Epidemic | 180 |
| Health exclusion | 78 |
| Natural disaster | 35 |



Activity highlights

These highlights do not give a complete overview of activities and are limited to where MSF staff have direct access to patients.

| Activity | Definition | Total |
|---|---|-----------|
| Outpatient | Total number of outpatient consultations | 7,334,066 |
| Inpatient | Total number of admitted patients | 362,266 |
| Malaria | Total number of confirmed cases treated | 983,425 |
| Therapeutic feeding centres | Number of severely malnourished children admitted to inpatient or outpatient feeding programmes | 301,297 |
| Supplementary feeding centres | Number of moderately malnourished children admitted to supplementary feeding centres | 69,258 |
| HIV | Total number of HIV patients registered under care at end 2010 | 210,450 |
| Antiretroviral treatment (first-line) | Total number of patients on first-line antiretroviral treatment at end 2010 | 180,868 |
| Antiretroviral treatment (second-line) | Total number of patients on second-line antiretroviral treatment at end 2010 (first-line treatment failure) | 2,936 |
| PMTCT – mother | Number of HIV-positive pregnant women who received prevention of mother-to-child transmission (PMTCT) treatment | 10,854 |
| PMTCT – baby | Number of eligible babies born in 2010 who received post-exposure treatment | 9,745 |
| Deliveries | Total number of women who delivered babies, including caesarean sections | 151,197 |
| Surgical interventions | Total number of major surgical interventions including obstetric surgery, under general or spinal anaesthesia | 58,326 |
| Violent trauma | Total number of medical and surgical interventions in response to direct violence | 39,993 |
| Sexual violence | Total number of cases of sexual violence medically treated | 10,430 |
| Tuberculosis (first-line) | Total number of new admissions to tuberculosis first-line treatment in 2010 | 30,090 |
| Tuberculosis (second-line) | Total number of new admissions to tuberculosis treatment in 2010, second-line drugs | 1,159 |
| Mental health (individual) | Total number of individual mental health consultations | 163,799 |
| Mental health (group) | Total number of counselling or group support mental health sessions | 24,794 |
| Cholera | Total number of people admitted to cholera treatment centres or treated with oral rehydration solution | 174,220 |
| Measles vaccinations | Total number of people vaccinated for measles in response to an outbreak | 4,542,353 |
| Measles treatment | Total number of people treated for measles | 188,704 |
| Meningitis vaccinations | Total number of people vaccinated for meningitis in response to an outbreak | 1,339,873 |
| Meningitis treatment | Total number of people treated for meningitis | 5,911 |

GLOSSARY OF DISEASES AND MSF ACTIVITIES

Chagas disease

Chagas disease is found almost exclusively in Latin America, although increased global travel and migration have led to more cases being reported in North America, Europe, Australia and Japan. Chagas is a parasitic disease transmitted by vinchuca beetles, which live in cracks in the walls and roofs of mud and straw housing. It can also be transmitted through blood transfusions, to the foetus during pregnancy and, less frequently, through organ transplants. Some people can have the disease but show no sign of it for years. Ultimately, debilitating chronic symptoms develop in approximately 30 per cent of people infected, shortening life expectancy by an average of ten years, with heart failure being the most common cause of death for adults.

Diagnosis is complicated, as doctors need to perform two or three blood tests. There are currently only two medicines to combat the disease: benznidazole and nifurtimox, both developed over 35 years ago. The cure rate is almost 100 per cent in newborns and infants, but in older children, adolescents and adults, treatment is only around 60 or 70 per cent effective. The treatment currently used can be toxic and can take one to two months to complete. Despite the clear need for more efficient and safer medication, there are few new drugs in development.

MSF admitted 1,254 new patients to Chagas treatment programmes in 2010.

Cholera

Cholera is a water-borne, acute gastrointestinal infection caused by the *Vibrio cholerae* bacterium and spread by contaminated water or food. The infection can spread rapidly and large outbreaks can occur suddenly. Most people will suffer only a mild infection, but the illness can be very severe, causing profuse watery diarrhoea and vomiting that

can lead to severe dehydration and death. Treatment consists of a rehydration solution – administered orally or intravenously – which replaces fluids and salts.

As soon as an outbreak is suspected, patients are isolated in specialised treatment centres to prevent the spread of the disease. Outside the centres, strict hygiene practices must be implemented and a safe water supply must be assured. Cholera is most common in densely populated settings where sanitation is poor and water supplies are not safe.

MSF treated 174,220 people for cholera in 2010.

Health promotion

When MSF opens a project, the local community needs to know what services are available and how these services can improve their health. Informing people and communicating about when and where staff will be available and what they can do is one of the first tasks for a team setting up a new clinic or programme.

During serious outbreaks of disease or epidemics, MSF provides communities with information on how the disease is transmitted and how to prevent it, what signs to look for in case someone becomes ill, and what to do. If MSF is responding to an outbreak of cholera, for example, teams work to explain the importance of good hygiene practices as the disease is transmitted through contaminated water.

HIV/AIDS

The human immunodeficiency virus (HIV) is transmitted through blood and body fluids and gradually weakens the immune system – usually over a three- to ten-year period – leading to acquired immunodeficiency syndrome or AIDS. A number of opportunistic

infections are able to develop as the immune system weakens. Tuberculosis is the most common opportunistic infection that leads to death.

A simple blood test can confirm HIV status, but many people live for years without symptoms and may not know they have been infected with HIV. Combinations of drugs known as antiretrovirals (ARVs) help combat the virus, reduce the spread of the infection, and enable people to live longer, healthier lives without their immune systems deteriorating rapidly. As well as treatment, MSF's comprehensive HIV/AIDS programmes generally include education and awareness activities, condom distribution, HIV testing, counselling and prevention of mother-to-child transmission (PMTCT) of the virus. PMTCT services involve the administration of ARV treatment during pregnancy and labour, and to the infant just after birth.

MSF provided care for over 210,000 people living with HIV/AIDS, and antiretroviral treatment for more than 183,000 people in 2010.

Human African trypanosomiasis (sleeping sickness)

Generally known as sleeping sickness, human African trypanosomiasis is a parasitic infection that occurs in sub-Saharan Africa and is transmitted by tsetse flies. More than 90 per cent of reported cases are caused by the parasite *Trypanosoma brucei gambiense*, which is found in west and central Africa. It attacks the central nervous system, causing severe neurological disorders or even death. The other ten per cent of cases are caused by *Trypanosoma brucei rhodesiense*, which is found in eastern and southern Africa.

During the first stage, the disease is relatively easy to treat but difficult to diagnose, as symptoms such as fever and weakness are

non-specific. The second stage begins when the parasite invades the central nervous system and the infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, convulsions and sleep disturbance. At this stage, accurate diagnosis of the illness requires a sample of spinal fluid.

Nifurtimox-eflornithine combination therapy, or NECT, is now the internationally recommended treatment. NECT is safer than melarsoprol, the drug that was used to treat the disease before, which is a derivative of arsenic, causes many side effects and can even kill the patient.

MSF admitted 1,293 new patients for treatment for human African trypanosomiasis in 2010.

Malaria

Malaria is transmitted by infected mosquitoes. Symptoms include fever, pain in the joints, headaches, repeated vomiting, convulsions and coma. Severe malaria, most often caused by the *Plasmodium falciparum* parasite, causes organ damage and leads to death if left untreated. MSF field research has helped prove that artemisinin-based combination therapy (ACT) is currently the most effective treatment for malaria caused by *Plasmodium falciparum*. In 2010 World Health Organization guidelines were altered to recommend the use of artesunate, a derivative of artemisinin, for the treatment of severe malaria in children.

Longlasting insecticide-treated bed nets are one important means of controlling malaria. In endemic areas, MSF systematically distributes nets to pregnant women and children under the age of five, who are most vulnerable to severe malaria, and staff advise people on how to use the nets.

MSF treated 1,622,721 people for malaria in 2010.

Malnutrition

A lack of essential nutrients causes malnutrition: growth will falter and a child's susceptibility to common diseases increases. The critical age for malnutrition is from six months – when mothers generally start supplementing breast milk – to 24 months. However children under five, adolescents, pregnant or breastfeeding women, the elderly and the chronically ill are also vulnerable.

“Wasting”, when a malnourished person begins to consume his or her own tissues to obtain needed nutrients, is a sign of acute malnutrition. Severe acute malnutrition is defined by very low weight for a person's height or visible severe wasting. Over a quarter of children suffering from severe malnutrition will die if they do not receive treatment.

MSF uses ready-to-use food (RUF) to treat malnutrition. RUF contains fortified milk powder and delivers all the nutrients that a malnourished child needs to reverse deficiencies and gain weight. With a long shelf-life and requiring no preparation, RUF can be used in all kinds of settings and allows patients to be treated at home, unless they are suffering severe complications. Where malnutrition is likely to become severe, MSF takes a preventive approach, distributing supplementary RUF to at-risk children.

MSF admitted more than 300,000 malnourished patients to feeding centres in 2010.

Measles

Measles is a highly contagious viral disease, and one of the leading causes of death among young children. Symptoms appear between 10 and 14 days after exposure to the virus and include a runny nose, cough, eye infection, rash and high fever. There is no specific treatment for measles – patients are isolated and treated for a lack of vitamin A, eye-related complications, stomatitis (a viral mouth infection), dehydration, protein deficiencies and respiratory tract infections.

continued overleaf ➤



Medical equipment at the MDR-TB section of Blue House Clinic, Mathare, Nairobi, Kenya.

continued **Measles** ➤

Most people recover within two to three weeks, but between 5 and 20 per cent of people infected with measles die, usually because of complications such as diarrhoea, dehydration, encephalitis (inflammation of the brain) or respiratory infections.

A safe and cost-effective vaccine against measles exists, and large-scale vaccination campaigns have drastically decreased the number of cases and deaths from measles. However, coverage remains low in countries with weak health structures, or among people with limited access to health services, and large outbreaks still occur.

In 2010 MSF treated 188,704 people for measles and vaccinated more than 4,500,000 people.

Meningococcal meningitis

Meningococcal meningitis is an infection of the thin membranes surrounding the brain and spinal cord. Meningitis can cause sudden and intense headaches, fever, nausea, vomiting, sensitivity to light and stiffness of the neck. Death can follow within hours of the onset of symptoms.

Five strains of the bacteria *Neisseria meningitidis* (A, B, C, W135, and X) can cause epidemics. People can be infected without showing symptoms and spread the bacteria when they cough or sneeze. Suspected cases are properly diagnosed through the examination of a sample of spinal fluid and are treated with specific antibiotics. However, even with treatment, five to ten per cent of patients will die and as many as one in five survivors may suffer from after effects that can include hearing loss and learning disabilities.

Meningitis occurs throughout the world, but the majority of infections and deaths are in Africa, particularly across the “meningitis belt”, an east–west geographical strip from Ethiopia to Senegal, where epidemics are most likely to be caused by meningitis A. A new vaccination against this strain provides protection for 10 years and even prevents healthy carriers from transmitting the infection. Such long-term protection means that preventive vaccination campaigns are now a possibility, potentially changing the lives of millions of people living in the meningitis belt.

MSF treated 5,911 cases and vaccinated more than 1,330,000 people against meningitis in 2010, participating in the campaign introducing the new vaccine in Mali and Niger.

Mental healthcare

Traumatising events – suffering or witnessing violence, the death of loved ones, the destruction of livelihoods – can generate intense fear and horror, and are likely to affect a person’s mental wellbeing. MSF provides early psychosocial support to victims of trauma in an effort to reduce the possibility of long-term psychological problems developing.

Psychosocial care focuses on supporting a community to build its own coping strategies after trauma. Counsellors help groups to talk about their experiences and process their feelings so that general stress levels are reduced. This approach fosters mutual support and enables a community to rebuild itself according to its own cultural beliefs, taking back control of the situation as soon as it is able. It is complemented with individual counselling and psychiatric care for those who need it.

MSF staff held more than 188,000 individual and group counselling sessions in 2010.

Relief items distribution

MSF’s primary focus is on providing medical care, but in an emergency teams often distribute relief items that contribute to psychological and physical survival. Such items include clothing, blankets, bedding, shelter, cleaning and hygiene materials, cooking utensils, and fuel. In many emergencies, relief items are distributed as kits – cooking kits containing a stove, pots, plates, cups, cutlery and a jerrycan so that a family can prepare meals, or a hygiene kit with soap, shampoo, toothbrushes, toothpaste, and laundry soap for a family to be able to wash themselves and clean their clothes.

A shelter provides both protection from the elements and a measure of security. Where materials are not locally available, MSF distributes emergency supplies – rope and plastic sheeting or tents – with the aim of ensuring a roof for each family. A minimum standard of 3.5m² is allocated per person, with 2 metres between shelters to help prevent fires. In cold climates more substantial tents are provided or teams try to find more permanent structures.

MSF distributed 341,507 relief kits in 2010.

Reproductive healthcare

Comprehensive emergency and neonatal obstetric care is part of MSF’s emergency response, and many of MSF’s longer-term programmes offer more extensive maternal healthcare. Medical staff assist births and perform caesarean sections where necessary, perinatal care is provided and sick newborns and babies with a low birth weight receive medical care.

Several antenatal visits are recommended to meet medical needs during the pregnancy and to identify potentially complicated deliveries. Family planning counselling is provided as part of postnatal care, as is information and education on sexually transmitted infections (STIs).

Around two million women are estimated to have fistulas, which are injuries to the birth canal. Fistulas cause incontinence, which can lead to social stigma. They are often the result of a long, obstructed labour, and can be prevented by good antenatal and obstetric care. Fistulas can also be repaired. In 2010 specialist MSF teams operated on about 1,000 women with obstetric fistulas.

MSF held more than 700,000 antenatal consultations in 2010.

Sexual violence

MSF offers medical care, treatment to prevent the development of sexually transmitted infections, and psychological, social and legal support to patients who have suffered sexual violence. In settings where the incidence of sexual violence is higher, such as conflict zones or refugee or displaced persons camps, dedicated teams care for people who have experienced sexual violence. Staff work with the community to raise awareness of the problem of sexual violence, to inform them of the care that MSF provides, and to promote social and legal support.

MSF treated more than 10,000 patients for sexual violence-related injuries in 2010.

Tuberculosis

One-third of the world’s population is currently infected with the tuberculosis (TB) bacillus. Every year, nine million people develop active TB and close to two million die from it. Ninety-five per cent of these people live in low-income countries.

TB mainly affects the lungs and is spread through the air when infected people cough or sneeze. Symptoms include a persistent cough, fever, weight loss, chest pain and breathlessness in the lead-up to death. Not everyone becomes ill, but 10 per cent of people will develop active TB at some point in their lives. The incidence is much higher among people with HIV, for whom TB is a leading cause of death.

The drugs used to treat TB were developed in the 1950s, and a course for uncomplicated TB takes six months. Multidrug-resistant TB (MDR-TB) is identified when patients are resistant to the two most powerful first-line antibiotics. MDR-TB is not impossible to treat, but the required regimen causes many side effects and takes up to two years. A newer strain, extensively drug-resistant tuberculosis (XDR-TB), is identified when resistance to second-line drugs develops on top of MDR-TB. The treatment options for XDR-TB are limited.

MSF treated over 30,090 people for tuberculosis, and 1,159 for MDR-TB, in 2010.

Vaccinations

The use of immunisation to prevent infectious diseases is one of the most cost-effective medical interventions in public health.

However, it is estimated that approximately two million people die every year from diseases that are preventable by a series of vaccines recommended for all children by the World Health Organization. Currently, these are DTP (diphtheria, tetanus, pertussis), hepatitis B, *Haemophilus influenzae* type b (Hib), BCG (against tuberculosis), human papillomavirus, measles, polio and rotavirus.

In countries where vaccination coverage is generally low, MSF strives to offer routine vaccinations for all children under five as part of the basic healthcare programme. Immunisation also forms a key part of MSF's response to outbreaks of measles, yellow fever or meningitis. Teams often take part in large-scale vaccination campaigns. Staff work to raise awareness in the community about the benefits of immunisation, and vaccination posts are set up in places where the community is likely to gather. A typical campaign lasts between two and three weeks and can reach hundreds of thousands of people.

Visceral leishmaniasis (kala azar)

Largely unknown in the developed world, kala azar – Hindi for “black fever” – is a tropical, parasitic disease that is transmitted through bites from certain types of sand fly. It is endemic in 62 countries, and of the estimated 500,000 annual cases, 90 per cent occur in Bangladesh, India, Nepal, Sudan and Brazil. It is characterised by fever, weight loss, enlargement of the liver and spleen, anaemia and immune-system deficiencies. Without treatment, nearly all patients will die.

Very suitable rapid diagnostic field tests are available, although backup confirmation testing – involving microscopic examination of samples taken from the spleen, bone marrow or lymph nodes – is invasive and requires resources not readily available in developing countries. Current treatment options include pentavalent antimonials. Although expensive, and evolving to become more simplified – studies showing the efficacy and safety of liposomal amphotericin B in the Indian subcontinent are promising – treatment options have significant limitations. The anticipated combination therapies intend to reduce the risk of the parasite developing resistance to the drugs, optimise the efficacy and safety of treatment, and reduce costs and hospitalisation time.

Co-infection of kala azar and HIV is a major challenge. Both diseases influence each other in a vicious spiral as they attack and weaken the immune system, making the person less resistant to the other disease and the treatment less effective.

MSF admitted 8,128 new patients for kala azar treatment in 2010.

Water and sanitation

Safe water and good sanitation are essential to medical activities. MSF teams make sure there is a clean water supply and a waste management system in all the health structures where MSF works.

In emergencies, MSF assists in the provision of safe water and adequate sanitation to people displaced by natural disasters or armed conflict. Drinking water and waste disposal are the first priorities. Latrines are built at a convenient, yet secure, distance from camps. Where a safe water source cannot be found close by, water will be trucked in containers. Staff conduct information campaigns to promote the use of facilities and ensure good hygiene practices.

In 2010, MSF distributed more than 577,000,000 litres of safe water and built or rehabilitated 1,986 latrines.



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A doctor checks a patient's notes at Silanga hospital, Nairobi, Kenya.

MEDICAL AND PSYCHOLOGICAL CARE IN DETENTION

Toward the end of 2010, the situation for migrants in detention in Greece became critical. Cells in border police stations and detention centres in the region of Evros, on the border with Turkey, were exceeding capacity two- or threefold. Men, women and children were obliged to share facilities, with 100 people typically having access to just two toilets. Detainees were not being allowed outside.

“What we witness every day inside the detention facilities is not easy to describe”, said Ioanna Pertsinidou, Médecins Sans Frontières’ emergency coordinator, in December. “In Soufli police station, which has space for 80 people, there are days when more than 140 migrants are detained there. In Tycherio, with a capacity of 45, we counted 130 people. In Feres, with a capacity of 35, last night we distributed sleeping bags to 115 detained migrants. One woman, who had a serious gynaecological problem, told us there was no space to sleep and she had no other option but to sleep in the toilets.”

The MSF team distributed sleeping bags and hygiene kits, and worked to improve sanitation. In Soufli and Tycherio police stations, two MSF doctors treated patients who were mainly suffering from respiratory and skin infections as a result of the harsh living conditions.

Where detention is an instrument of migration policy, the rights to medical care, humane treatment and respect for dignity are often ignored. In 2010, MSF provided humanitarian assistance and medical care in detention centres or prisons in Cambodia, the Democratic Republic of the Congo, Greece, Kyrgyzstan, Malta and Myanmar. “Our role is to provide emergency support and medical care to help detainees survive”, says Dr Apostolos Veizis, MSF head of programmes support.

The conditions of detention, even detention itself, have a significant impact on people’s health, but MSF cannot take on the responsibilities of immigration authorities or the Ministry of Health. As an emergency medical organisation,

MSF brings assistance to people in urgent need. But also, as Dr Veizis says, “We push the authorities to improve conditions by showing the positive impact of our activities and by speaking out on what we witness in these centres.” MSF lobbies hard to ensure the provision of acceptable living conditions and adequate healthcare for detainees.

In Malta, MSF staff had been providing medical care to detained migrants and asylum seekers since 2008, but in 2009 the team temporarily suspended activities when it became clear that living conditions were compromising the care and treatment that staff were providing. After persistent lobbying, authorities began to improve living conditions and the availability of

healthcare. MSF resumed its activities in June 2009, and in October 2010 staff handed over responsibilities to the Ministry of Health. The ministry had also started to recruit cultural mediators to help remove language and cultural barriers between medical staff and migrant patients in health centres and hospitals.

Mental healthcare

Despite feeling forced to leave their homes in order to survive, enduring painful and traumatic journeys, and experiencing overcrowding, lack of food, lack of exercise and insanitary conditions in the places where they end up, the single most important complaint for most migrants is the mere fact of their detention. Three per cent of migrants



A prisoner with TB takes his daily medication, Bishkek, Kyrgyzstan.



© Nondas Paschos

A mental health counselling session at Venna detention centre, Rodopi, northern Greece.

who received care in Greek detention centres attempted suicide or self-harm, 39 per cent of detainees showed signs of anxiety, and 31 per cent had symptoms of depression. MSF offered psychosocial support to detainees in Malta and Greece, providing individual and group counselling to help migrants cope after their traumatic experiences.

But in an emergency intervention staff have little time to gain the trust that is necessary for the provision of quality medical care, particularly mental healthcare. MSF's principle of independence is therefore crucial to our work in places of detention. Teams working in detention centres make it clear to everyone that although they are present with the consent of the authorities, their activities are carried out independently. Confident of MSF's independence, trust can be built with the detainees more quickly. According to Dr Veizis, MSF staff members are "some of the few people detainees can talk with".

Tuberculosis care in prisons

Prisoners are also often in need of assistance, and MSF provides medical care in a number of penitentiary facilities.

In Kyrgyzstan, MSF has been collaborating with the Ministry of Health, prison authorities and international organisations such as the International Committee of the Red

Cross (ICRC) to support the treatment of tuberculosis (TB) in prisons. TB is 20 to 30 times more prevalent among prisoners than among the general population. Patients diagnosed with TB are referred to treatment facilities in three prisons in and around the capital Bishkek. Overcrowding and poor ventilation are key factors in facilitating the spread of the disease, so MSF staff have refurbished the medical rooms in the prisons and TB patients' cells.

Prisoners with TB are often transferred or released before completing their treatment, and former inmates often struggle for the bare necessities of life. They do not consider the continuation of their medication to be their highest priority. The disruption of TB treatment not only risks the patient's recovery, but also the development of drug-resistant TB, which involves a much longer and more difficult treatment regime. In 2007 MSF staff began providing counselling, food, and money for transport to help ex-prisoners in Kyrgyzstan continue their treatment.

Improving conditions

In 2010, a successful collaboration with the government and the ICRC in the Democratic Republic of the Congo (DRC) ensured a long-term improvement in prison conditions in Bunia, eastern DRC.

When 17 prisoners died of malnutrition at the hospital in Bunia in just two months, an MSF team visited the prison. The team found 540 men, women and children living in a structure with a capacity for 100. There was no guaranteed food supply and no safe water. MSF immediately began treating malnourished patients with ready-to-use food and organised medical consultations. A safe water supply was installed, the sanitary block was renovated, and a reliable food supply was assured. The government allocated extra funding to the prison and in March 2010 MSF handed over its activities to the government and the ICRC.

FORTY YEARS OF MEDICAL INNOVATION

Since it was first created by a small group of doctors and journalists in France in 1971, Médecins Sans Frontières (MSF) has always striven to find better ways of saving the lives and improving the health of more people through emergency medical action. This persistent search for innovation in public health emergencies is rarely highlighted, but has been crucial in how MSF delivers humanitarian medical assistance today.

MSF provides medical aid to people whose lives are threatened by epidemics, malnutrition, healthcare exclusion, natural disasters and armed conflict. During its first decade, it gradually became clear that certain obstacles were standing in the way of MSF making a difference to the lives of people most in need. For example, the very nature of medical humanitarian intervention is working with large numbers of people from poor communities in remote and insecure places, but the capacity to train staff of varying levels in such settings can be limited. These environments are often unfamiliar to international doctors, material and facilities tend to be limited, and staff turnover is generally high, limiting the possibility of building an experienced workforce. That is why MSF piloted and implemented a number of innovations, in order to adapt its work to the demands specific to the countries it is present in.

One of the earliest innovations took place in the 1980s, when, in a bid to standardise medical procedures, streamline operational management and empower staff, MSF adapted a technique already used by the emergency medical service in France, and introduced guidelines and standardised drugs and equipment. This soon led to MSF developing pre-packed, ready-to-go, custom-designed medical kits that contained basic drugs, supplies and equipment and were adapted to specific field situations, climates and diseases. The first emergency kit, applicable to many emergency situations, formed the basis for an interagency kit. The World Health Organization (WHO) coordinated the development of this kit, which was first available in 1990 and has been

regularly revised since. Advances such as these resulted in an increased capacity for rapid intervention on a higher technical level, which had previously existed only in the military and civil defence forces of developed countries. MSF has since developed many other kits for vaccination campaigns, surgery, and even one to build a field hospital from inflatable tents.

In continually trying to find innovative ways to supply the best drugs to patients, and in recognising the need for further research, MSF created the non-profit organisation Epicentre in 1987. The aim was to provide scientific evidence that would support operations. Epicentre carries out studies on the incidence, prevalence and causes of epidemics and infectious diseases in large populations. At the time, few other non-governmental organisations were capable of doing research in the emergency situations in which MSF operated.¹

For more than 20 years, Epicentre has conducted many surveys, often under very difficult conditions, producing research that has contributed to improving patient care. Between 1996 and 2004, the centre, mandated by MSF, carried out studies and clinical trials on malaria treatment, in order to officially prove drug-resistance to the most commonly used medication at the time, and to give leverage to changing the protocols. Epicentre's research also contributed to proving how much more effective several artemisinin-based combination therapies (ACT) were. In several malaria-endemic countries, these results helped support changes in national treatment protocols for malaria.²

Throughout the 1980s and 1990s, MSF teams worked in the "meningitis belt" of sub-Saharan Africa. Their experience, regarding the mostly successful use of oily chloramphenicol as a first-line treatment for bacterial meningitis, led to a study to prove its efficacy, and in 1991, it was included on the WHO's essential medicines list. An equivalent study, comparing this drug with another, ceftriaxone, was carried out in 2002, with the result that both treatment protocols became international standards for outbreaks in the meningitis belt. MSF also worked closely with the WHO to define new control strategies for the disease.

Unfounded perceptions and unfairness were preventing many HIV-positive people from receiving treatment in the 1990s. Although medication to treat the pandemic already existed in the form of antiretroviral (ARV) treatment, the cost was between US\$ 10,000 and US\$ 15,000 per year – prohibitive for millions, particularly in developing countries. Some also had the perception that it would be too difficult to implement complex ARV regimens in resource-poor settings.

MSF, seeing the need for advocacy to challenge this notion, and in order to overcome the price barriers to treatment, set up the Campaign for Access to Essential Medicines in 1999, which pushed for the manufacturing of more affordable, generic versions of ARV medicines. Soon, the drugs were being produced in Brazil, India and Thailand, opening up the possibility of treating many millions of HIV-positive people. Today, the price of a year's treatment has dropped by 99 per cent and more than six million patients are being treated with ARV drugs. MSF alone provides ARV treatment to more than 170,000 patients in 19 countries. MSF's Access Campaign has also been very active in raising awareness about other neglected diseases prevalent in developing countries, and in securing the production of much-needed affordable or adapted medication to treat them.

In recent years, major changes have occurred in the international pharmaceutical market, as drugs are now being produced in countries

where the markets are less regulated than those in Europe and the United States. Therefore, under the supervision of MSF medical directors, the organisation's pharmacists established and implemented a qualification system that would ensure that any medication used to treat people in MSF projects is no less effective and no more toxic than that used in developed countries.

Although drugs for specific diseases are now being manufactured in more countries, the market-driven nature of the pharmaceutical industry meant that in the 1990s, drugs for certain diseases were still too expensive, or else ineffective or highly toxic. In some rare cases, manufacturing had stopped altogether. In 2003, seven agencies from around the world, including MSF, came together to form the Drugs for Neglected Diseases initiative (DNDi), a non-profit drug research and development organisation.

In 2003, MSF and Epicentre sponsored clinical trials for the treatment of sleeping sickness (human African trypanosomiasis), a deadly parasitic disease threatening 60 million people across sub-Saharan Africa. The medication available was either highly toxic or difficult to administer, especially in remote settings. The following year, DNDi, along with other organisations, joined the research. The trials proved that nifurtimox-eflornithine combination therapy (NECT) was the best combination medication, showing it to be efficient, well tolerated by patients and easier for healthcare staff to administer. In

2009, nifurtimox (to be used in combination with eflornithine) was added to the WHO's list of essential medicines, so NECT could be used throughout Africa, leading to improved healthcare for patients with sleeping sickness.

MSF has also taken an innovative approach to treating malnutrition in areas prone to food shortages by supplying nutritious "ready-to-use food", before children at risk develop severe malnutrition. It can be administered to children at home. Since opting for this pre-emptive tactic, rather than the reactive approach alone, in which malnourished children are treated after displaying symptoms, teams have found that the number of admissions to feeding centres has been lower than in previous years.

The nature of MSF is to act as a medical humanitarian organisation in crisis periods when people's very survival is threatened. Over the years, it has implemented sustainable models of care that have proven effective, efficient and affordable, and which have since been built upon by other actors, including ministries of health. In South Africa, for example, MSF operates an HIV and tuberculosis treatment project in the township of Khayelitsha, near Cape Town. The programme uses a decentralised model of care in its operations, training nurses to initiate treatment and counsellors to test for the virus. This increases the number of people being diagnosed and treated, and also provides training that benefits people long after MSF has gone.

These are examples of only some of the innovations that MSF has initiated in its first forty years. As Dr Unni Karunakara, MSF International President, summarises, "Throughout the decades, the organisation has always tried to adhere to its social mission of protecting and alleviating the suffering of the poorest and most disadvantaged, while respecting human dignity. MSF will strive to continue its work of saving lives, reducing pain and suffering, and helping restore the lives, potential and dignity of people who find themselves in life-threatening circumstances."

This article is largely based on Jean-Hervé Bradol and Claudine Vidal (eds), 2009, Innovations médicales en situations humanitaires, L'Harmattan. The English translation, Medical Innovations in Humanitarian Situations, is available at www.doctorswithoutborders.org/publications/book/medicalinnovations/

1. Interview with Alain Moren in Jean-Hervé Bradol and Claudine Vidal (eds), 2009, *Innovations Médicales en Situations Humanitaires*, L'Harmattan, p. 36.
2. Vincent Brown, Philippe J. Guerin, Dominique Legros, Christophe Paquet, Bernard Pécou, Alain Moren, 2008, "Research in Complex Humanitarian Emergencies: The Médecins Sans Frontières/Epicentre Experience", *PLoS Medicine* 5(4), at www.plosmedicine.org



A nurse checks the contents of an emergency kit, Burundi.

INNOVATION IN ACTION: A TALE OF TWO VACCINES

Médecins Sans Frontières (MSF) teams have participated in the launch in Africa of two eagerly awaited vaccines – one against a deadly strain of meningitis and the other against pneumococcal disease.

Both will undoubtedly save the lives of many people in the countries where the vaccines have been rolled out. But the story behind each also illuminates both the risks and rewards of working to open up access to lifesaving vaccines as widely as possible in the places where we work.

Every year, during the dry months – the epidemic season – the fear among communities who live in Africa's meningitis belt is palpable as they wait for this debilitating and often fatal disease to strike. And every year, there are many fatalities; those who survive are often left with long-term mental and physical disabilities.

MSF has long been involved in fighting the disease across the region and regularly mounts large reactive vaccination campaigns to combat the disease. However, in 2010, MSF teams, supporting the national health authorities in Niger and Mali, helped roll out a new vaccine that could finally put an end to the shattering cycle of meningitis epidemics in this region once and for all.

"A revolution and game-changer to end epidemics"

The new vaccine has many advantages over the older vaccines – it protects young children more effectively and lasts up to ten years. Most importantly, the vaccine will stop transmission of the bacteria that causes meningitis within the population by eliminating the carriage of the germ. And this could mean an end to epidemics. "This new vaccine opens up whole new possibilities. In 2009, MSF vaccinated more than seven million people for meningitis A. We were confined to emergency response, trying to slow and stop epidemics.

The traditional vaccine conferred very short-term protection making true long-term prevention impossible", says Dr Cathy Hewison, medical advisor at MSF. "This new vaccine gives four times greater protection and lasts ten years. It's a revolution and a game changer to prevent epidemics in the future."

But beyond the public health revolution, the way in which the vaccine was developed – tailored specifically to protect the target population in sub-Saharan Africa for an affordable price – is also groundbreaking.

Responding to urgent medical needs, not only the market

Effective meningitis vaccines already exist in high-income countries but, as with the overwhelming majority of vaccines, medicines and diagnostic tools, the pharmaceutical research and development agenda has been driven by wealthy markets and largely fails to address the needs of people who live in poorer countries. This means that drugs and other health tools are developed to respond primarily to diseases prevalent in rich countries, and are adapted to developing country contexts in a second stage. Diseases that mostly afflict developing countries either go unaddressed, or patients must wait far longer for new medical products to reach them.



The new pneumococcal vaccine is prepared, Silanga hospital, Nairobi, Kenya.

© Bruno De Cock

This project, in contrast, was launched directly in response to a call from African governments to tackle this merciless killer. A clear brief set out the requirements: the vaccine should be targeted to protect people from meningitis A, the particular form of meningitis prevalent in sub-Saharan Africa. And an affordable target price was set at no higher than 50 US cents.

Following a period in which major pharmaceutical companies considered and then walked away from the brief, a consortium of academics and scientists from both developing and high-income countries came together to collaborate on the vaccine. The scientific know-how on the production of the vaccine was transferred from a US institution to the Serum Institute in India, linking top scientific capacity to low production costs.

Further collaboration took place as African scientists contributed to the design of the research and conducted the clinical trials. Finally, the World Health Organization gave the vaccine its quality stamp of approval, providing assurance of the product's safety and efficacy, and allowing the roll-out to begin.

With development costs a fraction of those usually incurred, the vaccine development has been greeted as a victory for public health and a shining example of what can be achieved outside the normal product development paradigms.

As Dr Tido Von Schoen-Angerer, director of the MSF Campaign for Access to Essential Medicines, says: "This is a complete revolution compared to the usual patent-based, profit-driven model. It's a striking contrast to the blockbuster vaccines developed by the largest commercial developers for Western markets that fetch extremely high prices and aren't produced with developing country needs in mind."

A different approach: the pneumococcal vaccine

Meanwhile, across the continent in Kenya, MSF and other healthcare providers have started using a new pneumococcal vaccine that again could save thousands of young lives. But a look at its development tells a very different story to that of the meningitis vaccine.

For more than a decade, infants in wealthy countries have benefited from a pneumococcal vaccine, and research has kept on delivering, with two improved versions introduced in Europe and the United States in 2009 and 2010. Now, finally, children in developing countries also stand to benefit.

The medical benefits of the vaccine are clear – pneumococcal diseases include some forms of meningitis and pneumonia, and the vaccine has the potential to prevent millions of bouts of illness and countless deaths – yet it



A child is vaccinated at Silanga hospital, Nairobi, Kenya.

has taken more than a decade for this vaccine to become available to children in developing countries. What's more, the price tag is very high, and raises fears that the vaccine may prove unaffordable in the long run.

The devil is in the detail

So what's gone wrong here? In an effort to push this vaccine out more widely, an innovative financial mechanism was devised called the Advance Market Commitment. Essentially this is an international subsidy that donors pay to pharmaceutical companies in exchange for them agreeing to sell the vaccines in developing countries at lower prices than those paid in wealthy

markets. The idea is that the poorest countries get to access the vaccines at discounted rates, and sooner than otherwise would have been possible.

But the devil is in the detail and closer examination reveals a different picture. In contrast to the meningitis vaccine, where affordability was established as a core objective, the final prices for the pneumococcal vaccine negotiated with the pharmaceutical companies are still high. In addition to the multi-million dollar subsidy received by each company, donors,

continued overleaf ➤

with small co-payments from developing countries, are paying US\$ 10.50 for each child vaccinated. This is of great concern both to donors who are currently footing most of the bill, and for the developing countries that must eventually pay the full cost of the vaccines themselves. Securing long-term affordability is all the more crucial when you consider that the cost of this vaccine will have to be added to the cost of other routine vaccinations against measles and other common childhood diseases.

The big picture shows that the big pharmaceutical companies have received a vastly inflated and unwarranted subsidy for providing pneumococcal vaccine to developing countries – when they are already reaping blockbuster profits from the same vaccines in wealthy countries. And, once donor support ends, those same developing countries may end up unable to afford the vaccine.

It's likely that a considerably lower price could have been achieved if donors had granted more support to low-cost producers – similar vaccines in the pipeline could cost only US\$ 6 per child vaccinated, but will not be available for several years. With

a financial squeeze on all areas of global health funding, the exaggerated sum spent on this project could now mean a shortfall in the funding available for other important vaccines to protect young children in poor countries from killer diseases.

As Dr Nitya Uday Raj, medical coordinator for MSF in Kenya, says: "Pneumonia is a primary morbidity for young children in Dagahaley Camp, where we provide health services to Somali refugees and we are excited about adding this vaccine. During our conversations with the Ministry of Health about the roll out, they expressed concerns about how they would manage when they stop getting donor subsidies."

MSF is committed to working with national authorities to boost and expand effective childhood vaccination programmes in the places where we work. But to ensure that those ambitions are sustainable over the long run, it's essential not only for us to support and nurture new and creative approaches to the development of vaccines, but also to remain vigilant that the public health interest is prioritised above all else. The tale of two vaccines is a cautionary one.

MSF's Campaign for Access to Essential Medicines works to help our medical teams give quality care to the people we treat through

promoting the development of new vaccines, medicines and tests, and challenging existing barriers to treatment – such as cost – for patients in poorer countries.

To learn more about the Access Campaign's activities, visit www.msfacecess.org or follow @MSF_access on Twitter.



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The new vaccine could save thousands of lives.



A patient and her mother after the final surgery for a broken leg, Lubutu, DRC.

- | | |
|--|-----------------|
| 22 BURKINA FASO | 39 LIBERIA |
| 23 BURUNDI | 40 MALAWI |
| 24 CENTRAL AFRICAN REPUBLIC | 41 MALI |
| 26 CHAD | 42 MOROCCO |
| 28 CAMEROON | 43 MOZAMBIQUE |
| 29 REPUBLIC OF THE CONGO | 44 NIGER |
| 30 DEMOCRATIC REPUBLIC OF THE CONGO | 46 NIGERIA |
| 32 DJIBOUTI | 48 SOMALIA |
| 33 EGYPT | 50 SIERRA LEONE |
| 34 ETHIOPIA | 51 SOUTH AFRICA |
| 36 GUINEA | 52 SUDAN |
| 37 KENYA | 54 SWAZILAND |
| 38 LESOTHO | 55 UGANDA |
| | 56 ZIMBABWE |
| | 58 ZAMBIA |

AFRICA

BURKINA FASO



© Jessica Dimmock/VII Network

Women wait for their weekly visit to one of MSF's mobile feeding clinics, near Samba.



Malnutrition is a chronic problem in Burkina Faso, but hits particularly hard in the period between the two annual harvests, known as the "hunger gap".

Young children are vulnerable to malnutrition because a lack of essential micronutrients and vitamins can lead to restricted mental and physical growth. Malnourished children are also more susceptible to other diseases, such as malaria, diarrhoea and respiratory infections, and severe malnutrition can cause death.

Treating malnutrition in young children

Since 2007 Médecins Sans Frontières (MSF) has been treating malnutrition in children under the age of five in the northern towns of Yako and Titao. MSF testing and treatment programmes are based in 16 local health centres, bringing care closer to more people's homes.

Staff measure the circumference of infants' upper arms to test for malnutrition. Children suffering severe medical complications, such as other diseases, are admitted to hospital. If there are no complications the children are given ready-to-use food, which is a peanut-based paste containing all the calories, proteins, vitamins and micronutrients that a child needs to recover. Caregivers are given enough food sachets to last for a week so that they can feed their children at home. This home-based treatment does not interfere with the parent's work, and the child's progress is monitored weekly at the clinic. The children usually recover fully after about four weeks.

"Detecting and treating malnutrition in its early stages is essential, as it means that treatment can be offered quickly and ensures a much faster recovery time for the

children", said Sylvie Goosens, medical coordinator for the project. "Also, treating children earlier requires fewer resources, which means we can treat more", she said.

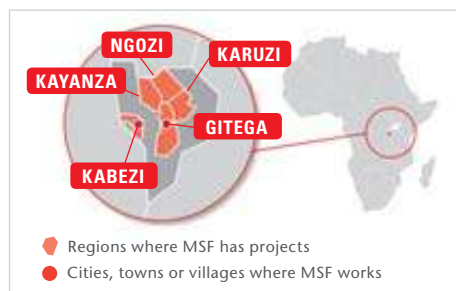
Nonetheless, as more children are screened for malnutrition and able to access treatment, more will need to be hospitalised. MSF expanded the hospital in Titao in 2010, building an extra structure that increased capacity from 80 to 150 beds. In 2010, more than 11,700 children received care for malnutrition. Since the project started in 2007, 50,940 children have received care.

Reinforcing care for malaria

Malaria is very common in Burkina Faso and in 2010 MSF increased its efforts to combat the disease, offering testing and treatment to every visitor to every centre where it was working. Between August and December, approximately 74,300 people received treatment, including 780 children who had more serious forms of malaria.

At the end of 2010, MSF had 268 staff in Burkina Faso. MSF has been working in the country since 1995.

BURUNDI



Although Burundi has a policy of free healthcare for children and pregnant women, access to care is limited, primarily because of a shortage of staff.

This particularly affects women. According to the World Health Organization, 4,000 women die in childbirth and approximately 1,000 women develop an obstetric fistula every year.

In western Burundi, Médecins Sans Frontières (MSF) operates a centre providing emergency obstetric and gynaecological care in the town of Kabezi, in Bujumbura Rural province. The centre offers medical care for pregnant women experiencing complications in delivery and for newborn babies. MSF also runs an ambulance service that transports women needing emergency care from 23 health centres in the area and brings them to Kabezi.

Obstetric fistulas

Obstetric fistulas are injuries caused to the birth canal. Many women with obstetric fistulas have to live with the unpleasant and debilitating effects of incontinence, which can also result in social exclusion.

In July 2010, MSF opened the Urumuri centre in the city of Gitega, central Burundi, to treat women with obstetric fistulas. It is the only centre in the country that provides free, around-the-clock treatment. MSF is planning

to treat 350 women per year for the next three years, and will be training Burundian doctors in specialist fistula surgery.

Malaria

Malaria is the main cause of mortality and illness in Burundi. It is responsible for 48 per cent of deaths among children under five. In 2010, two MSF teams treated 175,000 people for malaria and distributed 134,000 mosquito nets in the provinces of Kanyanza, Ngozi and Karuzi.

An MSF team is dedicated to the surveillance and evaluation of medical alerts in Burundi. The team supported the national health authorities during outbreaks of cholera and measles in 2010, treating patients and assuring follow-up. MSF staff also took part in a measles vaccination programme.

At the end of 2010, MSF had 237 staff in Burundi. MSF has been working in the country since 1992.



A woman feeds her child, who is recovering from malaria at Ngozi hospital.

© Martina Baigalupo

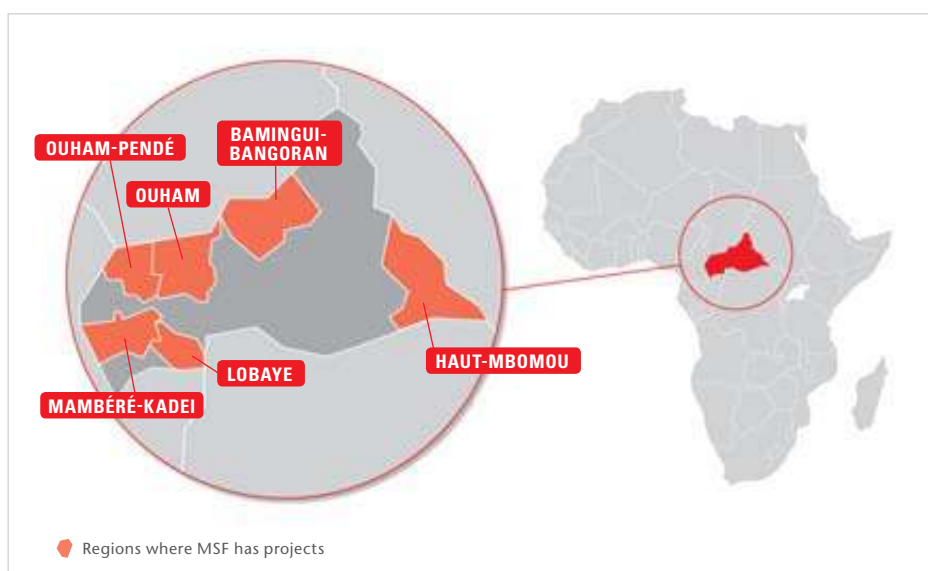
CENTRAL AFRICAN REPUBLIC

The Central African Republic has suffered armed conflict between rebel groups and the government for the past five years. People face enormous difficulties in accessing healthcare.

Many live in extremely isolated regions, and travelling is dangerous as banditry is widespread. In 2010, Médecins Sans Frontières (MSF) supported hospitals and health centres in violence-affected areas in the north of the country, and responded to emergency health needs in the southwest and southeast.

Ouham-Pendé prefecture

Since 2006, MSF has been working in the referral hospital in the town of Paoua in the northwest of the country. Teams provide paediatric, surgical, maternal, emergency and outpatient care. More than 35,150 consultations were carried out in 2010, and over 6,900 patients were admitted to hospital. Staff held more than 7,400 antenatal consultations, and assisted more than 1,500 births. Teams also cared for 320 HIV/AIDS patients, including patients infected with both tuberculosis (TB) and HIV. Staff worked in seven health centres in the surrounding



area, carrying out nearly 4,000 consultations every month.

MSF provided a paediatric service in Bocaranga hospital, 100 kilometres west of Paoua. Teams admitted around 160 children to the hospital and held an average of 1,000 consultations with children under five every month.

Ouham prefecture

In Ouham prefecture, east of Ouham-Pendé, MSF staff work in rebel-controlled territory

on the border with Chad. The Boguila project was opened in May 2006 on the site of a former missionary hospital, and it has since become the referral hospital for the region. The hospital has 115 beds and a laboratory, and offers surgery, maternity care, mental healthcare, HIV and TB treatment, outpatient services and a maternity waiting house. Women at risk of complicated deliveries can spend the last few weeks of pregnancy at the waiting house, where they are within easy reach of medical care. In November a four-week "surgical camp" was set up in the grounds of the hospital to help women suffering from obstetric fistulas, debilitating injuries to the birth canal that cause incontinence. Seventy-eight women received repair surgery at Boguila.

Staff train community members to provide basic health services and treatment at seven health centres in the surrounding area. Among other tasks, the community health workers diagnose malaria, one of the main causes of death in the country, and treat milder cases of the disease.

Maitikoulou clinic was opened in early 2009 to treat sleeping sickness (human African trypanosomiasis), after MSF teams recorded a high prevalence of the disease in the district. Sleeping sickness is a parasitic infection transmitted by tsetse flies that occurs in



An MSF nurse makes her morning rounds, checking on patients at Zémio hospital.

© Sarah Elliott



© Sarah Elliott

Patients need to drink large amounts of water before and after fistula surgery, Boguila hospital, Ouham prefecture.

sub-Saharan Africa. It attacks the central nervous system, causing severe neurological disorders. If not treated it causes death.

In 2009, more than 1,000 people were treated for sleeping sickness, but screening in 2010 resulted in only 50 people being diagnosed and treated. The clinic was therefore converted into a 70-bed general hospital. More than 48,320 consultations were carried out, and more than 2,370 people were hospitalised. Staff also provided medical care in four health centres in the area.

Not far from Maitikoulou clinic, MSF worked in a Ministry of Health hospital in Markounda town. Staff operated an outpatient department and a 26-bed inpatient department. In October MSF handed its work in these departments over to Ministry of Health staff. Teams continued to work in several health centres in the district, most of which were located along the Chadian border.

Many of the people living in the town of Kabo have been repeatedly displaced by violence. MSF staff provided emergency medical care, maternal and paediatric care, surgery and treatment for HIV/AIDS and TB at Kabo health centre, and supported four neighbouring health centres. Staff conducted almost 104,000 consultations and admitted more than 2,850 people to hospital. MSF also supplied basic survival kits containing hygiene products, food and blankets to families displaced by conflict.

Batangafo is in an isolated area around 60 kilometres from Kabo. The facility here was originally a health centre, and has now become a referral hospital with more than 170 beds. Teams provide maternal and paediatric care, surgery, and general and emergency medical care. MSF supports five health centres on the outskirts of the town and has one mobile clinic. Nearly 48,000 people were treated for malaria, more than 1,000 surgeries were performed, and staff assisted almost 1,300 births.

Bamingui-Bangoran prefecture

Armed conflict in Bamingui-Bangoran, in the north of the Central African Republic, is displacing people from their homes for months at a time. Some have found refuge with host families in Ndele, the prefecture's capital, while others are in hiding in the bush. Almost all are living in very poor conditions. MSF started working in Ndele hospital in July 2010 and set up mobile clinics to make basic healthcare accessible to as many people as possible. More than 28,700 consultations were held and 300 patients were admitted to the hospital.

Treatment for child malnutrition

In the southwest of the country, MSF treated more than 2,800 children for malnutrition in emergency programmes in Carnot, Mbaïki and Pissa. Children with malaria, diarrhoea and respiratory infections also received treatment. In Gadzi, MSF supplied and hired

staff to support several health centres and ran a feeding programme for children under 15.

Emergency care for displaced people

In November 2009, MSF launched a programme on the Ubangi River, on the border between the Central African Republic, the Republic of the Congo and the Democratic Republic of the Congo (DRC). The population in this area had grown by tens of thousands as refugees crossed the river to escape violence in DRC.

MSF staff provided medical care to 15,000 refugees as well as the host population, carrying out 5,000 consultations each month on average. In February, 12,500 children aged between six months and five years were vaccinated against measles.

In May, thousands of people flocked into the town of Zémio, on the border with DRC, fleeing attacks from the rebel group the Lord's Resistance Army. An MSF team opened an outpatient department in the town's hospital and a health centre near the refugee and displaced persons camps. Staff carried out more than 14,750 consultations, set up a feeding programme and conducted a measles vaccination campaign in an effort to prevent an outbreak of the disease in the crowded camps.

At the end of 2010, MSF had 1,263 staff in the Central African Republic. MSF has been working in the country since 1997.

CHAD

In 2010, the heaviest rains for 40 years destroyed crops, flooded wells and cut off entire villages in Chad. These floods followed a long drought in 2009, which had already resulted in a significant drop in farm production.

Chadians faced a major food crisis and several outbreaks of disease, including cholera, meningitis, measles and malnutrition. One quarter of children under the age of five were suffering from acute malnutrition in the Sahel region of western Chad in 2010. In eastern Chad, conflict continued.

Insecurity in eastern Chad

The political relationship between Chad and Sudan improved in 2010. Based on an agreement between the two countries regarding the provision of weapons and protection of insurgent groups, the UN peacekeeping mission MINURCAT left the country in December 2010. But sporadic clashes continued to be reported in eastern Chad and humanitarian staff were targets of kidnapping, robberies and violence. Many aid organisations were obliged to reduce their activities, or stop work altogether,

making life even more difficult for people living in the region.

In Dogdoré, 30 kilometres from the border with Sudan, residents live alongside a large number of displaced people. Médecins Sans Frontières (MSF) teams carried out more than 12,100 consultations and treated 430 patients in hospital during the first seven months of 2010. They provided 2,460 antenatal consultations, assisted more than 200 births and vaccinated some 1,060 children against measles. More than 430

people were admitted to the nutritional rehabilitation programme.

In July 2010, however, MSF was forced to close the programme. Repeated security incidents made it impossible to maintain a team in Dogdoré. Before leaving, MSF donated drugs and medical supplies to the hospital to help ensure the continuation of medical care after the team's departure.

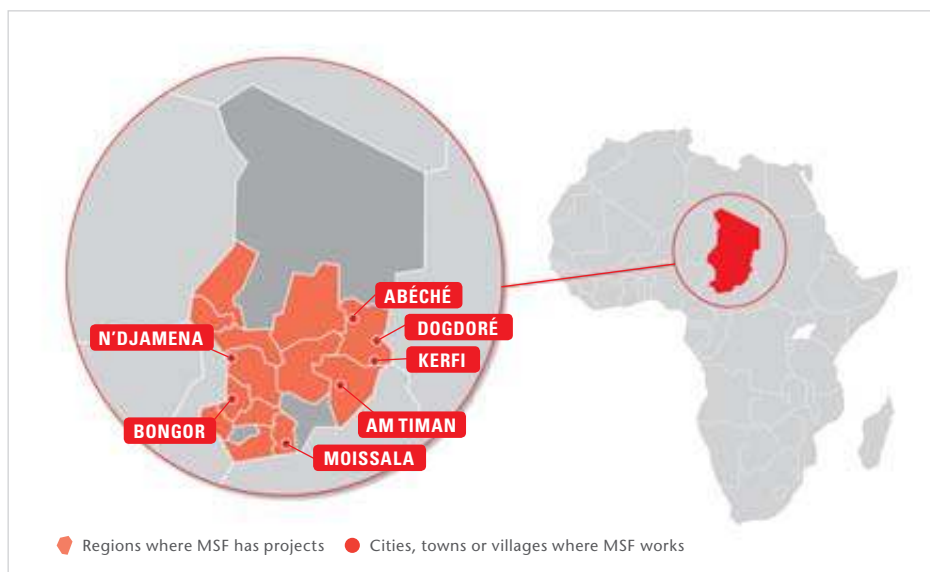
In Kerfi, in the southeast, MSF staff worked in a small health centre where both displaced people and members of the settled community came for treatment. In 2010, almost 26,700 consultations were carried out, and more than 1,500 patients were hospitalised. Staff held more than 3,000 antenatal consultations, assisted close to 100 births, and admitted more than 1,000 people to the nutrition programme.

In February 2010, MSF staff began providing care to patients in the paediatric and maternity departments of Am Timan hospital. By the end of the year the team was also working in three health centres around Am Timan. They set up mobile clinics to make treatment for malnutrition more easily available to more people, and offered antenatal care. In total, close to 1,030 babies were delivered, more than 1,750 patients were hospitalised, and 2,970 children were admitted to the nutrition programme.

In the city of Abéché, MSF assisted more than 3,400 deliveries and treated 144 women with obstetric fistula (injuries to the birth canal).

Malaria in Moissala

In Moissala, a district in southern Chad, malaria is endemic throughout the year,



Hundreds of people attend MSF's feeding programme at Massakory hospital, Hadjer Lamis region.



© Mathieu Bichet/MSF

Measles vaccination in N'Djamena, Chad.

although the number of cases peaks during and after the rainy season, between July and November. If a person with malaria is not treated quickly, the disease can cause death, especially in children and pregnant women. In several health centres in the region, MSF staff trained community health workers to screen patients for malaria and offer early treatment for simple cases. People suffering complicated cases of malaria were referred to Moissala hospital, where MSF runs a 50-bed malaria treatment unit. More than 20,000 patients were treated for malaria over five months. More than 1,030 patients were hospitalised in the malaria treatment unit.

Measles

During the first months of 2010, there was an outbreak of measles in the capital city, N'Djamena. Staff cared for more than 1,000 patients, nearly 420 of whom had to be hospitalised. MSF also donated drugs and medical supplies to help health centres treat more than 2,770 patients. In March and April, MSF immunised more than 482,000 children.

Emergency nutrition programmes

While responding to the measles outbreak, MSF staff observed high rates of acute malnutrition among children. This led to the opening of a nutrition programme in N'Djamena in March. The existing nutrition programmes in Dogdoré, Kerfi and Am Timan were strengthened, and a further 11 emergency programmes were opened in N'Djamena, the western regions of Hadjer Lamis, Kanem, Lac, Mayo Kebbi Est and Chari Baguirmi, Batha and Guera in central Chad, and Salamat in the southeast. In total, MSF treated more than 27,650 children, of whom more than 21,740 were severely malnourished.

Cholera

In September, there was an outbreak of cholera in N'Djamena. MSF teams set up treatment centres in three of the city's hospitals.

"The fact that more people are getting sick with cholera now is probably related to the fact that the heavy rains and floods hit a population that was already weakened.

There have been recent outbreaks of measles and high levels of malnutrition, so people's immune systems are low – a typical scenario for cholera outbreaks", said Alexis Bahati, medical team leader in Bokoro. Staff treated close to 1,300 patients and donated drugs in the Bongor and Madelia districts, south of the city, and responded to outbreaks in Bokoro, Pala and Fianga, where almost 700 patients were treated. By the end of the year, 6,300 cholera patients had been registered across the country.

Meningitis

In March and April, MSF treated more than 1,280 patients for meningitis in the southern regions of Logoné Oriental and Tandjilé. Vaccination campaigns were carried out in Logoné Oriental, Mandoul and Tandjilé, and MSF and the Ministry of Health vaccinated some 765,000 people between the ages of 2 and 29.

At the end of 2010, MSF had 773 staff in Chad. MSF has been working in the country since 1981.

CAMEROON



The first people to be put on ARV treatment in Cameroon started in 2000, and the country now has a longstanding group of patients on treatment. About 10 per cent of all people on ARV treatment develop resistance to the medication after a number of years, according to a study carried out by Médecins Sans Frontières (MSF) in Douala, Cameroon's largest city. These patients need to switch to a second-line protocol in order for their treatment to remain effective. However, second-line treatment is generally unavailable in developing countries, primarily because of its prohibitive cost.

In Nylon District Hospital, Douala, MSF supports a pilot project for the country that helps switch patients to second-line therapy. MSF is providing medical expertise, training, medication and advocacy, and hopes that the project will help prove the feasibility and necessity of implementing second-line

A pilot HIV/AIDS project in Cameroon is working to switch patients who have developed resistance to their first-line antiretroviral (ARV) treatment regimen to second-line treatment.

treatment in developing countries. Fifty-eight patients began this lifesaving treatment in the last months of 2010.

Staff are also working to improve care for those still on first-line treatment, replacing the most widely used type of medication with one that has fewer side effects, and should result in fewer patients developing resistance. In 2010, 295 people began ARV treatment on the new medication and 187 patients were transferred to the new medication.

Buruli ulcer

Buruli ulcer is an infection related to leprosy and tuberculosis, which can cause painful wounds and physical deformations, and often leads to social stigma for people with the disease. Early diagnosis and treatment are vital to prevent irreversible deformities, but treatment is complicated, expensive, and can take over a year, involving antibiotics, skin transplants, special wound dressings and physiotherapy.

Since 2002, more than 1,000 patients have been treated at MSF's programme in Akonolinga, a town in central Cameroon. MSF has set up a

"Buruli pavilion" in the town's hospital, where 120 patients received care in 2010. MSF is conducting outreach activities from the pavilion so that people living further away can access care more easily. In 2010, the Ministry of Health declared the pavilion a national reference point for the treatment of Buruli ulcer.

Cholera outbreak

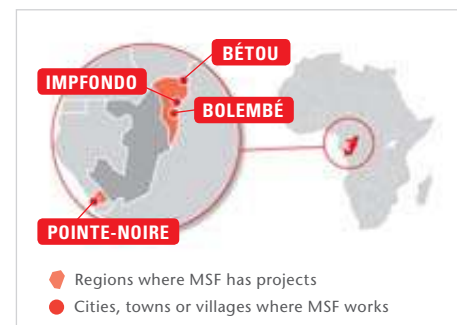
Cholera is endemic in the far north of Cameroon. But an outbreak that began in early May, and which also affected the neighbouring countries of Chad, Niger and Nigeria, infected far more people than usual. In Cameroon, MSF assisted the authorities' response by donating sanitation and medical supplies, setting up and managing two cholera treatment units in the towns of Maroua and Mokolo, and supporting units in Kolofata and Mogode with expertise in hygiene and case management. Between May and September, 6,200 cases were registered in the region of Extrême Nord, and 410 people died from the disease.

At the end of 2010, MSF had 68 staff in Cameroon. MSF has been working in the country since 2000.



Wound dressing at MSF's Buruli centre in Akonolinga.

REPUBLIC OF THE CONGO



At the end of 2009, tens of thousands of people crossed the Ubangi River to the Republic of the Congo, seeking refuge from fighting in Equateur province of the Democratic Republic of the Congo.

The population of Likouala province, in the Republic of the Congo, has doubled. Médecins Sans Frontières (MSF) teams have been working with people living along the river to improve the availability of healthcare in the area.

When MSF arrived in the town of Bétou, only the hospital and one of the three district health centres were functioning. The hospital had been built by MSF in 2003, and teams set to work reorganising the emergency, outpatient, medical, paediatric and surgical departments. Gynaecological, obstetric, nutrition and laboratory services were added. Each month, 340 patients were admitted to the hospital and around 3,000 consultations were held, mostly in relation to respiratory infections, malaria and diarrhoea.

There are now six functional health centres in the district. To reach more remote settlements, mobile MSF medical teams travel up and down the river by boat, providing general consultations and antenatal care, and treating severe malnutrition. These teams carried out on average 10,000 consultations a month, with the most urgent cases being referred to Bétou hospital.

Further south, in the town of Impfondo, MSF started the year supporting the medical, emergency, maternity, surgical and paediatric wards in the general hospital. Teams also worked in health centres and operated mobile clinics to the north and south of the town, carrying out around 3,600 consultations a month. In July, MSF moved its activities to the 20-bed hospital in Bolembé, 60 kilometres south of Impfondo, to be closer to the refugee population.

Polio epidemic

At the end of 2010, a polio epidemic broke out in the southeast of the country, centred in the city of Pointe-Noire. In total, 542 cases were recorded by the national health authorities, and 220 people died. The resurgence of the disease, the extremely high mortality rate, and the fact that males

aged 15 to 30 were the most affected group were all cause for grave concern.

At the request of the Ministry of Health and the World Health Organization, MSF began work in the intensive care unit at a hospital in Pointe-Noire at the beginning of December. The peak of the epidemic had already passed by the end of the year, but dozens of patients were still being admitted every day. Medical teams treated the symptoms of the disease (such as breathing difficulties and muscle spasms) and two outpatient physiotherapy centres were set up to help patients who had left hospital before

their treatment was complete. The programme will end in 2011 and the association Handicap International will take on the provision of physiotherapy and mobility aids to patients.

The health authorities and international agencies carried out a polio vaccination campaign, targeting around three million people. MSF lent logistical support for the vaccination of some 90,000 people living around Bétou.

At the end of 2010, MSF had 384 staff in the Republic of the Congo. MSF has been working in the country since 1997.



Polio vaccination in Likouala department.

DEMOCRATIC REPUBLIC OF THE CONGO

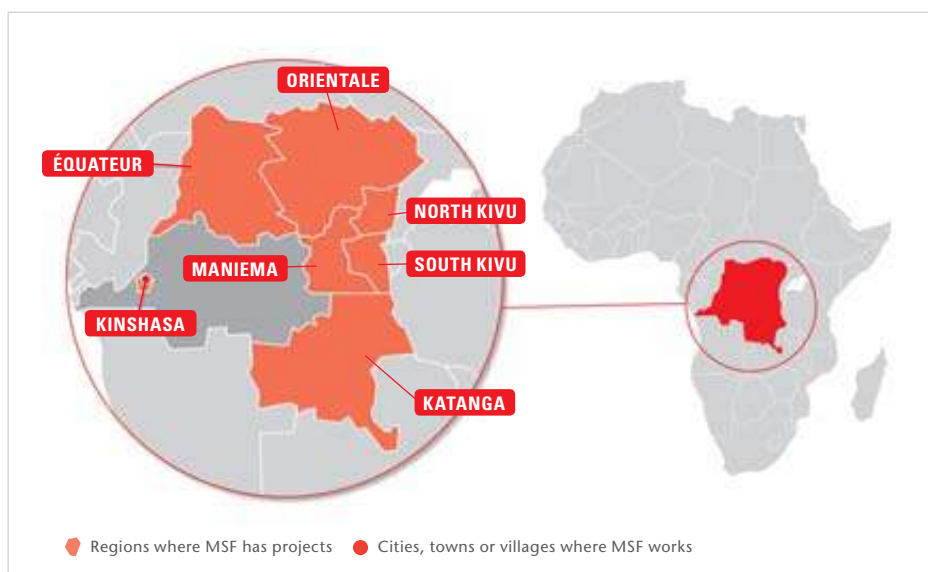
In the east of the Democratic Republic of the Congo (DRC), civilians have borne the brunt of more than a decade of violent conflict. Villages have been pillaged and destroyed, armed men have forced people to flee, and rape has been used as a tool of war.

In 2010, thousands more people were displaced from their homes by violence. Throughout the country, decades of neglect of the health system have resulted in a rise in infant and maternal mortality rates and, according to the World Health Organization, life expectancy is among the lowest in the world.

Providing healthcare in conflict zones

The project in DRC – in terms of programmes, staff and budget – is Médecins Sans Frontières's (MSF) biggest. Teams offer general and specialised medical care in hospitals, health centres and mobile clinics in various provinces, including the capital city Kinshasa and the wartorn east of the country. In 2010, MSF staff carried out more than one million medical consultations, performed more than 10,000 surgeries and assisted 19,200 births. Staff treated patients for HIV/AIDS, tuberculosis, cholera, haemorrhagic fevers, measles, malaria, sleeping sickness (human African trypanosomiasis) and more. Teams carried out vaccination campaigns and emergency surgery, ran nutrition programmes and offered paediatric care. Mental healthcare was also offered, as well as women's healthcare, including specialised assistance to victims of sexual violence.

After three years of relative stability in the Bunia region, Orientale province, MSF handed its activities in Bon Marché hospital over to the Ministry of Health. SOFEPADI, a



Congolese non-governmental organisation that specifically helps female victims of sexual violence, will take on responsibility for the women's health department. Teams provided care for 675 women in the six months before the handover process began.

In other places, conflict intensified, and poor infrastructure made accessing remote areas even more difficult. Around the town of Pinga in North Kivu, where the community is trapped by fighting across a constantly shifting front line, teams used motorbikes to hold mobile clinics and provide medical supplies. In Hauts Plateaux, a very isolated and mountainous part of South Kivu, teams walked for up to six hours to reach displaced communities and carried out close to 13,800 medical consultations. Supplies can only reach Shabunda by cargo plane, and MSF teams then used bicycles and motorbikes to bring medical care to 22,000 displaced people. In the Uélé area, in Orientale province, insecurity means that many displaced people can only be reached by plane.

Staff at mobile clinics, health centres and hospitals in Bunia, North and South Kivu, and Haut-Uélé and Bas-Uélé provided

medical, psychological and social support for almost 6,000 victims of sexual violence. In North Kivu, where it is difficult to reach the more remote settlements, MSF also trained a network of women counsellors to respond to the needs of victims of sexual violence and, where necessary, to refer patients to the hospital for further care.

Rapid response units

In the capital Kinshasa, Kisangani in the north, Lubumbashi in the south and Mbandaka in the west of the country, MSF teams work closely with the Ministry of Health to monitor the epidemiological situation in DRC. Evaluation teams investigate any claims of infectious disease outbreaks or other quick-onset medical emergencies, and are prepared to respond within days. In 2010, the units responded to ten crisis situations, including yellow fever and measles outbreaks, and supplied emergency medical aid to people caught up in fighting in Équateur province.

Responding to outbreaks of disease

Measles epidemics occurred throughout the country in 2010. MSF teams vaccinated 2,700 children in Nyanzale, North Kivu,



A support team and much-needed ice packs, which keep medication cool, arrive at Bebungo village, northern Bandundu province.

nearly 90,000 in the Baraka area in South Kivu, 103,000 in Sakania, 40,000 in Dilolo and 8,000 in Bendera in Katanga province.

The poor living conditions in displaced persons camps and the lack of clean water also facilitated the spread of cholera in South Kivu in 2010. MSF emergency teams set up cholera treatment centres and treated more than 1,600 patients in Kabizo, Makobola, Minova, Mwenga and Shabunda. MSF staff supported the response to cholera outbreaks in two displaced persons camps in Kalemie, Katanga province, providing case management expertise and medical supplies.

Malaria is among the leading causes of illness and death in DRC. MSF teams treated 27,000 patients in Katanga province, 26,000 in North Kivu, and 19,000 in South Kivu. Many were children under five.

Haut-Uélé and Bas-Uélé are two of the areas in Africa most affected by sleeping sickness. MSF staff treated 829 patients for this deadly disease, which is transmitted to humans through the bite of the tsetse fly.

Obstetric fistula surgery

In Masisi hospital in North Kivu, and in

surgical “camps” in Shamwana and Manono in Katanga, more than 130 operations were carried out on women suffering from obstetric fistulas. Fistulas are injuries to the birth canal which can occur as a result of complications in childbirth or, occasionally, extreme sexual violence, and which can cause incontinence and crippling social stigma.

Specialised emergency burns intervention

In July, MSF launched a specialised emergency intervention when a fuel tanker crashed and exploded in Sange in South Kivu. More than 230 people died and 96 were seriously injured. Teams provided medical care and mental health support to 52 patients with severe burns in two hospitals in the region. Surgeons conducted skin grafting (a skin transplant that encourages rapid healing), and teams provided burns patients with individual intensive nursing care and physiotherapy.

HIV/AIDS

Teams started more than 850 new patients on antiretroviral (ARV) treatment in MSF's HIV/AIDS project in Centre Hospitalier de Kabinda in the centre of Kinshasa in 2010, bringing the total number of patients receiving the medication to 2,631.

MSF also began supplying medication, financial and technical assistance to “Postes de Distribution”. These are community-based ARV distribution points that give patients responsibility for their own care. The centres were set up and are managed by people living with HIV/AIDS who are members of the Réseau National d'Organisations Assises Communautaires (RNOAC), a nationwide patient support group.

At the end of 2010, MSF had 2,766 staff in the Democratic Republic of the Congo. MSF has been working in the country since 1981.

DJIBOUTI



© Marcus Bleasdale/VII

A child is given a gastric nasal tube to help feed her, MSF's inpatient feeding centre, Djibouti.



Drought, rising food prices and increased numbers of migrants passing through the country have had a profound impact on Djibouti. Levels of malnutrition exceeded emergency thresholds in a number of locations in 2010.

Médecins Sans Frontières (MSF) has concentrated its efforts on reducing malnutrition among children in the slums of Djibouti City.

Treating malnutrition in the capital

In 2010, MSF provided medical care for malnourished children in the districts of Balbala, Hayableh, Arhiba and PK12. These districts are home mainly to migrants, asylum seekers and Djiboutians who have moved to the city from rural areas.

In order to reach as many of the 200,000 inhabitants of the slums as possible, teams travelled from door to door to identify acute malnutrition in children and to raise awareness about the disease. According to their level of malnutrition, children were referred to one of six MSF feeding centres that provide outpatient care, or to MSF's 35-bed therapeutic feeding centre, where children suffering from malnutrition with complications receive 24-hour medical care. Almost 1,030 malnourished children were hospitalised in 2010 and more than 3,620 received outpatient care.

MSF also vaccinated young patients against measles and provided medical follow-up. In 2010, almost 140 malnourished children in the feeding centres tested positive for tuberculosis (TB). Staff treated the children

for both TB and malnutrition before referring them to the national TB programme.

Chronic food insecurity

Fluctuating rainfall and drought are intrinsic to arid and semi-arid lands such as Djibouti. The agricultural community is able to meet only 25 per cent of domestic food demand, and the country is heavily dependent on imports. Rising food prices and migrants passing through the country, who in many cases have left their homes due to food shortages, place additional burdens on food security. Malnutrition is chronic, and cases increase between the months of August and November, a period known as the hunger gap, when food stocks tend to run out. MSF found that admissions to some of its feeding centres doubled during the hunger gap.

In August 2010, a fire in the district of Ambouli left 125 families homeless. MSF organised a distribution of food and other relief items for the affected families.

At the end of 2010, MSF had 128 staff in Djibouti. MSF has been working in the country since 2008.

EGYPT



In 2010, Médecins Sans Frontières (MSF) began supporting the Egyptian organisation Al Shehab in opening and operating a maternal and child health clinic in the Cairo slum of Ezbet el Haggana, home to hundreds of thousands of people. Residents include Egyptians who have left their rural homes, long-term inhabitants of Cairo,

Egypt's public health system is well established, but has limitations in fields like maternal health. Despite healthcare being subsidised, people with low incomes may still not be able to access care.

and migrants who mainly come from Somalia and Sudan.

MSF provided technical and managerial supervision to Al Shehab staff working in the clinic. From June until November 2010, clinic staff carried out more than 5,200 paediatric consultations, referring patients to national health facilities for vaccinations. Almost 1,500 antenatal consultations were held, and more than 200 women were referred to hospital for delivery. The referral system ensured all patients received free care in hospital. Administrative considerations relating to

Al Shehab's clinic registration meant that the clinic's activities had to be suspended in November 2010.

Since 2009, MSF has developed an extensive network of contacts in the country, which is helping us identify gaps in healthcare and is facilitating our efforts to provide assistance in Egypt. At the end of 2010, MSF's registration in the country was being processed.

At the end of 2010, MSF had 19 staff in Egypt. MSF started working in the country in 2010.



A patient leaves a consultation with a prescription for free medication that can be collected from a designated pharmacy nearby, Cairo.

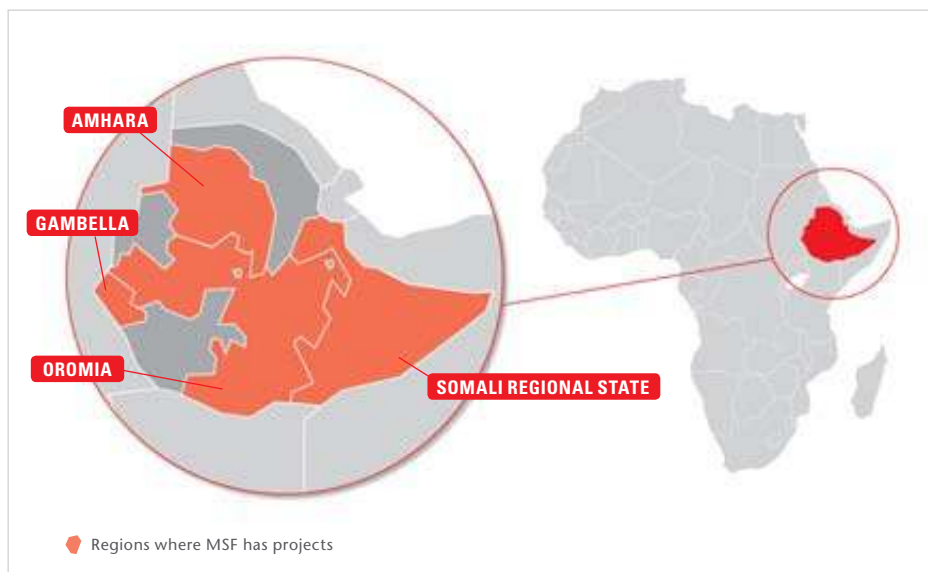
ETHIOPIA

In 2010, Médecins Sans Frontières (MSF) helped to meet health needs in four regions: Somali, Oromia, Amhara and Gambella.

Somali region

The Somali region is one of the least developed in Ethiopia and is particularly prone to food insecurity. Poor water quality makes water-borne diseases like eye infections, skin disease and diarrhoea common, and tuberculosis (TB) is a major public health problem. The few health services that are available are hard to reach. Military confrontations between government forces and insurgent groups make access to healthcare even more difficult. Infrastructure and public services suffer from the insecurity, and it is difficult to attract qualified medical staff from other parts of the country.

East and West Imey districts are located on the border between Gode and Afder zones, toward the south of the Somali region. In July 2009, an MSF team built a health centre in East Imey town. By October, the centre was able to provide a full range of services, including antenatal care, a 15-bed inpatient department, a maternity ward, a nutrition programme and a vaccination programme. In 2010 staff at the centre held medical consultations with more than 800 people each month. Patients requiring more specialised care were taken to the nearest hospital, in Gindir, which is between six and eight hours' drive away. A TB diagnosis and treatment



programme was started in December 2010, and 15 patients were admitted to the programme during that month.

In West Imey, MSF continued to support a health centre that provides general medical consultations, antenatal care, treatment for malnutrition and vaccinations. Today, an average of 1,000 medical consultations are held at the centre each month. Teams have started holding weekly mobile clinics for those who live far from the centre. In 2010, more than 29,300 people were treated in East and West Imey.

Parts of Wardher zone, in the east of Somali region, are also affected by armed conflict between the Ethiopian army and the Ogadeni National Liberation Front.

MSF supported several Ministry of Health facilities in three of the zone's four districts, providing basic healthcare, reproductive healthcare and treatment for malnutrition and TB. MSF staff also cared for more than 1,400 patients at the inpatient department in 2010. Staff held more than 63,700 consultations, assisted 342 births, and admitted 158 patients to the TB programme. In 2010 more than 1,200 patients were treated for measles.

MSF supported the Regional Health Bureau's hospital in Degehabur, in the north of the region. Teams provided antenatal and postnatal care, family planning services, maternity services, treatment for sexual and gender-based violence, emergency services, an inpatient therapeutic feeding centre, a general medical ward and outpatient consultations. Mobile medical teams visited more remote communities, offering health and hygiene education, general consultations, nutritional screening, psychosocial counselling and referral of patients requiring more specialised care to hospital.

Violence and insecure living conditions in Somalia have led many Somalis to cross the border into Ethiopia. At Dolo Ado transit camp, in the south of Somali region, MSF provides emergency medical care to refugees before they move on to the Boqolmayo and Malkadida refugee camps. At these camps, MSF offers basic healthcare, a nutrition programme and measles vaccinations. Staff also provide maternity and paediatric care, nutritional assistance and vaccinations at a health centre in the town of Dolo Ado.

Oromia region

In Anchar district in Oromia region, 300 kilometres east of the capital Addis Ababa,



A nurse examines a patient in East Imey clinic.

© Julie Rémy



© Julie Rémy

A patient injured in a fight has his wound cleaned and dressing changed, West Imey clinic, Somali region.

there is not enough food even when the harvest is good. MSF staff make regular visits to 25 Ministry of Health feeding centres, where they also ensure supplies of drugs and food rations. In 2010, 533 severely malnourished children received treatment at the centres. A 20-bed inpatient therapeutic feeding centre provided care for 147 severely malnourished children who also had medical complications, such as pneumonia or anaemia, and needed intensive medical care.

With the help of an MSF health promotion team, community members set up committees to improve the care being provided for children with malnutrition. Committee members referred children they suspected to be suffering from malnutrition to the feeding programme and helped to trace patients that had missed visits to the feeding centres.

In an effort to prevent children becoming seriously malnourished, MSF started a supplementary feeding programme, providing food rations to children, pregnant women and breastfeeding mothers in earlier stages of malnutrition. More than 1,000 children and 680 women were admitted to the programme.

Amhara region

Migrant labourers travel north from all over Ethiopia to work in the Amhara region during the sowing and harvesting seasons.

Levels of kala azar (visceral leishmaniasis) and TB are high among the region's largely transient population, and the prevalence of HIV/AIDS is twice the national average. But there are few health structures in the region.

In Abdurafi, a town near the border with Sudan, MSF focuses on diagnosing and treating kala azar, a deadly disease spread by the bite of the sand fly. Almost 1,500 people were screened for kala azar in 2010, and 394 patients were treated for the disease. MSF staff also provide care for HIV/AIDS and 416 patients began antiretroviral treatment. Nearly 600 patients were admitted to the nutrition programme.

In the district of Telemt, MSF began an emergency response to the deteriorating food situation in the area. Working in eight different locations, staff treated more than 960 severely malnourished children. The project was handed over to the Ministry of Health at the end of 2010.

Gambella region

The Nuer population of the Gambella region, in the far west of Ethiopia, has grown as people have crossed the border to escape violence in south Sudan. In May 2010 MSF moved into a new health centre. Staff held close to 29,000 consultations, and 873 patients were hospitalised.

The main illnesses suffered by patients were respiratory tract infections, diarrhoea and malaria. Maternity staff assisted an average of 10 births per month. Depending on the season, mobile teams travelled by car or by boat to provide care to the most isolated populations, carrying out 6,800 consultations between April and December.

At the end of 2010, MSF had 1,049 staff in Ethiopia. MSF has been working in the country since 1984.

Sefinas

18 years old

Sefinas has kala azar. He has been in MSF's clinic for the past two weeks. "The illness had weakened me, I would have died if I had not come here", he said. "Now my body is strengthening, the medical staff are following me day and night, I am getting injections and food."

Sefinas says that he will make sure not to get reinfected with kala azar, and will apply basic rules about prevention that he has learned from MSF staff. "I will resume my work in the farms after I get cured and discharged. I have a bright hope now."

GUINEA



Health facilities are poorly distributed across Guinea, and the health system lacks staff, medicine and equipment. Where the national health system cannot meet needs, people are likely to turn to expensive private clinics or traditional medicine.

Médecins Sans Frontières (MSF) works in the capital Conakry and the remote region of Guéckédou, providing paediatric care, and treatment for malaria (the main cause of child mortality) and HIV/AIDS.

Paediatric care in Conakry

Residents of Matam, a district of Conakry, can rarely afford to go to public health centres, and this has a particularly heavy impact on the wellbeing of young children and pregnant or breastfeeding women. Almost half of all children who die before they are one month old have never been taken to a health facility.

MSF is working with the national health authorities to implement a paediatric programme in three centres in Matam. Sixty community health workers have been hired to help encourage people to make use of the health centres. More than 42,400 consultations were carried out in 2010, including 14,200 for malaria.

MSF staff also work at the National Institute for Children's Health in Conakry, training and advising medical staff and ensuring free care and drugs for children referred to the neonatal and nutrition wards of the institute. Almost 2,300 children were admitted to the neonatal department in 2010 and more than 1,000 were admitted to the feeding centre from March 2010, when MSF started activities, to December.



A member of staff prepares medication for HIV patients at Matam health centre, Conakry.

Reaching rural populations

Each year, malaria affects more than a quarter of the population of Guéckédou, an area in the south of the country around 700 kilometres from the capital. Artemisinin-based combination therapy, which is more effective than the treatment traditionally used against malaria and prevents the development of drug resistance, is now available in Guinea, but the drugs are still difficult to obtain in remote areas.

MSF has begun a project in Guéckédou to build a community-based malaria prevention and care system. Teams support the emergency and paediatric departments in Guéckédou hospital, but also work in 15 health centres. MSF's community health workers distribute mosquito nets, conduct awareness campaigns, and implement early detection measures, ensuring that people with malaria receive treatment as rapidly as possible. In the last quarter of 2010, when MSF started activities, more than 9,700 consultations were held with patients thought to be affected by malaria. More than 5,800 patients were diagnosed with and treated for malaria.

Treating HIV/AIDS

The prevalence of HIV/AIDS in Guinea is not high compared with some countries in sub-Saharan Africa, but there are major gaps in the national HIV programme. MSF's projects are the main initiatives on HIV in the country, but only cover some of the HIV care needs. More than 5,000 people were receiving antiretroviral (ARV) treatment from

MSF at the end of 2010, about one-third of those being treated in the country.

Four health centres in Conakry receive support in providing HIV care. MSF supplied medicines, power and water to the centres. A team supervises activities relating to HIV/AIDS and trains HIV/AIDS staff. In 2011, MSF will work with two more health centres in the city, strengthening prevention of mother-to-child transmission services in particular.

At the end of 2010, MSF had 213 staff in Guinea. MSF has been working in the country since 1984.

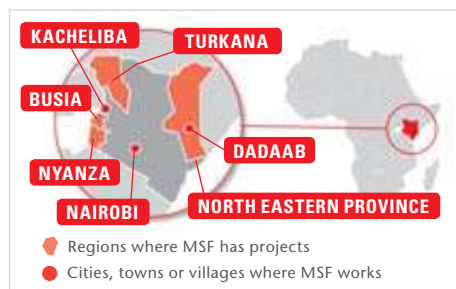
Aïssata

"I am a 36-year-old woman, and it was in 2009 that I found out about my HIV status. I was very troubled by the news, which almost pushed me to suicide. I was discriminated against and stigmatised.

"I ended up being referred to the health centre in Matam, the centre of MSF's programme in Conakry. I had a check-up and I weighed only 42 kg. I felt I was accepted and listened to, especially by the psychosocial team, who gave me a lot of information about HIV/AIDS – and the ARV treatment is free.

"After six months I weighed 82 kg. Not long after, I was recruited by MSF as an 'expert patient' to help others with the disease. Today, I feel positive about my life."

KENYA



Healthcare in North Eastern province

The camps near Dadaab, where Somalis seek refuge from civil conflict at home, are filled beyond capacity. Some 300,000 people are living in a space made for 90,000, and new arrivals have been forced to settle in makeshift shelters outside. MSF has taken charge of the healthcare needs of refugees living in Dagahaley camp.

“Each week, we have 1,400 or 1,500 new arrivals from Somalia. This is making the camp very overcrowded, and it means there is less space and many more difficulties for those who are already living here”, said Mohammad Daoud, MSF’s field coordinator in Dagahaley. MSF runs a 110-bed hospital and four health posts, holding on average 10,000 general consultations and admitting 600 patients to the hospital every month.

In July MSF signed a memorandum of understanding with UNHCR, the UN refugee agency, for the provision of health services in a second camp, Ifo 2, located less than ten kilometres away from Dagahaley, which would accommodate 80,000 refugees. Construction work began and refugees were due to be relocated in November. However, negotiations between the Kenyan authorities and the UN stalled and by the end of 2010 no relocations had taken place.

In addition to continuing medical services in Dagahaley camp, MSF also provided shelter material to 700 families and, with other organisations, ensured the supply of water for the new arrivals.

In 2010 MSF teams began working in the remote Ijara district, which is also host to many refugees. Staff focused on reproductive healthcare, working in Sangailu dispensary and Hulugho hospital, and aim to expand services to include immunisation and tuberculosis (TB) care.

Taking HIV care to the community

Massive gains have been made in the fight against HIV/AIDS and TB in Kenya, but many

There are 1.5 million people living with HIV/AIDS in Kenya, and Médecins Sans Frontières’s (MSF) work in the country continues with a strong focus on HIV care. Teams are also providing relief and healthcare to hundreds of thousands of Somali refugees living in camps around the town of Dadaab.

people still suffer from these diseases. Homa Bay, along the shores of Lake Victoria, is the district most affected. In collaboration with the Ministry of Health, MSF ensured that treatment is available in eight clinics across Homa Bay: 10,000 people living with HIV received care, of whom 850 were children under 15 years of age.

In the capital Nairobi, MSF provides HIV/AIDS and TB treatment in two slum areas, Mathare and Kibera. Here, some 7,400 people living with HIV/AIDS are currently receiving care at MSF’s clinics and 5,800 are on antiretroviral (ARV) treatment.

In Kibera, MSF has set up a task force with local authorities to facilitate the handover of three health facilities to the Ministry of Health. As part of the handover, a new health centre will be built just outside the slum to provide healthcare to local people.

After 10 years, MSF’s HIV/AIDS project in Busia, a rural region in western Kenya, was handed over to other organisations. The project has effectively shown that ARV treatment with good outcomes is feasible in resource-poor rural settings, and that ARV treatment and the empowerment of people living with HIV reduce stigma and discrimination.

Sexual violence in the slums

Both the Mathare and Kibera projects have a particular focus on gender-based violence. In Kibera, the sexual violence clinic moved into its own building, so that patients could access services with greater confidentiality.

Meanwhile in Mathare, staff started operating a 24-hour on-call service. The clinics offer post-exposure prophylaxis – medication that greatly reduces the risk of HIV infection – counselling and social support. Staff treat around 70 patients every month, many of whom are children.

Making kala azar a national priority

After seven years of working with kala azar (visceral leishmaniasis) patients in Pokot, near the border with Uganda, MSF started a kala azar training programme in the



A doctor examines a patient suffering from malnutrition in Dagahaley hospital, North Eastern province.

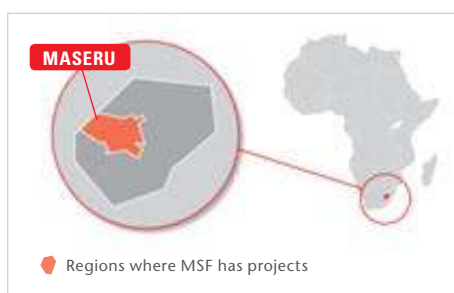
neighbouring districts of Turkana Central and Turkana South. Teams support and train Ministry of Health staff in the use of first-line medication and, where that fails, second-line medication. Kala azar is spread by sand flies and is fatal if left untreated. MSF is lobbying for treatment to be provided free of charge by the Ministry of Health and for rapid testing methods to be implemented more widely.

At the end of 2010, MSF had 691 staff in Kenya. MSF has been working in the country since 1987.

LESOTHO



A nurse examines a baby at St Barnabas clinic.



Lesotho is the poorest, high HIV-prevalence country in the world, with an estimated 280,000 people living with HIV/AIDS. More than 10,000 people have tuberculosis (TB) and 76 per cent of them are HIV positive.

In 2010, Médecins Sans Frontières (MSF) completed a pilot project in collaboration with national health authorities that provided integrated HIV and TB care in local health centres.

The project was carried out in 14 rural clinics and a hospital south of the capital Maseru, serving a population of around 220,000. At the

start of the project, around 31,000 people in the area were living with HIV and about 9,000 were in need of antiretroviral (ARV) treatment.

Integrated HIV and TB treatment

The project adopted a new operational strategy in order to have a rapid impact on the lives of people with TB and HIV in a context of extreme health needs. The team in Lesotho applied strategies and best practices from MSF projects in other countries in the region. Staff integrated HIV and TB care in local clinics, so that co-infected patients could receive all their treatment in one place, not too far from home. To enable provision of integrated HIV and TB care in a context with a critical shortage of health workers, routine tasks that had been previously carried out by doctors were shifted to trained nurses. This not only increased the number of medical staff available to carry out the work, but also built up the skills of local health staff and encouraged a cooperative professional network. The project also employed lay counsellors, many of whom are HIV positive. By June, when the project was handed over to the national health authorities, close to 7,000 people had been initiated on ARV treatment. All 15 sites were staffed and equipped to provide comprehensive HIV and TB services, including HIV counselling and

testing, ARV and TB treatment for adults and children, follow-up, and prevention of mother-to-child transmission of HIV.

Focus on maternal health

The annual number of deaths from pregnancy-related causes has more than doubled in Lesotho since 2000. According to the World Health Organization, almost 60 per cent of these deaths are a result of HIV, as pregnant women with HIV are more susceptible to opportunistic infections.

In 2011, MSF will start a new project focusing on reducing the rates of illness and death among pregnant women and babies in Lesotho. It aims to demonstrate that the number of infant and maternal deaths can be reduced by integrating HIV and TB care with maternal and reproductive health services, and by starting patients on ARV treatment sooner. The project will also reinforce basic healthcare services, decentralise services to bring them closer to people's homes, encourage nurse-centred care and improve HIV care, particularly prevention of mother-to-child transmission. MSF will encourage robust community involvement in order to reduce stigma, increase awareness and provide advocacy.

Field staff working in Lesotho are integrated with the figure for South Africa. MSF has been working in Lesotho since 2006.

LIBERIA



After 14 years of civil war ended in 2003, Liberia's government embarked on the enormous task of rebuilding the country's health systems.

In 2010, after 20 years of emergency healthcare provision in Liberia, Médecins Sans Frontières (MSF) closed its final two hospitals and the Ministry of Health took over responsibility for the services that MSF had been providing. Today, MSF remains in the country to provide comprehensive medical and psychological care for survivors of sexual violence.

Hospital handover

During the civil war, MSF provided emergency medical care and humanitarian assistance in

many of the 15 counties in Liberia. Since the end of the war in 2003, the organisation has been gradually handing over its activities. In June 2010, MSF finalised the handover of its last two hospitals in Monrovia, the capital. On average, MSF treated more than 20,000 women and children each year in these two hospitals.

On Bushrod Island, a very densely populated area of Monrovia, MSF ran the 150-bed Island hospital. The hospital provided neonatal intensive care and maternal emergency services, as well as offering treatment for chronic diseases such as HIV/AIDS and responding to medical emergencies in the area. In response to a measles outbreak in 2010, staff set up a tent within the hospital and treated more than 550 patients.

Benson hospital was opened in 2003, in an eastern suburb of Monrovia known as Paynesville, which is mainly home to displaced people who had come to the city in search of refuge from the conflict. The hospital provided a full range of services and housed the largest care programme for sexual and gender-based violence in Liberia. Between 2007 and 2008, with improvements in the national health system, MSF handed over many of its services and concentrated on specialist paediatric, gynaecological and obstetric care. From January

to April 2010, more than 1,560 children received free medical care in Benson hospital and some 320 babies were delivered. The Ministry of Health has now taken over these services too.

MSF has set up a new hospital (James N. Davies Junior Memorial Hospital) in Jacob Town Neezoe, Paynesville, and donated it to the Ministry of Health. This should help to ensure that the closure of Benson and Bushrod Island hospitals does not create major gaps in healthcare provision. MSF also added 80 beds to the paediatric department and increased support to the paediatric services available in Monrovia's main public hospital, Redemption hospital, by providing training, staff and medicines.

Sexual violence

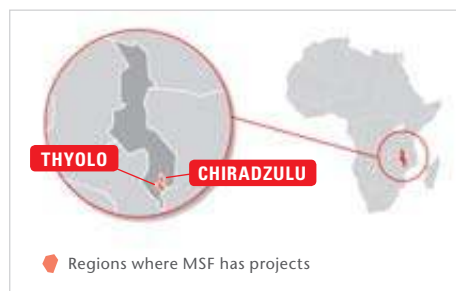
In July 2010, MSF began a new project in Monrovia in collaboration with the Ministry of Health, providing free care to survivors of sexual violence in two health centres. The programme provides comprehensive care, including medical treatment, psychological care and legal support. In 2010, staff treated more than 720 patients, 89 per cent of whom were under 18 years of age.

At the end of 2010, MSF had 147 staff in Liberia. MSF has been working in the country since 1990.



A mother at the door of her child's room in the burns unit of Island hospital, Monrovia.

MALAWI



In 2010, Malawi experienced its worst outbreak of measles since 1997: 105,000 cases and 251 deaths were reported. Between April and August Médecins Sans Frontières (MSF) teams helped authorities deal with the outbreak, conducting a vaccination campaign in nine districts among 3.3 million children aged between six months and 15 years.

MSF also supported the treatment of nearly 23,000 people for measles in 15 districts across the country, with a particular focus on the hard-hit southern region. The response to the emergency involved almost 1,800 MSF staff.

Malawi has an ambitious HIV/AIDS treatment plan, but it continues to face a severe shortage of healthcare professionals. A lack of international donor commitments to implement the treatment plan makes the fight against HIV a mammoth task. In 2009 more than 920,000 people (11 per cent of people aged between 15 and 49 years) were estimated to be infected with HIV, while the country had an average of only two doctors per 100,000 inhabitants. By the end of 2010, more than 345,000 people had been enrolled in the national antiretroviral (ARV) treatment programme, representing an estimated 63 per cent of patients requiring ARV treatment.

HIV/AIDS treatment

In 2003 MSF started providing ARV treatment to people with HIV in Malawi and its programmes soon evolved to include the prevention of mother-to-child transmission, the detection of treatment failure, and the provision of paediatric HIV care. MSF is also

assisting the Ministry of Health in instituting the provision of decentralised healthcare for HIV and tuberculosis (TB) from district-level hospitals to community clinics and rural health posts.

Since 2007, MSF has helped local health authorities achieve and maintain universal access to ARV treatment for people living in Thyolo district, in southern Malawi. (Universal access is defined as the provision of treatment to at least 80 per cent of patients in need.) This was accomplished through a combination of decentralisation of services, task-shifting from doctors to nurses, and the simplification of testing and treatment protocols. As of December 2010 more than 29,000 patients in Thyolo had started ARV treatment through Ministry of Health facilities, with support from MSF.

In the neighbouring district of Chiradzulu MSF supports HIV programmes in 11 health centres, offering testing, holding consultations, supplying medicines, and providing dedicated TB treatment services. By the end of 2010 more than 18,000 people living with HIV in Chiradzulu were receiving ARV treatment, with some 650 new patients starting the programme each month.

Dealing with healthcare staff shortages

In Malawi's rural areas, where few health personnel choose to work, needs for medical

care are huge. Between 2006 and 2009 MSF established new approaches to providing HIV care. Teams transferred skills from doctors to nurses and simplified treatment guidelines to help improve the provision of care closer to home. To meet the challenges of retaining skilled health personnel in rural areas MSF has also implemented scholarships for students in healthcare training programmes and hosted health worker retention conferences. In collaboration with the Ministry of Health, MSF has contributed to several other non-financial incentives and motivation strategies.

Impact of international HIV funding retreat

Despite having ambitious HIV treatment programme guidelines in line with new World Health Organization recommendations, implementation of these plans will be delayed or staged according to available resources. Malawi did not receive much-needed money from the Global Fund's most recent round of funding, which ended in December 2010. Dwindling funding commitments point to a growing disconnect between the international community's bold and ambitious visions for achieving global health goals, and its inability to fully support such recommendations.

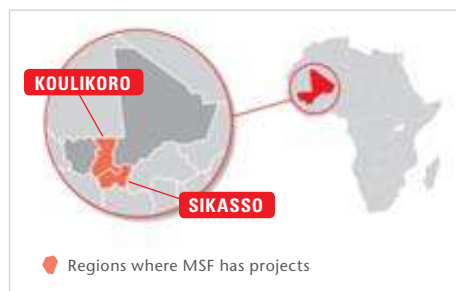
At the end of 2010, MSF had 827 staff in Malawi. MSF has been working in the country since 1986.



One of more than three million children vaccinated against measles in Malawi in 2010.

© Marit Helgenud

MALI



Mali has seen a reduction in humanitarian assistance because of the presence of groups linked to AQIM (Al Qaeda in the Islamic Maghreb) in the country. Health needs are significant, and child mortality rates are high. Médecins Sans Frontières (MSF) focuses on child healthcare in the regions of Sikasso and Koulikoro.

Child health in Koutiala

Rates of malnutrition and malaria are high in Mali. In the southern district of Koutiala (Sikasso region), near the border with Burkina Faso, more than one in five children die before reaching the age of five. In July 2009, MSF started offering paediatric care, including treatment for malnutrition, to children under five in Koutiala town and in five of the 42 health areas in the district. In 2010, staff conducted consultations with more than 48,100 children, 33,300 of whom were diagnosed with malaria. A further 5,360 children were treated for severe malnutrition.

MSF helped to increase the capacity of the paediatric department in the district hospital of Koutiala. A team of MSF and Ministry of Health staff set up a paediatric intensive care unit, built wards to allow the hospitalisation of malnourished children, provided medical care, offered staff training and assured a regular flow of drugs and medical material. More than 9,900 children were admitted to the hospital in 2010. Malaria was linked to more than 82 per cent of hospitalisations in the paediatric ward.

Early detection and prevention in Konseguela

The Ministry of Health and MSF began a joint project in the district of Konseguela, also in



A paediatric consultation in Konseguela, Sikasso region.

Sikasso region, in March 2010. The project aims to find new approaches to reducing mortality among children under five, and focuses on simplifying and decentralising the treatment, early detection and prevention of the main killer diseases – malaria, malnutrition, pneumonia and diarrhoea.

A baby clinic is held at the health centre in Konseguela, offering regular check-ups for children under two. These children receive ready-to-use food in an effort to prevent severe levels of malnutrition. In December 2010, more than 1,250 children were receiving this food. Families with young children also receive mosquito nets. Almost 50 per cent of the 15,000 consultations held at the health centre in 2010 related to malaria.

Every month, a team visits all 17 villages in the district and carries out routine immunisations against tuberculosis, polio, diphtheria, tetanus, pertussis (whooping cough), hepatitis B, *Haemophilus influenzae* type b (which can cause meningitis and pneumonia), measles and yellow fever.

In July 2010, trained staff in all of the villages began carrying out early screening for malaria, offering a rapid diagnostic test and treatment in order to reduce the development of severe forms of the disease. Staff treated 9,400 children under five for non-complicated malaria in 2010.

The programme has achieved a very high level of adherence. Of 1,775 children who received the first dose of the pentavalent vaccine (which provides protection against five diseases), 1,773 successfully completed the three-dose course. A sharp decrease in child mortality has been reported by local

authorities and communities since MSF began activities in Konseguela.

Preventive meningitis vaccination campaign

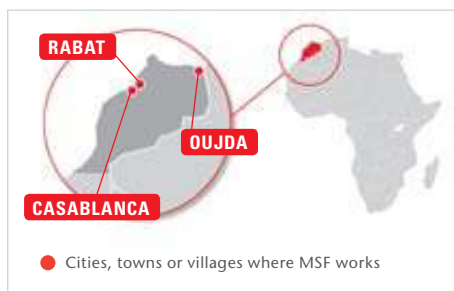
In December 2010, MSF participated in the national preventive vaccination campaign against meningitis using a new vaccine that provides extended coverage against the disease (over ten years) and stops transmission by eliminating the carriage of the germ. With Ministry of Health staff, 85 teams vaccinated more than 728,900 people aged between 1 and 29 years in three districts of the Koulikoro region.

Malaria in Kangaba

Since 2005, MSF has been supporting 11 health centres in collaboration with the health authorities in Kangaba province, Koulikoro region. As well as increasing access to basic healthcare, the project has a specific focus on malaria. Free care is offered to children under the age of five and pregnant women. Since the project started, the number of children under five visiting health centres has increased by 800 per cent. MSF has also trained 66 health workers, who visit villages that are more than five kilometres from the nearest health centre to test and treat people for malaria. Child mortality in the area has decreased by half thanks to the provision of good quality, free healthcare closer to home. MSF is using these results to support its advocacy for the government to provide free healthcare for all children under five.

At the end of 2010, MSF had 380 staff in Mali. MSF has been working in the country since 1992.

MOROCCO



Morocco is a country of both transit and forced stay for many migrants and asylum seekers from sub-Saharan Africa. A growing number of people are finding themselves stuck in the country, unable either to continue their journeys to Europe or return home.



Migrants' makeshift shelters among trees near Oujda.

Migrants and asylum seekers mainly come from central and west Africa. Many have left poverty and unemployment; a large number have escaped conflict and violence and, in some cases, sexual violence. In the winter months, migrants tend to head to the cities of Rabat and Casablanca, or stay in and around the town of Oujda, on the Algerian border, before trying to reach Europe. Living conditions are extremely poor.

Arrest and deportation across the Algerian or Mauritanian borders is a frequent occurrence. Migrants are easy prey for trafficking and smuggling networks. They are also at risk of attack and robbery by criminals who act with total impunity, in part because of their victims' irregular status. This precarious situation affects migrants' mental health: 25 per cent of people who had medical consultations

with Médecins Sans Frontières (MSF) staff reported non-specific symptoms usually related to stress and anxiety.

Direct medical care

MSF began working with sub-Saharan migrants in Morocco in 2000, and has teams based in Rabat and Oujda. There are two components to MSF's work: the provision of direct medical care and the facilitation of access to the Moroccan health system. In 2010, MSF staff carried out more than 2,500 medical consultations and provided psychosocial help to migrants through 182 individual mental health consultations and 48 group sessions. Psychosocial support helps patients to cope with the stresses and trauma of their lives. MSF staff also accompanied migrants to health centres, helping them to access medical care at national health facilities.

Denise*

from the Democratic Republic of the Congo

"When we managed to reach the border of Algeria and Morocco, we had to walk to get to the city of Oujda. The children were very thirsty, so when I saw a man on the street I asked him where I could find some water. He directed me to a nearby house. There a man gave water to my children. While my children were drinking the water outside the house, two men forced me inside the house and raped me, one after the other. They beat me and they raped me. And then they threw me and my children into the desert to die. Luckily we were found by some migrants who were crossing the desert, and they brought us to Oujda. There MSF helped me receive medical and psychosocial care."

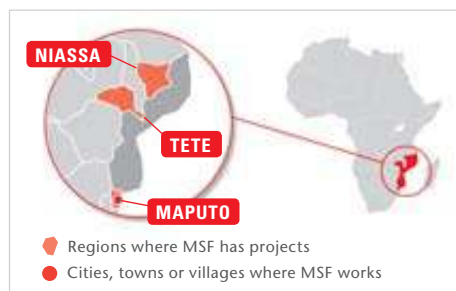
*The patient's name has been changed.

Sexual violence

In 2010, medical staff provided care to 145 victims of sexual violence. MSF found that one in three women treated by MSF medical staff in Rabat and Casablanca between May 2009 and January 2010 admitted having been subjected to one or more sexual attacks in their country of origin, on their journey, or in Morocco. Staff gathered testimonies from 63 patients, 14 of whom were under 18. These testimonies, which contribute to MSF's report *Sexual Violence and Migration*, illustrate the extreme vulnerability of these women throughout their journey.

At the end of 2010, MSF had 28 staff in Morocco. MSF has been working in the country since 1997.

MOZAMBIQUE



Despite Mozambique's recent economic growth many people in the country remain dependent on international aid. Of the 1.6 million people living with HIV, about 430,000 are in urgent need of life-extending antiretroviral (ARV) treatment.

Along with HIV, tuberculosis (TB) presents a serious public health concern, and up to 60 per cent of TB patients are also infected with HIV. For the majority of Mozambicans, access to healthcare remains very limited and the frail healthcare system struggles with the high number of people infected by both HIV and TB.

Médecins Sans Frontières (MSF) started caring for patients with HIV in Mozambique in 2001, striving to demonstrate the feasibility of treating HIV in poorly resourced urban areas, such as Chamanculo and Mavalane in the capital Maputo, and in remote areas such as the northern provinces of Niassa and Tete. Over the past decade, MSF has established standardised procedures for HIV care and treatment, paying special attention to treating HIV and TB co-infections.

With the number of people receiving ARV treatment steadily growing, it has become harder to enrol people in treatment programmes, especially in areas where there are no hospitals close by. MSF has focused on moving HIV care and treatment from central hospitals to local health clinics. This vital step has been successfully implemented in many of MSF's HIV programmes in Mozambique.

The comprehensive HIV/AIDS programmes offer testing, pre- and post-test counselling, treatment and prevention of opportunistic infections that can occur as a result of a compromised immune system, psychological support, paediatric diagnosis and treatment,

and prevention of mother-to-child transmission. At the end of August 2010, more than 200,000 patients were receiving ARV treatment in Mozambique, some 33,000 of whom were being treated with the assistance of MSF.

Shortages: doctors and drugs

To ensure that patients get care and treatment despite the country's shortage of healthcare workers, MSF is trying to develop programmes such as task-shifting. Task-shifting trains nurses to independently assess patients, diagnose and treat opportunistic infections, and initiate and monitor ARV treatment, thereby taking on some of the responsibilities of doctors. Where the supply of HIV and TB drugs falls short, MSF also provides a buffer supply to health facilities where it works.

Community ARV groups

In rural Tete province, MSF has piloted community ARV groups, which empower HIV patients to participate in the management of their disease. Consisting of about six neighbours, the group selects one person each month to visit the health centre to collect the ARV drug refills for everyone. The representative has a medical check-up while at the health centre and, upon returning, distributes the drugs to other group members, who sign in to confirm that they have received their refill. The community group system ensures that members adhere to treatment and enables group members to support each other in overcoming the stigma associated with HIV/AIDS in their communities. Treatment complications, however, are addressed during clinic visits.

This model has reduced the burden on healthcare services, since fewer patients need to queue at health centres for their medication. It has simplified how patients in remote areas obtain their ARV refills and helped those who cannot sacrifice a day at work for a trip to the clinic. The Ministry of Health has adopted the concept and community ARV groups are expected to be established nationwide.

Measles vaccination

In September 2010, MSF teams conducted an epidemiological survey in Niassa province following reports of measles cases and an epidemic in neighbouring Malawi. As a result, MSF staff worked with the Ministry of Health to conduct a measles vaccination campaign: 250,000 children



A child is weighed at the Primero de Maio day hospital, in Mavalane, Maputo.

were vaccinated in six districts. MSF staff helped plan the logistics of the campaign and trained ten vaccination teams from the Ministry of Health.

MSF has an emergency preparedness system in Mozambique that is ready to respond to natural catastrophes and outbreaks of disease in support of the national emergency bodies.

At the end of 2010, MSF had 507 staff in Mozambique. MSF has been working in the country since 1984.

NIGER

Nutritional crises are a chronic problem in Niger, but a particularly poor harvest in 2009 made the 2010 crisis far worse. Global acute malnutrition rates among children passed the emergency threshold of 15 per cent, with more than three per cent of under-fives suffering from severe acute malnutrition.

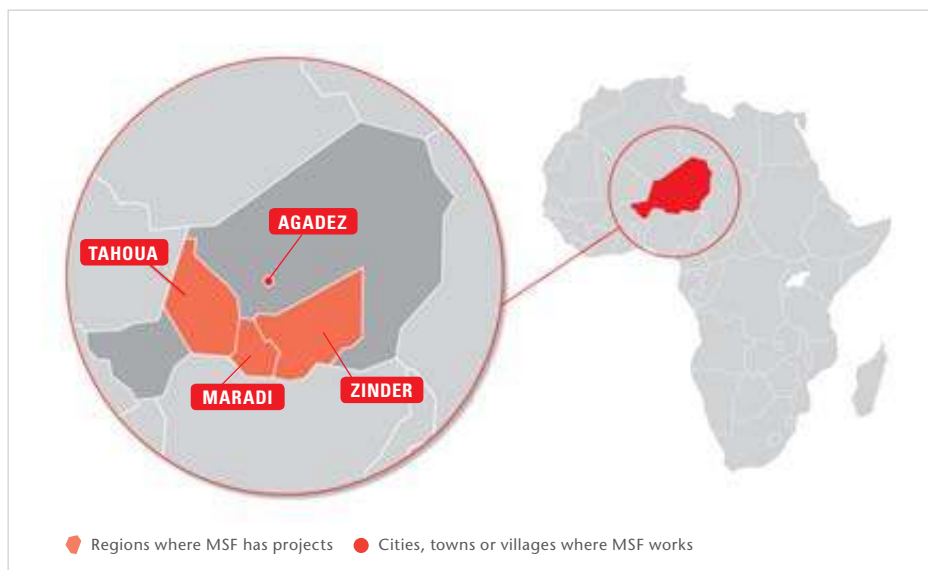
The extent of the food crisis was recognised early, and the Ministry of Health, international organisations and national associations treated 328,000 children for severe acute malnutrition. MSF cared for more than 148,000 malnourished children.

A preventive approach

Even when receiving good care in a high-quality nutrition programme, between three and five per cent of patients suffering severe acute malnutrition will die. For some years, Médecins Sans Frontières's (MSF) nutrition projects in Niger have been implementing a preventive approach. Children under two years of age who are suffering moderate malnutrition or are at risk of malnutrition are given ready-to-use supplementary food before their condition can deteriorate to the level of severe acute malnutrition.



A mother takes home a supply of ready-to-use food, Madarounfa, Maradi region.



In 2010, this innovative approach was taken up for the first time by the Niger government, the UN and their partner organisations. An ambitious target was set: to reach more than 650,000 children. MSF provided supplementary food rations to more than 202,000 children aged six months to three years, and preliminary results of a survey carried out in Mirriah, Zinder region and Madarounfa, Maradi region, during the second half of 2010 show that this strategy had a significant impact on mortality rates.

The worst-hit regions

Maradi, Tahoua and Zinder were some of the regions worst hit by the food crisis. MSF and its partner organisations worked to provide malnutrition care in as many locations as possible, so that treatment could be sought closer to home for more people.

In Maradi, up to five per cent of children were suffering from severe acute malnutrition. MSF teams screened and treated children for the illness, trained staff, provided supervision and supplied medicines to 19 health centres spread across the departments of Dakoro, Guidan Roumdji and Madarounfa, and in Maradi commune.

MSF worked with local medical organisation FORSANI (Forum Santé Niger) in Maradi town and Madarounfa, and more than 21,300 severely malnourished children were admitted to their feeding programme, almost 5,000 of whom were hospitalised in therapeutic feeding centres. More than 35,000 severely malnourished children were admitted to the feeding programmes in Guidan Roumdji and Dakoro. In Madarounfa and Guidan Roumdji, supplementary ready-to-use food was distributed as a preventive measure to 44,200 children.

In Zinder region, MSF supported 19 health centres in the departments of Mirriah and Magaria with feeding programmes, providing extra staff and essential drugs to ensure free care for children under five. A network of 250 community health workers was built up and dispatched across Magaria to screen children for signs of malnutrition and encourage parents to seek treatment for their children. MSF managed two therapeutic feeding centres. More than 34,000 malnourished children received treatment for severe and acute malnutrition. The supplementation programme in Mirriah district reached more than 106,500 moderately malnourished children or children at risk of malnutrition. MSF also provided technical support to BEFEN/ALIMA, a local association running 15 outpatient feeding centres and one therapeutic feeding centre in Mirriah department.

In Tahoua region, to the west, MSF provided free medical care and treatment for severe acute malnutrition at six health centres in Madaoua department, and treated 18,370 severely malnourished children under five. More than 2,000 of these children were admitted to intensive nutritional rehabilitation centres. In collaboration with the World Food Programme and local associations ADRA and GADED, MSF distributed more than 128,000 supplementary food rations to children aged between six and 23 months in the departments of Madaoua and Bouza.

Malaria

Malnutrition and malaria create a vicious spiral: malnutrition weakens a child's immune system, making it more difficult to fight against malaria. In turn, symptoms of malaria in children



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A MUAC (middle upper arm circumference) bracelet is used to check a child for malnutrition, Zinder region.

include anaemia, diarrhoea and vomiting, all of which can cause or complicate malnutrition.

In Zinder, MSF treated more than 72,500 cases of malaria. Over a quarter of the children hospitalised for malnutrition were also suffering from malaria. In total, more than 216,330 children under five received treatment for malaria in the regions of Zinder, Maradi and Tahoua.

Maternal and child health

MSF teams supported local hospitals and health centres, particularly paediatric and maternal health services, in many parts of Niger.

In Maradi, MSF supported the maternity and paediatric departments, and the sterilisation and laboratory services of Dakoro hospital. More than 2,500 births were assisted and more than 9,100 children were hospitalised. Staff also worked in health centres in Dakoro, and carried out 183,000 consultations with children under five.

In Guidan Roudmji hospital, also in Maradi, MSF provided medical supplies, medicines and staff to the paediatric department, the laboratory and the sterilisation service. A team also installed a clean water supply and sanitation system.

In Tahoua, MSF built a new paediatric ward for the Madoua district hospital. In Agadez,

MSF teams provided free gynaecological and obstetric care in five health centres. Staff assisted more than 2,600 births. Agadez is on the main migration route for people heading to Europe from west or central Africa, and MSF provided free medical care to more than 730 migrants and distributed 690 relief kits.

Meningitis

MSF supported the Ministry of Health's vaccination campaign against meningitis: in total, 490,000 people were vaccinated against various strains of the disease in Zinder, Maradi, Agadez and Madaoua (in Tahoua region).

With the support of MSF and other international organisations, the Ministry of Health carried out a second vaccination campaign in Dosso and Boboye departments in December 2010, using the new vaccine against meningitis A. The new vaccine provides four times greater protection than the one traditionally used, and this protection lasts for ten years, compared with three years for the older vaccine. Another major benefit is that the new vaccine can help stop meningitis transmission as it eliminates the bacteria even in healthy carriers of the disease so they cannot pass it on to others. Initial results indicate that more than 90 per cent of the 627,000 target population was

vaccinated. If the vaccine is used widely, there is real hope of seeing a sharp drop in the number of meningitis A outbreaks.

Cholera

Following a cholera outbreak in Zinder, MSF teams treated 249 patients in two treatment centres and cleaned four wells to help halt the spread of the disease.

At the end of 2010, MSF had 1,599 staff in Niger. MSF has been working in the country since 1985.

Kelima, 32 and Djamilou, 15 months

Kelima is a mother of four. She brought her son, Djamilou, who had lost a lot of weight, to the MSF Intensive Nutritional Care Unit in Zinder. The doctor diagnosed both severe anaemia and malaria and immediately fed the boy intravenously. Later, he was given therapeutic food. Day by day, he gained weight until, two weeks later, he was smiling again. "We will soon go back to our village", said his relieved mother. "This year, it was really too difficult to feed the children, we had only a few handfuls of millet for the whole family..."

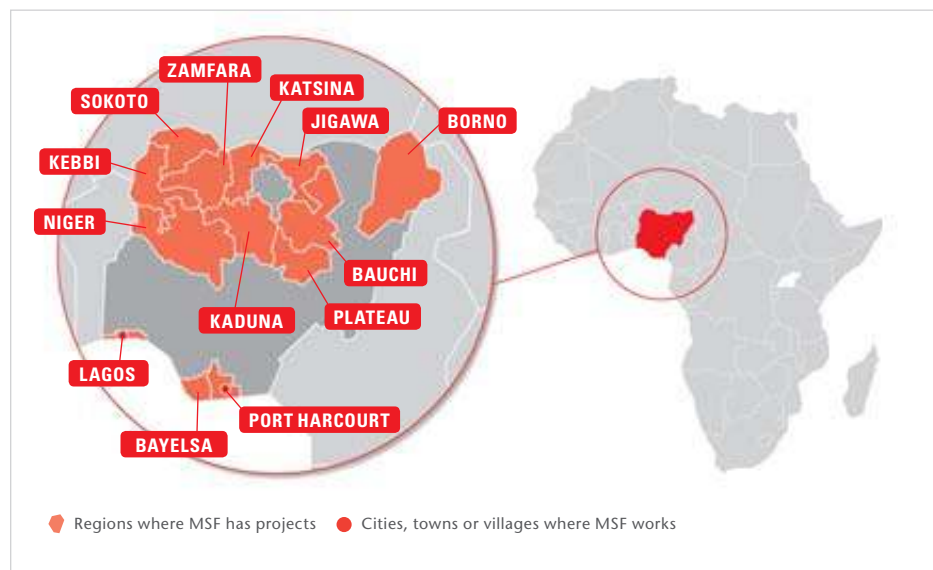
NIGERIA

Ethnic and religious tensions flared again both in the north and the south of Nigeria in 2010. Health services continued to suffer from a lack of resources.

Emergency response teams

A Médecins Sans Frontières (MSF) emergency response unit based in Sokoto, in the northwest of the country, provided rapid assistance for disease outbreaks, natural disasters, violent crises and population displacements in four states. The team intervened after flooding in Sokoto state, distributing relief items and basic medical care to thousands of displaced families. The team also treated patients after outbreaks of measles, meningitis and cholera. In the states of Katsina, Bauchi and Borno, MSF teams treated 9,481 patients for cholera between August and November.

In central Nigeria, emergency teams responded to cholera and measles outbreaks in Kaduna and Plateau states: staff vaccinated more than 15,600 children in Kaduna and treated some 2,600 patients for measles. Teams offered assistance after violence in the city of Jos, providing medicines and medical supplies to the main health facilities.



Lagos

Lagos has a population of around 18 million, and in such a large city the needs of vulnerable people are often neglected. In July 2010 MSF began working at Aiyetoro health centre in the slum area of Makoko, providing general and reproductive healthcare, and emergency care. Malaria, respiratory infections and chronic diseases were the most common illnesses suffered by patients. Using the centre as a base, MSF is extending its work via mobile clinics. The first began work in Otto in October 2010. In early 2011 a mobile clinic will serve the Badia and Riverine lagoon areas.

Maternal and child health

The lack of access to healthcare in northern Nigeria has a heavy impact on women and children. In Sokoto state, a mobile medical team supports the Goronyo health centre and surrounding villages. The team provides general healthcare, including obstetric and paediatric care, and runs a feeding programme. In 2010, a prevention of mother-to-child transmission programme was launched at Goronyo for pregnant women with HIV.

In Jigawa state, 402 women underwent fistula repair surgery. MSF's centre in Jahun, which opened in 2008, also offers comprehensive emergency obstetric and neonatal care. Such care can prevent fistulas, which are injuries to the birth canal often caused by long labour without a midwife or the option of a caesarean section. Many women with obstetric fistulas have to live with unpleasant and debilitating symptoms, including incontinence, which can result in social exclusion. More and more women are now coming to the hospital to give birth: there were 3,649 deliveries in the maternity ward in 2010, more than double the number in 2009.

A team working from Kazaure hospital, also in Jigawa state, started providing care for severely malnourished children in June following a regional nutrition crisis. More than 6,600 children received treatment at the feeding centre and 1,700 were hospitalised.

Trauma care

Violence remained a problem in the Niger Delta. The team operating the 75-bed trauma centre in Teme hospital, Port Harcourt, was one of the first MSF teams to



© Silvia Fernández

A consultation at the Aiyetoro health centre, Makoko, Lagos.



A new arrival in the maternity ward of Aiyetoro health centre, Makoko, Lagos.

use internal fixation to repair fractures. This technique allows patients to walk again within just a few weeks, in contrast to the old traction system, which requires months. In 2010, MSF staff treated 10,850 people in the emergency department, 42 per cent of whom had violence-related injuries. Overall, more than 2,000 patients were admitted to the trauma centre, and more than 3,500 surgical interventions were carried out. MSF also treated 645 victims of sexual violence, providing medical care and counselling.

Handover in Bayelsa

Since 2008, MSF has been running a health centre in Ogbia district, Bayelsa state, in the Niger Delta. In the first few months of 2010, MSF held 4,700 consultations and vaccinated 5,400 children after an outbreak of measles. Local and national authorities took over the project in April 2010.

Lead poisoning

Small-scale gold mining was directly related to severe lead poisoning in seven villages in Zamfara state, in the northwest of the

Flora and Caroline

Flora took over the care of Caroline, her niece, when she was just one day old. The baby had survived a complicated delivery that had killed her mother, and she herself was not well. When Caroline was three months old, she weighed less than 3.5 kg. The family took her to traditional healers and even travelled to neighbouring Benin in their search for someone who could help. But nothing worked.

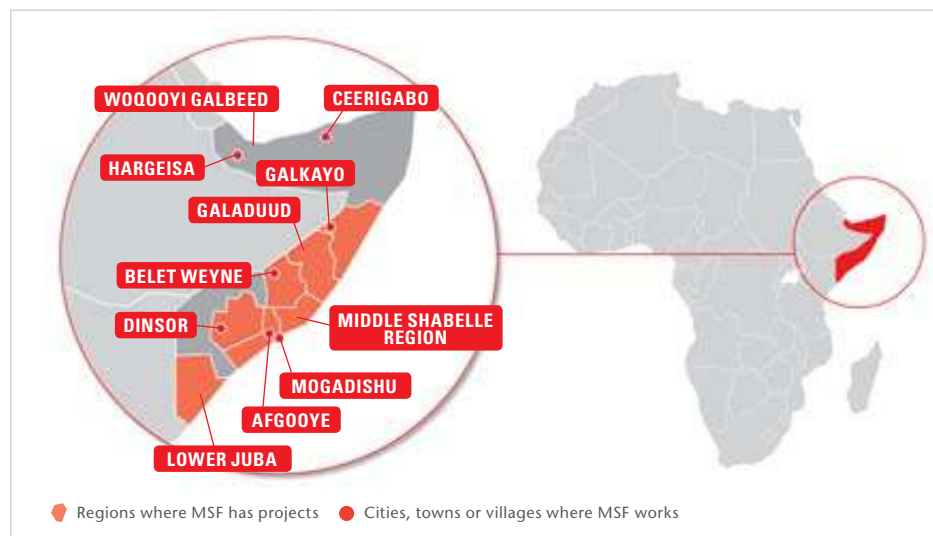
Flora took Caroline to the Aiyetoro health centre soon after it opened its doors. "She was given therapeutic milk and straightaway she started to improve", says Flora. After ten days in Aiyetoro, Caroline was referred to a long-term treatment programme at the local children's hospital, where she stayed for a month. When she had been discharged from hospital, Flora brought Caroline back to the centre for weekly check-ups. Caroline is now six months old; she is thin, but strong and lively, and she smiles all the time as she sits on Flora's lap.

country. Villagers were crushing and drying lead-containing ore in and close to their homes. At the request of the Ministry of Health, MSF treated more than 400 children for lead poisoning in two care centres, and staff worked with villagers to raise awareness of the risks of gold mining. The damage is

considered one of the worst recorded heavy metal contaminations in the world.

At the end of 2010, MSF had 954 staff in Nigeria. MSF has been working in the country since 1996.

SOMALIA



The security situation in Somalia deteriorated further in 2010 and while needs have grown, basic medical services continue to dwindle. Despite a number of incidents directly affecting its staff in recent years, Médecins Sans Frontières (MSF) is still working in the country.

International staff are unable to stay for long periods in Somalia due to the security risks, so MSF's projects depend heavily on the commitment of Somali staff, supported by teams of specialist staff based in Nairobi who visit the projects when possible.

Mogadishu

Fighting in Mogadishu was continuous in 2010, with major offensives in February and during Ramadan in August. It is estimated that only 500,000 people remain in the capital. For these remaining residents, healthcare facilities are virtually non-existent. There are two public hospitals, which provide surgery only for war-related injuries. The few clinics that are running charge fees for services that are of unreliable quality.

Daynile hospital is nine kilometres northwest of Mogadishu. MSF provides free emergency surgery and care for the war-wounded. The hospital has 59 beds and is equipped with two operating theatres and an intensive care unit. MSF also provides financial support and medical supplies. In 2010, more than 5,500 patients were admitted to the emergency department. Staff performed 1,136 surgeries.

Since it was forced to suspend activities in north Mogadishu in July 2009, MSF has provided short-term emergency assistance on several occasions. The resumption of activities in south Mogadishu, home to many displaced people and a scene of frequent conflict, is scheduled for early 2011.

In September, the agreed collaboration between Dr Hawa Abdi and MSF came to an end and MSF

ceased its activities in Hawa Abdi, an area on the outskirts of Mogadishu mainly inhabited by displaced residents of the city. Over three years, the team had admitted over 8,000 children to its paediatric department, more than 34,000 children received treatment for malnutrition, and more than 330,000 consultations had been carried out. MSF continued to support the community hospital in Afgooye: staff provided maternity and general medical services, consultations and an outpatient feeding programme for children under five.

Regional healthcare services

In the rural districts of Jowhar, Mahadaay and Balcad, in the Middle Shabelle region in central Somalia, MSF works from a network of four health centres. Through mobile and fixed clinics, staff offer general healthcare, mother and child care, a nutrition programme, and an extended immunisation programme. In June, MSF teams began providing tuberculosis diagnosis and treatment in the districts of Mahadaay and Gololey.

Teams provide care in hospitals and clinics in another five regions, working in the towns of Belet Weyne, Dinsor, Dhusa Mareb, Galkayo, Guri El, Hinder, Jamaame and Marere. Staff offer maternal and paediatric care, general medical care and treatment for malnutrition. Altogether, more than 240,000 consultations were carried out in the hospitals. Belet Weyne, Guri El and Galkayo hospitals also have surgical departments. In April 2010 MSF set up a one-week "eye surgery camp" with the organisation Right to Sight in Galkayo, which is in the Mudug region in northern Somalia. More than 3,000 people were screened for sight problems and more than 600 had operations to help them regain their sight.

In Marere, in Lower Juba region, the provision of medical care became more difficult after the local administration imposed a number of restrictions on operations, including a ban on receiving medical supplies by plane and a prohibition on visits from international staff. These measures significantly disrupted support to the project, while flooding, droughts and bad harvests increased health needs. Nonetheless MSF staff managed to carry out 46,315 consultations and admitted almost 2,000 patients to hospital.



MSF staff unload medical goods at Galkayo airport.

© Siegfried Modola



A lab technician tests for tuberculosis at Galkayo hospital.

Telemedicine in Guri El

In December, MSF launched telemedicine technology in Istarlin hospital in Guri El, central Somalia, in order to provide direct and real-time support to doctors working in the paediatric department from a medical specialist based in Nairobi. The nine telemedicine consultations that were held in December had excellent results, and the plan is to expand the use of telemedicine to other departments.

Natural disasters

In Belet Weyne, central Somalia, after severe flooding led to the displacement of over 10,000 people, MSF teams distributed plastic sheeting to help build temporary shelters and screened children for malnutrition.

Galgaduud experienced a significant drought at the beginning of the year. The teams working in Dhusa Mareb, Guri El and Hinder trucked water to people living in the towns, delivering 2.9 million litres.

Somaliland

Somaliland declared independence from Somalia in 1991. The international community, however, continues to recognise it only as an autonomous region of Somalia. Somaliland has few natural resources and continued to suffer from drought, lack of infrastructure and lack of quality healthcare in 2010. Clan rivalries and tensions were held in check by government and traditional leaders, and Somaliland remained relatively stable.

Ceerigabo hospital is the main referral centre for Sanaag region, but it was barely functioning when MSF's team arrived in June. MSF staff supported the emergency surgery department, the paediatric and maternity wards, and have established links with health centres in the area to encourage referrals. Between June and December staff performed 28 major surgeries, admitted 127 patients to the surgical ward, delivered 181 babies and admitted 68 children to the paediatric ward.

In Hargeisa, regional capital of Maroodi Jeex region and capital of Somaliland, MSF provided free basic healthcare to people who are not recently displaced but still live in camp conditions and cannot afford to pay for healthcare. MSF staff carried out more than 11,400 consultations with children under age five and more than 3,500 antenatal consultations.

Measles vaccination campaign

Vaccination coverage in Somalia and Somaliland is poor. MSF carried out a measles immunisation campaign for children under 15 and a tetanus vaccination campaign for adults aged between 15 and 49. The campaign focused particularly on increasing the number of women protected against tetanus, as they are more susceptible to infection.

The campaign took place in a district in Woqooyi Galbeed, Somaliland, and in two districts in Galgaduud, central Somalia. Staff trained a team of "community mobilisers" to

provide information about the vaccine and the date and location of the vaccinations. A telecommunications company also publicised the campaign by sending key information to its mobile phone subscribers. Almost 6,400 children were immunised against measles and almost 6,300 women were vaccinated against tetanus.

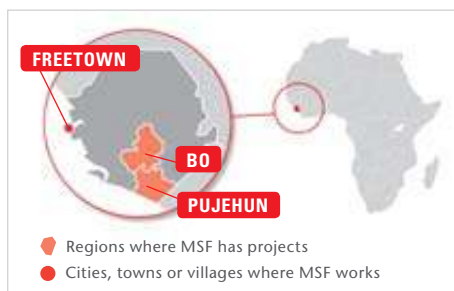
At the end of 2010, MSF had 1,461 staff in Somalia. MSF has been working in the country since 1991.

Abdiwahid two and a half

When Abdiwahid came to the hospital in Marere he was suffering from severe malnutrition, pneumonia, malaria, oral thrush and anaemia. He was too weak to eat or drink. Abdiwahid's brother was also malnourished, but less severely, and was admitted to the feeding centre.

The boys' parents had brought their children to an MSF mobile team on the advice of their neighbours, and the team had referred the family to Marere. After two weeks Abdiwahid was able to drink from a cup; he will be discharged from the hospital in a few weeks.

SIERRA LEONE



In April 2010, the government of Sierra Leone introduced a policy of free healthcare for children under five and for pregnant and breastfeeding women. But fewer than 200 doctors are employed by Sierra Leone's Ministry of Health to serve a population estimated at more than 5.8 million.

Médecins Sans Frontières (MSF) continued its longstanding focus on maternal and child health in Sierra Leone throughout the year, and in the second half of 2010 assisted the Ministry of Health in the implementation of the new policy.

Maternal and child health

Activities in and around Bo, the second largest city in Sierra Leone, focused on maternal and child health, and treating malnutrition and malaria. MSF runs the Gondama Referral Centre, a 215-bed specialised emergency hospital just outside the city. The hospital has a paediatric ward, a maternity ward with an operating theatre, an intensive care unit and an intensive therapeutic feeding ward for severely malnourished children.

In the Bo and Pujehun districts, MSF also provides technical and material support to five community health centres. These centres offer

general consultations, basic obstetric care, and treatment for malnutrition and malaria. MSF provides clinical, administrative and logistical training, drugs and other medical supplies and equipment, and access to its ambulance service to transfer patients to hospital.

Outside the capital of Freetown, MSF is one of the major maternal and paediatric healthcare providers in Sierra Leone. In late 2010, MSF decided to expand its work on maternal health. Teams supported and trained staff working in women's wards, assisted in the management of critical paediatric cases, and carried out health promotion activities in the five MSF-supported centres in Bo and Pujehun.

Ambulance referrals

Many patients were arriving at the Gondama Referral Centre in a critical condition, with very severe complications. MSF decided to improve its ambulance referral system for emergency cases, positioning ambulances at strategic locations, closer to the more distant clinics. MSF

also engaged more actively with the national hospital in Bo and with other ambulance providers in order to increase capacity for the transportation of patients requiring emergency care from rural clinics to hospital.

Malaria diagnosis and treatment

Malaria is extremely common throughout Sierra Leone. The availability of diagnosis and treatment for malaria has improved, but slowness to recognise symptoms, the distance to health centres and inconsistent drug supplies can all prevent people from receiving timely treatment. MSF has trained a network of 140 volunteers to diagnose and treat malaria within their communities, bringing care closer to people living in the district of Bo.

In total, MSF treated more than 14,000 hospital patients in a critical condition and carried out more than 210,000 consultations in Sierra Leone in 2010.

At the end of 2010, MSF had 439 staff in Sierra Leone. MSF has been working in the country since 1986.



An MSF doctor examines a malnourished child at the Gondama Referral Centre, Bo.

© Juan Carlos Tomasi

SOUTH AFRICA



An estimated 5.7 million people are living with HIV in South Africa, which makes up approximately 17 per cent of the world's HIV population, according to the World Health Organization.

HIV/AIDS and tuberculosis

In partnership with local health authorities, Médecins Sans Frontières (MSF) conducts an integrated HIV and tuberculosis (TB) treatment programme in Khayelitsha, a township on the outskirts of Cape Town, which has the highest prevalence of HIV/AIDS in the country. Seventy-one per cent of MSF's HIV patients in Khayelitsha are co-infected with TB. The project has been operational since 1999, and over the years has demonstrated increasingly innovative treatment integration of HIV and TB. Antiretroviral (ARV) treatment was introduced in 2001, and since then, more than 17,650 patients in Khayelitsha have begun ARV treatment.

Over its 12-year history, this project has contributed to the turnaround in South Africa's stance on HIV/AIDS. Collaborations with local and national health authorities, as well as operational research partnerships with the University of Cape Town, have helped promote a change in approach. Civil society groups and a vibrant local community have all helped to reduce the stigma relating to HIV/AIDS, increase public awareness, encourage discourse and bring about tangible change in national health policy.

In 2011, MSF, the Ministry of Health and the community of Khayelitsha will mark ten years of free ARV treatment and a community-based model of care developed in MSF's projects that has had local, national and global impact.

Support groups

MSF's community support groups for HIV, drug-resistant TB, and youth support



MSF staff carry out health screening in Caledonian, an inner city area of Johannesburg.

groups have helped people living with HIV enormously. Facilitated by peer counsellors and based in the communities where patients live, the support groups help members reduce the sense of stigma, find mutual comfort, adhere to complex treatment regimens, and encourage young people to have fun while taking active responsibility for their treatment. At the Zip Zap Circus School – a partnership between MSF, Zip Zap Circus, Cirque du Soleil and others – children living with HIV learn about teamwork, responsibility, community and creativity. They have fun, learn new skills, and improve their adherence to ARV treatment.

Survival migrants

The term survival migrant was coined to describe people who leave their home country not merely in search of economic opportunities, but to escape circumstances that challenge their survival, such as economic collapse, a non-functioning healthcare system, enduring conflict and insecurity, or sexual and gender-based violence.

Over the years, millions of people have arrived in South Africa in search of a better life. The journey is often difficult and, after arrival, migrants can face violent xenophobic attacks. Vulnerable to exploitation from agents pretending to offer assistance, migrants do not qualify for refugee status and, undocumented, they live in constant fear of discovery and deportation.

Many migrants from Zimbabwe find work as informal agricultural labourers at farms around

the border town of Musina. MSF teams travel to some of the largest farms, and provide free general healthcare and HIV and TB diagnosis and treatment. In 2010, teams carried out more than 16,400 consultations in Musina. More than 250 survivors of sexual violence received treatment. These patients had all been attacked on their journey to South Africa.

In central Johannesburg, MSF operates a free clinic located next to a church that has historically provided a safe refuge for migrants living in the inner-city slums.

Healthcare in the slums

There are an estimated 1,300 slum buildings in inner-city Johannesburg. Many of these are controlled by organised crime networks and, in many places, people live in squalid conditions. There is little or no provision of clean water or electricity, and residents are at risk of forced eviction by corrupt landlords or officials. Residents live in abject poverty, in cramped and unhygienic conditions that have an impact on health and personal security.

In 2010, mobile medical teams visited 40 of these buildings and carried out consultations with more than 26,100 patients. Teams also assisted residents in organising the clean-up of some buildings by providing materials and contracting waste management services.

At the end of 2010, MSF had 154 staff in South Africa. MSF has been working in the country since 1999.

SUDAN

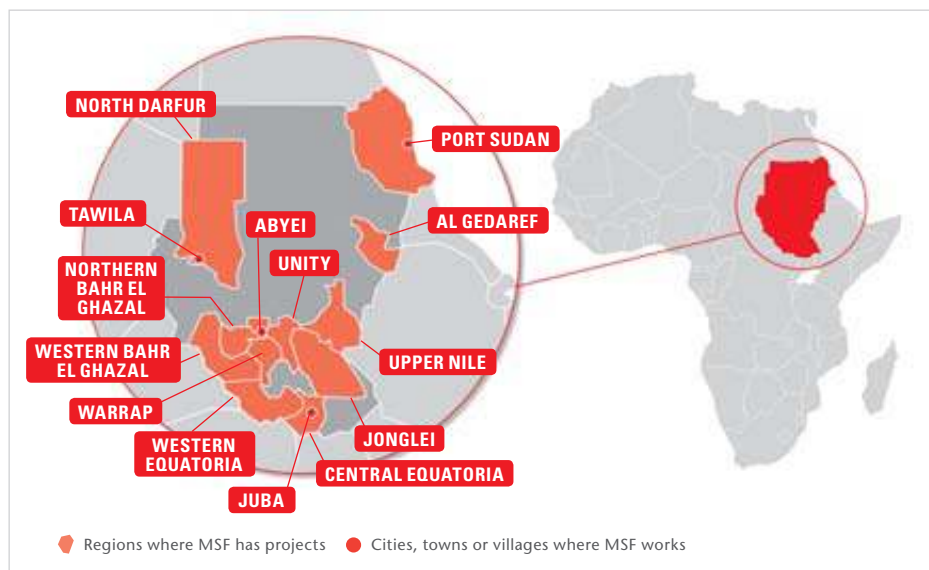
Medical needs among the people of Sudan remain significant, with insecurity and administrative constraints hampering efforts to reach the most vulnerable. In the south, access to healthcare is particularly poor. Médecins Sans Frontières (MSF) responded to several medical emergencies in 2010, including the biggest kala azar outbreak in the country in eight years, as well as treating victims of violence in Darfur.

Kala azar

The number of cases of kala azar (visceral leishmaniasis), which is endemic in Sudan, reached an eight-year peak in the south of the country in November. Transmitted by the bite of a parasite-carrying sand fly, the disease is deadly if left untreated. Timely treatment can cure most patients.

MSF treated 2,600 people for the disease in Upper Nile, Unity and Jonglei states. Patients were treated with a new drug called liposomal amphotericin B, which significantly reduces the length of treatment and has fewer side effects than other drugs.

In the north of the country, MSF opened a kala azar treatment centre in Al Gedaref state in collaboration with the Ministry of Health, and treated 1,100 patients.



A new dawn for the south?

A five-year-old peace agreement between the government in Khartoum and southern rebels has ended 22 years of brutal civil war, but conflict persisted in south Sudan as economic and political changes following the agreement have resulted in violent struggles for power.

Nonetheless, in anticipation of the January 2011 referendum on secession, hundreds of thousands of people made the journey back to south Sudan, adding to the two million who had already returned since the peace agreement was signed.

The health system is weak. Few people have access to adequate healthcare. Insecurity, violence and the mobility of the population facilitate the spread of diseases such as malaria, diarrhoea, respiratory infections, intestinal parasites, sleeping sickness (human African

trypanosomiasis) and kala azar, and there is little capacity to deal with the consequences. Preventable diseases – malaria, acute diarrhoea and measles – are common causes of death.

MSF has been working in the emergency, maternity and paediatric departments of Aweil Civil Hospital, in Northern Bahr El Ghazal state, since 2008. More than 18,000 returnees moved to camps around the town in 2010. MSF helped the hospital to cope with increased demand for medical care and staff held more than 37,000 antenatal consultations, assisted more than 3,000 births, and treated some 2,600 children for malnutrition. In August 2010, a team began working in the extremely isolated Raja county, Western Bahr El Ghazal state, focusing on emergency preparedness, emergency surgery and maternal and paediatric care.

In Western Equatoria state, which borders the Democratic Republic of the Congo, in addition to treating injuries and disease, MSF provided mental health services to people who had experienced violence, including children who had escaped from captivity. MSF staff work in mobile teams to reach both remote settled communities and displaced people living in camps. A team also works in Yambio hospital. Many patients had been injured in attacks carried out by the Uganda-based rebel group, the Lord's Resistance Army.

Working in eight states in south Sudan as well as the territory of Abyei, MSF carried out more than 588,000 outpatient consultations and provided antenatal care to some 96,000 women. More than 25,900 patients received treatment for malnutrition.

Emergency response and restricted access

Reaching people who are in dire need of healthcare in Darfur remains a struggle and



Children in Gorgrial, south Sudan.

© Joseph Thomas Noriega

MSF faces many challenges in delivering timely and lifesaving medical care. In May, MSF staff conducted a medical assessment in eastern Jebel Marra, a mountainous region in Darfur. However, lacking the proper authorisation, teams have not been able to return to provide medical care to the people who need it. In Shangil Tobaya, in North Darfur, staff held more than 30,000 outpatient consultations over the course of the year. In Kaguro, an MSF clinic offered emergency surgery, a nutrition programme, immunisation and general healthcare, and staff conducted almost 65,300 consultations. In coordination with the Ministry of Health, nutrition programmes were established in Abushok and El Salam displaced persons camps.

Security remains a pressing issue, as banditry and kidnappings continue to occur. This has limited MSF's freedom of movement and in many locations international staff are unable to stay long-term in projects, instead having to conduct "flash visits" twice a week. Nevertheless, MSF responded to several emergencies, including treating over 40 wounded people and distributing essential household items, like cooking and hygiene kits, after fighting between different groups in Tabarat, North Darfur, in September. Three months later, MSF provided medical and nutritional emergency care to newly displaced people who had been injured after fighting in Shangil Tobaya.

In the east of the country, MSF launched emergency nutrition programmes in Al Gedaref state. Staff treated more than

6,000 malnourished children under the age of five. Following the emergency response, MSF began an observation project with the Ministry of Health in order to formulate a quicker response if needed in the future.

Reproductive health

In the city of Port Sudan, the capital of Red Sea State in northeastern Sudan, MSF provided reproductive healthcare in the Ministry of Health's Tagadom hospital. Staff provided a range of services including antenatal and postnatal care, delivery services, family planning, treatment for sexually transmitted infections, and counselling. In early 2010, MSF built and equipped an operating theatre to enable surgery for women with complicated deliveries. Staff conducted over 14,000 antenatal consultations, helped deliver almost 2,000 babies and carried out 71 caesarean sections.

Approximately 98 per cent of women living in Tagadom and surrounding neighbourhoods have undergone some form of genital cutting. Genital cutting causes a variety of serious medical and obstetric complications and de-infibulation, the de-stitching of the vaginal outer lips, is performed when preparing an infibulated woman for delivery. MSF's gynaecologists do not re-infibulate, or stitch back, the mother after delivery.

Community health workers raised awareness about the importance of seeking medical care during complicated deliveries and about the harmful medical effects of female genital cutting. At the end of the year, MSF handed this project over to the Ministry of Health,

and donated a six-month supply of medicines and medical supplies to the hospital.

At the end of 2010, MSF had 2,226 staff in Sudan. MSF has been working in the country since 1979.

Thinjin

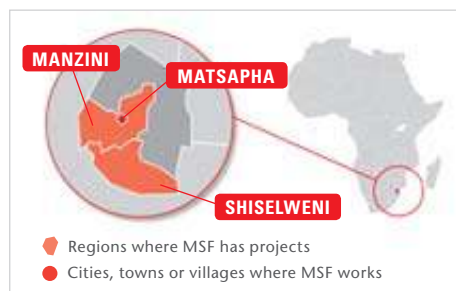
"Three of my four children are receiving treatment for kala azar here at the Malakal hospital. My youngest boy, Deng, is two years old. He became very sick in September with a very high fever. He was vomiting, had diarrhoea and became very thin. I brought him to our closest health clinic. There they told me he had malaria but the medicine for malaria did not help. Then they treated him for typhoid. That failed too.

"We were transferred to Malakal hospital. At MSF's kala azar treatment centre a doctor told us Deng had kala azar and they began his treatment. The treatment is very hard, and Deng became very sick with jaundice. Then he got pneumonia. He was so sick that we thought he wouldn't live. But eventually he got better. Now he is cured of both kala azar and pneumonia and today he has been discharged. Last month we would never have believed he would be standing healthy on his feet today!"



A consultation at the MSF mobile clinic in Abien Dau transit returnee camp, Warrap State, south Sudan.

SWAZILAND



Swaziland is facing a health emergency of immense proportions. According to the World Health Organization, HIV prevalence is the highest in the world, at 25.9 per cent among adults aged 15 to 49, and there are more than 1,250 cases of tuberculosis (TB) per 100,000 people.

TB is the leading cause of mortality among people living with HIV and, to make matters worse, cases of drug-resistant TB are increasing: 10 per cent of all TB cases diagnosed are resistant to TB medication. Life expectancy in the country has plummeted over the past two decades – from an average of 60 years to 41 years.

A community-based approach

Swaziland is a rural country of many small, isolated villages. The cost of long and frequent journeys to health facilities is often prohibitive for patients, so Médecins Sans Frontières (MSF) has developed a decentralised, community-based approach to care. People living in the community have been trained as HIV counsellors and to test for the disease. The aim is to increase the overall number of people being tested, so that more people with HIV can begin treatment earlier. By decentralising care, MSF hopes that fewer patients default from their treatment and, in general, patients' state of health will improve.

Throughout 2010, MSF supported all 21 clinics in Shiselweni, the poorest and most remote region in the country. Each of these clinics now provides fully integrated care for HIV/AIDS and TB. MSF tested some 14,500 people overall for HIV, tripling the number of tests given each month. The number of people starting antiretroviral (ARV) treatment has doubled. More than



A care worker visits the home of a patient with MDR-TB and prepares her daily injection, Mhlabeni, Swaziland.

2,550 new TB patients began treatment, including over 100 patients infected with drug-resistant TB (DR-TB). The results of TB treatment, which is a notoriously long and difficult process for the patient, also saw marked improvement.

Managing DR-TB is a growing challenge. MSF supported the decentralisation of DR-TB care to the three main health facilities in Shiselweni in an effort to improve patients' access to treatment. A new DR-TB ward with a laboratory is being built, and will be finished in June 2011.

In 2010, MSF began a new project in Manzini region, south of the capital, helping Ministry of Health staff to integrate and decentralise TB treatment from the hospital to health centres, and supporting the integration of HIV and TB care in a hospital in the west of the country. MSF also started treating DR-TB and supported the national TB programme's decentralisation of DR-TB services.

MSF has constructed a clinic for comprehensive healthcare, including HIV and TB care, in the town of Matsapha, specifically targeting the working population of this industrial centre. MSF supported services at the National Reference Laboratory.

Staffing crisis

Swaziland is desperately short of doctors, and because of limited resources, not enough nurses are being trained. For MSF, the solution

is to entrust more tasks and responsibilities to other personnel by training nurses to prescribe medicine or treat cases of uncomplicated, non-resistant TB, for example.

In line with this idea, MSF has enlisted the support of "expert patients". These are people living with HIV/AIDS who carry out screening, advise and inform new patients about treatment, and raise awareness of HIV in their communities. In 2010, 80 expert patients were working for MSF in Swaziland.

At the end of 2010, MSF had 160 staff in Swaziland. MSF has been working in the country since 2007.

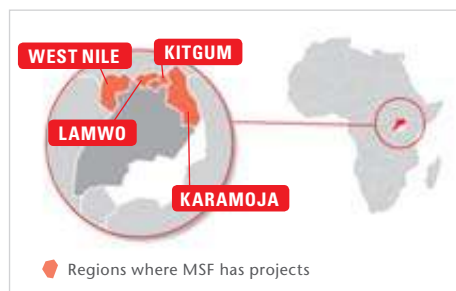
Caiphus*

A multidrug-resistant tuberculosis patient

"From where I live, the nearest road is two kilometres on foot. I had to go every day to the clinic for two months to get my daily injection for TB. I left home at 4 am, arrived at 9 or 10 am at the clinic, then reached home again at around 4 pm. A few times I rented a donkey for transport. Now it turns out that I have multi drug-resistant TB, which means I have to do this journey every day for six months! I'm a sick patient. How can I travel every day like this?"

**The patient's name has been changed.*

UGANDA



Security has improved in northern Uganda since peace talks began between the government and rebel group the Lord's Resistance Army in 2006. An estimated 95 per cent of the 1.6 million people who had been displaced by fighting have returned home.

The healthcare system is gradually being rebuilt, but there is a shortage of trained health staff, an irregular supply of medication, and a lack of care available to people suffering from HIV/AIDS, tuberculosis and malaria.

HIV care

The Arua Hospital Aids Program in Arua, northwestern Uganda, offers integrated treatment for people co-infected with tuberculosis (TB) and HIV. Staff also provide ready-to-use food for malnourished adults

and children living with HIV. Of the more than 8,000 patients currently registered at the hospital, almost 5,500 are receiving antiretroviral (ARV) treatment.

Médecins Sans Frontières (MSF) has been providing HIV treatment to patients living in the West Nile region since 2002. In 2010, an average of 158 patients were enrolled in the programme every month.

In the towns of Madi Opei and Kitgum Matidi, in the north, more than 1,120 HIV-positive patients were registered on MSF's treatment programme by the end of the year, and 520 of them were receiving ARV treatment.

Tuberculosis care

For TB treatment to be successful, patients must follow a long course of regular drug administration. Inadequate TB services, coupled with recurrent displacement due to conflict in northern Uganda, have disrupted treatment for many patients. This increases both their resistance to the drugs, and the prevalence of drug-resistant tuberculosis (DR-TB), for which treatment is even more complex and can take up to two years.

In 2010, MSF increased the number of TB screening sites in the northern districts of Kitgum and Lamwo from 7 to 13. More than 310 new TB patients started medication, and DR-TB care was introduced.

Malaria care

Malaria is the main cause of death among young children in Uganda, and the most

effective treatment is artemisinin-based combination therapy (ACT), which has low toxicity, few side effects and acts rapidly against the parasite. In 2010, MSF treated close to 26,000 patients for malaria, using ACT where applicable.

Sleeping sickness

Sleeping sickness (human African trypanosomiasis) is endemic in Uganda, the only country where two forms of the disease are present: an acute form known as "Rhodesian", and a slower-developing chronic form, known as "Gambian". Both forms of sleeping sickness attack the central nervous system and cause death. MSF supports the Ministry of Health's sleeping sickness programme in the West Nile region by offering screening and giving technical support and training to community health workers and other staff.

Maternal healthcare

Karamoja region, in northeastern Uganda, is an underresourced area where health services are scarce. MSF teams carried out more than 26,000 paediatric consultations at Kaabong hospital, in health centres and at mobile clinics across the region. MSF also opened a maternity waiting house in Kaabong in partnership with local non-governmental organisation AWARE. Here, women at risk of a complicated delivery can spend their last few weeks of pregnancy in a safe space close to medical care.

At the end of 2010, MSF had 572 staff in Uganda. MSF has been working in the country since 1980.

Christina

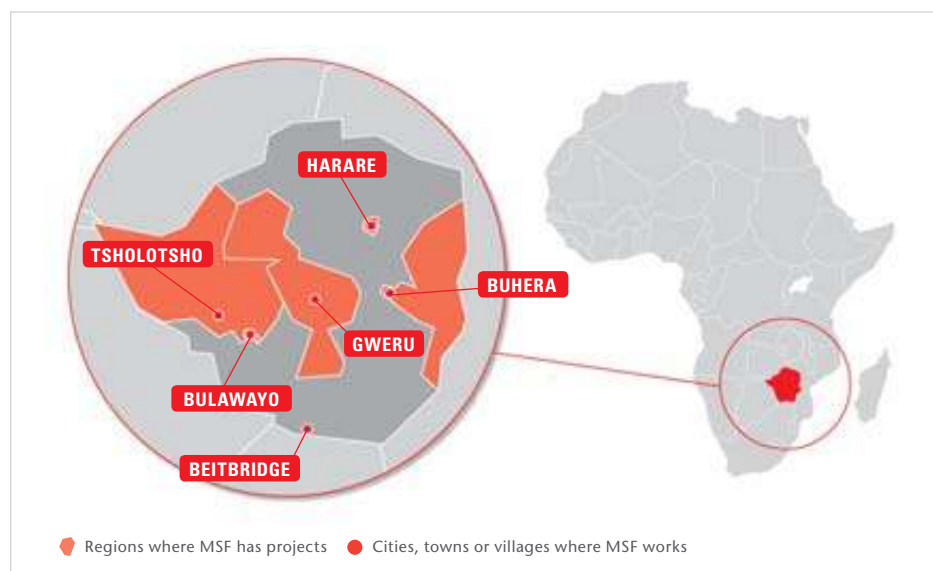
Christina is the mother of three-month-old Nancy. When she discovered she was pregnant Christina was in despair because of her HIV-positive status. She went to the Madi Opei clinic where she received counselling and was enrolled in the prevention of mother-to-child transmission programme. Now Christina is waiting to see whether her daughter has the HIV virus. "I was really worried about passing on the disease to my child. The last two tests for my baby have been HIV negative. It is a struggle and a long wait for that final day when I will know for certain."



A pregnant woman is examined by a doctor at the Madi Opei camp health centre, Kitgum district.

ZIMBABWE

After years of political and economic crisis, the situation in Zimbabwe has stabilised. However, the HIV/AIDS epidemic and outbreaks of disease continue to overwhelm the weakened healthcare system.



In 2010 MSF responded to an outbreak of measles alongside the Ministry of Health and other organisations, and five million children were vaccinated in total. Staff also supported the national health authorities' response to an outbreak of the H1N1 virus in Tsholotsho district, providing treatment and care to more than 14,000 patients.

Fighting HIV/AIDS

An estimated 1.2 million adults and children are living with HIV in Zimbabwe. Only 55 per cent of the almost 600,000 people in urgent need of life-prolonging antiretroviral (ARV) treatment are receiving it. Médecins Sans Frontières (MSF) operates HIV/AIDS programmes in health clinics in Bulawayo city, Beitbridge, Epworth, Gweru, Tsholotsho and Buhera. Each programme provides comprehensive HIV/AIDS care, offering counselling, testing, treatment and the prevention of mother-to-child transmission of the virus. In 2010, more than 34,000 patients were receiving ARV treatment through MSF's presence in Zimbabwe.



A nurse takes a blood sample from a patient in Murambinda, Buhera.

© Kenneth M. Tong



A nurse manages patients' referrals to MSF's mobile team in the Murambinda area, Buhera.

The cost of transport restricts access to the few functioning hospitals providing ARV treatment, which puts patients at risk of interrupting their treatment, especially those living in remote areas such as Buhera and Tsholotsho. MSF seeks to remedy this by decentralising services from hospitals to rural clinics, bringing free HIV care closer to patients' homes. MSF has also implemented task-shifting and clinical mentoring – training nurses in routine HIV care, including the administration of ARV drugs, so that more staff are able to treat more patients in more locations.

In Bulawayo, the MSF team focuses on tailoring services to meet the special medical needs of children and adolescents with HIV. Children who are in a stable condition can now be treated at local clinics rather than hospitals. Staff have also piloted specific medical and psychological support programmes for adolescents.

Improving tuberculosis care

Tuberculosis (TB) is the leading cause of death among people living with HIV/AIDS in sub-Saharan Africa, and there is growing concern over the spread of drug-resistant TB (DR-TB) through the southern African region, in part due to high levels of migration. DR-TB is difficult both to diagnose and to treat, and the Zimbabwean national TB

programme is already stretched. The MSF team in Harare is providing support and technical assistance to Zimbabwean health authorities in the implementation of a national DR-TB strategy. The number of people infected with DR-TB in Zimbabwe is not yet known. In December 2010 MSF enrolled its first patient on treatment, and the team has expanded service provision in Epworth through a community-based model of care. The aim is for 60 patients to start treatment by the end of 2011.

Impact of the international HIV funding retreat

In December 2010 the Global Fund to Fight HIV, Tuberculosis and Malaria rejected Zimbabwe's application for US\$ 220 million to finance the expansion of its HIV and TB programmes. Such a cut in funding may limit the number of new patients that can receive treatment, and it will further prevent the Zimbabwean health authorities from starting to implement the new, more progressive World Health Organization guidelines on ARV treatment.

Sexual violence

All of MSF's HIV programmes also offer care for victims of sexual violence. In 2010 teams in Bulawayo, Epworth, Gweru, Beitbridge and Tsholotsho treated a total of 1,325 patients

for sexual violence. Teams worked to increase the number of people who seek assistance, establishing a support group for victims of sexual and gender-based violence, and campaigning for education about the issue.

At the end of 2010, MSF had 895 staff in Zimbabwe. MSF has been working in the country since 2000.

Joyce

"At the age of six months, our baby fell ill. We would go to the hospital and get some form of treatment for Nokutenda. She would improve and then get sick again. My husband got fed up and left us. I was desperate. I went to an MSF clinic and my child was admitted to the therapeutic feeding programme. We both were diagnosed HIV positive. They also diagnosed TB in Nokutenda and started her on TB medication.

"Now she is three years old and MSF continues to supply her with ARVs. Being a single mother and not having a job, there was no way I could have done this on my own. My baby starts pre-school this year!"

ZAMBIA

The government of Zambia is providing free antiretroviral treatment to patients with HIV, but people living in rural areas still struggle to find care, as the shortfall in skilled health workers hits the countryside hardest.



A young patient receives treatment for cholera during an outbreak in Lusaka, Zambia.



Preventing mother-to-child transmission of HIV

Services preventing mother-to-child transmission (PMTCT) of HIV are available to just over 60 per cent of women in Zambia, but only 36 per cent of women who start treatment complete it, according to the Ministry of Health. PMTCT demands commitment from a patient: the pregnant woman must first visit a clinic for counselling and testing, and if she is HIV positive she must return for treatment during pregnancy, delivery and afterward. Only when the baby is seven months old will staff be able to tell whether the process has been successful. The long distances that many have to travel to reach clinics offering PMTCT services

and the social stigma attached to being HIV positive are significant obstacles to women taking up the service.

At the beginning of 2010 there was little antenatal care available in Luwingu, a rural district of northeastern Zambia. Without antenatal consultations, pregnant women are unlikely to find out whether they have HIV, and those who are HIV positive cannot receive PMTCT services. In June, Médecins Sans Frontières (MSF) mobile teams started working in four rural health centres in Luwingu, providing reproductive health services, antenatal care, emergency obstetric care and PMTCT services. Between June and December, more than 2,650 antenatal consultations were carried out, and 150 women received postnatal care. Staff provided special supplementary food to 52 HIV-positive women, and enrolled 41 women in the PMTCT programme. MSF has been researching two new World Health Organization protocols for PMTCT, testing their feasibility in remote settings and comparing the outcomes. In Luwingu town, an MSF team provided training in obstetric surgery to surgeons in the district hospital.

Cholera and measles outbreaks

One of the worst measles outbreaks in the country since 2003 struck the capital Lusaka in April. According to official figures, by the end of December 2010 more than 14,900 measles cases were reported in the city, and there had been 158 deaths. MSF staff worked in two hospitals, providing medical care to more than 1,860 patients.

There are often outbreaks of cholera in Lusaka during the rainy season, when houses and latrines flood and water collects in stagnant pools. Cholera is spread through contaminated water or food, and can spread rapidly, particularly if people are living in crowded and unsanitary living conditions. The disease causes watery diarrhoea and vomiting that can lead to severe dehydration and death.

In March, during an outbreak that infected more than 6,000 people, MSF teams set up three cholera treatment centres with a total capacity of 570 beds, and supported 19 treatment units with staff and materials, caring for around 5,000 patients in total. Water and sanitation specialists worked hard to halt the spread of the outbreak, providing over 500,000 litres of chlorinated water per day in the affected neighbourhoods. More than 100 volunteers conducted outreach activities, teaching people how to prevent cholera from spreading. MSF has been responding to cholera outbreaks in Zambia since 2004, and is urging local authorities and international donors to improve the country's preparedness for cholera outbreaks and prevent the loss of so many lives each year.

At the end of 2010, MSF had 51 staff in Zambia. MSF has been working in the country since 1999.

© Robin Meldrum



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Patients at the MSF health post in Bowen, Kupwara, Kashmir, India.

60 AFGHANISTAN

61 ARMENIA

62 BANGLADESH

63 CAMBODIA

64 CHINA

65 GEORGIA

66 INDIA

68 KYRGYZSTAN

69 MYANMAR

70 PAKISTAN

72 PAPUA NEW
GUINEA

73 PHILIPPINES

74 SRI LANKA

75 THAILAND

76 UZBEKISTAN

ASIA & THE CAUCASUS

AFGHANISTAN



Humanitarian needs grew in Afghanistan in 2010, as the war spread to almost all provinces. Health structures throughout the country lack medical staff and essential supplies. Unregulated and expensive private health services are often the only option.

The roads are dangerous and people often risk their lives in travelling to seek medical care. Sometimes, by the time a person reaches hospital, a condition that may have initially been relatively easy to treat has become life-threatening.

This general deterioration in healthcare provision motivated Médecins Sans Frontières's (MSF) return to Afghanistan in 2009. MSF secured agreements with the different parties involved in the conflict to begin activities in two hospitals: Ahmed Shah Baba hospital in east Kabul, the capital, and Boost hospital in Lashkargah, the capital of Helmand province in the south.

Hospital care in Kabul

The population of Kabul has tripled over the last ten years. Many people have fled conflict-torn areas for the relative safety of the capital; others have been pushed by poverty to try and make a living in the city. Returnees from Pakistan and other provinces of Afghanistan have also made their way to Kabul. As a result, the fragile health system has been stretched to its limit, leaving many people without access to medical care.

In Ahmed Shah Baba hospital, MSF doctors, midwives, nurses and surgeons worked with the hospital's existing medical staff. MSF focused on the emergency department, maternity services and treatment protocols, increasing the medical services available so that fewer patients would have to be referred elsewhere. Improvements were made to the maternity and emergency departments, and to the laboratory and X-ray services.

More than 50 newly recruited hospital staff were also given training and support. By October, an operating theatre and a small inpatient department had been put in place. The first surgery was performed at the end of October, and 40 more operations had been carried out by the end of the year.

Throughout the year, patient numbers increased significantly. Nearly 10,240 medical consultations took place in October, compared with 5,500 in October 2009, when MSF started its activities. In 2010, maternity staff held almost 7,400 antenatal consultations, assisted more than 4,070 births, and carried out more than 1,500 family planning sessions. Overall, more than 118,200 patients were seen in the various departments of Ahmed Shah Baba hospital.

Boost hospital, Helmand

In November 2009, MSF started to support Boost provincial hospital in Lashkargah. Helmand's one million inhabitants are among those who have suffered most from the ongoing conflict. Many rural health clinics are now dysfunctional, as qualified health staff have left the insecure areas, and supplying drugs and medical materials has become increasingly difficult. Insecurity has also made it difficult for people to reach specialist health services.

In 2010, MSF worked to return the 155-bed hospital to a functioning referral hospital – one of only two in southern Afghanistan. MSF extended its medical support to all wards, including the maternity, paediatric, surgical and emergency departments.

Medicines and medical equipment were also provided. As a condition of its support, MSF requested that the hospital implement a "no weapons" policy, which means all weapons must be left at the entrance, making the hospital less of a potential target and allowing patients to feel less threatened.

Halfway through the year, a nearby hospital for the war-wounded, operated by the Italian organisation Emergency, closed for four months. Boost was able to cope with the increase in trauma cases requiring surgery. Around 1,500 surgical operations were performed in 2010, nearly 400 of which were for war-related injuries. From May, the upgraded emergency department was able to stabilise critical cases around the clock before transferring them to Boost's other departments for more specialised care. From May to December, around 26,000 patients – ten per cent of whom were in critical condition – received treatment. Services that had been virtually non-existent before 2010 were approaching full capacity. Some 2,500 babies were born in the expanded maternity department: 480 deliveries were complicated.

Children accounted for 25 to 30 per cent of hospital patients. In September, a 16-bed extension of the paediatric ward meant children were no longer obliged to share beds. Overall, around 2,200 children were treated at the hospital in 2010, 550 of whom were newborns.

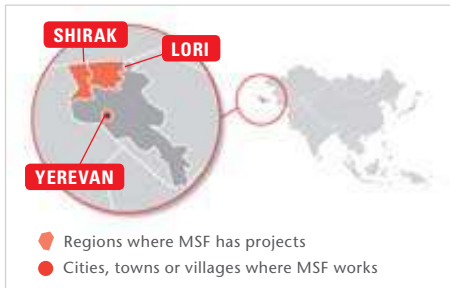
At the end of 2010, MSF had 200 staff in Afghanistan. MSF first worked in the country in 1984.



A man with gunshot injuries is transferred to Boost hospital for post-operative care, Lashkargah, Helmand province.

© Kate Holt

ARMENIA



In Armenia, Médecins Sans Frontières (MSF) is working with the staff of the national tuberculosis (TB) programme in tackling drug-resistant tuberculosis (DR-TB).

In the 1990s, as a result of patients not completing TB treatment or using drugs incorrectly, resistant forms of tuberculosis emerged. In 2005, an MSF team started working in Yerevan, Armenia's capital, assisting doctors with diagnosis and treatment of the various forms of DR-TB.

Regular TB treatment involves around six months of medication. Drug-resistant forms of TB require up to two years of treatment, which is expensive and is not always easily available. Treatment usually starts with a period of hospitalisation, where patients are closely monitored. Once they return home, patients must continue a gruelling treatment regimen. Many of the drugs are toxic and, for some patients suffering from side effects such as headaches, vomiting or dizziness, the regime can become unbearable.

It can be very difficult to complete the cycle of treatment. The severity of side effects is one of the most significant factors, but other patients stop their treatment because they begin to feel better. MSF tries to help patients cope with the side effects by providing individual or group counselling and offering food vouchers to ensure an optimally healthy diet. In some cases, MSF assists in the renovation of patients' homes to ensure adequate infection control. Improving ventilation and sunlight in a house increases the chances that any TB bacteria is killed or removed from the home. In 2010 the MSF team received intensive MSF training on patient education



A TB patient prepares to take his medication at home in Yerevan.

and counselling, and revised procedures have been drawn up to attempt to further improve adherence.

Some elements of the TB programme in Yerevan were handed over to national bodies: the Armenian Red Cross has taken over the provision of social support in some districts, and the national TB programme is now responsible for providing drugs for TB patients.

Reaching rural areas

In 2010 MSF expanded the TB project into Lori and Shirak, two rural provinces in the north of the country. Working in a rural setting poses additional challenges, as some patients live long distances from clinics that they must attend on a regular basis. As a result, the MSF team has introduced new approaches to treatment and care that are more convenient for patients and enable them to live at home. This also makes it easier for patients to adhere to the treatment regime.

A total of 559 patients have started TB treatment since 2005, and 246 patients are currently receiving care.

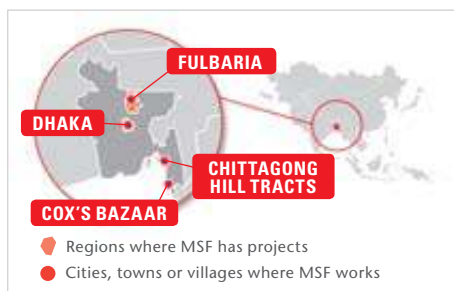
At the end of 2010, MSF had 68 staff in Armenia. MSF has been working in the country since 1988.

Larisa*

"When I found out it was drug-resistant TB I was shocked. I didn't expect it. But it was a fact and I had to go to the hospital and get treatment. When I heard that hospitalisation alone was to last two months, I couldn't imagine being there for such a long time. It was very difficult for me to get used to it. I thought first of all, that's it, I will die. It was very difficult physically and psychologically. Most patients find it difficult taking the tablets every day, starting the day with pills. "But going to the clinic and seeing smiling faces helped. They told me there is no expression, 'I can't' or 'I don't want to.' It gave me strength to go ahead, to fight."

** The patient's name has been changed.*

BANGLADESH



Many people who move to Dhaka, the capital of Bangladesh, end up living in slums where the availability of healthcare is often very limited. In April 2010, Médecins Sans Frontières (MSF) opened a health centre and a therapeutic feeding centre in the Kamrangirchar slum, which is home to nearly 400,000 people.

MSF's aim is to improve access to free care and treatment for children, focusing on severe acute malnutrition. Pregnant and breastfeeding women also receive treatment for malnutrition, and antenatal and postnatal care are provided.

Two-thirds of all deaths of children under five in Bangladesh are attributed to malnutrition. MSF is taking a community-based approach in Kamrangirchar. Teams go out into the community to screen children, and those who are found to be severely malnourished are admitted to a feeding programme and given ready-to-use food to eat at home until they regain normal body weight. During treatment, teams of health promoters regularly visit the children and provide support to ensure that the ready-to-use food is being given in the correct way. In 2010, MSF admitted 378 children and 440 pregnant or breastfeeding women to its nutrition programme and conducted over 10,000 consultations at its health centre.

Kala azar in Fulbaria

Kala azar (visceral leishmaniasis) is a deadly parasitic disease caused by the bite of infected sand flies, and is the second biggest parasitic killer worldwide after malaria. Medication to treat kala azar is expensive and hard to obtain. Few Bangladeshis are aware of the disease, its symptoms or its cause, so they do not know they need to protect themselves from the flies around them.



Villagers listen to a talk about kala azar, Fulbaria, Mymensingh district.

In collaboration with the Ministry of Health and Family Welfare, MSF opened a clinic providing free treatment of the disease in the subdistrict of Fulbaria, in the east of Mymensingh district. Fulbaria and neighbouring Trishal account for about 60 per cent of kala azar cases in Bangladesh. The clinic is the main provider of kala azar treatment in the subdistrict and the only such clinic in Bangladesh.

Outreach teams work with local communities to educate people about the disease and to identify suspected cases. Patients diagnosed with kala azar are treated with a new drug called liposomal amphotericin B, which is more effective, cuts the duration of treatment, and has fewer side effects than the drugs that were previously used. MSF also treats post kala azar dermal leishmaniasis (PKDL), a related skin infection that can appear long after a patient has seemingly been cured. By the end of 2010, more than 400 patients had received treatment for kala azar at the MSF clinic and more than 400 people were treated for PKDL.

Chittagong Hill Tracts

In the Chittagong Hill Tracts region in the south, MSF provided general and reproductive healthcare in Dighinala and Baghaichhari subdistricts. Teams operated eight health centres, and carried out almost 25,000 outpatient consultations and more than 1,000 antenatal consultations. More than 1,450 people were treated for malaria.

Kutupalong, Cox's Bazaar

Kutupalong is in Cox's Bazaar, a coastal area bordering Myanmar. In 2010, MSF continued to provide medical care to people

living in Kutupalong, including an estimated 30,000 unregistered Rohingya refugees living in a makeshift camp on the outskirts of the UNHCR-supported camp. MSF staff, many of whom are from the local area, treat common yet potentially deadly illnesses such as respiratory tract infections and diarrhoea.

In February 2010, MSF spoke out publicly to condemn a surge in violence against the unregistered Rohingya refugees. Since then the level of violence has dropped, but people remain highly vulnerable due to their lack of official status and the limited provision of assistance that this allows.

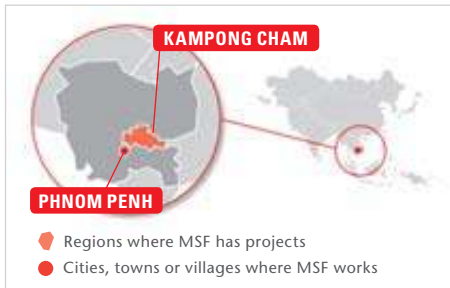
At the end of 2010, MSF had 291 staff in Bangladesh. MSF has been working in the country since 1985.

Abdul and Fatema

Abdul learned about the kala azar clinic in Fulbaria through MSF's outreach work. He has had kala azar, and so have many of his family members. Fatema, Abdul's five-year-old daughter, was treated for kala azar at the MSF clinic. It used to take 30 days of painful injections to treat the disease, but Fatema was treated with the new drug, which requires just three infusions over five days. Before, Abdul had to spend his savings treating his family for kala azar, but Fatema is treated for free. She was soon able to go home and return to school.

© Gazi Nafis Ahmed

CAMBODIA



In 2010, Médecins Sans Frontières (MSF) completed the handover of its activities in the infectious disease department of the Khmer-Soviet Friendship Hospital. More than 3,000 HIV patients were transferred to the care of the health authorities, and MSF shifted its focus to tuberculosis (TB) care.

Cambodia is one of 22 countries listed by the World Health Organization as having a high burden of TB. In Kampong Cham, the most populous province in the country, MSF worked to improve the diagnosis and care of people with TB and drug-resistant TB (DR-TB). Staff established a chest clinic within the TB ward of Kampong Cham provincial hospital, and began to actively seek patients with TB, visiting and offering TB testing to patients who had been admitted to hospital for other reasons.

By the end of 2010, the number of TB patients had increased by 25 per cent, and revealed a need for improved patient follow-up. MSF had carried out an assessment of facilities for TB care in four districts of Kampong Cham, and had begun providing TB care in local health centres. However, decentralised activities were temporarily suspended so that MSF staff could focus on its work in Kampong Cham hospital and ensure the follow-up of its patients. In the coming years, MSF will develop a comprehensive TB care approach throughout the province.

HIV and TB care for prisoners

Overcrowding, lack of ventilation and generally poor living conditions in prisons mean there tends to be a high risk of TB contamination. MSF extended HIV and TB services in Phnom Penh prisons to provide comprehensive testing, counselling and treatment for both diseases. Teams also provided general healthcare.

In Phnom Penh men's prison, more than 80 per cent of inmates agreed to be tested, and preliminary results showed 3 per cent

prevalence of HIV in comparison with 0.6 per cent among the general population, and 3.9 per cent prevalence of TB in comparison with 0.7 per cent among the general population. Prevalence was slightly lower in the city's women's and children's prison, at 2.7 per cent and 2 per cent, respectively.

Cholera outbreak

MSF teams also assisted during cholera outbreaks across the country in 2010. Staff provided technical support and cholera kits that were adapted for use in national treatment centres. In collaboration with other

organisations, MSF helped to strengthen the surveillance system for communicable diseases, especially cholera, dengue fever and measles. Staff are working with health programmes at national and provincial levels, investigating suspected cases and analysing the performance and challenges of the care given. This should enable timely identification of a medical crisis and a more efficient and appropriate response.

At the end of 2010, MSF had 145 staff in Cambodia. MSF has been working in the country since 1979.



A team tests prisoners for HIV and tuberculosis in Phnom Penh Correctional Centre No. 1.

CHINA



An MSF psychologist talks with another member of staff in the MSF/CDC clinic in Nanning, Guangxi province.

Cui*

28 years old. Receiving treatment for HIV since May 2008

"When I arrived in the clinic I was very sick, and people gave me a lot of encouragement. Before, I didn't know anything about treatment. I didn't understand the importance of taking antiretrovirals at the right time. However, the doctors and counsellors emphasised the importance of this and my health improved. It's good to talk to the counsellors. Talking with them is the only way to relieve my burdens. Every time I talk with them I cry."

*The patient's name has been changed.



In 2010, after seven years of providing HIV care in the city of Nanning, Médecins Sans Frontières (MSF) and the Guangxi Centre for Disease Prevention and Control (CDC) handed over their project to local health authorities.

HIV/AIDS treatment in Guangxi

Guangxi province, in southwest China, has one of the highest rates of HIV infection in the country. MSF, together with the CDC, established a project in the provincial capital Nanning in 2003.

The project targeted high-risk groups: the testing and treatment of injecting drug users, sex workers and men who have sex with men. Patients responded well to the treatment and were able to stick to it. Prior

to the project's opening, Chinese health officials had doubts regarding the likely adherence of drug users to antiretroviral (ARV) treatment. Dr Wu Zunyou, director of the National Centre for AIDS/STD Control and Prevention, said: "In the early stages, we had no experience in providing treatment to drug users and AIDS patients overall. We just started in 2003 and we were very hesitant to launch antiretroviral treatment for drug users because we were not convinced they had good adherence rates, but we reviewed MSF data and found they did not have worse adherence rates than non-drug users."

Targeting people living with HIV from particularly marginalised populations was a key part of the project in Guangxi. Teams went out into these communities to encourage people to seek testing and treatment. This approach saved lives, and once the disease was managed effectively through medication, patients' quality of life was greatly improved. Counselling, previously regarded with suspicion by health authorities, became an important part of patient care.

People on ARV treatment often suffer from opportunistic infections that take hold as a result of their weakened immune systems. Over the course of the project in Guangxi, MSF was able to implement new protocols for the treatment of such infections. Tuberculosis was the main opportunistic

infection targeted and treated. MSF also helped train national staff to diagnose and treat cytomegalovirus, a viral infection that can cause blindness in people with HIV.

Over seven years, the project team had developed a system of care that addressed the psychological and medical needs of patients. MSF staff assisted in drafting guidelines for the testing and treatment of HIV/AIDS that formed a basis for the province's approach. Aspects of the provincial guidelines were then used in the national protocol for tackling the epidemic. The project provided training for many health workers in Guangxi, which now has 45 antiretroviral treatment centres, compared to a handful in 2003. A total of 1,724 patients received free and confidential treatment and care. Around 80 per cent of these patients were continuing to follow treatment at the time of the handover.

Earthquake in Tibetan Autonomous Region

In April, a 6.9 magnitude earthquake hit Qinghai province, killing around 2,700 people and injuring some 12,000. MSF sent a team to explore the possibilities of assisting the population in Jiegu, the worst affected town, where around 100,000 people were made homeless. MSF made donations of coal, medical kits and other equipment to help the affected population.

At the end of 2010, MSF had 24 staff in China. MSF has been working in the country since 1988.

GEORGIA



Tuberculosis programmes

Treatment for TB was developed in the 1950s, and is a long and complex process. It involves daily medication over a period of six to eight months, which many patients struggle to adhere to. However, for patients to be cured, it is crucial that the full course of treatment is followed without interruption. If medication is interrupted, there is a risk of drug-resistant TB (DR-TB) developing, which necessitates even longer, more arduous treatment.

The DR-TB programme in Zugdidi, western Georgia, opened in November 2006. In 2010, the programme adopted a flexible, home-based and multidisciplinary approach to the management of DR-TB

Almost 20 per cent of tuberculosis (TB) cases in Georgia are estimated to be multidrug-resistant forms of the disease, according to the World Health Organization. Médecins Sans Frontières (MSF) collaborates with the national TB programme, and facilitates access to healthcare for marginalised people.

cases. Adherence teams of medical and psychological staff tried to take into account all the medical, social and economic factors that affect patients' adherence in an effort to detect problems earlier and manage them more effectively. With a stronger support structure around them, patients found the programme easier to follow and, despite the debilitating side effects, about 70 per cent of patients adhered well to the treatment.

Substantial funding, mainly from the Global Fund to Fight AIDS, Tuberculosis and Malaria, has strengthened Georgia's fight against DR-TB. The Georgian Ministry of Health opened a new TB hospital in Tbilisi in August 2008, and in September 2010 it took over MSF's activities in Zugdidi. Over almost four years of operation, 256 patients had been enrolled in the programme.

MSF continues to support the national TB programme in Abkhazia, a separatist region in northwest Georgia, providing direct support for DR-TB. Staff provide health education and counselling in order to improve patients' adherence to treatment. In 2010, 36 new patients were enrolled in the programme.

Health access

An MSF programme aimed at assisting people who have difficulties accessing healthcare in Abkhazia has been considerably reduced as national capacity has improved. The programme started in 1993 with a peak of 6,000 patients, and in 2010 only 108 people, mainly home-bound and bedridden, were registered.

At the end of 2010, MSF had 133 staff in Georgia. MSF has been working in the country since 1993.



A consultation between a doctor and a patient with tuberculosis is carried out at Gulprish TB dispensary, Abkhazia.

© Alexander Glyadyelov

INDIA

In India, Médecins Sans Frontières (MSF) provides general healthcare and treatment for tuberculosis, malaria, HIV and kala azar (visceral leishmaniasis) and offers basic and specialised medical care to people living in areas afflicted by violence and conflict.

Kala azar and nutrition in Bihar

In Vaishali district, Bihar state, eastern India, MSF provides free diagnosis and treatment for people suffering from kala azar (visceral leishmaniasis). Between July 2007 and January 2011 more than 7,000 patients received treatment with liposomal amphotericin B, which is more effective and has fewer side effects than the drugs previously used. More than 98 per cent of patients recover with liposomal amphotericin B treatment and MSF hopes the national kala azar programme will adapt its treatment protocol in the near future.

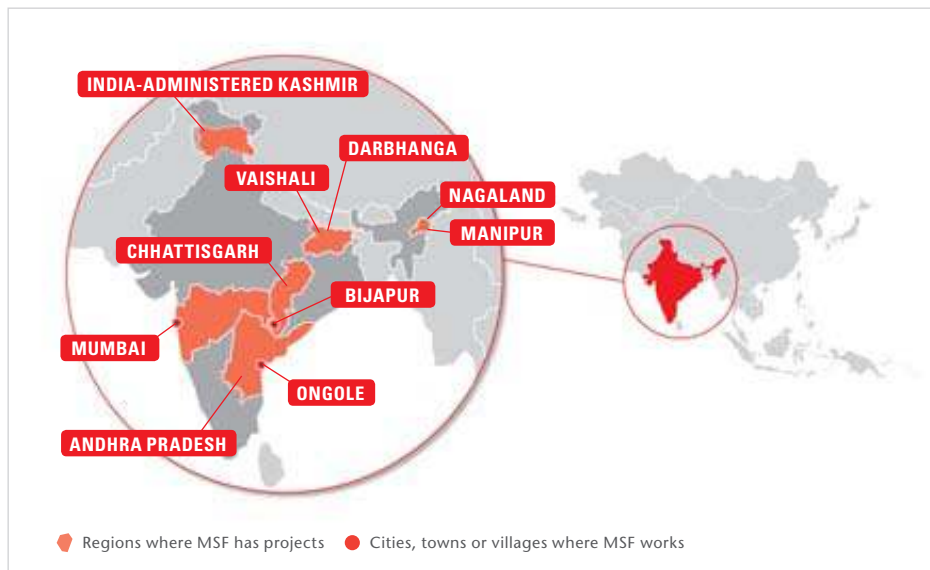
In Darbhanga district, MSF provides healthcare for children aged between six months and five years who suffer from severe acute malnutrition. In 2010, more than 6,000 children received treatment, mostly on an outpatient basis.

Healthcare in Chhattisgarh

MSF operates fixed and mobile clinics in villages and camps along the Andhra

Pradesh and Chhattisgarh border as well as in Chhattisgarh, eastern India. Healthcare is provided to people living at the centre of a conflict between Naxalite (Maoist) groups and government forces. Staff held almost 60,000 consultations, providing antenatal care, nutritional support to malnourished children and pregnant women, and treatment for malaria and tuberculosis (TB). Health promotion activities on malaria prevention and hygiene practices, among other topics, were also conducted.

In the district of Bijapur, MSF runs a mother and child health centre, and a team set up a TB isolation room and opened an on-site TB laboratory to allow for prompt diagnosis. MSF also supports the district hospital's surgical activities.



The northeast

In August, MSF opened a new project in the northeastern state of Nagaland. MSF supported the district hospital of Mon with human resources, management expertise, training, rehabilitation of the hospital structure, waste and sanitation management, and medical supplies. From July to December, medical staff conducted almost 6,250 consultations and performed more than 150 minor surgeries in the operating theatre.

In neighbouring Manipur, MSF continued to provide medical assistance, including reproductive and child health services, to vulnerable people who otherwise would have difficulty accessing healthcare. In 2010, 25,500 general consultations and 6,650 antenatal consultations were carried out. Staff provided HIV counselling, testing and treatment as part of the basic healthcare programme. The care of some 200 patients on first-line antiretroviral (ARV) treatment in Churchandpur was handed over to the Ministry of Health. MSF continued to care for around 400 patients on second-line treatment. TB care was also offered: more than 100 patients received treatment for tuberculosis and 11 for multidrug-resistant TB (MDR-TB).

HIV/AIDS and TB in Mumbai

In Mumbai, the largest city in India, MSF provides comprehensive care for people with HIV who require treatment not yet available in the public sector. This includes people who experience severe side effects from first-line medicines, patients with co-infections and those who urgently need second-line ARV drugs but do not meet



A health educator gives a presentation at the feeding centre in Biraul block, Darbhanga district, Bihar State.

© Stephanie Sinclair/VII

the public healthcare system's criteria for treatment. The MSF team also offers treatment to people who, because of social stigmatisation, may face difficulties in accessing the public system, such as transgender people, sex workers and men who have sex with men. At the end of 2010, 310 patients were receiving ARV treatment at the clinic, 186 of whom were on second-line treatment. In addition, 23 HIV patients were also receiving care for MDR-TB.

Mental health in Kashmir

MSF offered psychosocial care to a population heavily traumatised by more than two decades of violence, providing mental healthcare to almost 4,500 patients in 2010. After an escalation of violence in July, and with the cooperation of hospital staff who treated physical injuries, MSF counsellors visited 1,900 wounded patients and offered psychological assistance to

them and their families. Such "psychological first aid" helps the patients to cope after experiencing trauma. Counsellors listen to the patients' stories, helping them come to terms with what happened, and offer practical advice on how to deal with any further psychological consequences.

As well as mental health activities, more than 16,500 basic healthcare consultations were conducted in remote rural areas of India-administered Kashmir.

Emergencies

In May, MSF teams distributed 1,500 shelter, hygiene and cooking kits to people in Ongole in Andhra Pradesh who had been affected by cyclone Laila. In June and July, in collaboration with the Ministry of Health, MSF helped respond to an outbreak of acute diarrhoea in south Chhattisgarh. In August, teams provided medical assistance

to people affected by flash floods in Leh and surrounding areas, and distributed shelter and cooking and hygiene kits to families in need.

Following a sharp increase in malaria cases in Mumbai during the monsoon season, MSF stepped in to support the Mumbai health authorities' fight against the disease by providing malaria diagnostic kits and treatment kits.

At the end of 2010, MSF had 656 staff in India. MSF has been working in the country since 1999.



An MSF doctor examines a young patient at the women's clinic run once a week in Thyan, Kupwara, Kashmir.

© Giulio di Sturco / VII Mentor

KYRGYZSTAN



In April 2010, President Bakiyev of Kyrgyzstan was ousted by a popular revolt. Then in June the south of the country was shaken by violence between Kyrgyz and Uzbek communities. Médecins Sans Frontières (MSF), running projects in Kyrgyzstan to treat prisoners infected with tuberculosis (TB), was able to assist those in need during the emergencies.

Political and intercommunal violence

When rioting began in the capital Bishkek, MSF provided drugs and medical supplies to four health centres. In the south, MSF donated medical supplies and drugs to hospitals and clinics in the provinces of Osh and Jalalabad within days of violence breaking out. Almost 400,000 Uzbeks were displaced, and around 2,000 homes were destroyed. Many people in need of treatment were too afraid to leave their communities, so between June and August MSF ran mobile clinics to reach people in need of care. MSF psychologists held over 660 mental health consultations and 3,700 patients participated in over 550 group therapy sessions.

Months later, tension and mistrust between the communities still hindered access to healthcare. MSF identified 50,000 people from all ethnic groups, in ten districts of Osh city, as particularly vulnerable: some because they had lost their homes,



An MSF nurse carries out a consultation with a returning refugee in Suratosh, a village on the border with Uzbekistan.

businesses or livelihoods in the clashes, others – single mothers, the elderly living on very small pensions, or large families with no income – were already in precarious situations before the June events. MSF operated in seven public health facilities, where staff helped to ensure the provision of care in a non-discriminatory and neutral manner.

Treating TB in prison

MSF has been treating prisoners infected with TB in Kyrgyzstan since 2005. The incidence of the disease in prisons has declined over the years: the number of patients detected each year dropped from 700 to 350 between 2006 and 2010. This is mainly because of a reduction in the prison population. Around two-thirds of infectious TB patients in the penitentiary system have drug-resistant TB (including all forms of drug-resistant TB). The treatment programme for drug-resistant TB is often very long and difficult. In 2010, MSF treated 230 new TB patients.

Prisoners diagnosed with TB are referred to treatment facilities in three prisons in and around Bishkek, where staff work in collaboration with the Ministry of Health,

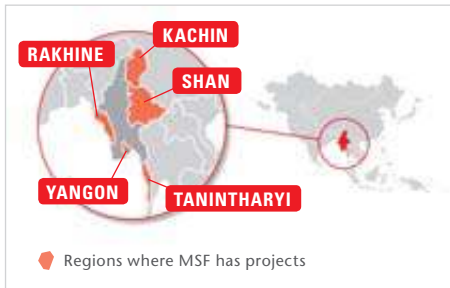
the prison authorities and international organisations such as the International Committee of the Red Cross.

One of the most important challenges is to assure uninterrupted treatment after release, as one-third of TB patients are released from prison before treatment is completed. MSF provides medical and social support to former prisoners with TB and is working to find ways to motivate them to complete their treatment. In 2010, 78 TB patients were released from prison, and 57 of them were still receiving treatment at the end of the year. MSF is advocating for a national TB control policy in the penal system.

At the end of 2010, MSF had 93 staff in Kyrgyzstan. MSF has been working in the country since 2005.

© François Dumont

MYANMAR



Myanmar remains largely isolated on the international stage and faces severe restrictions from the international aid community. Despite the return of the Global Fund, the country continues to suffer from a chronic lack of resources to tackle diseases like HIV/AIDS, tuberculosis and malaria.

Working closely with local communities, Médecins Sans Frontières (MSF) offers lifesaving treatment to people living with HIV/AIDS, basic healthcare, health education and reproductive healthcare, including antenatal and postnatal care, and nutritional assistance. MSF has been providing healthcare in Shan, Rakhine and Kachin states as well as in Yangon and Tanintharyi regions through a network of HIV/AIDS clinics and health centres. MSF teams conducted nearly 660,000 general consultations across the country in 2010.

HIV/AIDS

More than 240,000 people are living with HIV in Myanmar, and an estimated 120,000 are in need of lifesaving antiretroviral (ARV) treatment. However, treatment is currently available to only 21,000 people, and MSF was treating 18,300 of these people in 2010. Staff also provided symptomatic and palliative care and managed common opportunistic

Low national and international investment in the health sector combined with tensions and low-intensity conflicts limit access to healthcare in many areas of Myanmar.

infections, which patients suffer from as a result of their compromised immune systems.

In Yangon, MSF operated four HIV clinics. In addition to treatment, staff offered health education, especially to high-risk groups such as intravenous drug users, men who have sex with men and sex workers, and helped prevent the transmission of HIV through voluntary testing and counselling and mother-to-child transmission prevention services. MSF continued to work in close collaboration with the Ministry of Health and other agencies in building up the technical capacities and resources of the various HIV/AIDS care programmes in the country.

Tuberculosis and HIV

Myanmar ranks among the 22 countries with the highest burdens of tuberculosis (TB) in the world. The national TB programme is underfunded and the lack of adequate regulation of the private sector means that there is no proper regimen for treatment, which leads to high levels of treatment failure and increased drug resistance.

TB is the most common opportunistic infection and the main cause of death for people living with HIV. MSF provides TB treatment within the context of its HIV programmes and is currently giving free treatment and counselling to 2,540 TB patients across the country, most of whom are also HIV positive.

In Dawei, in the south of Myanmar, MSF runs an HIV and TB clinic for a local population consisting mainly of migrant workers and

fishermen. Staff also conduct outreach activities in the surrounding district, going out in the community to test people and see patients who may not be following their treatment regime.

In Yangon, an MSF pilot project offers treatment and care for multidrug-resistant TB (MDR-TB) in partnership with the Ministry of Health. This is the first programme in the country offering treatment for MDR-TB. In 2010, 44 patients enrolled in the programme. In October, MSF set up an HIV and TB programme in Insein prison in Yangon.

Malaria

Malaria is one of the leading causes of mortality in Myanmar. MSF clinics provide free diagnosis, treatment and prevention measures in areas where the disease has high prevalence rates. In Rakhine state, for example, MSF tested more than 400,900 people and treated more than 122,380 patients for malaria in 2010.

Natural disaster

Cyclone Giri hit the west coast of Myanmar in November. In its aftermath, MSF conducted around 17,000 medical consultations through mobile and fixed clinics and distributed food as well as construction kits to help rebuild affected communities.

At the end of 2010, MSF had 1,169 staff in Myanmar. MSF has been working in the country since 1992.



Staff working in the dispensary at one of MSF's clinics in Yangon, Myanmar.

Myek*

33 years old

"I came to the MSF clinic for the first time four years ago and was put on ARVs around three years ago. It was my mother who recommended that I come here; personally, I had never suspected my status. After discussing with the counsellor, I decided to take a test. When it turned out positive it was a huge shock for me. I thought 'that's it; it's the end of my life'. I talked a lot to my mother and to the counsellor and they really helped. This clinic offers good care and is the only place where I can find free treatment. Because I can't afford my treatment, it's really important that it's free."

** The patient's name has been changed.*

PAKISTAN

The floods that hit Pakistan in 2010 affected around 14 million people. The waters swept down from the mountainous northeast into the heavily populated river valleys and plains, driving desperate people ahead of them. In a country already suffering gaps in healthcare provision the need for assistance grew enormously.

In the Federally Administered Tribal Areas (FATA) and Khyber Pakhtunkhwa province, Médecins Sans Frontières (MSF) teams continued to provide emergency services for people caught up in fighting between government forces and armed opposition groups. Further south, in Balochistan, MSF worked with Afghan refugees and Pakistanis, assisting with a range of medical services, mother and child healthcare and nutrition programmes.

Floods

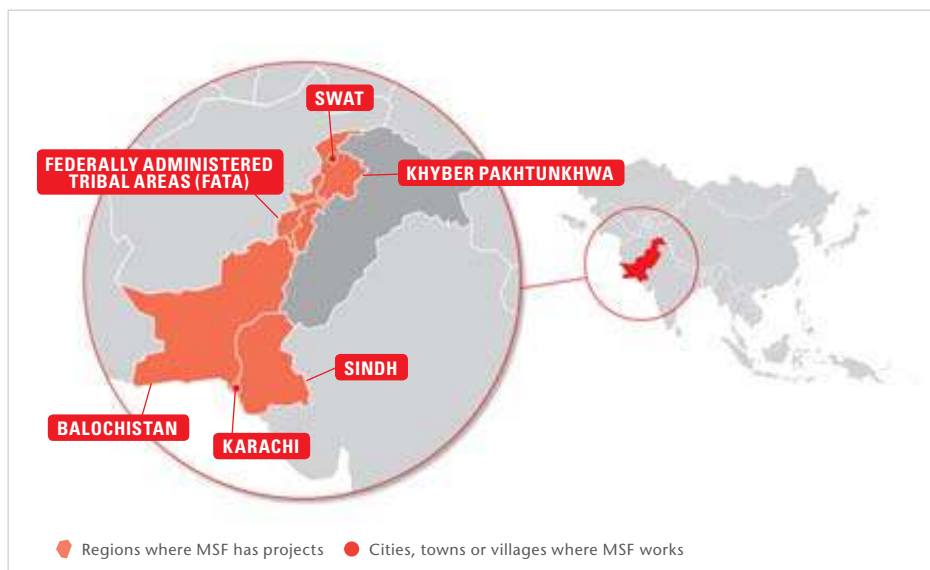
As the exceptional monsoon rains fell, rivers broke their banks, washing away bridges, roads, villages and livelihoods. Food and safe water were in short supply. The risks of

illness and contagion, and the sheer number of vulnerable people completely exposed to the elements were major challenges for the relief effort.

MSF staff fanned out to identify the areas and communities most in need. At the height of the flood response, more than 1,600 staff were supporting hospitals, treating injuries and illnesses, running mobile clinics and distributing tents, shelter materials, and washing and cooking kits. One of the most urgent needs was for safe drinking water and MSF quickly engaged in trucking water, distributing up to 2.1 million

litres a day. Set against the requirements of so many uprooted people, even these figures were dwarfed by the scale of the disaster.

By October, the waters had largely retreated and MSF reduced some of its activities, but at the end of the year teams were still providing medical care and water and sanitation services in Sindh, where the waters were slowest to retreat. Staff were working to provide shelters for the winter and to support the nutritional needs of children whose families had lost their farms or incomes. MSF also started running mobile clinics, and distributing safe water and relief



Staff talk to a young patient in the operating theatre of Hangu hospital, Khyber Pakhtunkhwa province.

Gulatun

Gulatun is due to give birth in two months' time, but the placenta is blocking her uterus, meaning she will need a caesarean section: "I became worried about my baby when I started bleeding for a few days. Someone in the camp told me I should come to this hospital. I really hope my baby will be safe." Gulatun is one of the millions of people who have been displaced by the devastating floods that have destroyed homes and livelihoods in many areas of Pakistan. Her home for now is a makeshift shelter in an open space on the outskirts of Dera Murad Jamali in Balochistan province, but Gulatun will receive free emergency obstetric services at Dera Murad Jamali's hospital.



© Seb Geo

Emergency relief kits are distributed to people displaced by the floods, Shahbaz, Punjab.

kits in the camps where people had taken refuge in the city of Karachi. Overall in the emergency, MSF conducted over 100,000 consultations in five hospitals, seven mobile clinics and six diarrhoea treatment centres.

Surgery

Fighting continued in the northern regions of the country before, during and after the floods, as it had for the last five years. In Khyber Pakhtunkhwa and FATA, the violence shut down hospitals, access roads and the transport of medical supplies. Even if emergency patients found their way to hospital, the limitations of nursing care and low standards of equipment and hygiene did not ensure good quality services. More than one million people depended on MSF to provide free emergency surgery. In Khyber Pakhtunkhwa, MSF worked in the emergency department and operating theatre in Dargai in Malakand district, where staff cared for around 130 patients each month. MSF started working again in Swat after having left in April 2009, when security incidents had made it difficult for staff to work safely. In May 2010, the team returned and was soon treating around 6,000 patients a month. In Timurgara in Lower Dir, there were some 4,200 patients in MSF's

emergency facilities every month. A new project covering emergency department services and emergency surgery was opened in Hangu district, close to the tribal areas, and treated around 1,300 patients a month. In the town of Chaman, Balochistan province, on the Afghan border, MSF supported the emergency department of the district hospital, ensuring that hospital staff could treat and stabilise patients and provide immediate lifesaving care.

Maternal and child health

Emergency obstetric care is only available in urban areas of Pakistan, often because of a severe shortage of trained female staff. Women traditionally give birth at home and MSF has been working to reduce the risks by improving access to screening, the availability of skilled birth attendants, and provision of emergency obstetric and neonatal care. In Dargai, Timurgara, Hangu, Kuchlak, Chaman and Dera Murad Jamali hospitals MSF staff are equipped to carry out deliveries and can perform caesarean sections in some facilities. In 2010, more than 7,100 women delivered in an MSF facility or an MSF-supported hospital; 481 delivered via caesarean section.

Cutaneous leishmaniasis

In Quetta, the capital of Balochistan, and also in Kurram Agency, in FATA, many people suffer from cutaneous leishmaniasis, the most common form of leishmaniasis, a parasitic disease transmitted by sand flies, which causes ulcer-like lesions and can lead to severe disfigurement. In 2010, MSF launched programmes to provide the simple but lengthy treatment required for the disease, and treated more than 400 people.

At the end of 2010, MSF had 1,177 staff in Pakistan. MSF has been working in the country since 2000.

PAPUA NEW GUINEA



Social violence is rife in Papua New Guinea and Médecins Sans Frontières (MSF) provides medical and psychosocial care to survivors of sexual and domestic violence.

Contributing factors to the violence are manifold and include poverty, urbanisation and unemployment, drug and alcohol

abuse, and limited government capacity to provide adequate care.

Lae is Papua New Guinea's second largest city, and MSF runs a Family Support Centre at Angau Memorial General Hospital. Family Support Centres offer a safe space to people escaping domestic or social violence. Patients receive medical care, but also social and psychological support. MSF staff at the centre offer comprehensive, free, medical and psychosocial care to around 200 new patients a month.

In the rural town of Tari, in the southern highlands, MSF teams provide emergency surgery at Tari hospital and work in a Family Support Centre. In 2010, staff carried out more than 13,000 general consultations and more than 5,400 mental health consultations in Tari and Lae general hospitals.

Hidden and Neglected: The Medical and Emotional Needs of Survivors of Family and Sexual Violence in Papua New Guinea was published in December 2010 and reports

on MSF's experience in the provision of medical and psychosocial care in the country. MSF makes a number of concrete recommendations for action by national authorities, civil society and international donors, particularly regarding the establishment and operation of Family Support Centres.

Cholera outbreaks

The emergency response to a cholera outbreak in East Sepik province, in the north of the country, concluded in mid-2010. MSF set up 12 treatment units, 2 treatment centres and 22 oral rehydration points, and trained over 1,000 health workers in clinical management and infection control. MSF also provided material, training and staff in response to a further outbreak in the Fly River area in November 2010. In total, MSF treated more than 580 people for cholera in 2010.

At the end of 2010, MSF had 133 staff in Papua New Guinea. MSF has been working in the country since 2009.



Intensive care at Angau Memorial General Hospital in Lae.

© Fiona Morris

PHILIPPINES

A renewed outbreak of the conflict between the Philippine government and the Moro Islamic Liberation Front (MILF) in 2008 resulted in the displacement of more than 750,000 people.

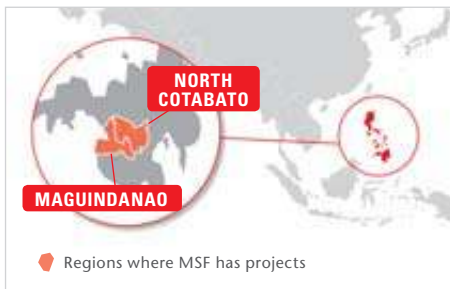


People wait at an MSF clinic in a displaced persons camp, the Philippines.

Jahaira

30 years old, MSF community health worker

"I was in the small town of Butilen, visiting some relatives, when the conflict erupted unexpectedly. For the first time, I heard bombs and the whirring sound of helicopter blades. I was really afraid and very concerned about my community's fate. We had to manage everything on our own. We did not want to go to evacuation centres – they were overcrowded and dirty – so we decided to stay at home, despite the daily bombings. I was going to Cotabato to work every day, bringing all my belongings and important documents in case I couldn't go back home. For months, there was bombing and fighting every day. People of my community were suffering from the lack of food. Many had diarrhoea and high fever. Some of them had to build their own shelters as their houses were destroyed. Some decided to go to evacuation centres in the end."



Médecins Sans Frontières (MSF) started working in Maguindanao, in the Autonomous Region in Muslim Mindanao, and North Cotabato, in a neighbouring region of Mindanao, because the local health system was overwhelmed and struggling to meet the people's basic healthcare needs.

Responding to trauma

In 2010, MSF provided healthcare in five evacuation centres. These government-run centres provide a temporary home to people displaced by violence. Special attention was paid to children, women and individuals suffering severe consequences of trauma and violence. MSF held more than 27,500 consultations through mobile clinics or in

existing health centres, providing care for 3,455 pregnant women and treating 267 children for severe acute malnutrition.

Mental health problems were a major unaddressed issue in the evacuation centres. Many of the displaced people had had traumatic experiences, losing family members and their homes, and living in precarious circumstances for long periods of time. The public health system did not offer treatment of post-traumatic stress disorder, so MSF integrated a mental health component into its medical response to trauma and violence and treated 1,155 people in 2010.

The organisation helped rehabilitate health structures by setting up waste disposal and improving water supplies and sanitation in the districts of Datu Piang, Libutan, Lumpong and Libungan Torreta. MSF also distributed relief items, including plastic sheeting and soap, to 800 families.

Stability returning

In May 2010, following the presidential election, efforts have been made to settle the conflict between the government and MILF. The situation on the ground remains

fragile, but displaced people have started moving back home or integrating into host communities. As a consequence, MSF reduced its medical activities. In October, MSF handed over its projects to the public authorities.

At the end of 2010, MSF had 51 staff in the Philippines. MSF has been working in the country since 2008.

SRI LANKA



The 26-year civil war in Sri Lanka ended in May 2009. Hundreds of thousands of people who had been displaced from their homes in the north and confined to camps were resettled or allowed to return home by the beginning of 2010, and Médecins Sans Frontières (MSF) adapted its activities in light of these developments.

Vavuniya

Set up at the end of 2009, the MSF rehabilitation programme in Pampaimadhu hospital, close to the northern town of Vavuniya, assists patients who have suffered spinal cord injuries. Such injuries are frequently sustained in conflict zones as shrapnel, gunshot and explosive blasts can cut, pull or compress the spinal cord. Victims can become numb or even paralysed from the point of injury down,

and frequently lose normal bladder and bowel control. Rehabilitation has a huge impact not only on patients' quality of life but also on their life expectancy. This innovative programme integrates medical treatment, physiotherapy and mental healthcare.

In partnership with Ministry of Health staff, MSF helped patients to manage their health issues and assisted them with daily physical rehabilitation activities to improve mobility. MSF also conducted 840 counselling sessions. In 2010, 40 new patients were admitted to the programme.

In Vavuniya general hospital, MSF built an operating theatre for reconstructive orthopaedic surgery and supplied specialist surgeons, anaesthetists and nurses to operate on patients with complicated war-related injuries. Patients received long-term post-operative care to ensure full recovery. In total, 58 surgical procedures were carried out in the operating theatre during 2010.

Mental healthcare in Kilinochchi district

Since November 2010, MSF has provided counselling to people suffering from mental trauma in partnership with the Kilinochchi District Mental Health Unit, in the far north of Sri Lanka. Most patients were suffering from bereavement or missing family members because of the conflict. Staff held both individual and family counselling sessions.

Menik Farm camp

Many of the people in the government-run camp for displaced people at Menik Farm witnessed deeply traumatic events during

the last phase of the civil war. To support the efforts of the Ministry of Health and the psychiatry department of Vavuniya hospital, at the beginning of 2010 MSF began offering mental healthcare to people living in the camp.

A psychiatrist and a psychologist worked with Sri Lankan counsellors and community social officers to identify and treat people who needed care. The team treated a total of 1,520 patients and gave around 4,300 counselling sessions in 2010. The project was closed in November, as over the course of the year people left the camps to return to their homes. MSF provided mental healthcare to many returnees in the district of Mullaitivu.

MSF also provided supplementary food to 8,864 people in Menik Farm camp at the beginning of the year to prevent vulnerable groups from suffering from severe acute malnutrition. By February, the need for nutrition activities had decreased and MSF handed its programme over to the organisation World Vision International.

Hospital support

The scene of some of the fiercest fighting at the end of the civil war, Mullaitivu district saw a steady stream of people returning home in 2010. MSF assisted in the provision of emergency care, gynaecological and obstetric care, and surgery in the Mullaitivu district hospital. An MSF team helped improve the water supply and waste disposal in the hospital and also rehabilitated the laboratory.

In the last months of the year, a doctor and an operating theatre nurse started working in the emergency unit, and over November and December held 564 consultations. Mobile clinics, providing basic healthcare, were conducted in the surrounding area.

MSF continued to support specialist activities in Point Pedro hospital, the second largest health structure in the Jaffna peninsula. Staff provided emergency healthcare, gynaecological and obstetric services, as well as surgery. Nearly 3,000 consultations took place in the emergency department, with around 390 patients admitted to the intensive care unit. Surgeons performed 963 major surgeries, which required general or spinal anaesthetic. More than 4,200 women received antenatal care and 1,130 babies were delivered.

MSF also offered training to hospital staff in laboratory services, hygiene and sterilisation, and was able to fill gaps in the provision of medical supplies as well as medicines.

At the end of 2010, MSF had 428 staff in Sri Lanka. MSF first worked in the country in 1991.



An MSF physiotherapist holds a session with a patient at the spinal injury unit in Pampaimadhu hospital, Vavuniya.

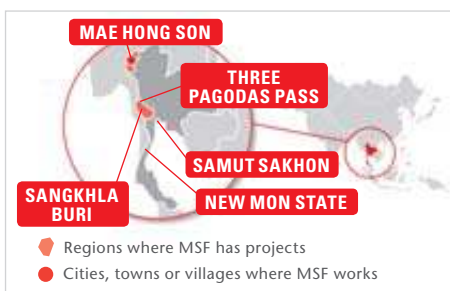
© Pete Masters/MSF

THAILAND



© Francesca Di Bonito

Patients are transferred to an MSF clinic.



Kayah backpackers

The Kayah backpackers project is based in Mae Hong Son, in the north of Thailand. MSF staff in Thailand train “backpackers” from Myanmar so that they can provide basic healthcare. The backpackers then travel back across the border and work as mobile medical teams, visiting people living in remote villages in Kayah state, eastern Myanmar, who would otherwise not have any access to medical care.

MSF closed its malaria project in New Mon State, in Myanmar, at the end of June. Staff working from a base on the Thai side of the border had been supporting malaria control initiatives in Myanmar, distributing mosquito nets, training community health workers, and diagnosing and treating patients.

In Thailand, Médecins Sans Frontières (MSF) helps improve access to healthcare for some of the estimated three million unregistered migrant workers in the country. Staff also train health workers to provide basic healthcare to people living across the border in Myanmar.

Three Pagodas Pass

Thousands of migrant workers cross the border between Thailand and Myanmar at the Three Pagodas Pass every day. Many come to work in factories, some move further into Thailand. Unregistered migrant workers are being excluded from healthcare, and undocumented migrants in need of care often fear that a visit to a health centre may result in deportation. MSF helps to provide access to medical care by operating a mobile clinic in the Three Pagodas Pass area, which provides basic healthcare. Staff conducted 146 antenatal consultations and referred pregnant women to Ministry of Health hospitals for delivery. Some 460 people were vaccinated against measles. In May, MSF distributed relief items when political tensions led to an influx of people from Myanmar. In November, staff provided healthcare to 331 people when post-election violence in Myanmar led to some

3,000 people crossing the border to Thailand. In December a fixed clinic was opened to increase the availability of care.

Samut Sakhon

In Samut Sakhon province, an industrial zone where thousands of undocumented migrants live and work, MSF staff operated a clinic offering basic healthcare, including vaccinations for children under five, antenatal care and medical care for people suffering physical trauma. More than 540 people attended health education sessions.

Working in collaboration with the Ministry of Health, MSF diagnosed and treated 170 people for cholera after an outbreak at the end of October.

At the end of 2010, MSF had 41 staff in Thailand. MSF has been working in the country since 1976.

UZBEKISTAN



An MSF laboratory scientist carries out tests to check for tuberculosis.

Gulziyma

"I was so afraid of the disease. I got good treatment, but what if it happened again? What will people say when they find out I am sick? Can I have a family? Will I be a mother? I was afraid of all the things that might never be. Like many patients, I was afraid of never being a full human again. I felt like a disabled person.

"Now I have completely forgotten all my fears. I was a patient and now I am a counsellor. I began to get rid of my fears with the counselling I received. Then I wanted to help others to get rid of theirs. Now I can say that I had TB. It's important that I use the past: I HAD tuberculosis. And recently I even became a mother."



In May 2010, Médecins Sans Frontières (MSF) began extending its programme in the Autonomous Republic of Karakalpakstan, northwestern Uzbekistan, from the capital Nukus and the district of Chimbay. By the end of 2010, MSF was working to provide TB care in four districts.

In 2010, 385 patients started treatment and a new test, which diagnoses drug resistance faster, was introduced. The aim of this test is to speed up the beginning of treatment and the isolation of DR-TB patients, helping to prevent transmission. The first patients to take the new test began treatment in October 2010.

Social and psychological support

The provision of support to the patient as well as to family members before and during treatment has been at the centre of the project. The majority of DR-TB patients suffer from side effects of their medication. Some of these, such as nausea, headaches and sleep disturbances, are quite powerful and long term, presenting a major obstacle to treatment adherence. MSF staff hold individual, group and family counselling sessions to help patients manage these side effects and the social effects of the disease, and to improve their adherence.

MSF continues to promote new approaches in diagnostics and treatment to Uzbekistan's Ministry of Health, including outpatient care options and psychological and social support, and will continue to lobby the ministry to integrate these services into its structure.

Expanding the TB programme

In 2011, MSF will enrol its 1,500th patient in the DR-TB programme in Karakalpakstan and further expand its comprehensive TB care programme to another three districts. MSF will improve infection control mechanisms and improve TB drug supply management practices, as well as train health staff.

Assisting refugees

In June 2010 approximately 100,000 people crossed the border from Kyrgyzstan to Uzbekistan in search of refuge from civil conflict. The relief operations for the refugees were strictly controlled by the government of Uzbekistan, but MSF staff managed to visit almost all the camps. The team provided relief items, including washing and cooking kits, and offered counselling to traumatised refugees.

At the end of 2010, MSF had 117 staff in Uzbekistan. MSF has been working in the country since 1997.

The prevalence of drug-resistant tuberculosis (DR-TB) in Uzbekistan is one of the highest in the world, but less than ten per cent of the population has access to adequate DR-TB treatment. There is an urgent need to expand comprehensive TB care so that everyone in need can be properly diagnosed and treated.



© Mads Nissen

Father and son, Genareros, Arauca, Colombia.

- 78 BOLIVIA
- 79 BRAZIL
- 80 COLOMBIA
- 82 GUATEMALA
- 83 HONDURAS
- 84 HAITI
- 86 PARAGUAY

THE AMERICAS

BOLIVIA



Chagas disease is one of the leading parasitic killers in the Americas and Bolivia is the country most affected.

If not treated in the early stages, Chagas can cause cardiovascular, gastrointestinal or neurological problems later in life. Diagnosis is complicated, and the Bolivian Ministry of Health does not have adequate financial or human resources to diagnose and treat the disease across the whole country.

The ministry concentrates on treating young people with Chagas disease because treatment is far more successful with children. For a child under the age of 10, the likelihood of being cured is almost 100 per cent, whereas an adult's chances could be less than 50 per cent. Children are also more likely than adults to suffer the more severe consequences of Chagas.

Chagas treatment programmes

In the department of Cochabamba, Médecins Sans Frontières (MSF) runs free Chagas programmes that are integrated into rural health centres offering basic healthcare. MSF staff diagnose and treat adults, but their main objective is to treat children under 15 years of age and women under 45. Women in this age group are a priority to help prevent the possibility of them passing the parasite to the child should they become pregnant. The side effects of the medication prevent women with Chagas from being treated while pregnant or breastfeeding, so they are monitored and then treated as soon as they finish breastfeeding. More than 1,300 patients started treatment in 2010.

The prevalence of Chagas among women of childbearing age is 70 per cent in some parts of Cochabamba's Narciso Campero province, and travel to health centres can be difficult. MSF staff screen people for Chagas and provide treatment in 26 rural communities, as well as in Aiquile, Pasorapa and Omereque hospitals. More than 1,450 people were diagnosed with Chagas and 908 began treatment in 2010.

In Cochabamba city, MSF is working in 18 health centres, integrating Chagas care into general healthcare. During 2010, 1,085 people were confirmed to have Chagas and 436 started treatment. The Ministry of Health will take over the project in 2011.

Raising awareness of Chagas

Besides diagnosis and treatment, MSF is also working on prevention. Chagas is transmitted to humans by the vinchuca beetle and preventing the beetles from re-infecting patients who have finished treatment is vital. Since mid-2009, MSF has been training patients to evaluate the presence of vinchuca beetles in their homes. MSF offers this training while visiting villages and treating patients for the disease.

Another component of MSF's awareness campaign is the "Chagas bus", which travelled from the Altiplano region to the eastern lowlands, through the semi-desert of the Chaco and the central valleys. The team on the bus informed people about prevention and encouraged them to seek testing and treatment. They also provided information so that people could educate the rest of their community about the disease and how it is spread. In addition, in the town of Aiquile and the cities of Cochabamba and Santa Cruz, three patient groups have been created to promote education and awareness about Chagas.

In May 2010 the World Health Assembly adopted a resolution on Chagas disease control and elimination, which included many steps advocated by MSF: the integration of the

diagnosis and treatment of Chagas into primary healthcare for all patients; the reinforcement of the provision of treatment in disease-endemic countries; and the promotion of operational research on the control of Chagas to promote the development of a valid and accessible test of cure. This step forward at the international level should encourage the improvement of care and treatment for the millions of people infected with Chagas disease.

At the end of 2010, MSF had 49 staff in Bolivia. MSF has been working in the country since 1986.

Pamela

21 years old

"I have been living in Cochabamba for 11 years and I have two children: Griselda, aged one, and Kevin, aged three. I was in the health centre waiting for my consultation when I heard a woman talking about Chagas. When she mentioned that the vinchuca beetle transmitted the disease, I remembered that when I was a girl we had vinchucas in my house. I was afraid of the injection but I decided to do the test. I had to take my children for testing too. Two weeks later they confirmed that we were all positive. When I got home I cried as I felt guilty that my children, my only family, were sick because of me. Kevin and Griselda have completed the treatment without pain. I am now reaching the end of treatment too."



An MSF outreach worker explains how the vinchuca beetle is responsible for much of the spread of Chagas disease, and how to protect against it.

© Anna Surmyach

BRAZIL



MSF staff set up latrines after the floods in Alagoas state.



In June, Alagoas state in northern Brazil suffered severe flooding: 34 people died, 54 were reported missing and 25,000 people were displaced from their homes.

In the days after the floods, a Médecins Sans Frontières (MSF) team found thousands of people crowded into churches, schools and other public buildings.

“At one school, nearly one thousand people were sharing six latrines”, said Cristina Sutter, one of the first MSF psychologists to arrive. “The situation was chaotic in the bigger, collective shelters. There was a strong smell of urine and a major lack of hygiene”.

Large, temporary shelters had been constructed, and to improve living conditions MSF teams installed taps, showers and latrines where they were most needed. Teams also distributed washkits containing items such as plastic bowls, towels, soap and toothbrushes.

Having lost everything in the floods, many people were suffering from anxiety and

depression. In the villages of Branquinha and Murici, MSF staff carried out 300 psychological consultations.

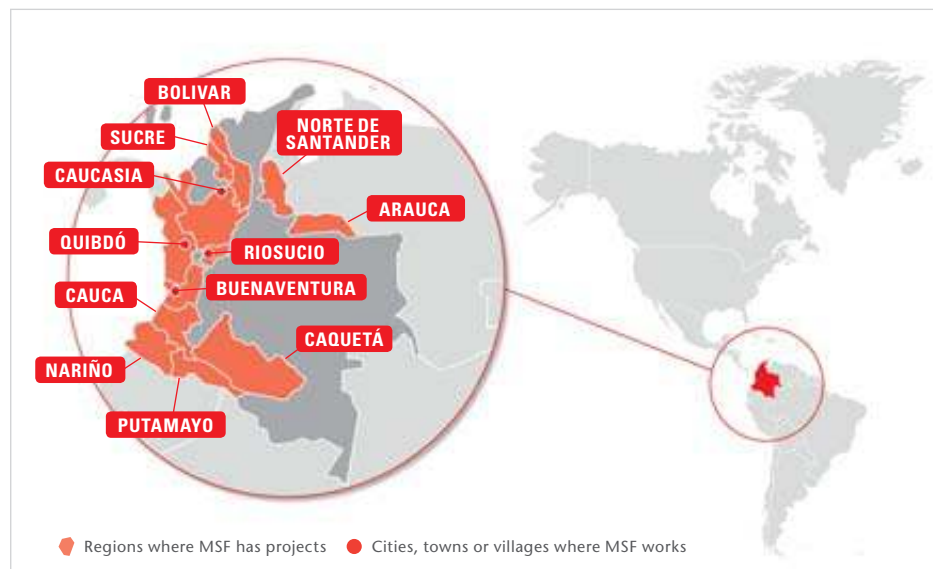
“Mental health support is essential, as it helps prevent psychological and mental problems from becoming chronic. It helps people restructure and start their lives again in a healthier and more balanced manner”, said Sutter.

After two months, the emergency phase came to an end. MSF handed over its activities to local authorities and other organisations at the end of August. MSF provided training to more than 200 local medical staff as part of the handover process, in order to ensure continuity of psychological care and to assist local organisations in improving their emergency response.

At the end of 2010, MSF had 11 staff in Brazil. MSF has been working in the country since 1991.

COLOMBIA

In 2010, formally demobilised paramilitary groups re-emerged in many areas across Colombia. The violence in the country prevents many people from accessing healthcare and Médecins Sans Frontières (MSF) projects focus on meeting the medical needs of people living in conflict zones or displaced by conflict.



Reaching people in conflict zones

In the north of the country, MSF carried out more than 13,000 consultations in the districts of Sucre and Bolivar that were most affected by violence. MSF also ran mobile clinics in Norte de Santander, carrying out almost 9,000 general consultations as well as consultations on reproductive healthcare.

In Cauca, Putamayo and Nariño, in southwest Colombia, mobile teams visited rural areas that are often the scene of violent conflict and provided general healthcare, as well as reproductive, antenatal and psychological care. In Nariño and Cauca, MSF also assisted in 11 emergencies, providing aid to more than 2,600 displaced people.

In Caquetá, MSF provides mental health services and primary healthcare. Staff managed to reach people living in rural areas of the districts of San Vicente del Caguán and Cartagena del Chairá, who are highly exposed to armed conflict, and where health services are scarce. In total, MSF teams carried out more than 50,777 general medical consultations in Caquetá, Cauca, Nariño and Putamayo.



A member of staff examines test results for a patient with Chagas disease, Genareros, Arauca.

Mental healthcare

Mental healthcare is particularly important for people who are exposed to high levels of violence, but it is a service that has been neglected by Colombia's health system. MSF provided care for more than 12,000 patients in the departments of Caquetá, Cauca, Nariño, Putamayo, Norte de Santander, Sucre and Bolívar. Staff held individual consultations, group consultations and psychosocial support sessions. In 2010, MSF drew attention to mental health needs with its report on Caquetá: *Three Times Victims: Victims of Violence, Silence and Neglect, Armed Conflict and Mental Health in the Department of Caquetá*, Colombia. The report concluded that there is a significant need for specialised mental health services, and that it is possible to effectively provide good quality mental health services to Colombians caught up in conflict.

Healthcare in Chocó

San Francisco de Asís hospital's maternity unit, in the town of Quibdó, Chocó department, is the referral centre for all complicated obstetric cases in the department. Since MSF started work in the unit in 2003, it has set up a neonatal ward, trained staff, provided care to victims of sexual violence, and held more than 40,000 consultations. In 2010 MSF handed the project over to a local healthcare provider that has the capacity to take over the activities.

The mobile and fixed clinics along the San Juan River, as well as a boat ambulance, were also handed over. Remote villages along the river will continue to receive healthcare, and MSF staff will continue to operate along the Baudo River.

The MSF clinic in the town of Riosucio, in Chocó department, will continue to provide free healthcare. Staff offer mental health and reproductive health services, and a programme providing medical and psychological assistance to victims of sexual violence. More than 4,400 consultations were carried out in 2010. MSF also supported and provided emergency obstetric care in Riosucio hospital.

Healthcare in Buenaventura

People living in rural areas of Colombia are often forced to choose between living under the threat of violence and taking the risk of giving up everything to move to the city.

Many people displaced by conflict have moved to the Pacific coast. A large number of displaced people have moved to Buenaventura city, in the department of Valle del Cauca. In 2007, MSF set up a health centre providing free consultations to those without any other access to medical care. Staff provided antenatal and postnatal care, vaccinations, emergency services, reproductive healthcare, mental healthcare, treatment for malnutrition and support for victims of sexual violence.



Chagas screening in Genareros, Arauca.

Between January and September 2010, 15,520 general consultations were carried out, mainly treating skin and respiratory infections.

In Miramar, a district of the city built on stilts, lack of access to safe water was a significant factor in the incidence of skin and gastric diseases. An MSF team ensured a safe water supply to the residents of the district and, in doing so, repaired more than 700 metres of bridges.

The number of people in Buenaventura suffering from multidrug-resistant tuberculosis is more than three times the national average – Buenaventura is a busy port, and it is likely that the movement of goods and people facilitates the spread of the bacteria. At the end of December 2010, MSF began to support the national tuberculosis control programme with testing and treatment.

Chagas programme

Chagas disease is endemic in Colombia, yet detection and treatment programmes are non-existent at the departmental and national

levels. MSF's Chagas programme in Arauca is integrated into the mobile clinics that offer general healthcare. More than 2,750 people were screened, and 34 patients were found to have Chagas in 2010, half of whom had completed treatment by the end of the year (the others are still receiving treatment). There are plans to extend Chagas care to the department of Norte de Santander in 2011.

Relief after the rains

Higher than average rainfall in 2010 led to flooding, which made more than 1.5 million people homeless. MSF participated in the emergency response by providing relief items, including plastic sheeting for temporary shelters, mattresses, blankets and hygiene kits to thousands of displaced people in the departments of Bolívar, Caquetá, Chocó, Nariño and Sucre.

At the end of 2010, MSF had 306 staff in Colombia. MSF has been working in the country since 1985.

GUATEMALA



© Marcell Nimfuehr

A nurse explains to hospital visitors the consequences of sexual violence and the treatment services offered by MSF, Guatemala City.



There is a national protocol in place for treating victims of sexual violence, but it has only been implemented at one clinic in the capital. Many survivors are unable to access treatment, and are often unaware that their physical and mental symptoms can be treated.

MSF's programme takes a multidisciplinary approach to treating sexual violence. MSF offers medication that significantly reduces the likelihood of patients contracting HIV and other sexually transmitted infections if taken within 72 hours of the incident. In 2010 around 57 per cent of patients arrived early enough for this treatment to be effective. A psychological team provides counselling to help patients cope with the

In 2010, Médecins Sans Frontières (MSF) was providing medical, psychological and social care to victims of sexual violence in two clinics in Guatemala City, as well as in the General Hospital and the Ministry of Justice, where assaults are reported. Although thousands of cases of sexual violence are reported each year, it is estimated that 75 per cent of sex crimes go unreported.

acute stress, anxiety and other effects arising from their experience. A social worker is also available and provides support by, for example, helping patients to find a safe place to stay if they are still in danger.

In 2010, MSF treated 870 new patients. Including those who had started treatment in previous years, 1,200 patients received medical care, and 2,800 received psychological counselling.

In the coming years, MSF aims to encourage more and better implementation of national guidelines in clinics. Teams will also use community information networks, medical conferences and the media to raise awareness that medication is available to help prevent the transmission of infections such as HIV, and that treatment must be sought as early as possible.

Natural disaster

The eruption of volcano Pacaya and tropical storm Agatha at the end of May killed almost 200 people. Overflowing rivers, collapsed bridges and the damage caused by mudslides resulted in the displacement of tens of thousands of people. Teams from MSF assisted people in the departments of Retalhuleu, Escuintla and Santa Rosa. Over 20 days, staff distributed hygiene kits (containing toothbrushes, soap, sanitary towels, buckets, etc.), and provided medical care, drinking water and mental health support to people affected by the flooding.

At the end of 2010, MSF had 39 staff in Guatemala. MSF has been working in the country since 1984.

HONDURAS



Honduras has the highest murder rate in Central America, and people living on the streets of the capital city Tegucigalpa are especially vulnerable to violence. In a Médecins Sans Frontières (MSF) survey carried out in 2010, almost 59 per cent of homeless people under the age of 18 reported having been subjected to physical violence in the last year, and 45 per cent claimed to have suffered sexual violence.

People living on the streets are therefore in particular need of medical and psychological care. Often, however, health centres in the city deny treatment to homeless people because of a perceived security threat.

From 2005 to 2010, MSF staff operated a centre providing medical treatment for people under the age of 24 who were living on the streets. Staff gave medical and social support to 460 young people over five years. Patients most often required treatment for respiratory diseases, skin infections and injuries resulting from violence. The centre also provided a space where visitors could wash, eat and try to recover from the effects of drug abuse. Patients received psychological support, which helped some to move on and find work or a place to live.

A change in approach

In 2010 MSF undertook an evaluation of the services it was providing to homeless people in Tegucigalpa, and decided that a new approach would meet the people's needs more effectively. The centre was closed at the end of August and a team has begun preparing for a new programme. This will provide broader services to all age groups in a larger geographic area. Instead of expecting people to visit a centre, MSF staff will go out on to the street and actively reach out to vulnerable groups living in the most

deprived areas of the capital. This approach should enable MSF to assist more people and to respond better to the full range of their needs.

Dengue outbreak

An alarming increase in cases of dengue fever in mid-2010 prompted MSF to offer support to local health services' response in the capital, where the majority of cases were reported. Dengue is a viral disease transmitted by mosquitoes. Symptoms are similar to flu, and its most severe form, haemorrhagic dengue, causes bleeding and can lead to irreversible shock and death.

Between August and September MSF teams provided medical care, vector control – controlling the means of transmission of the disease – and community education. Staff set up an emergency paediatric ward in San Felipe hospital, where 163 children received treatment. Mobile teams also worked to identify and eliminate sources of infection in the Manchen settlement, on the outskirts of Tegucigalpa. Staff travelled from house to house to raise awareness of how to stop the mosquitoes breeding and spreading the virus. The teams also fumigated some 1,600 households and donated more than 400 mosquito nets to hospitals.

At the end of 2010, MSF had 28 staff in Honduras. MSF has been working in the country since 1988.



A young patient is examined in the MSF dengue ward at San Felipe hospital, on the outskirts of Tegucigalpa.

HAITI

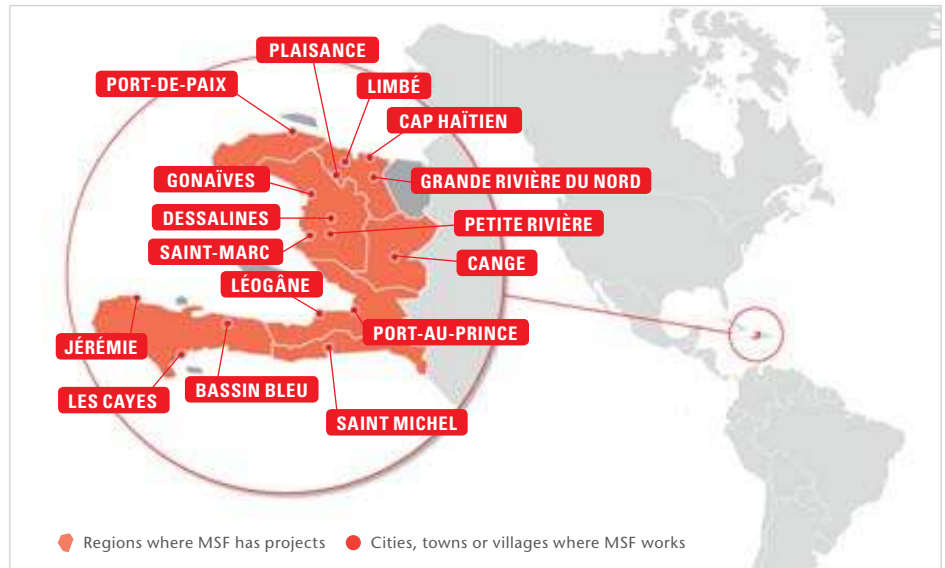
In the wake of the devastating earthquake of 12 January 2010, which killed an estimated 222,000 people and left 1.5 million homeless in Haiti, Médecins Sans Frontières (MSF) mobilised the largest emergency response in the organisation's 40-year history.

Just ten months later, MSF staff supported their Haitian colleagues in tackling a nationwide cholera outbreak that would infect more than 180,000 people in less than three months.

Before the earthquake struck, healthcare was out of reach for most Haitians, as fees charged by both public and private health facilities made it unaffordable. Public hospitals and clinics were plagued by management problems and strikes, and shortages of staff, drugs and medical supplies. Patients could be turned away because the hospitals were full, or would have to abandon treatment when they ran out of money. Giving birth was a risk: Haiti's reported maternal mortality rate was 630 deaths per 100,000 live births.

Then the earthquake hit and threw Haiti into a period of turmoil that went beyond anything even its most beleaguered residents had known.

Thousands of Haitians, most of whom were directly affected by the disaster, mobilised along with hundreds of international staff to



help MSF provide assistance. MSF's regular deployment of 800 field staff in Port-au-Prince quickly expanded to 3,400 people working in 26 hospitals and four mobile clinics. From 12 January to 31 October, medical teams treated more than 358,000 people and performed more than 16,500 surgeries.

Treating the wounded

Sadly, 12 Haitian MSF staff members were killed in the earthquake. The MSF obstetric and trauma hospitals were destroyed. Only the Martissant emergency facility, in south Port-au-Prince, was still operational, but it was quickly overwhelmed. Within hours of the earthquake, more than 400 critically injured patients had arrived at Martissant.

At the MSF centre in Pacot, which provided post-operative care, only one operating table was available for minor operations. In and around the collapsed La Trinité hospital, surgery was carried out in tents and, after a few days, in a converted shipping container. Within approximately 48 hours, MSF identified available rooms and a dressing station at the Ministry of Health's Choscal hospital and managed to start surgical activities in two operating theatres there. By 15 January, major surgery was also being provided in tents around Carrefour hospital. MSF surgeons performed more than 5,700 major surgical procedures during the first three months, 150 of which involved amputations.

Emergency field hospitals were set up in all kinds of structures – a dental clinic at Bicentenaire, a school in Carrefour, and semi-permanent buildings in Léogâne, west of Port-au-Prince. An inflatable tent hospital replaced the destroyed La Trinité hospital and provided emergency medical care as well as more specialised trauma and orthopaedic surgical care. In Sarthe, MSF opened a centre for post-emergency surgery and post-operative care. More than 500 patients underwent specialised orthopaedic or reconstructive surgery. Handicap International physiotherapists worked in collaboration with MSF to help patients recover and adapt to prosthetics. Mental healthcare was also provided.

Jacmel, a town on the south coast, was also badly hit by the earthquake, and MSF teams started supporting the 80-bed Saint Michel hospital on 22 January. Staff carried out 662 surgical operations and delivered 1,443 babies over the course of the year.



A man carries a woman infected with cholera into St Nicholas hospital, Saint Marc.



Staff operate on a patient with broken legs at a makeshift surgery outside Carrefour hospital, Port-au-Prince.

Emergency obstetric care

As MSF's emergency obstetric hospital had been destroyed, MSF started offering staff, drugs and obstetrics expertise to support the Ministry of Health maternity hospital, Isaïe Jeanty, which had not been damaged by the earthquake. Isaïe Jeanty treats pregnant women with medical complications such as eclampsia and malaria, and provides neonatal and postnatal services and a blood bank. In Léogâne, MSF set up a 120-bed field hospital, which was later replaced with a more permanent container hospital. More than 15,000 babies were delivered in MSF-supported facilities in 2010.

Specialised care

When La Trinité hospital was destroyed, Haiti lost its only specialised treatment unit for severe burns. Re-establishing this unit became a priority, especially given the dangerous living conditions. By late March, a new 30-bed burns unit had been set up under canvas within the nearby Saint Louis hospital compound.

Psychiatric care was also organised at Saint Louis hospital for patients who required mental health services and could be referred from other MSF programmes or other health providers. MSF gave psychosocial or psychiatric support to more than 40,000 people during the initial emergency phase.

Non-medical assistance

By the end of June, MSF had distributed more than 28,640 tents, approximately 2,800 rolls of plastic sheeting, and close to 85,000 relief supply kits (made up of items such as cooking utensils, hygiene products and blankets) to people living near the epicentre of the earthquake. In Léogâne, for example, MSF made distributions to 3,000 families.

Much of MSF's water and sanitation work focused on creating the appropriate hygiene conditions to carry out medical and surgical programmes. Teams ensured the supply of safe water, constructed or rehabilitated latrines, and set up the safe evacuation of waste at MSF's 26 facilities.

Cholera outbreak

In mid-October, suspected cases of cholera, a disease not reported in the country for decades, emerged in the Artibonite region, western Haiti. MSF dispatched teams to the town of Saint Marc and they immediately began treating patients for severe dehydration from diarrhoea in the Ministry of Health hospital.

The outbreak would eventually touch every province in the country. From 22 October until the end of the year, MSF treated more than 91,000 of the 171,300 people reported as having cholera nationwide. Specialised treatment centres were set up for pregnant women in Isaïe Jeanty hospital and in

Léogâne. Teams established over 4,000 beds in 47 facilities around the country. More than 1,000 tons of medical and logistical supplies were delivered, and more than 5,500 staff dedicated to cholera treatment.

In 2011, MSF will relocate its medical activities – including the obstetric centre and the only burns treatment unit – into three newly constructed hospital facilities in Port-au-Prince. Outside the capital, MSF will continue to operate a 120-bed general hospital that it has built in Léogâne. For more on MSF's activities in Haiti, see the photo essay on pages 100–103.

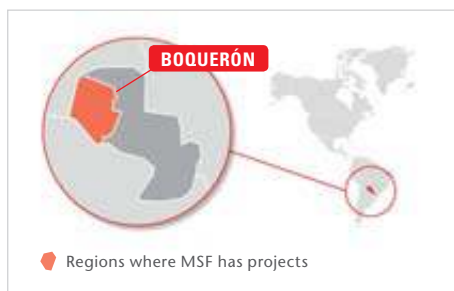
At the end of 2010, MSF had 2,918 staff in Haiti. MSF has been working in the country since 1991.

Nanoune

28 years old

"I was expecting twins and I gave birth prematurely at six months of pregnancy. I live in a camp ten minutes from Choscal hospital. My first baby came in the tent but was stillborn. Immediately my sister accompanied me to the hospital. My second baby was born here but she is too small. The nurses have been taking care of my daughter for five days. She has yet to be named ... I pray to keep her."

PARAGUAY



Chagas disease is endemic in the Gran Chaco region, which borders Paraguay, Argentina and Bolivia. In November 2010, Médecins Sans Frontières (MSF) began a Chagas diagnosis and treatment programme in Paraguay.

Chagas disease is a parasitic, potentially life-threatening illness. Up to 30 per cent of people infected end up developing serious cardiovascular, gastrointestinal or neurological problems in their adult years if the disease is not diagnosed and treated in the early stages. Diagnosis itself is complicated, and staff or facilities are often not available to carry out the necessary tests.

Boquerón department is in the Paraguayan Chaco, a sparsely populated and semi-desert region in the west of the country. Access to healthcare is poor here and MSF teams are visiting remote settlements, screening the people for Chagas and giving those infected the treatment they need. MSF has trained health workers in Boquerón to diagnose and treat the disease, and the main laboratory in the regional hospital has been equipped to be able to confirm it. In the last two months of 2010, MSF staff screened 426 people for Chagas disease.

The “Chagas Bus” arrived in Boquerón from MSF’s project in Bolivia, and the team on board has been travelling around schools and villages, educating and informing people about the disease and how to prevent transmission, and encouraging them to seek testing and treatment.

At the end of 2010, MSF had 6 staff in Paraguay. MSF started working in the country in 2010.



An MSF team visits a village in the Paraguayan Chaco to inform people about Chagas disease and encourage them to get tested.



© Olmo Calvo

Migrants and asylum seekers held in a detention centre in Malta.

88 FRANCE

89 GREECE

90 MALTA

91 RUSSIAN FEDERATION

92 IRAQ

94 IRAN

95 LEBANON

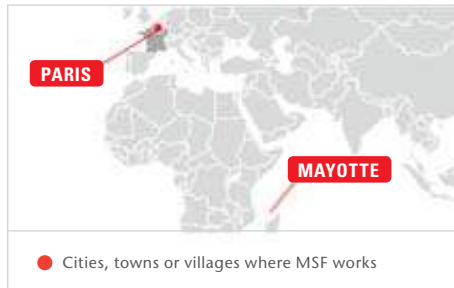
96 OCCUPIED
PALESTINIAN TERRITORY

97 SYRIA

98 YEMEN

EUROPE & THE MIDDLE EAST

FRANCE



Many asylum seekers in France do not receive a residence permit or their asylum applications are denied. Not having any legal status has serious social consequences – no home, no social assistance, no right to work – which in turn cause problems in accessing healthcare.

Psychological support

In 2007, Médecins Sans Frontières (MSF) established a centre for asylum seekers in need of psychological support in Paris. The patients are mainly Afghans, Chechens, Guineans,

Eritreans or Sri Lankans who have escaped armed conflict or persecution. MSF staff assess the patients' condition and ensure that they get the necessary medical and psychological care. The programme focuses on assisting those whose distress is the most severe, who do not speak French or who do not have a residence permit, as these people find accessing healthcare especially difficult. In 2010, 210 patients received psychological care.

Anxiety levels are extremely high among patients: 40 per cent speak of having suicidal thoughts. Many have had traumatic experiences in their home country, on their journey, or in Europe. The vulnerability and uncertainty of the migrant's or asylum seeker's current situation can exacerbate stress.

Conditions for such migrants are likely to get even worse, as at the end of 2010 restrictions were placed on access to healthcare for vulnerable foreigners – undocumented migrants and foreigners with serious illnesses that cannot be treated in their home country.

Medical intervention

An outbreak of scabies in mid-2009, when local hospitals were overstretched, led MSF staff to begin medical consultations for migrants living in the streets of the 10th district of Paris. The team continued its

work in 2010, holding more than 1,900 consultations for around 400 patients.

Healthcare in Mayotte

In May 2009, MSF opened a health centre in a shanty town in Mamoudzou, the capital of the French island of Mayotte, in the Indian Ocean. Many of the people living in the shanty town do not have a clear legal status, despite around half of them having been born in Mayotte. Increasingly repressive policies toward those with irregular status (in 2010 more than 21,000 people were expelled to the Comoros Islands) make accessing healthcare very difficult. MSF staff provided basic healthcare and carried out more than 20,000 consultations for 7,500 patients between May 2009 and September 2010. In September 2010 MSF decided to halt activities. The objective had been to provide access to healthcare for marginalised people by bringing it directly to them. It became clear over the course of the project that critically ill people could obtain treatment, especially in emergencies, and that the main obstacles to medical care were linked to legal issues and fear of arrest, which are beyond MSF's mission.

At the end of 2010, MSF had 14 field staff in France. MSF has had operational activities in the country since 1987.



A doctor examines a patient at the health centre in Kaweni, Mamoudzou, Mayotte.

© Isabelle Ferry

GREECE



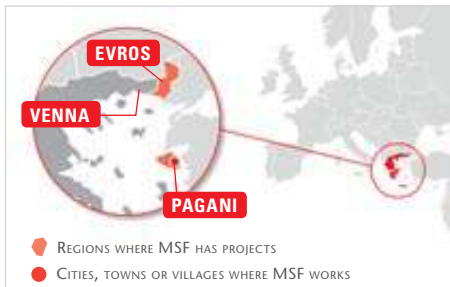
A doctor examines a young patient who has been detained in the border police station of Soufli, Evros.

Azar*

detained in a border police station in Evros

"It's been 64 days now that I have been detained at this border police station, and the conditions are unimaginable. The cell is for 35 people, and there are 124 of us. There is no space to lie down and sleep, you cannot get to the toilet. All of us who are detained in this place are reaching a point where we don't know how all this is going to affect our bodies or our mental health. A free human being has two metres free space to walk, and can go out in the yard – why should we be treated like animals? I cannot have any dreams for my future."

** The patient's name has been changed.*



Irregular – undocumented – migrants and asylum seekers are systematically detained upon arrival in Greece. In 2010, many of the detention centres and police stations where they are held were overcrowded, operating at two or three times their capacity, and living conditions were appalling.

Psychosocial support

Between August 2009 and May 2010, Médecins Sans Frontières (MSF) provided psychosocial support, helping migrants and asylum seekers to cope with their situation in three detention centres: Filakio and Venna, both in northeastern Greece, and Pagani on the island of Lesbos. Psychologists offered individual and group counselling sessions, and held more than 380 consultations with 305 patients, as well as nearly 80 group sessions.

Detention has exacerbated existing distress and contributed to new symptoms of trauma.

In 2010, more than 47,000 undocumented migrants and asylum seekers were arrested at the land border between Greece and Turkey, according to Greek police data. Many had left unstable or wartorn countries, or were escaping persecution, human rights violations or extreme poverty.

Of the migrants who received care from MSF, 39 per cent showed signs of anxiety, while 31 per cent had symptoms of depression. In June 2010, in the report *Migrants in Detention: Lives on Hold*, MSF documented the unacceptable living conditions in the three detention centres and the impact of detention on the wellbeing and mental health of the migrants.

Emergency assistance in Evros

In December 2010, the situation for migrants held in detention in the Evros region had become critical. Men, women, young children and unaccompanied minors were being crowded together in the same cells. People had to sleep on the floor next to the toilets. A typical situation was for two toilets and two showers to be shared by more than 100 people, and cleaning and personal hygiene materials were scarce. Freezing temperatures and a non-functioning heating system made conditions even worse.

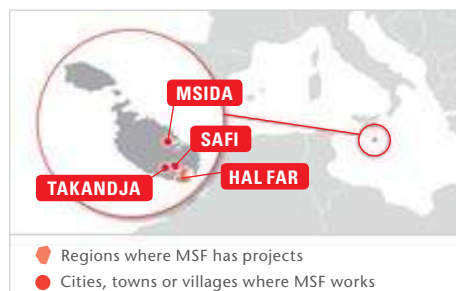
The Ministry of Health medical staff working in some of the detention centres were too few

to care for the thousands of migrants. Medical services were inadequate: new arrivals were not systematically screened by medical staff and there were no interpreter services.

Since the beginning of December 2010, MSF teams have been providing emergency medical and humanitarian assistance to improve living and hygiene conditions in Evros, the border police stations of Tycherio, Soufli and Feres, and the Filakio detention centre. Doctors treated more than 850 patients, referring 15 to local hospitals, between December 2010 and the beginning of 2011. The team also distributed 3,500 sleeping bags and 2,500 personal hygiene kits.

At the end of 2010, MSF had 8 field staff in Greece. MSF has had operational activities in the country since 2008.

MALTA



Thousands of migrants and asylum seekers are living in detention or in open centres in Malta, and conditions can be very hard. Unwelcoming measures are affecting migrants' health. In 2008, Médecins Sans Frontières (MSF) set up a programme to provide medical and psychological care in the detention centres to which all new arrivals were sent.

There have been improvements in making healthcare available to migrants over the past two years, but access remains difficult for those without official permission to stay in the country, particularly those whose asylum applications have been rejected.

Medical care in detention centres

From August 2008 until October 2010, MSF ran medical activities in Safi, Lyster Barracks and Takandja detention centres. In Safi and Lyster Barracks, appalling living conditions and poor access to healthcare contributed to the deteriorating physical and mental health of detainees.

Many migrants have experienced multiple psychological traumas relating to violence, including sexual violence. These may have occurred in their country of origin, on their journey to Europe or upon arrival in Europe. Poor living conditions, a precarious social situation and a lack of future prospects exacerbate the effects of mental trauma and many people have difficulty coping.

In 2009, MSF suspended its work in the detention centres as the poor conditions in the centres were compromising the effectiveness of its medical care. MSF resumed work in Takandja between June 2009 and October 2010, screening new arrivals and carrying out consultations. In total, from 2008 until 2010, MSF staff held more than 4,670 medical consultations and 724 psychological consultations in the detention centres, and almost 3,000 people participated in health or hygiene promotion workshops.

Working in open centres

Until June 2010, MSF medical teams worked at a clinic located at Hal Far, in southern Malta, holding more than 2,150 medical and 727 mental health consultations between August 2008 and June 2010 for migrants

and asylum seekers who had been moved from detention to open centres. Health promotion teams held 165 workshops on hygiene and other topics both on site and at the open centres.

By the second half of 2010, fewer arrivals and an improvement in healthcare provision for asylum seekers and migrants meant that the emergency phase was over. MSF focused its energy on the creation of a sustainable network that would be able to provide mental health support on a long-term basis.

Cultural mediation

Cultural mediators facilitate communication between patients and health staff by removing many barriers of language and culture. MSF successfully advocated for and initiated the provision of cultural mediation services, assisting almost 7,700 consultations in this way. In 2010 the national health authorities employed five cultural mediators to assist in the provision of care at health centres, four positions were opened in Mater Dei hospital, the largest public hospital, and plans were made to create positions at Mount Carmel hospital.

At the end of 2010, MSF had 9 staff in Malta. MSF has been working in the country since 2008.



Abdi

24 years old, from Somalia

"I am now living in this tent... in the sun, in the rain. In the afternoon it is impossible to stay inside because it is too hot. And we have nothing to do. In the camp there are these classrooms, but there is no teacher. We don't learn anything. I have been here for one year and I haven't been taught one single word of Maltese. I can't study, I can't buy books, I can't help my family back in Somalia either. In Malta I have no future, no life, no education, no opportunity for development. We are all stuck. Our lives are wasted here. But we can't go back."

RUSSIAN FEDERATION

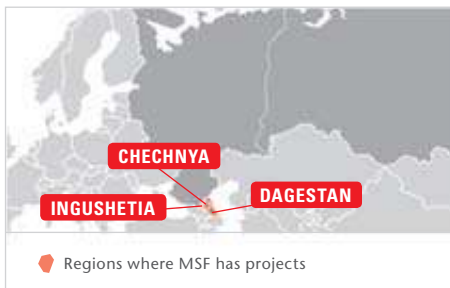


A counsellor holds the youngest member of a displaced Chechen family who are receiving psychosocial support from MSF.

Leïla

35 years old

Leïla has just given birth to her eighth child, by caesarean section. She survived the two wars and, unlike younger mothers, she managed to finish school, but she has never worked. She cannot afford to see a specialist for a postnatal consultation, and instead visits the MSF gynaecological clinic in Kalinovskaya, a large village in the north of Chechnya, where she can get free medical care.



The number of violent incidents in the North Caucasus, in the south of Russia, increased in 2010. Most occurred in the Republic of Dagestan, although Ingushetia, Chechnya and Kabardino-Balkaria also saw more deaths as a result of violence.

The security problems are affecting the availability of medical care, and poor economic conditions and a shortage of medical staff make the situation more difficult. MSF is working to improve access to healthcare across the region.

Supporting victims of violence

In Ingushetia and Chechnya, Médecins Sans Frontières (MSF) ran a psychosocial support programme for residents and displaced people affected by violence. In 2010, the programme focused on providing counselling services to people living in mountainous areas, where violent incidents are more frequent.

In Dagestan, MSF staff are working in the city of Khasavyurt, providing general healthcare and counselling services to displaced people and migrants in the market area of the city.

Assisting mothers and children

Since 2005, MSF has been operating gynaecological and paediatric clinics in two districts of Grozny, the capital of Chechnya. These clinics focus on providing care for

vulnerable groups such as mothers raising large families on low incomes. MSF also donated drugs and medical supplies to the mother and child centre in Grozny, and to health facilities in Shatoy, Sharoy and Itum-Kale in the south. In August 2010, MSF opened gynaecological and paediatric clinics in two rural locations in northern Chechnya (Naursky and Shelkovskoy districts).

Strengthening the Chechen TB programme

In 2010, MSF played a stronger role in helping to develop capacity within the Chechen tuberculosis (TB) programme. The main focus was on improving quality in TB dispensaries and laboratories. In 2010, MSF found significant levels of multidrug-resistant tuberculosis (MDR-TB) among its patients, so in 2011 MSF is aiming to expand its programme in Chechnya to include MDR-TB treatment.

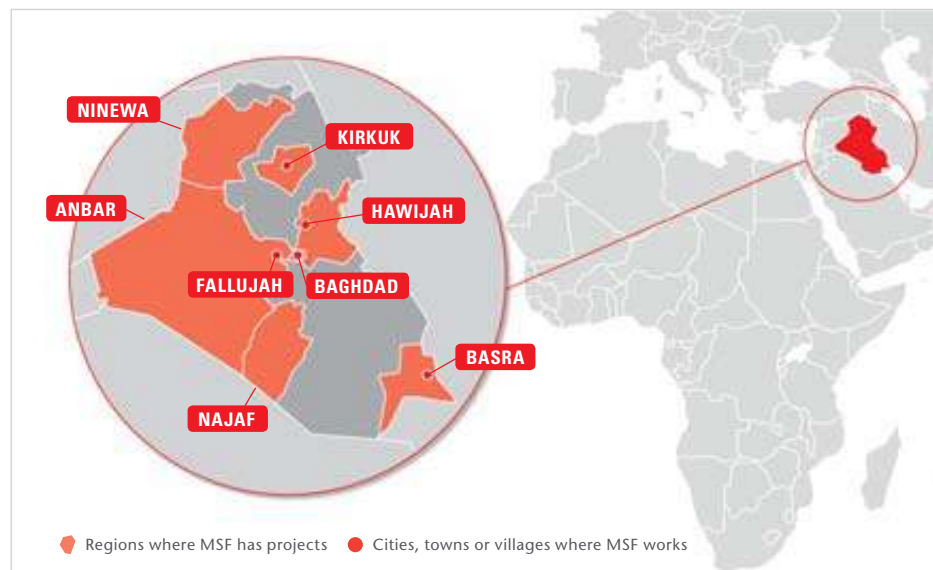
At the end of 2010, MSF had 192 staff in the Russian Federation. MSF has been working in the country since 1988 and in the North Caucasus since 1995.

IRAQ

The seventh year of violence and political tension since the war itself saw continuing pressure on the emergency capacity of the health system in Iraq. The needs are not only for trauma care following explosions but for a whole range of specialist services.

Médecins Sans Frontières (MSF) has been attempting to fill some of the gaps that have been identified in obstetric care, mental health and other specialised services. It has also sustained its training and support for general surgery and its reconstructive programme for severely wounded people who are brought to neighbouring Jordan for treatment.

Activities are still considerably restricted by the remaining threats to staff but the response to pressing needs in the country developed in new directions in 2010. The ability to travel



and work in some of the more stable parts of the country has increased MSF's capacity to support these more complex areas of medicine and to raise standards of care.

In the areas most affected by violence, bombings and assassinations continue and dozens of people are killed or wounded

every month. Fear of violence has driven people from their homes, while others are trapped inside them with significant consequences for their physical and mental health. Direct access to victims of the violence in the most densely populated areas remains limited for international and independent humanitarian organisations.



A physiotherapy session for a patient with a hand injury, Amman, Jordan.

© Philippe Conti



© Khalil Sayyad

Neonatal care in Basra general hospital, Iraq.

Although many health facilities are functioning, the quality of care has been affected by a shortage of specialised staff and lack of training. According to the Iraqi health ministry, hundreds of medical employees have been killed in the course of the conflict and great numbers have fled the country. Iraq is short of nurses and of specialist doctors, including psychiatrists and psychologists. There has been no upgrading of skills since the early 1990s. Iraq's doctors once provided some of the highest quality and best resourced services in the region, but now the quality of some medical services is seriously impaired.

Maternal and child health

Just one of the consequences is that maternal and infant mortality has been rising in the country. In October 2010, MSF started a project to improve the quality of obstetric and perinatal care in Al Zahra district hospital, the main specialist referral centre in Najaf governorate. Staff worked in the neonatal unit, and also focused on supporting emergency facilities, infection control, drug supply and staff training. That form of support has also been the pattern for MSF's work in the setting of the general hospital in the major southern city of Basra, where MSF has worked since 2006. Staff treat as many as

20,000 people a month for the whole range of injuries and illnesses. In the northern city of Hawijah, an MSF surgical team of Iraqi doctors in the general hospital performs around 300 operations a month.

Renal dialysis

In the city of Kirkuk, MSF supports the dialysis unit of the public hospital and started a renal treatment programme in June 2010 for patients with severe kidney failure. The target is to treat around 80 people who need the complex dialysis procedure. A visiting Swiss specialist, Dr Patrick Ruedin, was advising the team. "The number of patients concerned is indeed very limited. However, they would all die if they couldn't get the treatment. One could look at dialysis as an elite treatment while there are more glaring needs, but Iraq has the means of reintroducing the specialty; they just need a bit of a boost."

Reconstructive surgery

The reconstructive surgery programme in the Jordanian capital of Amman, which was started in 2006, continued to receive Iraqi patients. In 2010, more than 300 people benefited from the orthopaedic, maxillofacial and plastic specialties. Treatment and follow-up are complex,

requiring months of hospitalisation. As an illustration, 19,000 individual physiotherapy sessions were carried out over the year.

Mental health services

A more recent development has been in the neglected area of mental healthcare. Hospital staff from the Ministry of Health were trained as counsellors by MSF and are now working in units in two hospitals in Baghdad and one in Fallujah. In 2010, over 5,000 sessions took place to reduce the mental trauma patients were experiencing from their exposure to violence and insecurity. The counsellors are supported by video-conferencing systems, which allow international staff to work with them from outside the country.

The pattern of remote support for Iraqi staff and for Ministry of Health facilities still prevails, with MSF providing triage training to doctors from three hospitals in Kirkuk, and in Ninewa.

At the end of 2010, MSF had 273 staff in Iraq. MSF first worked in the country in 2003.

IRAN



Hundreds of thousands of Afghans live in Sistan-Baluchestan, a remote province in southeast Iran where living conditions are poor and opportunities are limited. Afghans face restrictions on work, access to education and access to health services. In 2007, the province was declared closed to foreigners. According to officials, this was to control cross-border crime.

For more than a decade, Médecins Sans Frontières's (MSF) assistance in Iran has focused on medical support for vulnerable and minority groups. MSF has opened three

One to two million undocumented Afghans are estimated to be living in Iran. People are continually crossing the border between the two countries, both voluntarily and under pressure from Iran's policy of repatriation. Most of the Afghans living in Iran are longstanding residents.

clinics in Zahedan, the provincial capital of Sistan-Baluchestan. In 2010 staff held more than 6,300 consultations per month. MSF refers patients requiring specialist medical and surgical care to Ministry of Health structures, covering the costs of emergency care, specialist consultations, treatment and hospitalisation. All referrals are followed up by an MSF doctor.

Maternal care

In a fourth clinic, MSF focuses on maternal and paediatric care. The team ensures that straightforward deliveries are referred to the national safe delivery centres, and high-risk births are referred to the city's hospitals. A home

visitor team, which includes midwives, brings some postnatal care directly to patients at home.

Relief for vulnerable people

Providing care for the most vulnerable people remains MSF's first objective, and there is a team responsible for identifying vulnerable people and ensuring that they get the care they need. Staff make home visits in Zahedan to find returnees, identify their needs, offer training in basic hygiene and distribute relief items such as food, cleaning materials, blankets and heaters.

At the end of 2010, MSF had 94 staff in Iran. MSF has been working in the country since 1996.



A patient is tested for malnutrition at the mother and child clinic in Zahedan, Sistan-Baluchestan.

© Marit Helgerud

LEBANON



Following the 2006 war in Lebanon between Israel and Hezbollah, a Médecins Sans Frontières (MSF) evaluation of the medical needs indicated that one in six people in the country were in need of psychological care.



A girl on her way home from school, Burj el-Barajneh refugee camp, Beirut.

In 2008, MSF opened a mental health centre in Burj el-Barajneh, in the southern suburbs of Beirut. Close to the mental health centre is Beirut's most densely populated refugee camp: some 18,000 Palestinians live in just 1.5 km². Despite some improvements made in 2010, general conditions in Burj el-Barajneh camp remain poor. Running water and electricity are available for only a few hours a day and, on average, one room is shared by four people. There are few education or employment opportunities, and minimal health and social service provision. This has a serious impact on the mental wellbeing of individuals. Many Palestinians are also deeply affected by the absence of prospects for the future.

The MSF mental health centre provides free mental healthcare, including home visits, counselling and social support. It primarily serves Palestinian refugees. In 2010, 780 new patients, mainly aged between 25 and 40, received care from the MSF team of psychiatrists and psychologists. The main

diagnoses observed so far are depression, anxiety, psychosis and personality disorders.

MSF mental health services have also been established within the United Nations Relief and Works Agency (UNRWA) clinic and the hospital run by the Palestinian Red Crescent Society, which are both located inside the camp. MSF's community mental health centre serves as a referral clinic for the most complicated cases. This set-up should facilitate the future integration of mental healthcare into the health system available for Lebanese residents as well as Palestinian refugees in Lebanon.

To reduce the stigmatisation of mental health issues among the people of Burj el-Barajneh, to mark World Mental Health Day in October 2010, MSF organised an art exhibition in its mental health centre and a theatrical performance in the camp.

At the end of 2010, MSF had 23 staff in Lebanon. MSF first worked in the country in 1975.

Hakim

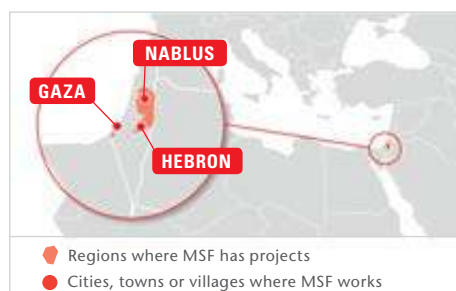
resident in Burj el-Barajneh camp

"Living conditions here are very difficult; I don't think anyone can tolerate them. Houses are congested and built in close proximity to each other, metal roofs cause temperatures to rise in the summer and allow them to drop sharply in the winter, the infrastructure is nearly non-existent, and there is very little privacy, which makes everyone seem short-tempered. Sometimes, when someone says hello, you want to start a fight with them."

"I was introduced to MSF randomly one day, while at the UNRWA clinic. They were distributing brochures that described the symptoms related to mental health disorders."

"It said, if you have one of these symptoms, you should consult a therapist. When I read it, I laughed to myself because I realised I had them all. After speaking to the community health worker, she advised me to visit the MSF centre and gave me an appointment, so I went."

OCCUPIED PALESTINIAN TERRITORY



The conflict with Israel and the inter-Palestinian conflict within the Occupied Palestinian Territory continued to traumatised the population in 2010. Economic, social and political pressures are all making an already poor health situation far worse.

The demand for psychological care is high, but capacity is limited because of a significant shortage of trained medical staff. It can be difficult for people in need of mental healthcare to find help. Médecins Sans Frontières (MSF) teams in Gaza, Nablus and Hebron provide psychological care as well as medical and social support to address the traumatic and violent consequences of the conflicts.

Gaza Strip

Teams have been working in the Gaza Strip since 2000, adapting their activities according to the needs of the population. In 2010, despite having been partially lifted, the blockade was still affecting healthcare, restricting availability, provision for people with special needs, and the general quality of care. One of MSF's main objectives is to transfer expertise to local Palestinian staff, who are unable to leave the territory for professional training. MSF is also filling specific gaps in medical care,



Staff help a patient outside the post-operative care clinic at Nasser hospital, Gaza.

providing specialised surgery (reconstructive and orthopaedic) and rehabilitation for trauma patients, as well as medical and psychosocial assistance to help patients cope after experiencing trauma. In 2010, more than 180 surgical operations were performed and mental health staff held almost 3,400 consultations. The rehabilitation team carried out more than 33,000 physiotherapy sessions.

Nablus

In the city of Nablus, MSF is running a medical and psychosocial programme for people suffering from trauma because of the conflicts. After therapy, and depending on their needs, patients are referred to MSF doctors and social workers or other aid organisations for more support in resuming everyday life. The team in Nablus extended its activities to Qalqilya, to the west of the city, and more than 2,700 psychological consultations were held in 2010.

Ahmad

23 years old

Ahmad has been arrested and detained several times in Palestinian and Israeli prisons over the last few years. He said he had been badly mistreated on some occasions. He talked about having flashbacks of the arrests, sleeping problems, aggressiveness, fear and anxiety. Since January 2010, Ahmad has been seeing an MSF psychologist. "Without exaggeration, MSF provides me with psychological relief. If it is not complete, it has certainly alleviated my frustration, the thinking, the worrying. It is very useful."

Hebron

In 2010, MSF staff carried out 1,000 individual mental health consultations, more than 350 group counselling sessions and nearly 300 medical consultations in Hebron and East Jerusalem. The majority of patients had suffered violence from Israeli forces or settlers, but others had survived violence related to internal Palestinian disputes, or domestic or sexual violence. MSF has started preparations to extend services to migrants crossing from Egypt and nomadic Bedouins in the neighbouring area of Negev who are in need of medical attention or humanitarian aid.

At the end of 2010, MSF had 169 staff in Occupied Palestinian Territory. MSF has been working there since 1989.

SYRIA



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A young Iraqi refugee, Damascus.



During 2010, Médecins Sans Frontières (MSF) carried out medical activities in Damascus, the capital of Syria, in partnership with the local organisation Migrant's Office.

According to UNHCR, the UN refugee agency, around 152,000 Iraqi refugees were registered in Syria in July 2010. Far more are living in the country without official refugee status. Estimates of how many vary between 200,000 and 1.1 million. Without documentation permitting their stay in Syria, many refugees and asylum seekers are living in precarious conditions: they are excluded from healthcare and suffer political neglect and marginalisation. Syria is also host to migrants and refugees from Afghanistan, Egypt, Lebanon, Somalia, Sudan and other countries in the region, who are living in similarly precarious conditions.

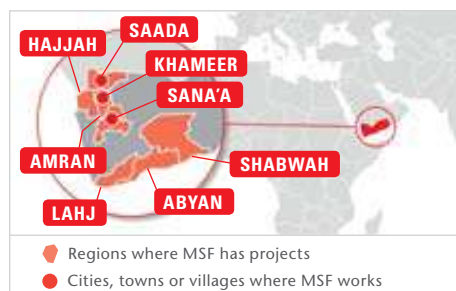
A Migrants' Office–MSF medical team of doctors, gynaecologists and a psychologist work in the clinic in the centre of the city. They provide basic healthcare services,

reproductive and sexual health consultations and mental healthcare to the most vulnerable Iraqi refugees and migrants living in Damascus, as well as to other vulnerable residents.

Last year, more than 6,200 patients received medical care. Staff held more than 1,000 antenatal consultations and deliveries were referred to the public university teaching hospital in Damascus. More than 1,000 patients received mental healthcare through individual consultations and group sessions.

At the end of 2010, MSF had 5 staff in Syria. MSF has been working in the country since 2009.

YEMEN



Conflict in northern Yemen

The sixth round of conflict in the northern governorate of Saada, between the Yemeni government and the al-Houthi armed group, was the most intense since the beginning of the war in 2004. A ceasefire was negotiated in February 2010, but sporadic clashes continued to occur throughout the rest of the year.

After having had to suspend activities for several months due to the intense fighting, MSF resumed work in Al Talh hospital, just outside the town of Saada, in March, and in Razah hospital, near the Saudi border, in April. In total, MSF staff carried out more than 32,000 consultations. During a measles outbreak between April and June, MSF and Ministry of Health staff treated more than 1,500 patients, 400 of whom were hospitalised, and carried out a vaccination campaign. In July, MSF opened a nutrition programme in Al-Jamouri hospital, also in the town of Saada, and treated 820 severely malnourished children. Staff also supported the teaching hospital in Saada.

MSF teams provided water, relief items and medical care to people displaced by the conflict but still living within Saada. Thousands more have moved to neighbouring governorates. In Amran, capital of Amran governorate, MSF supported three health structures. Staff provided emergency, postnatal and outpatient services at the Beit-el-Sultan health centre to help the centre cope with the increased number of people needing care. MSF also began assisting the emergency, surgery, maternity and reproductive health departments, as well as the nutrition programme at Al-Salam hospital in the town of Khameer. Staff carried out more than 10,000 emergency consultations, admitted some 900 people to hospital, performed 443 surgical interventions and assisted 313 births.

Around the small town of Al Mazraq, in the Hajjah governorate, there are three camps for displaced people. MSF provided general healthcare to more than 21,500 patients in the camps and ran a feeding programme, treating more than 3,300 malnourished children. Mental health teams carried out psycho-educational activities for more than 2,250 people and held 885 individual counselling

Yemen is facing a number of emergencies: multiple conflicts, displacement and a massive flow of migrants. Many people are in need of healthcare, and in 2010 Médecins Sans Frontières (MSF) expanded its activities in the country.



A newborn baby is examined by an MSF midwife, Amran governorate.

sessions. Special support was given to patients in the nutrition programme, and for victims of sexual and gender-based violence.

In August MSF began managing the hospital built by the Organization of the Islamic Conference and the Qatar Red Crescent Society, the only hospital in Al Mazraq. Since opening, staff have conducted around 3,370 emergency consultations, admitted more than 640 patients, and held antenatal consultations with more than 1,750 women.

Southern Yemen

Conflict was not confined to the north of the country. There were frequent clashes between the Yemeni army and separatist groups in the south. In July 2010, MSF teams began working in the public hospital in Radfan, Lahj governorate. More than 5,000 people received emergency treatment, over 390 surgeries were performed, and more than 300 people were admitted to hospital.

Reception of migrants

Despite being a conflict zone itself, thousands of refugees and migrants arrive in Yemen every year, escaping conflict, poverty and instability in the Horn of Africa. MSF staff provided medical assistance to new arrivals on the shores of the Abyan and Shabwah governorates. Alerted by local people to the

migrants' arrival, teams brought first aid and psychological assistance, as well as food, water and kits with clothes and hygiene products.

The migrants then moved on to be registered and spend a few days at the Ahwar reception centre. MSF ran the health facility at the reception centre and provided assistance in the emergency department of Ahwar hospital. In April 2010 MSF handed over the project to the UN refugee agency UNHCR and its implementing partners, as the number of people arriving decreased and there was less need for MSF's emergency assistance. Between September 2007 and March 2010, MSF provided medical to more than 25,000 new arrivals.

HIV care in the capital

The number of people living with HIV in Yemen is relatively low (prevalence is estimated at less than 0.2 per cent), but there is a very high level of stigma and discrimination against people who are HIV positive. MSF worked in Al Gumhuri Hospital in Sana'a, the capital of Yemen, supporting the Ministry of Health's counselling and testing services. Elsewhere in the city, MSF supported a health centre offering a prevention of mother-to-child transmission programme, and four counselling and testing services.

At the end of 2010, MSF had 467 staff in Yemen. MSF has been working in the country since 2007.

© Agnes Montanari

MSF SPECIAL REPORTS 2010

Experience Treating the Most Neglected of the Neglected Tropical Diseases **February 2010**

MSF documents its experience providing diagnosis and treatment for kala azar (visceral leishmaniasis), human African trypanosomiasis (sleeping sickness), Chagas disease and Buruli ulcer.

Bangladesh: Violent Crackdown Fuels Humanitarian Crisis for Unrecognised Rohingya Refugees **February 2010**

Without official recognition, the stateless Rohingya are prevented from supporting themselves and are not permitted to receive official relief. Action is needed now to stop this humanitarian crisis.

Sexual Violence and Migration **March 2010**

Sexual violence against sub-Saharan migrant women who arrive in Morocco on their way to Europe is a growing problem. Through data and testimonies gathered in its projects, MSF hopes to contribute to finding a comprehensive answer to this problem.

Afghanistan: A Return to Humanitarian Action **March 2010**

The space to provide neutral, independent and impartial humanitarian assistance in Afghanistan has been lost, given away or taken. This has dire consequences for the population of Afghanistan, but also for people caught up in other conflicts.

Turkmenistan's Opaque Health System **April 2010**

In Turkmenistan, HIV/AIDS, tuberculosis and sexually transmitted infections are more prevalent than reported figures would suggest. This report sheds light on some of the key issues in Turkmenistan's healthcare system and raises concerns about the role of international actors in the country.

No Time to Quit: HIV/AIDS Treatment Gap Widening in Africa **May 2010**

After years of political willingness and financial commitment to combat HIV/AIDS, donors now seem to be disengaging from the fight. Any retreat will have far-reaching and very real negative consequences for people living with HIV.



Giving Developing Countries the Best Shot: An Overview of Vaccine Access and R&D **May 2010, Oxfam and MSF**

MSF and Oxfam show how access to newer vaccines and the development of products for developing countries is faltering and failing to provide lifesaving vaccines to children in developing countries.

Migrants in Detention: Lives on Hold **June 2010**

This report documents the unacceptable living conditions in the three Greek detention centres where MSF intervened between August 2009 and May 2010 and presents data from psychological counselling sessions as well as individual testimonies.



Emergency Response after the Haiti Earthquake: Choices, Obstacles, Activities and Finance **July 2010**

Six months after the earthquake that devastated Haiti, this report attempts to explain the scope of the medical and material aid provided to Haiti by MSF since the catastrophe, and to set out the considerable challenges and dilemmas faced by the organisation.



The Ten Consequences of AIDS Treatment Delayed, Deferred, or Denied **July 2010**

This document draws upon data from MSF field research and experience providing antiretroviral treatment over the last ten years.

Three Time Victims, Victims of Violence, Silence and Neglect: Armed Conflict and Mental Health in the Department of Caquetá, Colombia **July 2010**

The mental health profile recorded among patients in Caquetá demonstrates the direct impact of the armed conflict on the mental health of the population, which the country's mental health services fail to cover.

Untangling the Web of Antiretroviral Prices **13th edition, July 2010**

This report provides a window onto the evolution of antiretroviral drug prices and sheds light on the continuing gaps in treatments needed for patients in developing countries.

Joint Review of Guangxi CDC/MSF-F HIV Project, Nanning, Guangxi Province, China, 2003–2010 **October 2010**

In early 2003, Guangxi province had the third highest rate of HIV infection in China. Seven years later, 1,724 patients have received care, many clinicians have been trained, and a comprehensive, adapted, treatment and care model has been designed and implemented.

Fighting a Dual Epidemic: Treating TB in a High HIV-prevalence Setting in Rural Swaziland **November 2010**

Swaziland is at the epicentre of a co-epidemic of tuberculosis and HIV affecting the whole of southern Africa. MSF draws upon its experience in the Shiselweni region to define the urgent practical action that must be taken in response to this major health emergency.



Hidden and Neglected: The Medical and Emotional Needs of Survivors of Family and Sexual Violence in Papua New Guinea **December 2010**

This report highlights the urgent unmet medical and emotional needs of survivors of family and sexual violence in Papua New Guinea and recommends concrete action in order to meet these needs.

MSF in Mozambique 2001–2010: Ten years of HIV projects

MSF has been helping the Ministry of Health in Mozambique develop a comprehensive plan for widespread provision of antiretroviral (ARV) treatment since 2001. At the end of August 2010, more than 200,000 patients were on ARV treatment in Mozambique, showing that the scale-up and provision of ARV treatment is indeed possible in a resource-poor country.

Ten Stories that Mattered in Access to Medicines in 2010 **December 2010**

In 2010, new tools were developed for meningitis A and for tuberculosis, promising research was published on severe malaria, an innovative mechanism was created to make lifesaving HIV medicines more affordable, and the quality of food aid improved. But donors are turning their back on AIDS, and pursuing policies that threaten access to generic medicines, measles is making a comeback, and neglected tropical diseases continue to take a heavy toll.

To read and download these reports, go to www.msf.org/reports

HAITI: A YEAR OF CRISIS

On 12 January 2010, a 7.0 magnitude earthquake rocked the capital of Haiti, Port-au-Prince, and surrounding areas. As many as 220,000 people are estimated to have died, and more than 300,000 were injured. Médecins Sans Frontières (MSF) mounted its largest ever single emergency response.

For more details on MSF's activities in Haiti, see pages 84-85.



A surgical team carries out a lifesaving procedure on a young girl in a makeshift operating theatre in Port-au-Prince.

© Frédéric Sautereau

Thousands of people needed surgery and care for physical trauma. MSF estimated that it had treated more than 3,000 wounded people in Port-au-Prince by the end of the first week after the earthquake. Many patients needed intensive nursing care after surgery: wound dressing and cleaning, physiotherapy, rehabilitation and mental healthcare. MSF established a post-operative care centre in a former nursery in the capital, and provided similar services in a number of structures around the city as well as in the town of Léogâne, west of Port-au-Prince. In the capital, an MSF team in Saint Louis hospital focused on the provision of psychosocial and psychiatric care. During the initial emergency phase, MSF provided mental health support to more than 40,000 people.



Mental healthcare is given to patients at the MSF hospital in Léogâne.



MSF provides post-operative care, physiotherapy and mental healthcare in its Kindergarten Mickey centre, in Port-au-Prince.



© Kadir van Lohuizen/Noor

A father with his newborn at Isaïe Jeanty maternity hospital, Port-au-Prince.

Prior to the earthquake, maternal mortality rates in Haiti were the highest in the western hemisphere, and MSF focused on maternity care, operating a specialist emergency obstetric hospital in Port-au-Prince. The hospital was destroyed in the earthquake, so MSF offered staff, drugs and expertise to support the Ministry of Health's Isaïe Jeanty hospital, which treats pregnant women with medical complications. In Léogâne, MSF established a new hospital offering emergency obstetric and trauma care. In 2010, more than 15,000 babies were delivered in facilities supported by MSF.



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Premature babies receive care at Isaïe Jeanty maternity hospital.



MSF medical staff treat cholera patients at a hospital in Saint Marc, where the outbreak began.



MSF's 600-bed cholera treatment centre in a gymnasium in Cap-Haïtien.

In mid-October, suspected cases of cholera were reported in western Haiti. MSF dispatched a team to the town of Saint Marc who immediately began treating patients in the Ministry of Health hospital. From then until the end of 2010, MSF teams established over 4,000 beds in 47 cholera treatment facilities around the country and treated more than 91,000 of the 171,000 people reported as having cholera nationwide.

FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, independent, private and not-for-profit organisation.

It comprises 19 main national offices in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States. There is also an International Office in Geneva and delegate offices in the Czech Republic, Ireland and South Africa.

The search for efficiency has led MSF to create ten specialised organisations, called “satellites”, which take charge of specific activities such as humanitarian relief supplies, epidemiological and medical

research, and research on humanitarian and social action. These satellites, considered as related parties to the national offices, include: MSF-Supply, MSF-Logistique, Epicentre, Fondation MSF, Etat d’Urgence Production, MSF Assistance, SCI MSF, SCI Sabin, Ärzte Ohne Grenzen Foundation and MSF Enterprises Limited. As these organisations are controlled by MSF, they are included in the scope of the MSF Financial Report and the figures presented here.

These figures describe MSF’s finances on a combined international level. The 2010 combined international figures have been prepared in accordance with MSF international accounting standards, which comply with most of the requirements of the International Financial Reporting Standards (IFRS). The figures have been jointly audited by the accounting firms KPMG and Ernst & Young, in accordance with International

Auditing Standards. A copy of the full 2010 Financial Report may be obtained at www.msf.org. In addition, each national office of MSF publishes annual, audited Financial Statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

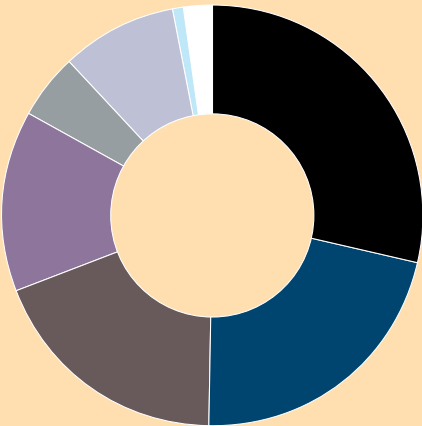
The figures presented here are for the 2010 calendar year. All amounts are presented in millions of euros.

Note: Figures in these tables are rounded, which may result in apparent inconsistencies in totals. Geographical divisions differ between the Financial Report and the International Activity Report: for financial reporting, Asia and the Middle East are combined, and Papua New Guinea is classified under Oceania.

WHERE DID THE MONEY GO?

Programme expenses by nature

| | |
|----------------------------------|-----|
| ■ National staff | 29% |
| ■ International staff | 21% |
| ■ Medical and nutrition | 19% |
| ■ Transport, freight and storage | 14% |
| ■ Operational running expenses | 5% |
| ■ Logistics and sanitation | 9% |
| ■ Training and local support | 1% |
| ■ Consultants and field support | 2% |



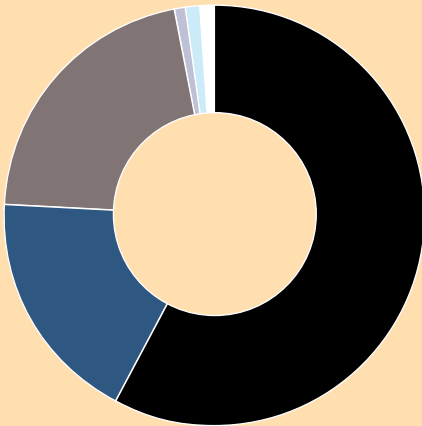
The biggest category of expenses is dedicated to the staff operating in the field: about 50 per cent of expenditure comprises all costs related to national and international staff (including plane tickets, insurance, accommodation, etc.).

The medical and nutrition category includes drugs and medical equipment, vaccines, hospitalisation fees and therapeutic food. The delivery of these supplies is included in the category of transport, freight and storage.

Logistics and sanitation comprise building materials and equipment for health centres, water and sanitation and logistical supplies.

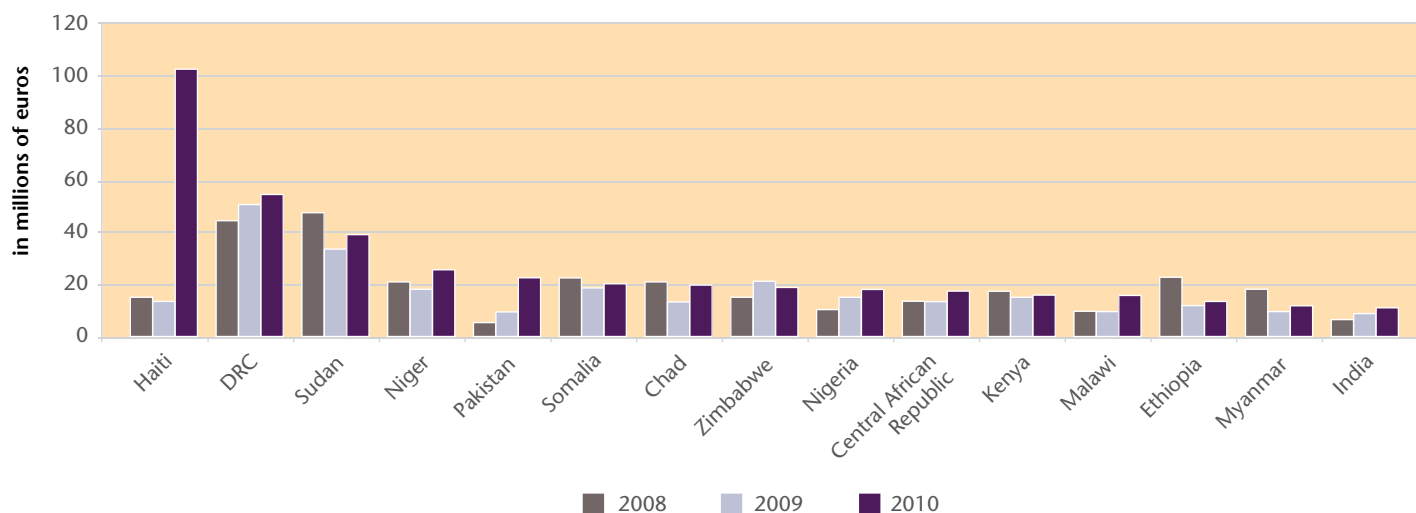
Programme expenses by continent

| | |
|---------------|-----|
| ■ Africa | 58% |
| ■ Asia | 18% |
| ■ Americas | 21% |
| ■ Europe | 1% |
| ■ Oceania | 1% |
| ■ Unallocated | 1% |



COUNTRIES WHERE WE SPENT THE MOST

Countries where MSF expenditure is more than 10 million euros



AFRICA

| | <i>in millions of €</i> |
|----------------------------------|-------------------------|
| Democratic Republic of the Congo | 54.5 |
| Sudan | 38.9 |
| Niger | 25.5 |
| Somalia | 19.5 |
| Chad | 19.0 |
| Zimbabwe | 18.4 |
| Nigeria | 17.5 |
| Central African Republic | 16.8 |
| Kenya | 15.1 |
| Malawi | 15.1 |
| Ethiopia | 13.4 |
| Uganda | 8.6 |
| Mozambique | 7.6 |
| Mali | 6.2 |
| Burundi | 6.0 |
| Republic of the Congo | 5.5 |
| South Africa | 5.2 |
| Guinea | 5.2 |
| Swaziland | 5.2 |
| Sierra Leone | 4.7 |
| Liberia | 4.1 |
| Burkina Faso | 3.0 |
| Zambia | 2.4 |
| Djibouti | 1.8 |
| Cameroon | 1.6 |
| Other countries * | 2.2 |

Total 323

ASIA AND THE MIDDLE EAST

| | <i>in millions of €</i> |
|--------------------------------|-------------------------|
| Pakistan | 21.8 |
| Myanmar | 11.2 |
| India | 10.4 |
| Iraq | 9.1 |
| Yemen | 7.6 |
| Afghanistan | 5.8 |
| Occupied Palestinian Territory | 4.6 |
| Sri Lanka | 4.5 |
| Bangladesh | 3.7 |
| Kyrgyzstan | 3.5 |
| Uzbekistan | 3.2 |
| Iran | 2.5 |
| Armenia | 1.8 |
| Georgia | 1.6 |
| Cambodia | 1.3 |
| Thailand | 1.2 |
| Other countries * | 4.4 |

Total 98.2

UNALLOCATED

| | <i>in millions of €</i> |
|------------------------|-------------------------|
| Transversal activities | 4.4 |
| Others | 2.9 |

Total 7.3

THE AMERICAS

| | <i>in millions of €</i> |
|-------------------|-------------------------|
| Haiti | 102.3 |
| Colombia | 9.7 |
| Guatemala | 1.0 |
| Bolivia | 1.0 |
| Other countries * | 2.6 |

Total 116.6

EUROPE

| | <i>in millions of €</i> |
|--------------------|-------------------------|
| Russian Federation | 5.5 |
| Other countries * | 2.3 |

Total 7.8

OCEANIA

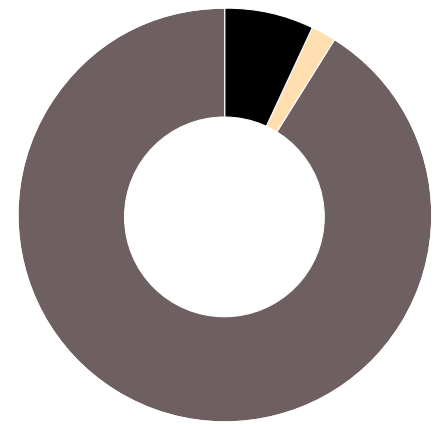
| | <i>in millions of €</i> |
|-------------------|-------------------------|
| Papua New Guinea | 2.7 |
| Other countries * | 0.0 |

Total 2.7

* 'Other countries' combines all the countries for which programme expenses were below one million euros.

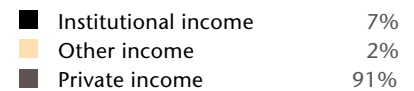
WHERE DID THE MONEY COME FROM?

| | 2010 | | 2009 | |
|----------------------|-------------------------|-------------------|-------------------------|-------------------|
| | <i>in millions of €</i> | <i>percentage</i> | <i>in millions of €</i> | <i>percentage</i> |
| Private | 858.9 | 91% | 572.4 | 86% |
| Public institutional | 69.3 | 7% | 77.9 | 12% |
| Other | 15.1 | 2% | 15.1 | 2% |
| Income | 943.3 | 100% | 665.4 | 100% |



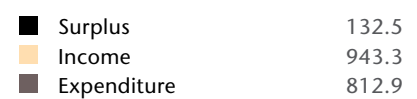
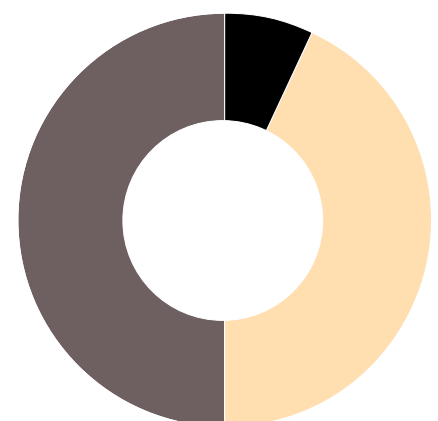
HOW WAS THE MONEY SPENT?

| | 2010 | | 2009 | |
|--|-------------------------|-------------------|-------------------------|-------------------|
| | <i>in millions of €</i> | <i>percentage</i> | <i>in millions of €</i> | <i>percentage</i> |
| Programmes | 555.3 | 68% | 393.3 | 64% |
| Headquarters programme support | 78.7 | 10% | 69.1 | 11% |
| Témoignage/awareness-raising | 26.4 | 3% | 21.7 | 4% |
| Other humanitarian activities | 5.7 | 1% | 6.4 | 1% |
| Social mission | 666.1 | 82% | 490.5 | 80% |
| Fundraising | 103.7 | 13% | 87.4 | 14% |
| Management, general and administration | 43.1 | 5% | 38.9 | 6% |
| Other expenses | 146.8 | 18% | 126.3 | 20% |
| Expenditure | 812.9 | 100% | 616.8 | 100% |
| Net exchange gains/losses | 2.1 | | 2.9 | |
| Surplus | 132.5 | | 51.5 | |



YEAR-END FINANCIAL POSITION

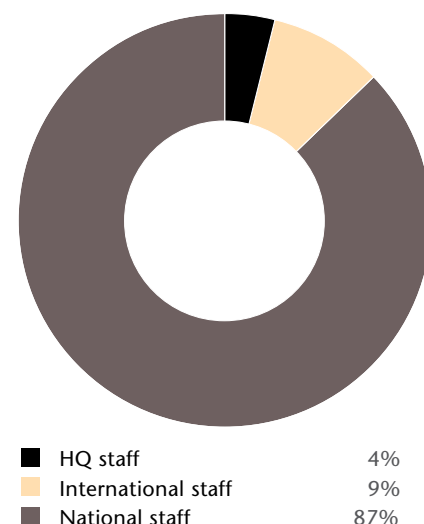
| | 2010 | | 2009 | |
|--|-------------------------|-------------------|-------------------------|-------------------|
| | <i>in millions of €</i> | <i>percentage</i> | <i>in millions of €</i> | <i>percentage</i> |
| Cash and equivalents | 600.9 | 84% | 433.3 | 80% |
| Other current assets | 71.1 | 10% | 68.5 | 13% |
| Non-current assets | 43.2 | 6% | 36.6 | 7% |
| Assets | 715.2 | 100% | 538.4 | 100% |
| Permanently restricted funds | 2.5 | 0% | 2.5 | 0% |
| Unrestricted funds | 608.1 | 85% | 475.5 | 89% |
| Other retained earnings and equities | 8.7 | 1% | -9.8 | -2% |
| Retained earnings and equities | 619.3 | 86% | 468.2 | 87% |
| Current liabilities | 95.9 | 14% | 70.2 | 13% |
| Liabilities and retained earnings | 715.2 | 100% | 538.4 | 100% |



HR STATISTICS

| | 2010 | | 2009 | |
|---|------------------|-------------------|------------------|-------------------|
| | <i>no. staff</i> | <i>percentage</i> | <i>no. staff</i> | <i>percentage</i> |
| Medical pool | 1,672 | 25% | 1,239 | 26% |
| Nurses and other paramedical pool | 2,002 | 31% | 1,459 | 31% |
| Non-medical pool | 2,887 | 44% | 2,046 | 43% |
| International departures (full year) | 6,561 | 100% | 4,744 | 100% |
| National staff | 25,185 | 91% | 20,447 | 91% |
| International staff | 2,465 | 9% | 2,015 | 9% |
| Field positions | 27,650 | 100% | 22,462 | 100% |

The majority of MSF staff (91 per cent) are hired locally in the countries of intervention. Headquarters staff represent 4 per cent of the total staff.



HAITI EMERGENCY

The earthquake that hit Haiti on 12 January 2010 prompted an enormous response from the public worldwide. MSF received an unprecedented amount of donations in 2010; 110.7 million euros were earmarked for Haiti. The cholera epidemic that occurred in October 2010 further increased the scale of MSF's emergency response in Haiti.

MSF spent a total of 106.1 million euros in 2010 on operations in the regions most affected by the earthquake and on

responding to the cholera epidemic. The funds were used for massive investments in health centres and hospitals, the rehabilitation and construction of medical facilities, medical supplies and equipment, drugs and the distribution of shelter materials and other relief items.

A balance of 2 million euros of restricted funds remained unspent at the end of 2010. This balance will be spent in Haiti in 2011.

EXPENDITURE

| | <i>in millions of €</i> |
|-----------------------|-------------------------|
| Programme expenses | 102.3 |
| Indirect supply costs | 3.8 |

2010 field-related expenses 106.1

INCOME

| | <i>in millions of €</i> |
|--------------------------------|-------------------------|
| Restricted private income | 108.1 |
| Restricted institutional funds | 2.6 |

Total funding of field-related expenses 110.7

Remaining restricted funds to be spent in 2011 -4.6

Total funding of 2010 field-related expenses 106.1

Sources of income

As part of MSF's effort to guarantee its independence and strengthen the organisation's link with society, we strive to maintain a high level of private income. In 2010, 91 per cent of MSF's income came from private sources. More than 5.1 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF include, among others, the European Commission's Humanitarian Aid Department (ECHO), and the governments of Belgium, Canada, Denmark, Germany, Ireland, Luxembourg, Norway, Spain, Sweden, Switzerland and the UK.

Expenditure is allocated according to the main activities performed by MSF. All expenditure categories include salaries, direct costs and allocated overheads.

Social mission includes all costs related to operations on the field (direct costs) as well as all the medical and operational support from the headquarters directly allocated to the field (indirect costs). Social missions costs represent 82 per cent of the 2010 total costs.

Permanently restricted funds may either be capital funds, where donors require the assets to be invested; or funds retained for actual

use, rather than expended; or the minimum compulsory level of retained earnings to be maintained by some of the national offices.

Unrestricted funds are unspent non-designated donor funds expendable at the discretion of MSF's trustees in furtherance of our social mission.

Other retained earnings represent foundations' capital as well as technical accounts related to the combination process.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. As of the end of 2010, their available part (the unrestricted funds decreased by the conversion difference) represented 9.1 months of activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, and/or a sudden drop of private and/or public institutional funding, the sustainability of long-term programmes (e.g. antiretroviral treatment programmes), and the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

The complete Financial Report is available at www.msf.org

CONTACT MSF

Australia Médecins Sans Frontières

Suite C, Level 1 | 263 Broadway Glebe NSW 2037
PO BOX 847 | Broadway NSW 2007 | Australia
T +61 28 570 2600 | F +61 29 552 6539
office@sydney.msf.org | www.msf.org.au
Pr Dr Nicholas Coatsworth | GD Paul McPhun

Austria Médecins Sans Frontières/ Ärzte Ohne Grenzen

Taborstraße 10 | 1020 Vienna | Austria
T +43 1 409 7276 | F +43 1 409 7276/40
office@aerzte-ohne-grenzen.at
www.aerzte-ohne-grenzen.at
Pr Dr Reinhard Doerflinger | GD Mario Thaler

Belgium Médecins Sans Frontières/ Artsen Zonder Grenzen

Rue Dupré 94 / Dupréstraat 94
1090 Brussels | Belgium
T +32 2 474 74 74 | F +32 2 474 75 75
info@azg.be | www.msf.be or www.azg.be
Pr Meinie Nicolai | GD Christopher Stokes

Canada Médecins Sans Frontières/ Doctors Without Borders

720 Spadina Avenue, Suite 402 | Toronto
Ontario M5S 2T9 | Canada
T +1 416 964 0619 | F +1 416 963 8707
msfcan@msf.ca | www.msf.ca
Pr Dr Joni Guptill | GD Marilyn McHarg

Denmark Médecins Sans Frontières/ Læger uden Grænser

Kristianiagade 8 | 2100 København Ø | Denmark
T +45 39 77 56 00 | F +45 39 77 56 01
info@msf.dk | www.msf.dk
Pr Jesper H.L. Jørgensen, RN
GD Michael G. Nielsen

France Médecins Sans Frontières

8 rue Saint Sabin | 75011 Paris | France
T +33 1 40 21 29 29 | F +33 1 48 06 68 68
office@paris.msf.org | www.msf.fr
Pr Dr Marie-Pierre Allié | GD Filipe Ribeiro

Germany Médecins Sans Frontières/ Ärzte Ohne Grenzen

Am Köllnischen Park 1 | 10179 Berlin | Germany
T +49 30 700 13 00 | F +49 30 700 13 03 40
office@berlin.msf.org
www.aerzte-ohne-grenzen.de
Pr Dr Tankred Stöbe | GD Dr Frank Dörner

Greece Médecins Sans Frontières/ Πατρών Χωρίς Σύνορα

15 Xenias St. | 115 27 Athens | Greece
T 30 210 5 200 500 | F 30 210 5 200 503
info@msf.gr | www.msf.gr
Pr Ioanna Papaki | GD Reveka Papadopoulou

Holland Médecins Sans Frontières/ Artsen zonder Grenzen

Plantage Middenlaan 14 | 1018 DD Amsterdam
The Netherlands
T +31 20 520 8700 | F +31 20 620 5170
office@amsterdam.msf.org
www.artsenzonderegrenzen.nl
Pr Dr Pim De Graaf | GD Arjan Hehenkamp

Hong Kong Médecins Sans Frontières

無國界醫生 / 无国界医生
22/F Pacific Plaza | 410 – 418 Des Voeux
Road West | Sai Wan | Hong Kong
T +852 2959 4229 | F +852 2337 5442
office@msf.org.hk | www.msf.org.hk
Pr Dr Fan Ning | GD Remi Carrier

Italy Médecins Sans Frontières/ Medici Senza Frontiere

Via Volturmo 58 | 00185 Rome | Italy
T +39 06 44 86 92 1 | F +39 06 44 86 92 20
msf@msf.it | www.medicisenzafrontiere.it
Pr Antonio Campopiano
GD Kostas Moschochoritis

Japan Médecins Sans Frontières/ 国境なき医師団

3F Waseda SIA Bldg | 1-1 Babashitacho
Shinjuku-ku | Tokyo 162-0045 | Japan
T +81 3 5286 6123 | F +81 3 5286 6124
office@tokyo.msf.org | www.msf.or.jp
Pr Dr Nobuko Kurosaki | GD Eric Ouannes

Luxembourg Médecins Sans Frontières

68, rue de Gasperich | 1617 Luxembourg
T +352 33 25 15 | F +352 33 51 33
info@msf.lu | www.msf.lu
Pr Dr Bechara Ziade | GD Dave Hudson

Norway Médecins Sans Frontières/ Leger Uten Grenser

Postboks 8813 Youngstorget | 0028 Oslo
Norway | Hausmannsgate 6 | 0186 Oslo |
Norway
T +47 23 31 66 00 | F +47 23 31 66 01
epost@legerutengrenser.no
www.legerutengrenser.no
Pr Kyrre Lind | GD Patrice Vastel

Spain Médecins Sans Frontières/ Médicos Sin Fronteras

Nou de la Rambla 26 | 08001 Barcelona | Spain
T +34 93 304 6100 | F +34 93 304 6102
office-bcn@barcelona.msf.org | www.msf.es
Pr Dr José Antonio Bastos
GD Aitor Zabalgogeaakoa

Sweden Médecins Sans Frontières/ Läkare Utan Gränser

Gjörwellsgatan 28, 4 trappor | Box 34048
100 26 Stockholm | Sweden
T +46 8 55 60 98 00 | F +46 8 55 60 98 01
office-sto@msf.org | www.lakareutangranser.se
Pr Kristina Bolme Kühn | GD Johan Mast

Switzerland Médecins Sans Frontières/ Ärzte Ohne Grenzen

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 84 | F +41 22 849 84 88
office-gva@geneva.msf.org | www.msf.ch
Pr Abiy Tamrat | GD Bruno Jochum

UK Médecins Sans Frontières / Doctors Without Borders

67-74 Saffron Hill | London EC1N 8QX | UK
T +44 20 7404 6600 | F +44 20 7404 4466
office-ldn@london.msf.org | www.msf.org.uk
Pr Dr Sid Wong | GD Marc DuBois

USA Médecins Sans Frontières/ Doctors Without Borders

333 7th Avenue | 2nd Floor | New York
NY 10001-5004 | USA
T +1 212 679 6800 | F +1 212 679 7016
info@doctorswithoutborders.org
www.doctorswithoutborders.org
Pr Dr Matthew Spitzer | GD Sophie Delaunay

International Office Médecins Sans Frontières

International Office and UN Liaison Office – Geneva
78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 00 | F +41 22 849 84 04
Pr Dr Unni Karunakara | SG Kris Torgeson
office-intl@msf.org | www.msf.org
Policy and Advocacy Coordinator: Emmanuel Tronc
emmanuel.tronc@msf.org

Other Offices

MSF Campaign for Access to Essential Medicines

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 8405 | F +41 22 849 8404
www.msfaccess.org
Director: Dr Tido von Schoen-Angerer

UN Liaison Office – New York

333 7th Avenue | 2nd Floor | New York
NY 10001-5004 | USA
T +1 212 655 3777 | F +1 212 679 7016
MSF UN liaison officer: Fabien Dubuet
fabien.dubuet@newyork.msf.org

MSF office in South Africa

Orion Building | 3rd floor | 49 Jorissen Street
Braamfontein 2017 | Johannesburg | South Africa
T +27 11 403 44 40/41 | www.msf.org.za

MSF office in Brazil

Rua Santa Luzia, 651/11º andar
Centro - Rio de Janeiro | CEP 20030-040
Rio de Janeiro | Brazil
T +55 21 2220 8277 | www.msf.org.br

MSF office in United Arab Emirates

P.O. Box 47226 | Abu Dhabi | UAE
T +971 2 6317 645 | www.msf-me.org

MSF office in Argentina

Carbajal 3211 | Código Postal 1426 | Belgrano
Ciudad de Buenos Aires | Argentina
T +54 11 4551 4460 | www.msf.org.ar

Pr President | GD General Director
SG Secretary General

ABOUT THIS REPORT

Contributors

Halimatou Amadou, Valerie Babize, Aurélie Baumel, Niklas Bergstrand, Jehan Bseiso, Andrea Bussotti, Brigitte Breuillac, Martyn Broughton, Talia Bouchouareb, Natacha Bühler, Jason Cone, Susanne Döttling, Olivier Falhun, Silvia Fernández, Isabelle Ferry, Benoît Feyt, Diderik van Halsema, Maimouna Jallow, Isabelle Jeanson, Julia Kourafa, Borrie la Grange, Laura McCullagh, Scotti McLaren, Isabelle Merny, Djamila Mili, Niamh Nic Carthaigh, Marcell Nimfuehr, Simon Petite, Yasmin Rabiyan, Ricardo Rubio, Victoria Russell, François Servranckx, Ewald Stals, Clara Tarrero, Sam Taylor, Véronique Terrasse, Kenneth Tong, Pascale Zintzen.

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English Edition

Managing Editor Jane Linekar

Editorial Support Rachel McKee

Photo Editor Bruno De Cock

Proof Reader Lory Frenkel

French Edition

Editor Laure Bonnevie, supported by Aurélie Grémaud

Translator Translate 4 U sàrl (Alette Chaput, Emmanuel Pons)

Italian Edition

Coordinator Barbara Galmuzzi

Translator Selig S.a.S.

Editor Barbara Galmuzzi

Spanish Edition

Coordinator Aloïs Hug

Translator Pilar Petit

Editor Eulàlia Sanabra

Arabic Edition

Coordinator Jessica Moussan-Zaki

Translator Mounir El-Boughdadi, Khalid Faiz

Editor Jessica Moussan-Zaki

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Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation. When MSF witnesses serious acts of violence, neglected crises, or obstructions to its activities, the organisation may speak out about this.

MSF is a not-for-profit organisation that was founded in Paris, France in 1971. Today, MSF is a worldwide movement with more than 19 national offices and an international office in Geneva, Switzerland. Thousands of health professionals, logistical and administrative staff manage projects in approximately 65 countries worldwide.

MSF International Office

78 rue de Lausanne, CP 116, CH-1211, Geneva 21, Switzerland

Tel.: +41 (0)22 849 8400, Fax: +41 (0)22 849 8404, Email: com-io@msf.org, www.msf.org

COVER PHOTO

A doctor holds a consultation with a woman displaced by the floods at a clinic in Shahbaz, Punjab, Pakistan.

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