MSF ACTIVITY REPORT 2009

MEDECINS SANS FRONTIERES

THE MEDECINS SANS FRONTIERES 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 work throughout the world between January and December 2009. Staffing figures represent the total of full-time equivalent positions per country in 2009.

Reasons for Intervention classify the initial event(s) triggering an MSF medical-humanitarian response as documented in the 2009 International Typology study. Country summaries are representational and, owing to space considerations, may not be entirely comprehensive.

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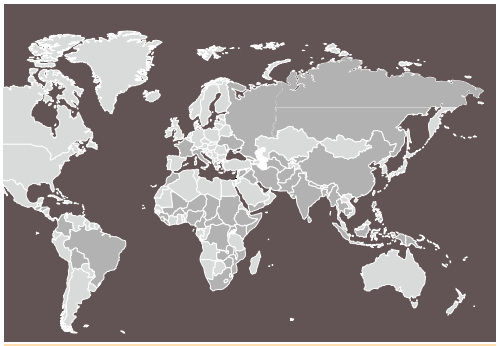

MSF MISSIONS AROUND THE WORLD

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THE YEAR IN REVIEW 2009

Kris Torgeson, Secretary General, MSF International
Dr Christophe Fournier, President, MSF International Council

A man has his injured foot bandaged at the MSF medical centre which serves the Dagahaley Camp in Dadaab, Kenya, which is home to 91,000 people.

For Médecins Sans Frontières, an organisation that has specialised in responding to emergencies as well as working in fragile and unpredictable contexts, no two years are the same. There is of course the ongoing work carried out by our thousands of staff around the world, who provide healthcare where it's lacking and deal with diseases that continue to take a high toll on populations. But over and beyond the more constant medical activity, each year brings new challenges to our organisation.

Two worrying developments stand out for 2009: the dwindling commitment of donor bodies for continuing the battle against HIV/AIDS and a sharp increase of security incidents that affect our ability to bring assistance.

In 2009, we started looking closely at the funding for HIV/AIDS in eight African countries. A clear pattern is starting to show of donor backtracking on earlier, widely publicised commitments to scale up the fight against the epidemic. The effects on availability and level of care for those infected are becoming clear in countries where we work. In some countries where infection rates for HIV/AIDS are high, patients are turned away from clinics, and clinicians are once again being forced into the unacceptable position of rationing life-saving treatment. MSF will emphasise the unacceptable nature of this withdrawal in appropriate private and public forums throughout 2010.

In conflict areas, where MSF is often one of very few providers of healthcare, our ability to assist has been put under immense pressure with a string of extreme security incidents. In February, two of our colleagues were brutally killed in Pakistan's Swat Valley, as they were trying to collect wounded people by ambulance from the scene of heavy fighting. Nasar Ali and Riaz Ahmad were known and admired for their dedication to the health and survival of others, but tragically paid the ultimate price for this.

In 2009, MSF workers were abducted in Pakistan, Sudan, Somalia and Chad. Luckily, we saw all of them released in good health. But if humanitarian workers are not safe from violence, the organisation that employs them faces tough questions. For MSF, our determination to be with the victims of conflict has not diminished – if anything, it has only grown – but we are forced to continuously evaluate how to bring lifesaving assistance in areas where our colleagues are so exposed to acts of violence.

A situation of war creates victims in a variety of ways. There are the direct victims, those that our surgical teams help and support. And then there are hidden victims. The impact of conflicts and subsequent mass displacement, on often precarious pre-existing health systems, is in most cases disastrous. It generally stimulates a dramatic rise of maternal and child fatalities or an eruption of epidemics. Victims of sexual violence and survivors affected by profound mental health traumas are also among the hidden casualties of war, and our medical teams assist them with a sense of urgency in many different countries

The military offensives in the Palestinian Territories left 1,300 people dead, 5,300 injured and an entire population dependent on medical aid and relief. We had a team on the ground before the offensive was launched – we have been offering mental health support for years in the Gaza Strip – but it was only when the offensive was put on hold that a complete MSF surgical team was allowed to enter Gaza City, despite our repeated efforts to enter earlier. We then set up two inflatable hospitals, and between January and July performed over 500 operations. Meanwhile, the psychological toll of the fighting was especially heavy on children. Additional MSF staff were brought in to help with consultations; more than half of the 400 new patients they saw for counselling were under 12 years old.

In the Democratic Republic of the Congo (DRC), ongoing conflict continues to cause huge critical needs, prompting one of MSF's largest interventions year after year. Again, we try to carry out a full range of medical activities there in the midst of what has become a chronic health emergency. MSF carried out 530,000 medical consultations in 2009, vaccinated 650,000 children against measles and cared for 5,600 rape victims in North and South Kivu.

In conflict-ridden Afghanistan in 2009, the deadliest year for civilians since the war began in 2001, we resumed our medical work after a five-year absence following the deliberate killings of five of our colleagues in 2004. Our immediate preoccupation, both in Kabul and in the province of Helmand, was to offer medical assistance to the general population rather than only focusing on war wounded. In Mardan, Pakistan, where around one million displaced people settled, having fled fighting in the Swat district, our teams supported referral hospitals, health centres and mobile clinics.

Our ability to bring care to people trapped in conflict is sometimes restricted by policies and actions of governments. In Sudan, providing food, water and health care for people in Darfur became much more difficult in March 2009 when the Sudanese authorities expelled 13 international aid agencies – including two sections of MSF—and three Sudanese organisations in the wake of the International Criminal Court's indictment of Sudanese President Omar Al-Bashir for war crimes and crimes against humanity.

The decision by the government effectively meant that not only MSF but also the needs of the population of Darfur were held hostage to political and judicial agendas. It also ignored MSF's binding and publicly communicated policy to refrain from any cooperation with the aforementioned Court, a policy based on the recognition that humanitarian activities must remain independent from political and judicial pressure in order to be able to provide medical assistance to populations in situations of violence. Today more than ever, it seems that we must relentlessly explain the principles of neutrality, impartiality and independence that guide our choices as a humanitarian organisation.

The conflict in Sri Lanka came to a climax, leaving many civilians in a vulnerable state as they tried to reach safe zones, but they all too often found themselves trapped by the violence. Access to medical facilities and aid was extremely difficult. More often than not, by the time they finally reached those who could help them, their health needs were critical.

Our work extends way beyond the conflict areas described above. In 2009, MSF organised large-scale immunisation

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campaigns, particularly against meningitis in western Africa, where we vaccinated almost eight million people in both Nigeria and Niger. Our teams intervened after major natural disasters throughout the year, by providing medical and mental health care, as well as shelter and other logistical support. Likewise we helped 150,000 people made homeless by floods in the Burkina Faso capital of Ouagadougou, in September, when the amount of rain that usually falls in a year fell in one single day. And other teams assisted 75,000 people hit by Cyclone Aila in Bangladesh, and 60,000 flood victims in India's Andhra Pradesh.

Our contribution towards reducing the HIV/AIDS and TB epidemics continued unabated. In 2009 over 190,000 people were being treated by MSF for HIV, and some 160,000 were on antiretroviral treatment. Many of these patients live remotely, have little money, and under normal circumstances would not receive medical care. But MSF continued to address this lack of access to treatment where possible. Teams offered testing and counselling, provided ART free of charge, reduced rates of transmission from mother to child and trained 'expert patients' often HIV patients themselves, to help others adhere to treatment. For example in Lesotho alone, 54,000 HIV tests were carried out and 6,000 patients began ART.

TB, which has become the leading cause of death among HIV patients, is also a growing concern for MSF: failure to adhere to the difficult course of treatment for TB can lead to drug-resistant strains of the disease developing, and these are even more problematic to treat, especially if the patient's immune system is already compromised by HIV. MSF is working hard to combine the treatment of HIV and TB in resource poor settings to try and reverse this trend. In 2009 MSF treated over 21,000 TB patients.

A number of neglected diseases are still not getting the international attention they require. Three in particular - sleeping sickness, Kala Azar and Chagas leave more than 500 million people at risk from infection. In response, in 2009 MSF committed 18 million Euros over the next six years to a joint initiative with the Drugs for Neglected Diseases initiative (DNDi) for continued research into critically needed new drugs to treat these diseases more effectively. MSF will also continue to provide support through its field programmes to the operational and clinical research needed to advance drug development. In 2009 MSF treated over 6,000 patients for these three diseases.

The neglected needs of migrants remain among our most pressing concerns. Migrants undergo journeys fraught with danger and uncertainty, and when they arrive – if they arrive – their health often continues to be compromised. Some are held for long periods in overcrowded detention camps; some are forced to live hidden away from the authorities, where their undocumented status makes it impossible for them to access basic care. MSF offers such people free medical and mental health consultations, protecting their identity where possible and referring them when necessary to local hospitals.

We give medical assistance at different stages of their journey. In countries of origin, such as Somalia, Afghanistan, DRC and Nigeria, we treat the medical consequences of violence and deprivation. In Morocco, Greece, Malta, Italy and France, our teams provide medical and psychological care to those who survived the journey; many migrants and asylum seekers are subjected to violence and abuse, are imprisoned and exploited or fall victim to smugglers and traffickers.

We equally assist migrants outside Europe. Many refugees and asylum seekers from the Horn of Africa seek safety in Yemen. The harsh conditions of the trip and sea accidents cause hundreds of deaths, and the state of health of those who do manage to reach the Yemeni coast is often poor. Around 9,000 people received medical assistance from MSF in Abyan and Shabwah governorates in the south of the country in 2009.

In Bangladesh, many thousands of Rohingya refugees from neighbouring Myanmar face a daily struggle to survive. Out of an estimated population of up to 400,000 Rohingya who have fled across the border, only 28,000 are recognised as official refugees by the government and accordingly entitled to assistance by UNHCR. MSF set up an emergency healthcare project to help 20,000 unrecognised Rohingya refugees living in harsh conditions in Kutupalong makeshift camp.

Just outside the scope of this reporting period, early 2010 saw the launch of the largest emergency operation in MSF history following the devastating earthquake that ruined large parts of Haiti and claimed many thousands of lives. Within the first four months MSF teams assisted 173,000 patients and performed more than 11,000 surgeries.

This tragedy has stretched our organisation and forced us into a difficult balancing act of staging such a massive and urgent emergency relief effort while fully retaining our commitment to the health and lives of people in many other parts of the world. Together with the need to mobilise donors for their continued support to reverse the HIV/AIDS epidemic, and the growing concern about increased violence against humanitarian workers, Haiti will set the tone for 2010.

The continued contribution of millions by people around the world who support MSF financially is key to our ability to bring medical assistance to those who need it urgently, and for keeping interference from political, military or economic agendas at bay. We are immensely grateful to all donors who make MSF's work in over 65 countries possible.

Thank you.

Treating a child with cholera in the midst of a huge outbreak in Zambia's capital, Lusaka, in March 2010.

OVERVIEW OF MSF OPERATIONS

Largest interventions based on project expenditure

1. Democratic Republic of Congo (DRC)
2. Zimbabwe
3. Somalia
4. Niger
5. Sudan South
6. Nigeria
7. Kenya
8. Chad
9. Haiti
10. Central African Republic (CAR)

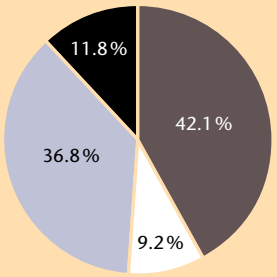
These 10 countries total a budget of 193,530,586 or **49.2 per cent** of the MSF operational budget.

Project locations by country

Number of projects

- Africa | 32
- Europe | 7
- Asia | 28
- Americas | 9

Percentage of programme portfolio

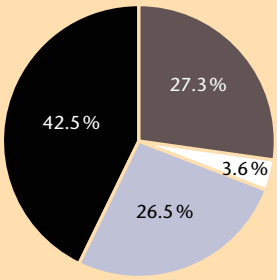


Context of interventions

Number of projects

- Armed Conflict | 99
- Post Conflict | 13
- Internal Instability | 96
- Stable | 154

Percentage of programme portfolio

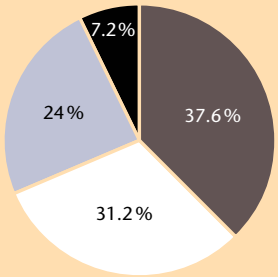


Event triggering intervention

Number of projects

- Armed conflict | 136
- Epidemic | 113
- Health exclusion | 87
- Natural disaster | 26

Percentage of programme portfolio



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	7,509,512
Inpatient	Total number of admitted patients	292,347
Malaria	Total number of confirmed cases treated	1,110,495
Therapeutic feeding centres	Number of severe malnourished children admitted to inpatient or ambulatory therapeutic feeding centres	154,133
Supplementary feeding centres	Number of moderately malnourished children admitted to supplementary feeding centres	41,288
Deliveries	Total number of women who delivered babies, including Caesarean sections	110,236
Sexual Violence	Total number of cases of sexual violence medically treated	13,624
Surgical Interventions	Total number of major surgical interventions including obstetric surgery, under general or spinal anaesthesia	49,680
Violent trauma	Total number of medical and surgical interventions in response to direct violence	88,765
HIV	Total number of HIV patients registered under care at end 2009	190,254
Antiretroviral therapy treatment (first-line)	Total number of patients on first-line antiretroviral treatment at end 2009	162,728
Antiretroviral therapy treatment (second-line)	Total number of patients on second-line antiretroviral treatment at end 2009. First-line treatment failure.	1,781
PMTCT - mother	Number of HIV-positive pregnant women who received prevention of mother-to-child transmission (PMTCT) treatment	8,704
PMTCT - baby	Number of eligible babies born in 2009 who received post-exposure treatment	10,406
Tuberculosis (first-line)	Total number of new admissions to tuberculosis first-line treatment in 2009	20,569
Tuberculosis (second-line)	Total number of new admissions to tuberculosis treatment in 2009, second-line drugs	943
Mental Health (Individual)	Total number of individual consultations	109,755
Mental Health (Group)	Total number of counselling or support group sessions	7,895
Cholera	Total number of people admitted to cholera treatment centres or treated with oral rehydration solution	130,220
Measles Vaccinations	Total number of people vaccinated for measles in response to an outbreak	1,419,427
Measles Treatment	Total number of people treated for measles	28,261
Meningitis Vaccinations	Total number of people vaccinated for meningitis in response to an outbreak	7,932,403
Meningitis Treated	Total number of people treated for meningitis	77,901

GLOSSARY OF DISEASES

Chagas Disease

First described by the Brazilian doctor Carlos Chagas, this parasitic disease is found almost exclusively in Latin America, though increased global travel has led to an increased number of cases being reported in the US, Europe, Australia and Japan. This potentially fatal disease can cause irreversible damage to the heart, oesophagus and colon, shortening life expectancy by an average of ten years.

The disease is transmitted by blood-sucking bugs that live in cracks in the walls and roofs of mud and straw housing, common in rural areas and poor urban slums in Latin America. It can also be transmitted through blood transfusions, from mothers to their children during pregnancy and, less frequently, through organ transplants or via the consumption of contaminated food. Debilitating and possibly life-threatening chronic symptoms develop in approximately 30 per cent of people infected, with heart failure being the most common cause of death for adults. Some people can have the disease but show no signs of it for years.

There are currently only two medicines to combat the disease: Benznidazole and Nifurtimox. Both were developed over 35 years ago, but through using research not specifically aimed at finding a cure for Chagas disease. 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.

Diagnosis is complicated, as doctors need to perform two or three blood tests to determine whether or not a patient is infected with the parasite and there is no test to know whether the treatment has been successful or not. The current lines of treatment can be toxic, take one to two months to complete and can have multiple side effects. They must be administered under medical supervision, which means having a weekly check-up with a trained healthcare worker. Despite the clear need for more efficient and safer medication, there are few new drugs in development.

MSF has tested over 65,000 people for Chagas disease and treated more than 3,000 patients since 1999.[1]

[1] Feasibility, Drug Safety, and Effectiveness of Etiological Treatment Programmes for Chagas Disease in Honduras, Guatemala, and Bolivia: 10-Year Experience of Médecins Sans Frontières.'

Cholera

The Greek word for diarrhoea, 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.

Although most people infected with cholera will have only a mild infection, the illness can be very severe, causing profuse watery diarrhoea and vomiting that can lead to severe dehydration and death. Required treatment is the immediate replacement of fluid and salts with a rehydration solution administered orally or intravenously.

MSF has developed cholera treatment kits to provide rapid assistance and sets up cholera treatment centres where there are outbreaks. Control and prevention measures include ensuring an adequate supply of safe drinking water and implementing strict hygiene practices.

MSF treated over 130,220 people for cholera in 2009.

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. Many people live for years without symptoms and may not know they have been infected with HIV. A simple blood test can confirm HIV status.

A number of opportunistic infections (OIs) such as candidiasis, pneumonia, and various kinds of tumours are able to flourish as the immune system weakens. Some can be treated, while others are life-threatening. The most common OI leading to death is tuberculosis (TB).

Combinations of drugs known as antiretrovirals help combat the virus and enable people to live longer, healthier lives without a rapid deterioration of their immune systems. It is simplest and easiest to take these drugs properly when they are combined into single pills (fixed-dose combination). MSF's comprehensive HIV/AIDS programmes generally include education and awareness activities so that people can learn how to prevent the spread of the virus, through condom distribution, HIV testing, pre and post-test counselling, treatment and prevention of opportunistic infections, prevention of mother-to-child transmission, and provision of antiretroviral treatment for patients in advanced stages of the disease.

MSF provided care for over 190,000 people living with HIV/AIDS and anti-retroviral therapy for more than 162,000 people in 2009.

Human African Trypanosomiasis (Sleeping Sickness)

Generally known as sleeping sickness, this parasitic infection 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 (T.b.g) which is found in west and central Africa. It attacks the central nervous system, causing severe neurological disorders or even death. The other 10 per cent of cases are caused by the Trypanosoma brucei rhodesiense (T.b.r.) 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 taking a sample of spinal fluid, and treatment is painful, requiring daily injections.

The most common drug used to treat the disease is the highly toxic Melarsoprol, a derivative of arsenic that was developed in 1949, that causes many side effects. In parts of Africa, it fails to cure up to 30 per cent of patients and actually kills up to five per cent of them. Eflornithine, though somewhat difficult to administer because it requires an intravenous drip and a complicated treatment schedule, is a safer, more recent alternative being used by MSF in its projects.

In 2009, a new treatment option called NECT (Nifurtimox-Eflornithine Combination Therapy) was added to the Essential Medicines List of the World Health Organization. It is now the internationally recommended treatment, although access to it must be carefully monitored. The development of NECT is a huge

continued overleaf ›

continued Human African Trypanosomiasis ›

advancement, as studies have shown that the therapy, a co-administration of oral Nifurtimox and intravenous Eflornithine, is a better treatment option for advanced-stage sleeping sickness, being safer than Melarsoprol and easier to use than Eflornithine. However, it is still far from ideal. Research and investment are urgently needed in order to further improve treatment (without injections) and to ensure that it is affordable, effective in both stages of the disease, and easy to use in remote health centres.

MSF admitted over 1,870 patients for treatment for Human African Trypanosomiasis in 2009.

Visceral Leishmaniasis (Kala Azar)

Largely unknown in the developed world, Kala Azar, which is Hindi for black fever, is a tropical, parasitic disease that is transmitted through bites from certain types of sand flies. It is endemic in 62 countries, and of the estimated 500,000 annual cases, 90 per cent occur in India, Bangladesh, Nepal, Sudan, and Brazil, often affecting the poorest people. 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 is potentially dangerous and requires lab facilities and specialists not readily available in countries with poor resources.

Current treatment options include pentavalent antimonials* and combination therapies will be available in the near future. Although extensive and evolving to become more simplified, treatment options have significant limitations. Despite this, studies showing the efficacy and safety of Ambisome® in the Indian sub-continent are promising, and 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.

A major challenge is co-infection of kala azar and HIV. 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 treated nearly 3,700 people for Visceral Leishmaniasis in 2009.

* (Pentostam®, generic SSG, Glucantime®), amphotericin-B deoxycholate, liposomal amphotericin B (Ambisome®), paromomycin and miltefosine)

Malaria

Caused by four species of the parasite plasmodium, malaria is transmitted by infected mosquitoes. Symptoms include fever, pain in the joints, headaches, repeated vomiting, convulsions and coma. Malaria caused by the plasmodium falciparum parasite causes the most severe form of the disease which, if left untreated, leads to death.

Malaria used to be commonly diagnosed on a basis of clinical symptoms alone. As the symptoms are similar to those of other illnesses, about half the people who presented with fever and were treated for malaria in Africa may not actually have been infected with the parasite. An accurate diagnosis can now be made through detection of parasites by microscope or a rapid diagnostic test. Both methods are now used by MSF in its projects.

Chloroquine was once the ideal treatment for malaria caused by plasmodium falciparum because of its price, effectiveness and few side effects; however, its effectiveness has decreased dramatically in the past few decades. MSF field research has helped prove that artemisinin-based combination therapy (ACT) is currently the most effective against this type of malaria and has urged governments in Africa to change their drug protocols to use ACT. Although all governments have made the change in writing, in many cases the drug is still not available for the majority of patients.

MSF treated over 1,100,000 people for malaria in 2009.

Meningitis

Meningococcal meningitis is caused by Neisseria meningitidis and is a contagious and potentially fatal bacterial infection of the meninges, the thin lining surrounding the brain and spinal cord. People can be infected and carry the disease without showing symptoms, spreading the bacteria to others through droplets of respiratory or throat secretions, for example when they cough or sneeze. The infection can also 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.

Without proper treatment, bacterial meningitis kills up to half of those infected. Suspected cases are properly diagnosed through examination of a sample of spinal fluid and treated with a range of antibiotics. Even when given appropriate antibiotic treatment, five to ten per cent of people with meningitis will die and as many as one out of five survivors may suffer from after effects ranging from hearing loss to learning disabilities.

Meningitis occurs sporadically throughout the world, but the majority of cases and deaths are in Africa, particularly across an east-west geographical strip from Senegal to Ethiopia, the "meningitis belt" where outbreaks occur regularly. Vaccination is the recognised way to protect people from the disease.

MSF treated nearly 78,000 cases and vaccinated more than 7,930,000 people against meningitis in 2009.

Tuberculosis

One-third of the world's population is currently infected with the tuberculosis (TB) bacilli. 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 poor countries.

This contagious disease affects the lungs and is spread through the air when infected people cough or sneeze. Not everyone will become ill, but ten per cent of non HIV-infected people will develop active TB at some point in their lifetimes. Symptoms include a persistent cough, fever, weight loss, chest pain and breathlessness in the lead up to death. TB is also a leading cause of death among people with HIV.

Drugs used to treat TB were developed in the 1950s and a course for uncomplicated TB takes six months. Poor management of or lack of adherence to treatment has led to new strains of bacilla that are resistant to one or more anti-tuberculosis drugs. Multi-drug-resistant TB (MDR-TB) is the most serious form of this, 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, making the treatment even more complicated.

MSF treated over 20,500 people for tuberculosis, including over 940 for MDR-TB in 2009.

Kabezi, Burundi. A grandmother surrounded by her family.

AFRICA

BURKINA FASO

REASON FOR INTERVENTION • Endemic / Epidemic disease • Natural disaster **Field Staff 285**

Around 80 per cent of the 14.3 million people in Burkina Faso depend on subsistence farming, and it is often a struggle for farmers to produce sufficient food for their families.

This can particularly affect children because if they do not get the nutrients and vitamins they need in the early phase of life, their mental and physical development can be impaired. They also become susceptible to infections and potentially fatal illnesses. Since 2007 MSF has been working in two provinces in the north of Burkina Faso where childhood malnutrition is frequently found.

In 2009, 16,000 malnourished children were treated in MSF centres in the two northern districts of Yako and Titao. Since the project began, 39,000 children have been helped. Using a decentralised and simplified system of testing and treatment, MSF teams are able to reach huge numbers of children. Those who are seriously ill are hospitalised free of charge by MSF teams in regional health facilities. However around 85 per cent of the children can be cared for at home by their parents because the ready-to-use nutrient-rich food is simple to administer. MSF also admitted patients suffering from tuberculosis, HIV/AIDS and malaria.

In 2009, the worst measles outbreak in years erupted in Burkina Faso. In poor communities with little or no access to care, around ten per cent of people with the illness can die. MSF had earlier offered to help the Ministry of Health in vaccinating against the outbreak, but the offer was declined. MSF then went on to assist the Ministry of Health to treat people with measles in the capital Ouagadougou, as well as in four districts in the east of the country where MSF treated nearly 4,000 children in total.

Flash floods

In one day in September, the same amount of rain that usually falls in a year fell on Ouagadougou. The resulting floods destroyed 24,000 houses and made 150,000 people homeless. Five MSF teams provided healthcare to those displaced by the flooding, and provided medical supplies to the regional health authorities.

Handover

In 2009 MSF handed over a long-running HIV/AIDS programme to the Ministry of Health. The programme was based in the capital and had been providing around 4,480 people with antiretroviral therapy.

MSF has worked in Burkino Faso since 1995.

Fati

A 35 year old mother of four, Fati, left her home in the capital Ouagadougou to come to the town of Titao in the north of Burkina Faso because her mother had fallen ill. However, she found it hard to feed her children and her youngest, a four year old girl, became malnourished. 'I came to the centre because my daughter's weight was too low,' said Fati. Health workers had spread the message in the area that parents could bring their children for treatment free of charge. 'My aunt heard about it and told me to come. All the women around here know that the treatment here is good. I have been coming for three weeks and now my daughter is better.'

© Kazuma Momoi

Yako hospital, Burkina Faso. A nurse with a baby who is recovering well, after having received treatment for acute malnutrition.

BURUNDI

REASON FOR INTERVENTION
- Endemic / Epidemic disease
- Social violence / Healthcare exclusion
- Natural disaster

Field Staff 61

An MSF ambulance transfers a mother and her new born baby.

Despite a presidential decree in 2006 that guaranteed free healthcare for pregnant women and children under five years old, Burundi has one of the highest maternal and neonatal mortality rates in the world, according to the World Health Organization.

Every year 1,000 women suffering from obstetric fistulas as a result of a complicated delivery are reported to the Ministry of Health. MSF works to provide care for women before and during delivery. MSF also responds to health emergencies such as nutritional crises or natural disasters.

Life-saving maternal care

In 2009, the MSF Centre for Obstetrical Emergencies in Kabezi assisted 2,300 women who were facing complications during pregnancy or delivery. The centre, which MSF constructed, has a capacity of 48 beds, a delivery room and an operating theatre. There is a 24-hour emergency service that can be used by the 20 community health centres in the region. The MSF team also provided treatment to 30 women with obstetric fistulas.

Treating sexual violence

In the capital Bujumbura, MSF handed over the Seruka Centre, which specialised in the treatment of victims of sexual violence, to a Burundi association known as Initiative Seruka pour les victimes de Viol (ISV). It was created in 2008 by staff working in the MSF centre. In the six years before the handover, the centre provided care for more than 7,800 victims of sexual violence.

Emergency response

Between February and June, MSF responded to a nutritional emergency in the northern province of Kirundo, where teams admitted more than 500 severely malnourished children to the centre in town. In addition, MSF provided support to therapeutic centres across the region and referred those needing further care to the hospital in Kirundo.

In March, when severe floods devastated several areas near the capital city Bujumbura, MSF ran mobile clinics and worked to improve hygiene conditions and access to clean water. Later in July and August, MSF responded to a cholera outbreak in several neighbourhoods of the capital, treating 90 patients.

MSF has worked in Burundi since 1992.

Mary

30 years old

She is one of thousands of women who have received help at the MSF birth centre in Kabezi. Mary, already a mother of five, was hospitalised before giving birth because she was severely malnourished. Her daughter was born anaemic and underweight, and was vomiting a lot after the birth. However, bit by bit she started to improve, and Mary also began to feel better. Her lips regained colour and the swelling in her legs decreased. 'If it wasn't for MSF my children wouldn't have a mother,' she said.

A medical team treat a patient for Buruli Ulcer.

CAMEROON

REASON FOR INTERVENTION
• Endemic / Epidemic disease
Field Staff 83

MSF is working in Cameroon to treat Buruli ulcer, one of the most underfunded, under-researched, but treatable diseases in the world. This bacterial infection causes deformation of limbs and disability if it is not treated in time.

As part of its Buruli programme, MSF has introduced modern wound dressings that reduce the need for complicated surgical procedures.

Buruli ulcer is an infection related to tuberculosis and leprosy. It is present in around 30 countries worldwide, but since the number of people affected is relatively small, there is no treatment available in most countries. In the rural district of Akonolinga in Cameroon, MSF has set up a Buruli centre that screens patients and treats the disease with antibiotics, skin grafting and physiotherapy. Treatment can take up to a year and, since setting up the centre in 2002, MSF assisted around 800 patients. The new wound dressing has enabled people living in remote areas to receive treatment without being hospitalised. The challenges ahead are to implement decentralised screening in order to better reach people in rural areas, and to make the Buruli centre a referral point for the whole country.

MSF set up its first HIV/AIDS programme in the city of Yaounde in 2000, and then another in Douala in 2003. After handing the programmes over to the Ministry of Health in 2008, MSF has been preparing a new project that will start in early 2010. This will help patients who, after five to ten years, have developed resistance to antiretroviral medication. These patients have had to be moved on to second-line treatment, without which the disease would develop and ultimately lead to death. However, this is still not widely available through the national health system in Douala, so MSF is returning to support the Ministry of Health in widening access and training staff.

Darlyse

She is a 17 year old girl from Libreville, Gabon who suffered with Buruli ulcer for over five years. After undergoing a number of ineffective treatments she was referred to the MSF Buruli centre in neighbouring country Cameroon. 'My case became very severe because it took so long to find the right treatment,' she explained. 'When I got there I was so tired of the pain and the many unsuccessful treatments that I just wished that they would cut my leg off.' Darlyse stayed in the centre for nearly a year, receiving wound care and skin transplants. It was a great relief for her eventually to be able to leave, cured. 'I still limp a little, but it is getting better every day. I can return home and go back to school again.'

MSF has worked in Cameroon since 2000.

CENTRAL AFRICAN REPUBLIC

REASON FOR INTERVENTION • Armed conflict • Natural disaster **Field Staff 963**

Since late 2005, fighting between the government and armed opposition groups and insecurity related to banditry has caused the displacement of hundreds of thousands of people in the northern regions of Central African Republic (CAR).

Nutritional centre, Central African Republic. A paediatric doctor cares for a child with malnutrition.

The situation remained fragile throughout 2009, in spite of a peace accord between the government and various opposition groups signed the year before.

People still live in extremely precarious conditions and access to healthcare remains a major problem even in areas that have not been directly affected by conflict. Despite an overall increase in aid over the past five years, CAR struggles with high infant and maternal mortality rates and little health infrastructure. People are particularly vulnerable to malaria, respiratory infections, diarrhoeal diseases and malnutrition.

MSF provided healthcare for people affected by armed conflict and violence in the north by offering medical assistance to displaced people and returnees through a network of mobile clinics, hospitals and health centres. Throughout 2009, more than 420,000 consultations were conducted. Thirty per cent of the patients were treated for malaria, and more than 24,600 patients needed to be hospitalised. MSF teams also assisted more than 3,600 deliveries and carried out more than 5,000 surgical interventions. Patients began treatment for tuberculosis and HIV/AIDS as well as malnutrition, and basic relief items were distributed to those who had been displaced by the violence.

In the northwest, close to the border with Cameroon, the situation remained relatively calm in comparison to previous years. Many cattle-raising communities that had fled to neighbouring countries returned, and people who had fled into the bush began coming back to their villages. This made access to health centres easier, and MSF teams were able to improve and expand their support to health posts further afield.

A medical programme was opened to help people suffering from sleeping sickness along the Chadian border in the northwest of the country. By the end of the year more than 1,500 patients had been treated. In 2009 a new treatment known as NECT (Nifurtimox-Eflornithine Combination Therapy) was introduced. These drugs, which are less expensive and easier to administer than previous treatments are now being provided to cure this potentially fatal disease.

In July in the southwest of the country, local health authorities reported high levels of acute malnutrition, which prompted MSF to open an emergency nutritional programme. A combination of poverty and insecurity in the region, and the lack of functional health facilities, contributed to the problem. In response MSF opened six programmes in the region and between July and December treated more than 7,200 malnourished people: 67 per cent were severely malnourished and 25 per cent required hospitalisation.

MSF has worked in the Central African Republic since 1997.

CHAD

REASON FOR INTERVENTION

- Armed conflict
- Endemic / Epidemic disease
- Healthcare exclusion

Field Staff 723

Hundreds of thousands of people were affected by conflict, violence and displacement in Chad in 2009.

Health services were restricted because of a lack of funding and qualified staff, and the situation was particularly severe in the east, where banditry, criminality and insecurity were widespread. More than 170,000 Chadians are still displaced in the east, having fled from the insecure regions near the Sudanese border which is also home to more than 256,000 Sudanese refugees and 67,000 refugees from the Central African Republic. MSF has been providing health services where the authorities have been unable to, paying special attention to displaced people and refugees.

© Minh-Ly Pham-Minh

André District, Eastern Chad. An MSF convoy travels to sparsely populated and highly insecure areas near the Sudanese border to bring measles vaccinations to the local people.

Security challenges

Insecurity made it difficult to assess the health needs of resident and displaced people, especially those living in more remote villages. According to the United Nations Department of Safety and Security, 500 security incidents against civilians, UN workers and NGO workers occurred in the east of Chad last year.

In the Dar Sila region in the east of the country, MSF provided care to 15,000 displaced people in Gassire camp. In nearby villages Kerfi and Adé, MSF provided care and treatment to 40,000 people affected by internal displacement and continuing violence. Activities were suspended in August, however, after two MSF staff members were abducted during a robbery in Adé. In Kerfi, the full medical programme was resumed only in October, and in Adé, services were resumed only in late November, when MSF provided remote support to Ministry of Health staff. Before the suspension, MSF carried out 1,600 - 2,000 consultations a month in Kerfi, and admitted 100 malnourished children each month for therapeutic feeding.

Overall, MSF was able to perform more than 106,000 consultations in collaboration with the Ministry of Health, despite these difficulties.

Eastern Chad

In Adré, a town with a population of 300,000 on the border with Sudan, MSF supported the local hospital throughout 2009. From January to October, more than 2,600 people were hospitalised, more than 900 of them children under five years old. Nearly 33,000 consultations were given in the first nine months of the year. However, insecurity made it impossible to access areas outside the town where other internally displaced people have settled.

In Dogdoré, a remote village near the Sudanese border, MSF provided healthcare to 30,000 people, 27,000 of whom are displaced. Security remained a challenge here, too, as banditry and criminality affected the people as well as the relief organisations. Relocation of international staff was necessary on two occasions, though local MSF staff ensured the continuity of medical activities.

In total, more than 23,600 consultations were carried out. 2,600 women received antenatal consultations, some 280 of whom gave birth in Dogdoré hospital. A tetanus vaccination campaign was also run to reduce the risks of neonatal deaths linked to this disease, and more than 5,500 women received the vaccine. As a result, newborn deaths linked to tetanus were reduced from 35 in 2008 to 11 in 2009.

Obstetrical fistulas

In Guereda in the east, near the border with Sudan, MSF closed the programme that was providing aid to the displaced and to the Birak refugees, since the International Committee of the Red Cross had begun working in the hospital and together with the health authorities were able to cover the needs.

However, since maternal mortality in the area is still very high and the development of obstetrical fistulas common (the United Nations Population Fund estimates that between two and five fistulas develop every 1,000 deliveries), MSF continued to send women with the condition to be treated in Abéché General Hospital in the east of the country. Between January and October, more than 140 women were treated.

Epidemics

MSF responded to an outbreak of measles in the Ouaddai region in the east of Chad. More than 226,000 children were vaccinated against the disease. MSF also responded to an outbreak of measles in Abéché, where 130,000 people under 15 years old were vaccinated, and in Adré where a further 6,000 children under five years old received the vaccine. More than 5,500 girls and women between 15 and 49 were vaccinated against tetanus in the same region.

There was also a meningitis outbreak in the southern regions of Mayo Kebbi Est and Ouest, and in the capital city N'Djamena. MSF supported the Ministry of Health in treating more than 1,200 people, and in a mass campaign that vaccinated 105,000 people.

Southern Chad

In the south of the country, the arrival of refugees from Central African Republic has meant that existing health services are struggling to cope with diseases such as malaria, meningitis and measles.

In Goré MSF continued to respond to medical needs until November when the programme was handed over. Between January and November, teams provided 16,800 consultations, more than 730 surgical interventions, and assisted 600 deliveries.

Emergencies

In March, 8,000 refugees escaped instability and violence in Central African Republic by moving to the Haraze district in the southeast of the country. MSF provided healthcare, set up a drinking water supply system and organised the referral of patients who needed surgery. More than 5,400 consultations were carried out during the two months of the intervention.

MSF has worked in Chad since 1981.

DEMOCRATIC REPUBLIC OF CONGO (DRC)

REASON FOR INTERVENTION • Armed conflict • Endemic / Epidemic disease • Healthcare exclusion

Field Staff 2,832

In 2009 the people in eastern Congo suffered continuous violence from different armed groups. Hundreds were killed, thousands raped and hundreds of thousands fled their homes.

MSF provided medical assistance by running hospitals, mobile clinics, vaccination campaigns and cholera programmes and treating victims of sexual violence.

In January 2009, Congolese and Rwandan armies launched military operations against the Forces Démocratiques de Libération du Rwanda (FDLR) rebels. This offensive led to a mass displacement of people and many villages were attacked, looted and burned. Throughout February and March some 100,000 displaced people arrived in the Kayna area and Lubero town. In response, MSF extended its existing programmes in Kayna and Kanyabayonga to the Lubero district.

North Kivu

In North Kivu, MSF provided emergency care and healthcare in the places most affected by armed conflict, and continued to work in the hospitals of Rutshuru, Nyanzale, Masisi, Mweso, Kitchanga and Kirotshe. MSF also supported health centres and ran mobile clinics and nutrition programmes in the surrounding areas, as well as providing medical and psychosocial care for victims of sexual violence. Overall MSF provided more than 177,000 consultations in these areas.

In Rutshuru, a 280-bed hospital, three surgical teams worked round the clock, performing an average of 15 operations per day. MSF also extended its activities by opening units to treat burns victims and provide neonatal care in Rutshuru hospital, north of Goma.

South Kivu

In the southern district of Kalonge, where 42,000 people were forced to flee their villages, teams provided free access to healthcare through the Chifunzi hospital and five rural health centres. MSF also supported a 148-bed hospital and a 100-bed cholera treatment centre in Baraka and provided medical and psychosocial care for 5,600 rape victims throughout North and South Kivu.

Mobile surgical teams went to Bunyakiri, Kayna and Nyamilima, three sites affected by violence whose people, until then, had no access to surgical care. Teams performed nearly 300 surgeries. More than 30 per cent of the injuries were caused by violence.

Epidemics, emergencies and challenges

MSF responded to recurring epidemics such as measles and cholera by treating people with cholera in special units in Rutshuru and Goma, and vaccinating children under five years old against measles.

In response to the violence in Shabunda Territory, MSF started an emergency four month programme in Lulingu in South Kivu, providing internally displaced people as well as the local communities with healthcare and nutrition. MSF treated more than 15,700 people during this period.

Insecurity continued to undermine MSF's attempts to support the weak and overstretched national healthcare system. In October, seven MSF vaccination sites came under fire during attacks by the Congolese army against the FDLR in the Masisi district, despite an assurance of safety from the government. MSF denounced this as an unacceptable attack on civilians.

Haut-Uélé, Bas-Uélé and Ituri

Since late 2008, the civilian population of northeastern DRC has been caught in a cycle of violence linked to attacks perpetrated by the Ugandan rebel group the Lord's Resistance Army (LRA), and a military offensive against the LRA. MSF continued to work in Dungu hospital and began to support hospitals and health centres in Faradje, Niangara, and Dingila. MSF also resumed its activities in Doruma after a suspension due to insecurity. In all its project locations, MSF provided psychosocial support, vaccination against measles, and distributed relief items to thousands of displaced people.

In the course of 2009, violence and armed confrontations have gradually expanded, now stretching from Haut-Uélé into Bas-Uélé in northeastern DRC, and to the neighbouring regions of southern Sudan and eastern Central African Republic. In the Faradje area, the situation improved so MSF decided to hand over its medical and psychosocial activities. But further west in Bas-Uélé new attacks displaced thousands of civilians. In response, MSF supported Ango Hospital by providing free medical care to the displaced and local people. During the first part of the year, teams assisted people who had fled to the Ariwara area in the province Ituri on the border of Uganda.

Following previous attacks, MSF had to suspend its activities in treatment centres for sleeping sickness (trypanosomiasis) in Bili and Banda, where MSF had treated 228 people in the first three months of the year.

In Bunia, Ituri district, 700 children under five years old were hospitalised and a further 2,000 received care through consultations every month. More than 1,000 women received medical and psychological care, mostly for rape. More than 8,000 people who fled violence in the Similiki area sought refuge in the town of Gety. MSF provided healthcare to 18,000 patients and, when security allowed, brought medical care to neighbouring Tchekele, Aveba and Songolo. Teams also vaccinated 15,000 children against measles in these areas.

Other areas

In more stable areas of DRC, health needs persist. Emergency teams based in Kinshasa, Lubumbashi and Kisangani responded to 12 emergencies including a cholera epidemic in Katanga and an outbreak of Ebola fever in West Kasai. MSF carried out vaccination campaigns against measles, inoculating more than 400,000 children mainly in the provinces of Orientale, Maniema, and North Kivu.

MSF continued to provide treatment to more than 2,000 patients with HIV/AIDS in the capital Kinshasa, but closed its two clinics offering treatment for sexually transmitted infections in the northern city of Kisangani as another organisation took over, ensuring continuity of treatment. At the MSF hospital in Lubutu, Maniema province, more than 120 patients a month were hospitalised.

In Katanga, MSF ran two hospitals in Shamwana and Dubie, and offered basic and maternal healthcare in 12 health centres. For the third year running, MSF organised a camp providing specialised surgery for women suffering from obstetric fistulas, a debilitating condition often the result of complications in childbirth. MSF teams also operated on women suffering from fistulas in North Kivu and Maniema provinces.

Refugees flee to Congo Brazzaville

Between October and December in Equateur province, western DRC, fighting started between different communities reportedly over farming and fishing rights. More than 100,000 people fled violence to the other side of the border in the Republic of Congo Brazzaville and more than 30,000 were displaced inside DRC.

According to a survey conducted in December among refugees in the neighbouring Republic of Congo Brazzaville by MSF's epidemiological centre "Epicentre", approximately 1,700 persons out of a population of 40,500 died from violence over a 50-day period.

In November, MSF started to assist Congolese refugees in the neighbouring Republic of Congo. At the same time, another MSF team assessed the needs and started working in western DRC.

MSF has worked in the Democratic Republic of Congo since 1981.

North Kivu, DRC. Refugees standing in front of Kitchanga camp.

DJIBOUTI

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 90


© Jean-FranÁois Herrera

A young mother waits with her child outside a malnutrition screening centre.

Child malnutrition rates in the shantytowns of Djibouti are high.

This is partly because this small country is dependent on imports from abroad. Fluctuations in food prices affect its 800,000 inhabitants deeply, especially since 60 per cent of the people are unemployed.

MSF is providing medical care for children aged between six months and five years who are suffering from acute malnutrition, particularly those who live in the shantytowns of the capital. Those forced to live in these shantytowns are mainly unregistered migrants, asylum seekers and poverty stricken Djiboutians who have fled drought-ridden rural areas. Thousands come each month to swell the shantytowns located west of the city. Moreover, according to the UNHCR, the country officially hosts some 10,000 refugees, most of them Somali.

MSF medical teams take care of children with severe malnutrition in Balbala, a suburb of Djibouti City, where some 200,000 people live. Mobile teams are working their way through the Balbala, Hayableh, Arhiba and PK12 districts, identifying those with severe malnutrition and referring them to health centres where they are treated. The most severe cases requiring hospitalisation are brought to the MSF therapeutic feeding centre for appropriate care. In the last few months of 2009, more than 14,000 children were screened, 16 per cent of whom needed further care. Overall in 2009, MSF treated nearly 1,730 malnourished children under five years old.

MSF has worked in Djibouti since 2008.

ETHIOPIA

REASON FOR INTERVENTION • Armed conflict • Endemic / Epidemic disease **Field Staff 589**

In 2009 MSF refocused its activities in Ethiopia, opening new projects in the Somali, Oromiya and Gambella regions of the country and handing over a long running kala azar project to the local health authorities in Tigray region.

Teams also treated people with HIV/AIDS, tuberculosis (TB) and malnutrition and provided aid to refugees in camps.

Kala azar treatment

In July, MSF handed over to the local health authorities its kala azar treatment programme in Humera on the border with Eritrea and Sudan. The move followed a series of important steps taken by the government and other organisations in tackling this parasitic disease which, if left untreated, is fatal. Steps have included treatment of the disease in all health structures and the introduction of a national training curriculum for health staff. In the 11 years that MSF worked in the Humera district, approximately 8,000 people suffering from kala azar were treated.

In the northwest Amhara region near the border of Sudan and Eritrea, a remote and often inaccessible area particularly during the rainy season, MSF continued to provide care for people infected with kala azar. Throughout the year, more than 800 people were screened for the disease and nearly 250 patients treated for it.

MSF also treated people with HIV, TB and malnutrition. Last year, more than 4,000 people received counselling and testing for HIV and 250 patients started their antiretroviral therapy. More than 500 people received therapeutic food including 250 malnourished children under five years old.

Somali region healthcare

In Ethiopia's conflict-affected Somali region, where many people have no access to healthcare, teams continued to provide free medical assistance. In one centre in Wardher, MSF provided general and maternal healthcare and treated malnutrition and TB. Staff focused on strengthening and promoting the maternal health services here, since few pregnant women in the region were coming to the clinic for help. These efforts were successful: more than 1,600 women received antenatal consultations and 200 women received assistance for births during the year. In Degahbur, MSF supported a hospital by providing general and maternal care and nutrition services. Mobile clinics were also placed in the area to help reach rural communities. Teams in Degahbur carried out nearly 20,000 consultations and treated nearly 13,000 children for malnutrition.

In February, MSF provided emergency medical assistance to Somali refugees living in transit camps as well as to those who had found accommodation within the local community. In Dolo Ado transit camp, teams provided free basic healthcare, nutritional screening and measles vaccinations for children under 15 years old. In the town of Dolo Ado MSF supported the health centre in providing general healthcare, maternal care, paediatric care, nutritional assistance and various vaccinations.


© MSF

Wardher town, Ethiopia. A team of midwives and local women outside the local health centre.

In May, MSF supported the local health authorities in opening a health centre in Geladi, also in the Somali region. MSF's intervention was initially focused on responding to an outbreak of diarrhoea, however in the last six months of 2009, teams worked on developing other services at the centre such as maternal and general healthcare.

In August, medical teams started working in East Imey, providing outpatient care, antenatal services and treatment for malnutrition. The centre has a 15 bed capacity and a maternity ward. In December, MSF expanded its activities to West Imey, where teams are supporting a healthcare centre and a nutritional centre.

Nutritional Support in Oromiya, Amhara and Somali regions

In November, MSF started providing nutritional care in Anchar worreda in the West Hararghe zone of Oromiya region. A stabilisation centre was built and more than 60 severely malnourished children with medical complications were admitted. The children received treatment over two months and a further 540 severely malnourished children were treated without being admitted. MSF also responded to nutritional emergencies elsewhere. More than 80 malnourished children under five years old were cared for in Bokh between September and November, and over 550 children were treated for malnutrition in Legehida.

Displacement in Gambella

Throughout the year escalating violence in the neighbouring regions of Sudan displaced people in the Gambella Region in the west of the country. MSF opened a programme to provide healthcare to approximately 20,000 residents and 15,000 displaced people living in the district of Wantaho Woreda. The clinic offers general, maternal and nutritional care. In 2009, teams provided nearly 1,800 consultations.

Diarrhoea outbreak

MSF responded to other emergencies throughout the year, primarily outbreaks of acute watery diarrhoea. Interventions in Moyale, on the border of Kenya, treated more than 500 people in one month and in the Afar region more than 1,000 people. MSF also intervened in South Omo in Southern Nations, Nationalities and People's Region and in the Oromiya region. In August diarrhoea became endemic in the capital, Addis Ababa, and its surroundings. Working together with the Ethiopian health authorities, teams treated more than 10,000 people in nine facilities throughout the city.

MSF has worked in Ethiopia since 1984.

GUINEA CONAKRY

REASON FOR INTERVENTION

- Armed conflict
- Endemic / Epidemic disease
- Social violence / Healthcare exclusion

Field Staff 175

Conakry, Guinea. MSF workers hand out insecticide-treated mosquito nets to local people in the fight against malaria.

In September, government security forces cracked down violently on a large opposition rally in the capital city of Guinea Conakry, leaving 150 people dead and hundreds injured. Political instability remained throughout 2009, and poverty and limited access to quality health services continued to affect the lives of most Guineans. MSF provided medical care, including treatment for HIV/AIDS and paediatric care.

Violence

On September 28, hospitals in Conakry were overwhelmed by hundreds of people that had been wounded in the government repression of the opposition protest. MSF responded by providing local hospitals and health centres with medical material and assisting with the evacuation, triage and treatment of the wounded. Teams treated more than 400 wounded, a third of whom for serious injuries and set up a centre where victims of violence could seek medical and psychological care.

Paediatrics

In February, MSF started a new paediatric programme in collaboration with the Guinean health authorities in Matam, a district of Conakry. Offering care specifically to children under five and to pregnant and breast-feeding women, this project aims to reduce the mortality rate of young children in the district, many of whom are affected by malaria, malnutrition, diarrhoea and other diseases. More than 5,500 consultations, half of which were for malaria, were carried out in Matam's three health centres in 2009. MSF also provides neonatal and nutritional care at Conakry's National Institute for Children's Health.

HIV/AIDS care and decentralisation

In 2009, MSF continued to run HIV/AIDS treatment programmes in the city Guéckédou in the southeast of the country and in the capital Conakry. MSF provided testing, treatment and psychosocial counselling, trained and supervised medical staff and upgraded medical units. By the end of the year, MSF was supplying more than 4,000 patients with antiretroviral therapy, including many patients co-infected with tuberculosis (TB). MSF has continued to push for the decentralisation of HIV/AIDS care to smaller health centres to allow patients to be treated closer to their homes.

Health in prisons

Having carried out an emergency medical and nutritional programme in several Guinean prisons, MSF issued a report to highlight the poor living conditions of prisoners. The report 'No food or medicine here until you die' found that in Guéckédou, one in three adult male prisoners was suffering from malnutrition, and the unhygienic conditions had led to dehydration and widespread skin and respiratory infections. Overcrowded cells meant that minors were being detained together with adults, and prisoners with TB alongside uninfected inmates. MSF demanded that the national and local authorities act immediately to meet the prisoners' basic needs.

Bednets

Malaria is the main cause of death in Guinea. Between August and October, MSF teams distributed more than 78,000 mosquito nets impregnated with insecticide to 38,000 households living in Matam district.

MSF has worked in Guinea Conakry since 1984.

KENYA

REASON FOR INTERVENTION • Endemic / Epidemic disease • Healthcare exclusion
Field Staff 629

In early 2009, as people fleeing the fighting in Somalia arrived in Kenya in their thousands, MSF teams re-started working in Dadaab refugee camp in Dagahaley in the northeast of the country after a five year absence.

Teams also responded to numerous emergencies, including fuel tanker explosions, the return of a cholera epidemic, and treated people with kala azar, HIV/AIDS and tuberculosis (TB).

Assisting Somali refugees

Dagahaley is one of three camps in Dadaab that were set up in the early 1990s to house Somali refugees. By the end of 2009, camps that had originally been built to accommodate 90,000 people were struggling to cope with close to 300,000 people. MSF provides healthcare in the camp via a 100-bed hospital that carries out surgeries and offers medical care, and four other health centres that administer vaccinations and give antenatal and mental healthcare. The medical needs are huge: the hospital provides around 10,000 patient consultations and admits 600 people every month. Between August and December last year, MSF cared for more than 67,000 patients, including more than 2,200 malnourished children.

Responding to emergencies

In January, more than 100 people died after a fuel tanker exploded in Molo town in Nakuru. Later in the same year, there was another tanker explosion in Kericho. Teams provided medical care to the survivors, many of whom suffered burns.

After a 12-year absence, cholera returned to Kenya in late 2008. In 2009 MSF responded to several outbreaks around the country and treated approximately 5,000 people.

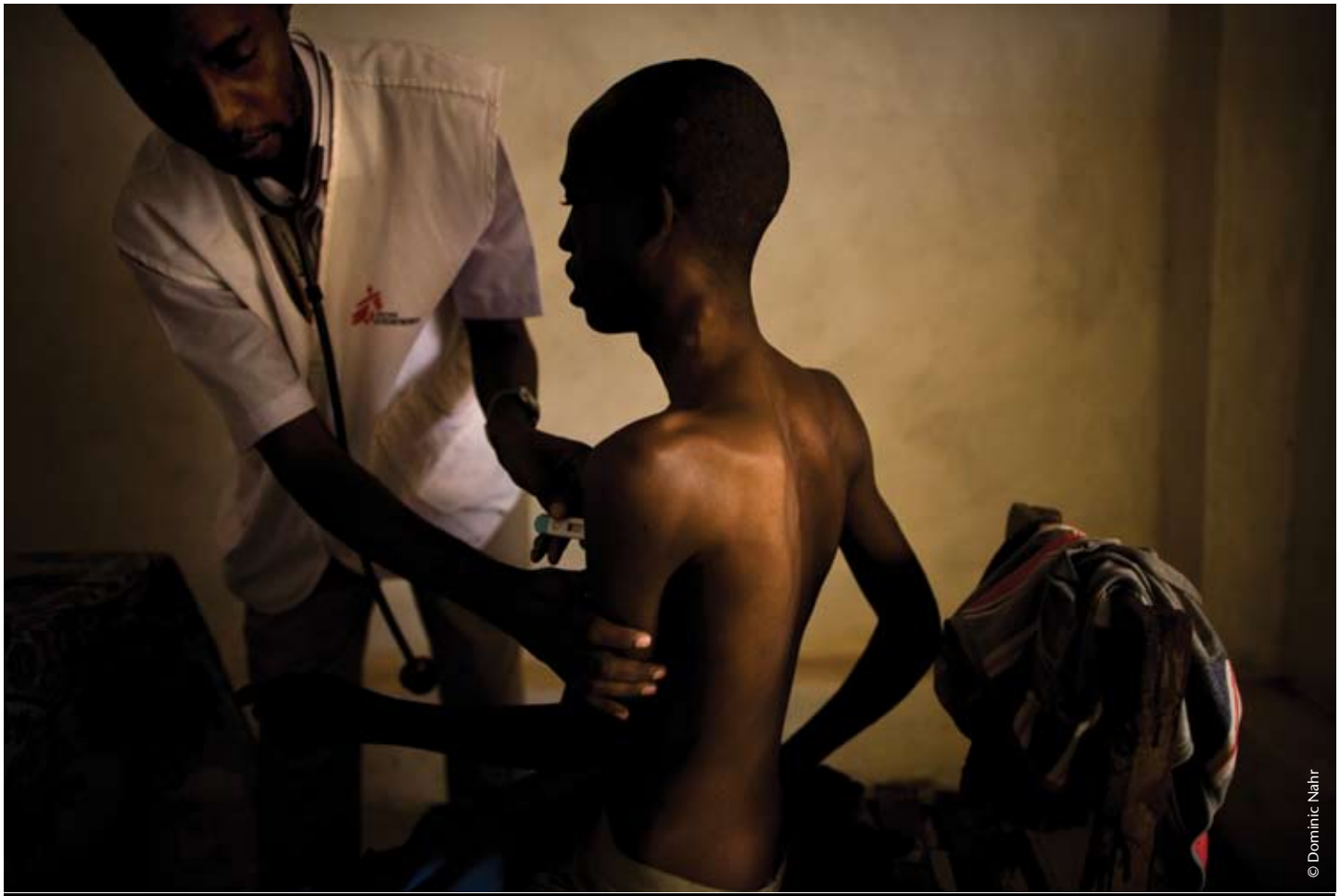
Kala azar

In the West Pokot District in western Kenya, teams cared for people infected with kala azar, a parasitic disease transmitted by the sand fly that is deadly without medication. Every month teams treated 40 to 50 people.

MSF is lobbying for treatment to be provided free of charge by the Ministry of Health and for rapid testing methods for the disease to be made readily available.

HIV/AIDS and TB

In western Kenya, MSF runs a HIV/AIDS and TB programme in Nyanza province, where the prevalence rate is one of the highest in the country. Working in Homa Bay District Hospital, MSF staff cared for 9,500 people living with HIV, 73 per cent of whom are receiving anti-retroviral treatment (ART). As a result of MSF's intervention, Homa Bay District Hospital was the first public facility in Kenya to offer free anti-retroviral treatment in 2001. However in this rural community, where poverty is rife, transport unreliable or expensive and stigma commonplace, medical teams were still seeing many patients who would only come to seek help when they were very seriously ill with HIV/AIDS. To try and prevent this, since 2006 MSF staff have focused on decentralising care in the district, working with the Ministry of Health to ensure that HIV/AIDS care is available in healthcare clinics around the district.



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Dagahaley camp, Dadaab, Kenya. A young Somali boy who has reached the later stages of cancer without any proper treatment is seen by a doctor.

LESOTHO

REASON FOR INTERVENTION • Endemic / Epidemic disease
Field Staff (this figure is integrated with those of South Africa)

St Barnabas clinic, Lesotho. Two nurses comparing notes.

In Lesotho, one of the countries worst-affected by HIV/AIDS, 270,000 people live with the virus, 117,000 of whom need antiretroviral therapy (ART). Yet only 41,000 people are receiving the life-prolonging treatment.

Four years ago, MSF and the national health authorities jointly launched a programme to provide HIV/AIDS care, including ART, in rural Lesotho. MSF has now handed over six of the 15 clinics it has been supporting in the Scott Hospital Health Service based south of the capital Maseru.

These six centres will now be run by the local health authorities to help decentralise care and bring treatment closer to people in rural areas. Nurses will be trained to administer treatment for HIV/AIDS and tuberculosis (TB). Lay counsellors, often HIV-positive themselves, will also be trained to support new patients and help them to adhere to the treatment.

The programme launched in Scott Hospital includes a district hospital and 15 health centres in remote rural communities. This covers around 220,000 people, 30,000 of whom are HIV-positive. In addition to general healthcare, the clinics provide comprehensive HIV/AIDS care including testing, ART and counselling as well as prevention of mother-to-child transmission. MSF has also worked to strengthen laboratory services, drug supply, infrastructure, and programme monitoring.

Throughout the year, nearly 54,000 HIV tests were carried out, and more than 6,000 patients were started on ART. The results for the first two years are encouraging; 80 per cent of adults and 93 per cent of children are still alive after 12 months of treatment. In addition, HIV transmission from mother to child has been reduced to less than five per cent.

However since 90 per cent of patients with HIV/AIDS are co-infected with TB, the programme is now also focussing on improving TB diagnosis and integrating HIV and TB services.

MSF has worked in Lesotho since 2006.

Mamatsoele

HIV-positive and a counsellor working in a remote mountain clinic

'When I talk to people about HIV, I make an example of my life and how I lived before knowing my status. Even if you are taking the medicine, if you don't accept your status, it won't help. Accepting my own HIV-positive status made me feel like a new person.'

As tuberculosis is the leading killer of people living with HIV/AIDS, a focus of MSF's work in Homa Bay is treating people with TB and multi-drug resistant TB (MDR-TB). In 2009, MSF constructed an eight bed isolation ward for MDR-TB treatment in Homa Bay district hospital. Medical teams also provide treatment for MDR-TB in Nairobi's slums, where people live in extremely cramped conditions without sanitation, running water or electricity.

In the Nairobi slums of Mathare and Kibera, MSF provides free comprehensive care for around 7,000 people living with HIV/AIDS and anti-retroviral treatment for more than 4,800 people. In 2009, outpatient consultations in MSF's three clinics in Kibera increased from around 4,700 a month to over 7,000. In Mathare, medical teams started providing voluntary counselling and testing in different locations around the slum in order to try and provide care for more people living with HIV/AIDS. Specialised treatment for survivors of sexual violence, a huge problem in the city's slums, is also provided. Post exposure prophylaxis, which greatly reduces the risk of infection with HIV, counselling and social support is offered. In Mathare MSF treats between 20-30 survivors every month, many of whom are children

Handing over

In Nairobi, MSF handed over its activities in Mbagathi hospital to the Ministry of Health after 12 years of intervention. In Busia, in Western Province near the border of Uganda, MSF also handed over its activities in the main district hospital and the support of eight out of nine health centres throughout the year. The handover of the last health centre is planned for April 2010. In the ten years that MSF worked in Busia, good progress was made in treating people living with HIV. Working closely with the Ministry of Health and ensuring that care was decentralised and integrated into healthcare clinics around the district, teams provided care for more than 13,300 people living with the disease, and more than 4,300 of these received ART.

MSF has worked in Kenya since 1987.

LIBERIA

REASON FOR INTERVENTION
- Endemic / Epidemic disease
- Social violence / Healthcare exclusion

Field Staff 694

Though Liberia has made significant moves towards stability and reconstruction following its 14-year civil war, many people still live in poverty and the weak health sector often struggles to provide adequate healthcare. Women and children are particularly at risk.

A mother watches over her daughter who is recovering from measles.

Maternal and paediatric healthcare

In 2009, MSF provided free healthcare in two hospitals and two health centres in Montserrado County in the northwest, which is home to more than 30 per cent of the country's population.

In a suburb of Paynesville, MSF worked in a 106-bed women and children's hospital offering neonatal intensive care and maternal emergency services for women, including surgery. Throughout the year, teams assisted nearly 7,000 patients, including more than 1,100 deliveries and 2,600 emergency surgeries.

MSF also provided healthcare in a 187-bed private paediatric hospital in Bushrod Island, an overcrowded area of Monrovia that is home to more than 500,000 people. More than 12,400 children were admitted in 2009. Teams focused primarily on maternal health, malnourished children with medical complications and integrating the treatment of chronic diseases such as HIV/AIDS and tuberculosis.

MSF also supported two health centres in collaboration with the Ministry of Health in Clara Town and New Kru Town, in the capital. Teams provided a range of services such as antenatal and postnatal care, vaccinations and the prevention of mother-to-child transmission of HIV. Together, the centres carried out more than 112,000 consultations, and delivered 2,200 babies.

Handover

In 2007, MSF started a gradual handover of projects to the Ministry of Health and other partners. In 2009, with the country firmly in a post-conflict reconstruction phase, MSF continued to hand over activities, including in Nimba County, northeastern Liberia in April, followed by activities in Clara Town health centre in August. MSF also scaled down activities in its two hospitals in Monrovia.

Before the handover of Saclepea in Nimba County, MSF successfully finalised a research project in collaboration with other partners for testing the anti-malarial drug known as artemisinin-based combination therapy.

Sexual violence

Sexual violence remains common in Liberia. MSF offered emergency medical and psychological support to survivors of sexual violence at Island hospital in Monrovia and at two health centres, treating an average of 70 patients a month in 2009. More than three-quarters were younger than 18 years old.

In the last months of 2009, MSF ran an awareness campaign in Monrovia, using radio advertisements, interviews, posters, banners, text messages and drama groups to urge more survivors of sexual violence to seek vital medical and psychological treatment, particularly in the first three days after an attack.

Free medical care for all

MSF continued to lobby for free care throughout Liberia. Though the government introduced a free treatment policy in 2006, and reconfirmed its willingness in 2009 to provide free healthcare to its people, considerable political will and resources from the international community are still needed to ensure these promises become a reality.

MSF has worked in Liberia since 1990.

Bestman

10 years old, a TB patient in Island Hospital, Monrovia

'I was very sick when they brought me here. I couldn't even play with my friends anymore and I was sweating and coughing so hard. My mother was worried. She thought she would have to pay a lot of money, but my family doesn't have money to pay. But everything here was free. After two weeks in hospital I had to come back once a month for six months to get medicine. Now I can play with my friends again.'

MALAWI

REASON FOR INTERVENTION • Endemic / Epidemic disease • Natural Disaster **Field Staff 514**

Malawi has been hit hard by the HIV/AIDS pandemic: nearly one million people, that is 12 per cent of those aged between 15 and 49 are infected.

There is chronic shortage of health professionals and demand for antiretroviral therapy (ART) remains considerable. At the end of 2009, more than 300 centres were supplying ART to more than 183,000 patients, but 300,000 people were still on the waiting list.

HIV/AIDS programme

Good quality HIV care is now provided in the districts of Chiradzulu and Thyolo, but is rare throughout the rest of the country. Indeed the scale of the need combined with the shortage of health staff has led MSF to adjust its approach, simplifying treatment protocols and delegating patient care to nurses within local health structures to bring care closer to patients' homes. Only where children and pregnant women are involved, or when there are complications, are cases referred to health specialists. Screening and psychosocial and nutritional support are provided by counsellors who help patients follow the treatment properly.

MSF is working to provide further care for HIV patients, such as preventing mother-to-child transmission, detecting treatment failure and providing paediatric care. There is a strong emphasis on integrating HIV services with general services, and integrating MSF's HIV support services into the Ministry of Health centres.

Since July 2009, the supply of ART drugs to Malawi has been unreliable. In response, MSF sent an emergency stock to the districts of Chiradzulu and Thyolo to help avoid any disruption to the medication of the 30,000 people on the programme. Any breaks in treatment increase the risk of patients developing drug-resistance.

At the end of 2009, MSF was providing ART to more than 15,000 patients at Chiradzulu, and another 15,000 at Thyolo.

In July last year at the International AIDS Conference in Cape Town, South Africa, MSF gave a presentation on Malawi. This was an opportunity to show that offering ART on a larger scale need not increase the burden on the health system. The programme in Thyolo, where 80 per cent of those in need have access to this life-saving care, was used as an example.

Shortage of staff

In Malawi the nurse and doctor-to-patient ratio is dangerously low. Medical staff in the districts where MSF works face high workloads: as many as 150 to 200 consultations a day. These shortages make it nearly impossible to provide good-quality healthcare and improve HIV services. One of the reasons why staff numbers are so low involves sickness and death that is often HIV-related. MSF has addressed this by supporting a clinic in Thyolo hospital where staff can receive health services.

Cholera outbreak in Lilongwe

The capital, Lilongwe, was hit by a cholera outbreak at the end of 2008 and in early 2009. The principal cause was the lack of access to safe water and sanitation. Authorities requested assistance and MSF provided supplies and medical staff and gave intensive training to health workers. Teams cared for more than 3,700 patients during the epidemic, and gave logistical support to improve water and sanitation services in nine health centres and one district hospital.

Earthquake in the north of the country

On December 20, an earthquake of magnitude 6.2 hit the rural province of Karonga in the north of the country, killing four and injuring 200 people. Some 1,500 people were made homeless. Since the financial and material assistance provided by other agencies was adequate, MSF focused more on technical support, setting up a health centre in the camp for those who had been made homeless and providing sanitation and access to drinking water. The team also ensured that the earthquake victims had access to HIV care.

MSF has worked in Malawi since 1986.

© Isabelle Merny

Chiradzulu, Malawi. Children outside a health centre, from which MSF provides antiretroviral treatment to more than 15,000 patients with HIV.

Nouma

MSF patient from Chiradzulu

'It was difficult for me to get to the district hospital. I have difficulty walking and don't have a vehicle. Finding the money for transport is a problem too because it's a long way to go. Now, I just need 30 minutes to get to the health centre.'

MALI

REASON FOR INTERVENTION
- Endemic / Epidemic disease
- Healthcare exclusion

Field Staff 133

A combination of factors makes access to healthcare difficult for Malians, including cost, the distance people live from health centres and, in the northern part of the country, the nomadic lifestyle.

Malaria is a leading cause of death in children under five years old, and the maternal mortality rate is high.

Throughout 2009, MSF provided general healthcare, treatment for malaria and obstetric fistulas and nutritional support to children.

Malaria

Teams worked in the Kangaba region in southern Mali, where malaria is most prevalent. MSF supported 11 health centres and mobile teams, including 66 'malaria village workers'. These people are trained to detect and treat uncomplicated malaria in children in remote villages during the rainy season. Workers also learned how to recognise signs of severe malaria so they could refer the more serious cases to health centres.

In 2009, MSF carried out more than 118,000 consultations. 60,000 people were treated for malaria and more than 1,150 patients were hospitalised for severe malaria. Early detection kept the number of people needing hospital treatment relatively low.

Measles epidemic

MSF responded to a measles epidemic in the north of the country by providing treatment in remote villages in the Timbuktu and Gao regions. The most severe cases were referred to MSF centres, where more than 2,800 patients received care.

Although the number of infected people had already surpassed the epidemic threshold, MSF carried out a vaccination campaign in the Timbuktu region in collaboration with the Ministry of Health in order to prevent the disease spreading further. More than 322,000 children between six months and 15 years of age were vaccinated.

Fistula operations

In the northeast regions of Timbuktu and Gao, MSF treated women for obstetric fistulas. This condition is common in remote regions because there are few hospitals and therefore little access to Caesarean section operations. Fistulas occur during childbirth when complications leave those who survive with permanent injuries to the birth canal. They can lead to chronic leaking of urine and/or bowel waste and women who suffer from the condition are often socially isolated and treated as outcasts.

In collaboration with the Timbuktu regional hospital and the Gao regional hospital, MSF operated on more than 80 women.

High infant mortality rate

According to a 2006 study by Enquete Démographique et de Santé du Mali, one in four children die before reaching the age of five in the southeastern region of Sikasso. More than 40 per cent of the 120,000 children in the region suffer from malnutrition, and high levels of infant malaria also contribute to this statistic. Diarrhoea and respiratory infections are also common and cause numerous infant deaths.

In collaboration with the Ministry of Health, MSF launched a medical and nutritional programme in 2009. MSF supports five health centres with supplementary staff and provides medicines and therapeutic food. Children requiring hospitalisation are transferred to Koutiala hospital where a Paediatric Intensive Care Unit and a Therapeutic Feeding Centre have been set up.

Between July and December more than 22,300 consultations were carried out in the health centres supported by MSF. Two out of three children were treated for malaria, 3,200 children were treated for severe malnutrition and more than 1,100 children were hospitalised.

MSF has worked in Mali since 1992.

A community from a small village listen to a talk on malaria prevention.

Ablo

A 10 year old malaria-sufferer from a village in the Kangaba region.

'Every month, I get sick with malaria because of the mosquitoes. The health worker from MSF came to our school and explained it to us. At home, we sleep under a mosquito net, but the mosquitoes also bite in the evening and I like to run around with my friends at the end of the day. But the medicine works very fast. After two days, I can go back to school, I can look after our cattle and care for my baby brother.'

A consultation is carried out in the back of an MSF vehicle.

MOROCCO

REASON FOR INTERVENTION

• Social violence / Healthcare exclusion

Field Staff 30

Due to the migration policies adopted by the Moroccan authorities, the global economic situation, the financial crisis and rising unemployment, the number of migrants arriving in Morocco decreased in 2009.

However, the migration of young women is still high, mainly because of trafficking networks. Many are victims of sexual violence and suffer from resulting health problems.

In the cities of Oujda, Rabat and Casablanca, teams used mobile clinics to reach people in need of healthcare and referred those with more complex problems to the Moroccan health authorities. However the projects in Rabat and Casablanca closed in December when direct access to the national healthcare system improved for migrants and the MSF programme was no longer needed.

In 2009, MSF treated 5,550 patients and provided help to many people who had suffered from sexual violence. However, as teams considered these people to be only a small proportion of those who had actually been attacked, they began asking all patients directly whether they had experienced sexual violence-38 per cent reported that they had.

Stranded between countries

Currently, migrants are being expelled from Morocco to a 'no-mans land' known as 'Kandahar' on the border between Mauritania and Morocco. In Mauritania, they are detained by the authorities and kept in a detention centre called Guantanamito. During 2009, an exploratory mission was conducted in Mauritania and, based on this, a project will open in 2010 to provide medical care to the migrants. A further assessment will take place in 2010 in Argelia on the eastern border with Algeria to assess the needs of migrants along the migration routes there.

MSF has worked in Morocco since 1997.

Patient story

Woman from Democratic Republic of Congo interviewed in Morocco

'We came on foot. To make this journey on foot you have to be very strong. You have only the water that you can carry, and when this water runs out you have to drink water that you get from camels. There is so much sand, and when you are with small children, it's hard, it's really hard. When we arrived in Gadamés we had only a few things to eat. Some men came to us and said, "We need women." I asked them why they needed women. They told me again that they needed women and started to beat me. They were so strong. I was raped. I cried to God but there was no miracle that could help me escape. You find yourself wishing for death. But death didn't come.'

MOZAMBIQUE

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 502**

HIV/AIDS, malaria and tuberculosis are widespread in Mozambique. 15 per cent of people aged 15 to 49 are infected with HIV making it one of the worst affected countries in the world.

Maternal mortality is high and diarrhoeal diseases are endemic. Furthermore, the national healthcare system was shattered during the 16 years of civil war that ended in 1992, as were most social and economic infrastructures.

All MSF projects are focused on HIV/AIDS treatment and care, including the prevention of mother-to-child transmission of the disease. In the capital Maputo, teams work in two districts, supporting two day-hospitals and nine health centres. Teams train staff, and provide psychosocial counselling for HIV-positive patients, including children. 18,000 patients receive antiretroviral therapy (ART).

MSF is developing and promoting innovative models to help meet the high demand for healthcare and is lobbying the government to introduce a 'task shifting' approach in hospitals to help to counter the shortage of doctors and nurses. This includes training local medical staff to prescribe ART drugs and administer repeat prescriptions, and permitting the use of lay counsellors.

MSF is supporting the care and follow-up of HIV-positive patients in provincial hospitals in the northwest of the country and is providing technical support to health centres. In Tete city, following a decentralisation of patient care from hospital to health centre level, the project is now focused on training and supervision of Ministry of Health staff, with the view to handing back the project in 2010.

During 2009, MSF carried out 240,500 consultations and provided ART to 25,500 patients.

MSF has worked in Mozambique since 1984.

Margarida

'I live in a village outside the city of Tete, in northwest Mozambique. Other people know that I'm HIV-positive, but I'm not worried or ashamed of my disease. MSF encouraged me to help others with HIV. I am now the leader of one of MSF's HIV patient groups. My role is to collect medication at the health centre and distribute it to the others in the group. Before, each member used to pay one hundred meticals ($3.40) to travel back and forth to the health centre. Now, each member pays me seven meticals ($0.24), and I bring the medication to their house. The patients in the group appreciate this, because many don't have enough money to travel to the health centre.

It's great to be able to help others to take care of their illness. I'm taking medication but I am healthy and working like other people. I want other HIV-positive people to join me and enjoy life.'

© Tomas Munita

Maputo, Mozambique. A doctor explains antiretroviral drugs to a man with HIV and his brother.

NIGER

The people in this mainly rural, sub-Saharan country have only limited access to healthcare, and the facilities that do exist are largely underequipped and understaffed.

MSF has been working to provide nutritional aid to malnourished children as well as general and maternal healthcare, and last year launched a large meningitis vaccination campaign.

Zinder

The high level of malnutrition among young children during the dry season from June to October is an ongoing problem. According to a survey conducted by UNICEF in June 2009, 15 per cent of children under five and almost 22 per cent of children between six months and three years old were acutely malnourished in the Zinder region in the south of the country.

In Zinder, within the first nine months of the year, MSF admitted 6,400 children under five who were suffering from severe malnutrition, a third of whom needed to be hospitalised. MSF also supported two hospitals and 11 health centres in the region of Tahoua in the west of the country where 16,500 children under five received treatment for moderate and severe malnutrition. Nearly 12,000 other children were admitted to the clinic in the Nigerian border town of Magaria during the same period, 1,800 of whom needed to be hospitalised. In total MSF treated more than 34,000 severely malnourished children and provided a further 150,000 people with free healthcare in 2009.

The country was repeatedly hit by epidemics requiring emergency responses throughout 2009. One outbreak of meningitis lasted more than three months. MSF together with the Ministry of Health treated 3,300 people and immunised 1.5 million in the Zinder region, as well as a further 670,000 people in Tahoua.

REASON FOR INTERVENTION • Endemic / Epidemic disease • Natural disaster **Field Staff 1,189**

Doutchi, Niger. A doctor vaccinates children in one of MSF's biggest meningitis vaccination programmes ever.

Maradi

In Guidam Roudji district in Maradi region, severe malnutrition remains one of the main causes of death among children under five years old. In 2009, MSF provided treatment for more than 1,700 malnourished children in four health centres. MSF teams also worked in the paediatric ward of Guidam Roudji hospital where children with severe malnutrition are treated, and during the malaria season provided additional staff to the hospital.

In Dakoro district, Maradi, malnourished children received specialised care in MSF supported health centres. Those in need of intensive care were transferred to Dakoro hospital, where an MSF team provided intensive medical and nutritional care, paediatric care and emergency obstetric services. In 2009, there were over 2,300 admissions in the paediatric ward and more than 1,700 in the maternity ward, including nearly 280 caesarian sections. In five health centres – Adje koria, Sabon Machi, Alforma, Goula and Dakoro services including maternal health, family planning, ante and post natal consultations were offered. Altogether, MSF conducted an average of 10,000 consultations every month.

In Madarounfa district, still in Maradi region, a joint project for the treatment of malnutrition was started by MSF and 'Forsani', a Nigerian medical organisation. In the three sites of Gabi, Madarounfa and Dan Issa, more than 12,600 severely malnourished children were admitted to the programme – with more than 90 per cent successfully treated. During the malaria season between July and December, support was provided to three health centres in the district to help treat malaria cases in children under five. In total nearly 11,300 children were helped.

In May last year, MSF began working in three health centres in the city of Agadez in the north of the country, providing maternity and reproductive health services. At the end of the year, teams had conducted more than 5,700 consultations and had assisted more than 2,000 births.

In September, severe floods hit Agadez. MSF teams provided emergency medical assistance through mobile clinics to more than 9,500 people and distributed relief items to more than 2,000 displaced families.

MSF has worked in Niger since 1985.

NIGERIA

REASON FOR INTERVENTION • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 524**

Approximately 59,000 women die every year in Nigeria from complications in childbirth, giving the country the seventh-highest maternal mortality rate in the world according to the United Nations Population Fund.

In 2009 MSF provided maternal healthcare and surgical support, launched a widespread meningitis vaccination campaign that treated 4.7 million people, and provided treatment for cholera.

Improving maternal health in northern Nigeria

In the north of the country, the focus was on improving access to emergency maternal care in Sokoto State, where MSF supports the mother and child care programme at the main hospital. 8,100 malnourished children under five years old in Sokoto State and Kebbi State were also cared for.

MSF worked in emergency maternal care in Jigawa State. The team helped nearly 1,600 women give birth and treated more than 2,500 women for complications in pregnancy. In addition 219 women were operated on for fistula repair surgery.

Emergencies and epidemics

Throughout 2009, emergency teams dealt with epidemics and emergencies. This included conducting a comprehensive meningitis campaign that involved vaccinating 4.7 million people across nine states. Teams also provided 4,500 people with treatment following a cholera outbreak in Borno state.

Trauma care in the Niger Delta

MSF runs programmes in the Rivers and Bayelsa states in the Niger Delta. Here in Port Harcourt hospital MSF provides medical care via a 75-bed health centre. In 2009, 8,300 people received care, 42 per cent of whom were treated for violence-related injuries. Overall, more than 2,100 patients were admitted and more than 2,850 surgeries were carried out, and 450 victims of sexual violence received medical support and counselling.

In the southern part of Bayelsa State, MSF worked at the Oloibiri Health Centre. 1,000 consultations were carried out each month and a mobile clinic service provided consultations to more than 1,100 people in 14 different locations.

MSF has worked in Nigeria since 1996.

© Francois Servranckx

A doctor carries out a bedside consultation for a young boy with meningitis.

SIERRA LEONE

REASON FOR INTERVENTION • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 393**

© Vikki Stienen

MSF carries out a vaccination campaign targeting 525,000 people in response to an outbreak of yellow fever.

Patient story

In January, two exhausted parents arrived at the Gondama Referral Centre carrying a cold and pale child who was having difficulty breathing. His body was covered in multiple abscesses. The parents had carried the boy for three days so that he could receive treatment at the MSF hospital. The three had slept out in the open with no food or money, and had been soaked by torrential monsoon downpours. In the four subsequent weeks the child received treatment for severe pneumonia, an extensive staphylococcal skin infection and severe malaria. He recovered fully and returned home to his village, some 70 miles away.

Since civil war ended in 2002, Sierra Leone has been relatively stable politically. However, the economy has not yet recovered. Poverty is extreme, a severe lack of healthcare provision has resulted in the highest child mortality rate in the world, and malnutrition and malaria are widespread.

In 2009, MSF carried out 355,000 consultations, which included treatment of 202,000 people with malaria and 6,000 with severe acute malnutrition.

In January, MSF carried out a vaccination campaign in response to an outbreak of yellow fever in the city of Bo and the surrounding area. In total, 178,500 people were vaccinated.

MSF is currently providing healthcare in a hospital near Bo. The hospital has 215 beds, a paediatric ward, a maternity ward, an intensive care unit and an intensive therapeutic feeding ward for severely malnourished children. MSF also supports the operation of five community health centres and 30 community health posts in the Bo and Pujehun districts, providing healthcare including curative consultations, basic obstetric care, and treatment for malnutrition and malaria. In addition, MSF supports a network of 140 community volunteers who have been taught how to diagnose and treat malaria in their own villages.

Over the last few years there has been a sharp increase in the number of patients in MSF programmes, mainly due to a growing number of people coming from further afield in search of treatment. At the end of 2009, the hospital was overcrowded, with the paediatric ward and the therapeutic feeding ward overstretched by up to 40 per cent. Such overcrowding means people have to share beds or sleep on the floor.

MSF's experience in Sierra Leone has shown that moving to a system of free healthcare produces a sudden and dramatic increase in the number of patients seeking help for serious medical conditions. Currently, all patients are required to pay a fee when seeking treatment in the national health system. A doctor's consultation can cost the equivalent of 25 days' income. MSF has publicly called for the abolition of user fees and, in 2009, both the government and donors stated their support for it, starting with free care for children under five years old and pregnant women. However, it remains to be seen whether the authorities will receive the necessary funding and technical assistance to implement this policy fully.

MSF is an important provider of medical care countrywide, and is also the only major maternal and paediatric health provider outside Freetown. Each year, MSF provides primary healthcare to more than 300,000 patients.

MSF has worked in Sierra Leone since 1986.

SOMALIA

REASON FOR INTERVENTION • Armed conflict • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 1,201**

In 2009, the people of Somalia continued to be the victims of indiscriminate violence due to ongoing internal conflict.

Many thousands needed emergency healthcare but the overall humanitarian response was inadequate. MSF worked in nine regions to provide urgent medical care.

Insecurity and violence

Abductions and killings of international and Somali aid workers, and ongoing insecurity remained the biggest obstacles to MSF's efforts to respond to the vast medical needs throughout the country. In April two staff members were abducted in the Bakool region and held for ten days before being released. Following the abduction, MSF decided that it could no longer safely provide care to the people living in this region and closed its largest health centre in south and central Somalia, along with four other health posts.

In June an MSF employee died in an explosion in the Hiraan region that also killed 30 other people. In July, for the first time in 17 years, MSF had to suspend activities in its paediatric hospital and three other health clinics in northern Mogadishu because of heavy fighting. The following month, armed men raided the MSF nutritional treatment centre in Jilib, taking crucial medical supplies and forcing staff to leave hundreds of severely malnourished children without access to essential medical care. By the end of 2009 MSF had not been able to restart activities in Jilib. In December, two mortars hit Belet Weyne Hospital, injuring two MSF staff.

Overcoming the challenges

Despite these risks, MSF is still determined to provide medical care to the Somali people. In 2009, more than 1,300 dedicated Somali staff, supported by more than 100 staff based in Nairobi, carried out some 650,000 consultations, 238,000 of which were for children under five years old. More than 49,000 women received antenatal care and 26,000 people were admitted to MSF-supported hospitals and health clinics. Nearly 3,000 surgeries were performed, more than 900 of which were for injuries caused by violence. Teams treated more than 200 people suffering from the deadly neglected disease kala azar, 2,600 people for malaria and 1,300 for tuberculosis. More than 34,000 people suffering from malnutrition were provided with food and medical care and 224,000 children were vaccinated, including 92,000 for measles.

Responding to emergency needs

In two different regions, MSF was able to restart emergency surgical activities by recruiting doctors who had graduated from medical school in the capital Mogadishu in 2008. In the last five months of 2009, these doctors performed more than 100 major surgeries, nearly half of which were for injuries caused by violence.

In February, at a hospital just outside the capital, MSF staff treated people who had been injured in a dramatic upsurge in fighting. There were more than 120 admissions in just one day. More than 1,000 people, nearly half of whom were women and children under 14, were admitted for blast injuries. MSF's hospital in the central town of Belet Weyne received more than 170 war-wounded patients needing surgery and, in Guri El, in the neighbouring region of Galgaduud, more than 230 patients were treated following renewed fighting.

In early 2009, fighting in Guri El and Dhusa Mareb, central Somalia, prompted thousands of civilians to flee their homes. MSF supplied water and medical care to displaced people in the area. Throughout the year, teams also responded to outbreaks of cholera, treating 1,000 people. When the number of reported measles cases increased, MSF launched large-scale vaccination campaigns in four regions of Somalia. Approximately 73,000 children between six months and 15 years old were vaccinated in Belet Weyne, Hiraan, Middle Shabelle, Lower Shabelle and Bay regions and around 1,500 people suffering from the disease were treated.

Drought, combined with chronic poverty, bad harvests, high food prices, and continuing violence meant that the number of children needing treatment for severe malnutrition reached an all-time high in MSF's nutritional programme in Galcayo. Nearly 2,300 children were treated between October and December alone. Teams working in the Mogadishu suburbs treated more than 14,000 children for malnutrition during the year.

MSF has worked in Somalia since 1991.

Feeding centre, Galcayo, Somalia. Prolonged drought, fighting and high food prices means MSF's nutritional centre is often packed to capacity.

Dr Hafsa

MSF surgeon, Marere

'I chose to become surgeon because I wanted to help Somali women, particularly mothers who don't get good medical care, especially when they have difficult births and need surgery.'

SOUTH AFRICA

REASON FOR INTERVENTION
- Endemic / Epidemic disease
- Healthcare exclusion

Field Staff 158

In 2009 the new South African government completely reversed its stance on two of the country's biggest health challenges, and is now addressing HIV/AIDS and tuberculosis (TB) as major health priorities.

Khayelitsha township, Cape Town. A grandmother with one of five grandchildren that she is bringing up since the death of their mother from AIDS.

On World AIDS Day, President Jacob Zuma announced a number of long-awaited changes to strategies on HIV/AIDS treatment, including the use of higher-quality drugs for initial treatment, and a new model of care to address the deadly HIV/TB co-infection directly. Treatment will also be available for pregnant women and more nurses will be trained, which will give patients greater access to care. MSF has been continuing to provide HIV/AIDS and TB care to those in Khayelitsha and healthcare to refugees from Zimbabwe.

Khayelitsha, a township on the outskirts of Cape Town, is home to half a million people and has one of the highest incidences of HIV/AIDS in the country. Since 2001, MSF has been running a programme there in partnership with local health authorities offering antiretroviral therapy (ART). The Khayelitsha programme was the first in South Africa to provide ART free of charge to the public. By December 2009, more than 13,550 patients were benefiting from the service.

But challenges remain including the lack of specific HIV/AIDS medication to treat children and adolescents, and the need for further integration of HIV/TB treatment to cope with the high numbers of patients who are co-infected. There are also increasing numbers of people being diagnosed with drug-resistant TB (DR-TB). MSF hosts a pilot project in the country offering DR-TB treatment through regular health centre visits, rather than in specialised isolation hospitals. This model of integrated care for HIV/AIDS and TB patients has been replicated in many other settings and is promoted by the World Health Organization as a model for best practice. The programme has enrolled over 580 patients in the last three years.

Zimbabweans seek refuge in South Africa

MSF has been continuing its work in central Johannesburg and in Musina, a town on the border with Zimbabwe, to provide Zimbabweans seeking refuge in South Africa with medical care and mental health services. In 2009, MSF also made regular mobile healthcare clinics available to the farms along the border where many migrants work. Since April last year, MSF has been focusing on HIV/TB care and on improving services for victims of sexual and gender-based violence.

In these two projects, MSF treated more than 5,000 Zimbabweans a month, mainly for respiratory tract infections, sexually transmitted infections, gastrointestinal conditions and stress-related ailments. Almost 4,000 HIV tests were carried out across the two projects. In Musina, close to one third of people tested were found to be HIV-positive, 64 per cent of whom were women.

More and more migrants are being sent back to Zimbabwe from Musina by the authorities. But they often attempt to re-cross the border into South Africa at unofficial border crossing points, where they are sometimes attacked or raped by violent gangs.

In 2009 MSF medical staff treated more than 140 adults in Johannesburg who had been sexually abused, and more than half of these victims had been abused while crossing the border.

MSF has worked in South Africa since 1999.

Andile

An HIV-positive patient at the MSF clinic in Khayelitsha

'When I arrived in the support group I was able to see that there are other people living with HIV, who share their stories, who talk about it. That's when I started telling myself "No, man ... HIV is not the end of the world... maybe I should just stand up and look towards the future... maybe God has something here for me."'

PUNISHING SUCCESS? RISKS OF FALTERING HIV FUNDING

Ten years ago, Médecins Sans Frontières (MSF) began pioneering HIV/AIDS treatment in South Africa and Thailand. Today, millions of lives have been saved and people on treatment are able to live longer and enjoy a better quality of life. At the end of 2009, MSF was providing antiretrovirals (ARVs) to more than 160,000 patients in over 27 countries. In Khayelitsha in South Africa alone, more than 13,550 patients are benefiting from the HIV care that MSF is providing in collaboration with the local authorities.

This progress is now under threat. There are now worrying signs that international donors are capping, reducing or withdrawing their funding for HIV/AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria, which funds around two-thirds of all HIV/AIDS treatment in developing countries is currently facing a major funding shortfall. Donors are going back on their promises to fund and provide universal access to HIV care. The main U.S. initiative to combat the global HIV/AIDS pandemic, the President's Emergency Plan for AIDS Relief, known as PEPFAR, reduced its budget for the purchase of ARVs in 2009 and 2010, and also introduced a freeze on its overall HIV/AIDS budget. Other donors, such as UNITAID and the World Bank, have announced reductions over the coming years in the funding for antiretroviral drugs in the Democratic Republic of Congo (DRC), Malawi, Mozambique, Uganda, and Zimbabwe.

For some countries, this means a cap on their funding or restricting the numbers of those put on treatment, as seen in South Africa and Uganda, and in DRC – where the number of new patients has been cut six-fold. Already fragile health systems will become increasingly strained by an increasing patient load requiring more intensive care. What this means is that more patients are now being turned away from clinics and, as though we have regressed ten years, doctors are being forced to ration HIV drugs. There is also a risk that the new recommendations of the World Health Organization that call for the earlier initiation of improved drugs cannot be implemented.

MSF's Campaign for Access to Essential Medicines is a team of medical, scientific and advocacy experts that explores and champions solutions to the medical challenges MSF staff face in the field. Today, the Campaign is working with other health activists to demand that the international community adhere to their promises to fight HIV/AIDS, while supporting ambitious and innovative methods to ensure that the cost of drugs stays affordable.

We are also encouraging countries to make use of legitimate flexibilities in international trade rules to overcome the barriers to medicines posed by patents on drugs and to encourage, through competition, the development of affordable generic medicines. We are pushing pharmaceutical companies to participate in UNITAID's patent pool for HIV/AIDS medicines which could help speed up the availability of affordable, generic versions of new drugs.

We are at a critical point in fighting this disease, and this is not the time to turn back. HIV/AIDS remains an emergency. Much has been achieved but there are still nine million people who don't have access to the medicines they need. Donors and governments must not be allowed to throw away the gains we have so far made, but instead must move forward and commit to continued and increased funding in order that we may bring this devastating pandemic under control.

More on the Campaign's activities on access to medicines and medical innovation: www.msfaccess.org

© Mariella Furrer/THINK Pictures

HIV patients on antiretroviral treatment have to follow a strict drug regime to stay healthy.

SUDAN

REASON FOR INTERVENTION • Armed conflict • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 2,458**

There was a sharp rise in medical emergencies in several parts of Sudan in 2009. In addition to the continuing crisis in Darfur, people in southern Sudan faced escalating violence and outbreaks of disease. They have little or no access to healthcare.

Assisting victims of violence in southern Sudan

Escalating violence and disease outbreaks led MSF to launch several emergency interventions in southern Sudan in 2009. Medical needs, which were already at emergency levels in many parts of the country, increased dramatically during the course of the year as clashes between different communities left hundreds dead and thousands displaced. MSF led emergency interventions in Akobo, Torkej, Lekwongole, Panyangor, Duk Padiet and Terekeka. In the areas where MSF responded, staff recorded that three times more people were killed than were wounded, and high numbers of women and children were affected. Surgical teams in Nasir and Leer performed more than 1,000 surgeries in 2009, more than half of which were for injuries caused by violence.

Throughout the year the Ugandan rebel group, the Lord's Resistance Army launched frequent attacks on villages near the borders of the Democratic Republic of Congo (DRC) and Central African Republic, and in DRC itself. These caused thousands of Sudanese people to flee their homes and Congolese refugees to cross the border to seek refuge in Western Equatoria State in Southern Sudan. MSF has been in this area since the end of 2008, and adapted its activities to meet the changing needs. Medical staff started to work in Ezo, Naandi, Yambio and Makpundu, providing assistance to around 45,000 people living in camps or integrated within host communities. In 2009 teams carried out 14,000 consultations and provided psychological support to more than 800 people in Western Equatoria. Materials such as plastic sheeting, jerry cans, blankets, pans and mosquito nets were distributed to nearly 1,000 families, and latrines and water points were installed in refugee camps in the area. In February, MSF also launched an emergency response in Lasu, Central Equatoria State, providing medical care to more than 6,000 people.

Emergency medical needs

In October, there was a new outbreak of the deadly disease kala azar in Jonglei and Unity States. Teams had screened and treated more than 450 patients by end of the year.

These emergency interventions were in addition to medical care that MSF provides in its longer-term projects in southern Sudan. Throughout the year, 1,400 staff provided treatment and medical care to hundreds of thousands of people in seven states in southern Sudan and in the transitional area of Abyei. Over 431,000 people received care and more than 10,300 were admitted to MSF's clinics. Nearly 63,000 women had antenatal consultations and over 8,000 children were treated for malnutrition. More than 50,000 people suffering from malaria were treated and 188,000 people were vaccinated.

Humanitarian access reduced

Access to healthcare for people in the Darfur region of western Sudan was difficult in 2009,

continued overleaf ›

Naandi, South Sudan. A Congolese woman and her malnourished son being treated in a refugee camp for those fleeing unrest.

› *continued SUDAN*

especially following the expulsion by Sudanese authorities of 13 international aid agencies – including two sections of MSF. Shortly after the expulsions, four MSF staff were kidnapped in Serif Umra, North Darfur. They were released unharmed after a few days, but these kidnappings, the first of their kind in Darfur, marked the start of a spate of kidnappings in the region: 14 people were abducted by the end of the year. This increased risk forced many of the remaining aid agencies to scale back their activities in parts of Darfur.

More than half of MSF's programmes were forced to close as a result of the expulsions and insecurity. Two more projects in Serif Umra and Kebkabiya in North Darfur, and activities in Tawila, also in North Darfur, were suspended. MSF nonetheless provided over 168,000 consultations, more than 28,000 antenatal consultations, admitted nearly 2,500 people to hospital and treated some 4,500 people for malaria throughout the year. Teams handed over projects in Golo and Killin to the Ministry of Health in October, and in the same month were able to restart activities in Tawila. At the end of the year, MSF started working in a remote area of North Darfur, Um Baru, providing medical support to five rural health centres that care for very isolated communities.

In the city of Port Sudan, in the northeast of the country, MSF continued to provide reproductive healthcare in Tagadom Hospital. More than 13,500 women received antenatal consultations and 1,000 women received help giving birth. MSF operates a zero-tolerance policy on any type of female genital cutting. It is estimated that more than 97 per cent of women in the state are cut. This procedure causes serious medical complications for many women throughout their lives. MSF does not re-infibulate women following delivery or at any other time.

MSF has worked in Sudan since 1979.

Patient story

Woman from Burmath, Jonglei State, May 2009

'There were so many people who came to attack – all with guns. They burned the area and took the young girls, but not the boys, who they killed. Normally, they only deal with the men, but this time they killed the women and children. I am crying because we are not protected and our children are abducted or wounded. That wasn't the first time we were attacked but it was the first time it was like that.'

SWAZILAND

Swaziland has the world's most severe HIV/AIDS epidemic. A report from 2006/2007 estimated the prevalence of the disease among adults to be 25.9 per cent.*

Tuberculosis (TB) in HIV-infected people is the number one cause of death, and more and more patients who are being treated by the joint MSF and Ministry of Health teams are being diagnosed with drug-resistant forms (DR-TB). Since November 2007, MSF has been working in close collaboration with the Ministry of Health to respond to this epidemic by providing diagnosis and treatment for HIV/TB infected patients via rural clinics.

Currently, MSF is working in the south of the country in the rural Shiselweni region, where a fifth of the country's population live, mostly in villages or on remote farms. They often have to travel for hours to get to the closest health facility. MSF's aim is to reduce the number of deaths from TB and HIV by providing diagnosis, treatment and care as close as possible to where the patients live through small rural clinics, and also to bring some aspects of care into the communities themselves. In 2009, MSF supported one hospital, two health centres and 18 clinics in the area. By the end of 2009, more than 8,000 HIV patients were receiving antiretroviral therapy and 3,381 patients were receiving treatment for TB.

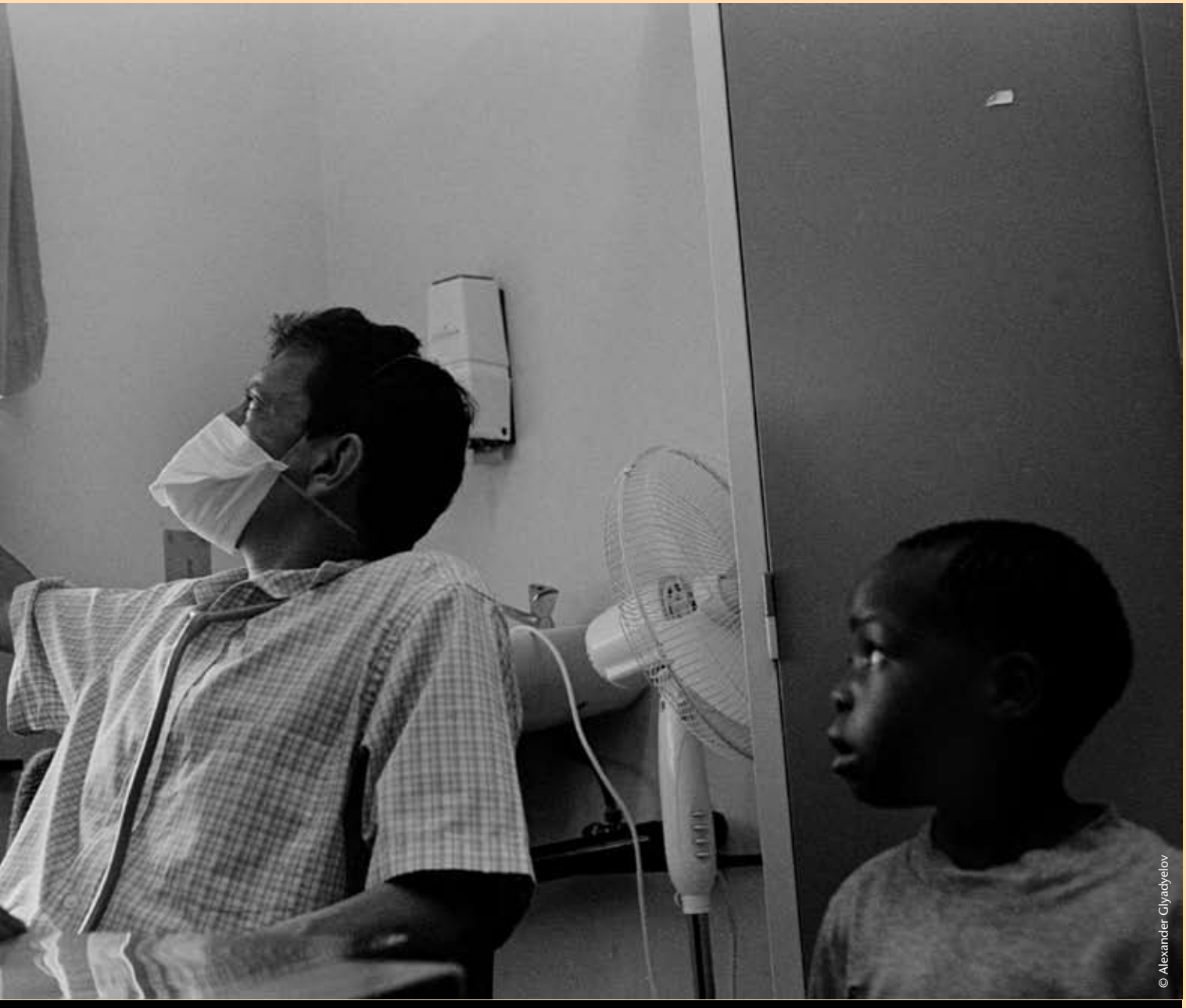
One important component of MSF's programme is to help patients to adhere to their treatment using guidance and counselling from 'expert patients' to teach others how to manage it. This is especially relevant today, since more and more TB patients in Swaziland are failing to respond to standard drugs. Those with DR-TB have to commit to an especially long, painful and difficult treatment regimen. In 2009, MSF teams provided intensive support to 96 patients infected with DR-TB.

A lack of qualified medical staff is another challenge facing the country's health system. In order to overcome this obstacle, MSF advised the authorities to implement a 'task shifting' policy that would allow nurses to take over some of the medical tasks currently performed only by doctors. This policy change was one of the recommendations of an International Consultative Workshop on the DR-TB and HIV crisis in the Southern African region, co-organised by MSF and the Swaziland Ministry of Health in October 2009.

MSF has worked in Swaziland since 2007.

*USAID Demographic and Health Survey

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 113**



A doctor examines a young boy's x-ray for signs of TB while the boy looks on.

Nonkululek

A 25 year old woman, HIV-positive and suffering from drug-resistant TB.

'I take a minimum of 15 pills each day just to fight against drug-resistant TB. These drugs are of different sizes. Some are the size of wheat grains or even bigger than that, the size of a big bean. It is difficult, but I don't have a choice because I want to live a normal life. After many months, I finally got used to taking a lot of drugs. But it would be better if all the drugs could be combined into one.'

UGANDA

REASON FOR INTERVENTION
- Armed conflict
- Endemic / Epidemic disease
- Healthcare exclusion

Field Staff 424

Madi Opei Camp, Kitgum District, Uganda. A doctor treats a baby, whose mother is HIV positive, for malaria. As yet it is too early to determine the baby's HIV status.

Cavine

10 years old, HIV-positive

Cavine's father died during the fighting. Her sick mother went to the hospital where she was diagnosed with TB and found to be HIV-positive. Cavine was also tested and found to be HIV-positive. Her mother was heartbroken when she found out Cavine was sick, but relieved when her other children were found to be not infected by the virus. Cavine said, 'I feel good now. I was sick, but when I started taking the drugs I got well.' Her grandmother added, 'I feel happy because I see that there is no difference between her and any other child in the family anymore. She is OK; she is doing all the work the others do. At school she is very bright. I am impressed!'

MSF is working to fight HIV/AIDS, tuberculosis (TB) and malaria in the country, and is providing nutritional programmes for malnourished children. In the West Nile region, in the northern part on the border with Sudan, MSF has provided treatment to more than 16,000 people with HIV since 2002.

In these northern districts, the healthcare system is slowly being rebuilt after years of conflict. The main challenges are the shortage of trained health staff and an irregular drug supply, especially for HIV/AIDS, TB and malaria. In the northwest Arua district MSF provides treatment for HIV patients co-infected with TB, nutritional support for adults and children living with the disease and antenatal care to prevent the transmission of HIV from mother to child. Of the 7,740 patients currently treated at the hospital, more than 5,000 are receiving antiretroviral therapy. MSF also supports decentralised HIV clinics in other rural areas.

MSF continued to provide assistance to refugees who had fled fighting in the Democratic Republic of Congo at the end of 2008, and brought medical and sanitation support to a refugee settlement in the southwest of the country from February to May.

Malaria is endemic in Uganda, but the most effective treatment, Artemisinin Combination Therapy, is not always readily available. In 2009 in Madi Opei, a rural area in the north of the country, MSF treated more than 27,000 people infected with malaria.

Hepatitis E is a viral infection transmitted through contaminated water or food. It cannot be cured and there is no vaccine available. The epidemic that started in Kitgum and Pader districts in the north of Uganda in 2007 continued throughout 2009. MSF teams provided patient care, worked to improve water and sanitation facilities and tried to prevent the disease from spreading further by seeking out new cases and carrying out health education campaigns. In 2009, MSF cared for more than 1,450 patients with this condition.

Decades of political neglect and underdeveloped health services have badly affected the people in the remote nomadic Karamoja region in the northeast of the county. Violence here has caused dozens of people to die each month. Access to healthcare has been impeded by insecurity, poor health exacerbated by a chronic food crisis, and there have been peaks of acute malnutrition. In 2009, MSF provided some 20,000 consultations, and 2,500 pregnant women were seen in either mobile clinics or at the hospital.

MSF has worked on Uganda since 1980.

ZAMBIA

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 94**

According to a 2007 national report, 14 per cent of the Zambian population aged between 15 and 49 are HIV positive.

Here the pandemic has affected mostly women and, in 2008, world development indicators estimated life-expectancy at birth to be only 46 years. It has laid a heavy burden on the country, but the Zambian government has taken significant steps to deal with the problem in the last few years.

MSF has worked since 2004 to provide treatment and care to thousands of people living with HIV/AIDS in Zambia, through antiretroviral therapy (ART) and medical care. MSF has also worked to raise awareness about the reality of HIV in Kapiri M'poshi district in the northeast of the country. MSF ran an HIV/AIDS clinic in the local district hospital and has been supporting 14 rural health centres in the area. Between 2004 and 2009, more than 66,500 people were tested for HIV, more than 12,000 were enrolled in the programme and more than 6,000 began ART.

In July 2005, the government began providing care free of charge to HIV patients, and in 2006 the national cost-sharing system of healthcare was abolished so that all treatment became free. In June 2009, MSF handed over its HIV/AIDS programme in Kapiri M'poshi to the Ministry of Health and a non-governmental organisation, Zambia HIV/AIDS Prevention, Care and Treatment Partnership, assured that all the services provided to the Kapiri community would continue to be free of charge.

MSF will continue working in Zambia, redirecting its focus towards the prevention of HIV transmission from mother-to-child.

MSF will also respond to other unmet emergency medical needs, especially cholera, and will continue to call for improved cholera preparedness measures in the country. Teams responded to an outbreak in March by setting up two treatment centres in the capital city of Lusaka, and treated more than 4,300 patients.

MSF has worked in Zambia since 1999.

Mary

She is one of the first patients to have received ART from MSF's HIV/AIDS programme in Kapiri. Since 2004, she has been involved in awareness-raising activities in the community to encourage people to be tested for HIV/AIDS.

'I was one of the first patients who started ART with MSF in Kapiri, which has been great for me. Now I can work, I even have a field from which I harvest 50 bags of maize. I have a garden; I feel happy, very happy. I didn't feel well when I was sitting at home. I feel happy to come out, just to come and help my fellow friends. A lot of them knew me when I was sick; they saw the way I was, and today I give my testimony to them. So they are happy and a lot have come out in the open about HIV, and stigma has been reduced in the community.'

Lusaka, Zambia. MSF responds to one of the worst cholera outbreaks in the country for many years.

ZIMBABWE

REASON FOR INTERVENTION
- Endemic / Epidemic disease
- Healthcare exclusion

Field Staff 911

In June 2009, the cholera epidemic that had started in August 2008 was officially declared over.

According to the UN, almost 100,000 people had contracted cholera and more than 4,000 people had died from the disease. Furthermore, the prevalence of HIV/AIDS is among the highest in the world. MSF responded to the cholera outbreak, treating more than 65,000 people, and also provided treatment for HIV and tuberculosis (TB).

Cholera and malnutrition

By June 2009, MSF had treated 65,000 people. MSF also worked in prisons to treat cholera patients and to prevent the spread of the disease. In addition, teams responded to a severe malnutrition crisis in 13 different prisons, providing treatment and improving sanitation and water supply.

Fighting HIV/AIDS and TB

According to the United Nations joint programme on HIV/AIDS (UNAIDS), there are 120,000 children living with HIV in Zimbabwe and at least one million children have been orphaned because of it. MSF increased the number of children under its care and provided treatment to prevent mother-to-child transmission of the virus, as well as counselling and patient education. MSF responded to the HIV/AIDS epidemic in five districts: more than 52,000 people received care, 39,000 of whom were put on antiretroviral therapy (ART).

MSF has been improving TB care and integrating TB and HIV/AIDS services. HIV care has been decentralised in order to bring services closer to the patients' homes, and nurses have been trained to administer ART. Such 'task shifting' frees up the doctors so they can concentrate on more complicated cases, and allows the nurses to carry out the daily HIV care.

Nutrition

MSF is running nutritional programmes in Epworth, near Harare, and Buhera, further south in the country. More than 1,700 severely malnourished children were cared for in 2009.

Sexual violence

In collaboration with the Ministry of Health, MSF has been providing both medical and psychological help for survivors of sexual violence in Gweru, in the heart of the country. More than 180 victims of sexual violence were treated last year.

Healthcare for migrants

Due to the political and economic crisis of recent years, many migrants have been leaving Zimbabwe to go to South Africa. MSF opened a project in Beitbridge, near the border most used by migrants and on a commercial route between these two countries. On average MSF teams carried out more than 1,000 consultations a month there.

MSF has worked in Zimbabwe since 2000.

© Joanna Stavropoulou

A doctor writes up her notes on an HIV patient who is improving since starting antiretroviral treatment.

© Yuri Kozyrev / Noor

Kutupalong camp, Bangladesh. A Rohingya woman and her child wait for medication.

ASIA & THE CAUCASUS

AFGHANISTAN

REASON FOR INTERVENTION • Armed conflict **Field Staff 51**

Conflict reignited throughout Afghanistan in 2009, especially in the east and south of the country. It was the deadliest year for civilians since 2001, when the war between Coalition and Afghan government forces and various opposition groups began.


© Pascale Zintzen

Ahmed Shah Baba Hospital, Eastern Kabul. A doctor records the notes of a consultation.

The country has some of the worst health indicators in the world. Infant mortality rates are especially high, with an estimated 257 deaths per 1,000 live births according to UNICEF. When it comes to comprehensive healthcare, until recently there was only one hospital in Kandahar, supported by the International Committee of the Red Cross, providing a complete range of medical services for the entire south of Afghanistan. In general people have to travel hundreds of miles through very dangerous areas, in order to get the medical care they need.

A return after five years

Having left the country after the brutal killing of five staff in Badghis province in June 2004, MSF returned to Afghanistan in 2009. Increasing signals that the overall situation for Afghans was getting worse rather than better motivated the return. The people have been trapped for years in impoverished conditions, and many lack access to medical treatment. Public hospitals do not function well and private clinics are often prohibitively expensive. In October 2009, MSF started supporting activities in a district hospital east of Kabul and in a hospital in the capital of Helmand province.

The lack of respect for medical facilities shown by all the belligerents involved in the conflict in Afghanistan has turned hospitals into battlefields where staff and patients do not feel safe. It was crucial for MSF to secure agreements with all parties to ensure the hospitals were safe environments, so a 'no weapons allowed' policy was successfully implemented. This approach seems to be working, and MSF is supporting both hospitals to ensure quality medical care free of charge.

Critical support and services

In the district hospital in the east of Kabul, MSF worked to improve treatment procedures, the emergency room, and maternity services. By the end of the year, nearly 19,000 consultations and 1,000 deliveries had been carried out, and almost 9,900 people had been immunised through the Extended Immunisation Programme, which protects against diphtheria, tetanus, pertussis, hepatitis B and Haemophilus influenza. MSF also repaired and refurbished parts of the hospital.

In November 2009, MSF also started to support Boost provincial hospital in Lashkargah, the capital of Helmand province. Lashkargah's inhabitants have been severely affected by the conflict, and this 150-bed facility is one of only two general care public hospitals in south Afghanistan. MSF extended its support to all health services in the hospital, including maternity, paediatrics, surgery and emergency rooms. Since the start of the project, 1,100 consultations, more than 60 surgical interventions and nearly 160 deliveries have taken place. By ensuring a permanent presence of medical staff and free services, MSF aims to get the hospital running 24 hours a day, seven days a week.

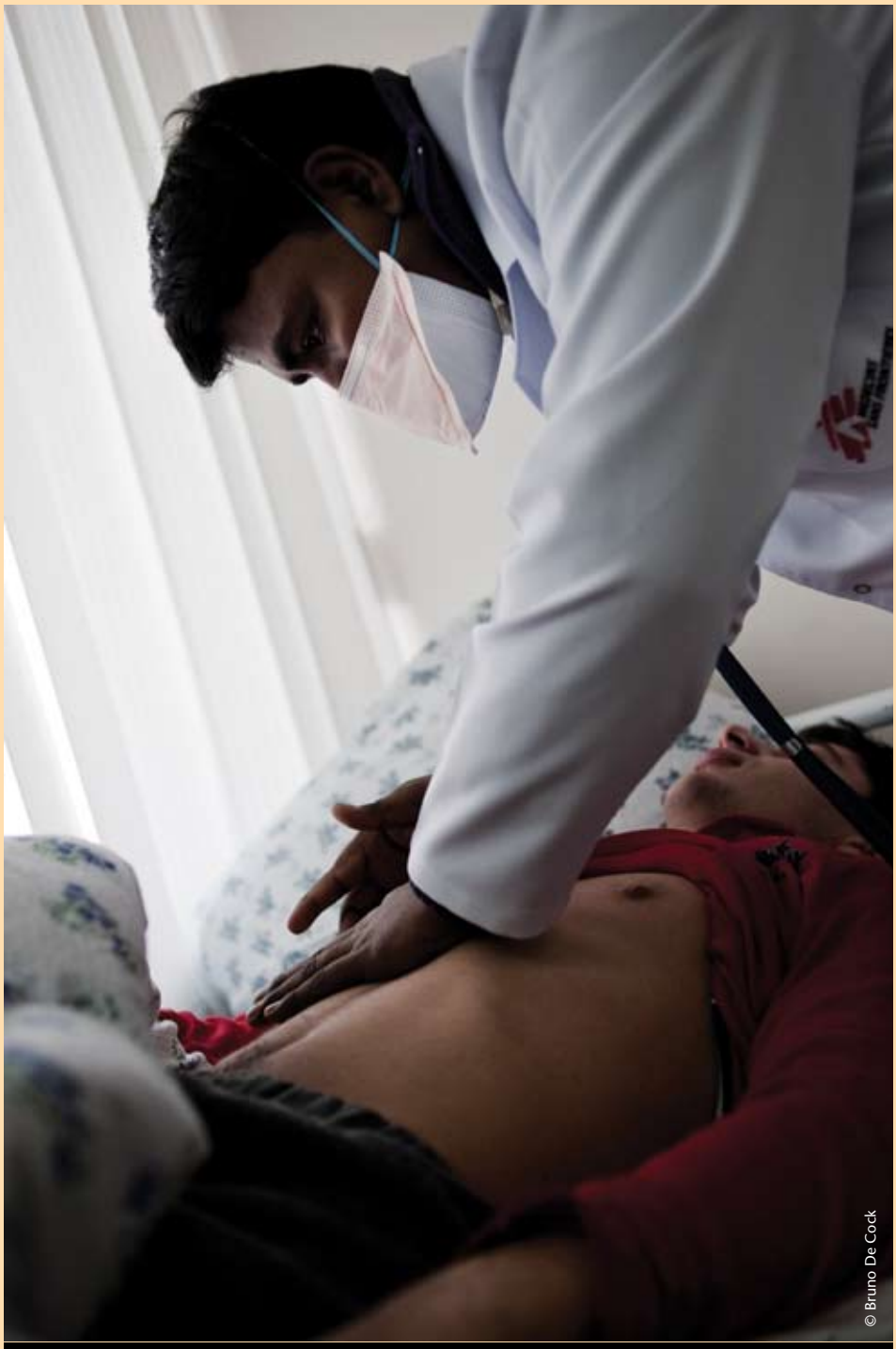
MSF plans to extend its support to hospitals and rural health centres in other provinces in Afghanistan in 2010.

MSF worked in Afghanistan between 1980 and 2004, and returned again in 2009.

ARMENIA

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 54**

Armenia has one of the highest per capita rates of drug-resistant tuberculosis (DR-TB) in the world, and since 2004 MSF has been collaborating with the Ministry of Health, running the only DR-TB treatment programme in the former Soviet Union country.



© Bruno De Cock

National TB Centre, Abovian, Armenia. A doctor examines a patient with drug-resistant TB.

In the capital Yerevan, MSF has been running a project to diagnose and treat DR-TB in collaboration with the Ministry of Health's National Tuberculosis Programme. In 2009, 130 new patients were enrolled in this project free of charge.

The treatment for DR-TB involves a daily cocktail of drugs that can cause side effects such as severe nausea, vomiting, renal problems and skin allergies. Treatment can last for up to two years, so MSF provides psychological and social support to encourage patients to complete it. 'The non-medical support for patients is an essential component, since it increases the chances that they will stick to the difficult drug regimen they must follow for months and sometimes years,' said MSF programme manager Jean-Luc Anglade.

MSF helps patients in five districts around Yerevan as well as prisoners in the central prison. In 2009 MSF also made more than 5,000 home-based visits to patients and distributed more than 1,600 food parcels.

MSF has worked in Armenia since 1988.

BANGLADESH

REASON FOR INTERVENTION • Social violence / Healthcare exclusion • Natural disaster **Field Staff 185**

In the Cox's Bazar district bordering Myanmar (Burma), thousands of 'unrecognised' Rohingya refugees face a daily struggle to survive. Out of an estimated refugee population of up to 400,000 Rohingya in Bangladesh, only 28,000 are recognised as official refugees by the government and accordingly entitled to assistance by the United Nations High Commissioner for Refugees (UNHCR). In sharp contrast, the vast majority of Rohingya refugees live in an appalling state, exposed to health risks and exploitation.

In March, MSF became aware of more than 20,000 unrecognised Rohingya refugees who were living in atrocious conditions in Kutupalong makeshift camp, situated on the edge of UNHCR camp for official Rohingya refugees. In response, MSF set up an emergency healthcare project, which included the treatment of large numbers of malnourished children and the improvement of water and sanitation facilities. Within one month, MSF had enrolled more than 1,000 malnourished children in its feeding programme and treated more than 3,700 children under five years of age.

The project soon developed into a primary healthcare programme responding to the increasing medical needs of those from both the makeshift camp and the host community. Over the year, MSF staff at Kutupalong performed more than 23,000 consultations, more than 1,000 antenatal consultations and, in response to a measles outbreak in the makeshift camp, vaccinated more than 11,000 children.

In June and July, MSF was outraged to witness local authorities violently removing thousands of people from parts of the makeshift camp. MSF teams treated a number of people for trauma related injuries, and spoke out against the abuse. The violence ceased for a short time, but in October MSF once again received refugees suffering from violence related injuries. This time patients told of being driven

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Kutupalong camp, Bangadesh. A doctor checks the health of a new-born baby in a camp for Rohingya regugees.

from their homes in the Bandarban and Cox's Bazar districts by the authorities and local citizens.

At the end of the year MSF initiated an advocacy campaign calling for an end to the violence, and urging the government of Bangladesh and UNHCR to take urgent action to protect all refugees.

Cyclone and disease

MSF assisted 75,000 people hit by Cyclone Aila in May by distributing relief items, repairing water sources and providing healthcare services. MSF also opened a healthcare programme in the Chittagong Hill Tracts region in the southeast of the country, an area lacking in health services and marked by ethnic tension. Teams have also been working in a clinic in Baghaihat in the southeast and have extended services to eight village health centres.

In 2010 MSF will launch a programme in the northeast of the country to provide treatment for kala azar, a parasitic disease that can lead to death. A new project will be opened to provide general healthcare and treatment for malnutrition in Kamrangirchar, the largest single concentration of slums in the area of Dhaka. Plans include opening a number of health centres, supporting existing health centres, and providing a system of home-based care for children under five years old who are suffering from severe malnutrition.

MSF has worked in Bangladesh since 1985.

Patient story

A Rohinga refugee at MSF's clinic in the Kutupalong makeshift camp

'I used to think I had a home in Bangladesh but, after two months of threats from people I have lived among for 15 years, I felt sad and came to the makeshift camp.'

© Brigitte Breuillac

Phnom Penh prison, Cambodia. A prison inmate receives a medical check-up for TB.

CAMBODIA

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 143**

MSF has been in Cambodia since 1979. Public health problems are dominated by HIV/AIDS and tuberculosis (TB) but MSF, the first to provide antiretroviral therapy (ART) for HIV patients, has helped to improve the situation by developing national treatment guidelines in tandem with the Ministry of Health.

A substantial increase in funding by international donors has helped fortify government efforts to tackle prevalent diseases, allowing MSF in turn to reduce its HIV programmes. Teams now focus on the treatment of TB and drug-resistant TB (DR-TB) in Kampong Cham, and on the detection and treatment of TB and HIV in prisons.

In Takeo and Siem Reap, MSF introduced a new model of care that treats HIV/AIDS as a chronic disease in clinics alongside diabetes and hypertension. The approach proved successful and teams were able to hand over these activities in June.

In the provincial hospital of Kampong Cham, MSF handed over HIV patient care to health authorities and local partners in March. At the same time, teams extended the TB programme started in September 2008 by building a new TB ward in the hospital and by providing technical support to the hospital laboratory. The initiative is focused particularly on drug-resistant patients, children, and patients co-infected with HIV, but aims to improve case detection and access to care for all TB patients.

In the Khmer-Soviet Friendship (KSF) hospital in Phnom Penh, MSF has been handing over the treatment and follow-up of patients in the infectious diseases ward, and has already transferred the 3,600 HIV-positive patients to health authorities in preparation for a formal handover in March 2010.

HIV and TB are particularly challenging to manage in closed settings such as prisons. Since 2007, MSF has been treating HIV patients in Phnom Penh's prisons via mobile clinics run by the KSF hospital team. MSF supported voluntary confidential counselling and testing, but teams have now scaled up activities to include HIV and TB case detection and improve access to care, treatment and follow-up of all prisoners in the three prisons. In the prison near Kampong Cham, MSF helped to provide healthcare to all inmates as well as conducting a five-month nutritional programme for those who had become severely malnourished.

MSF has worked in Cambodia since 1979.

CHINA

REASON FOR INTERVENTION • Endemic / Epidemic disease • Natural disaster **Field Staff 42**

China's Ministry of Health estimates that 740,000 people in the country were living with HIV/AIDS at the end of 2009.

Although less than one per cent of the overall population is infected, the minister warned that the disease is threatening to become a serious epidemic among high risk groups. Stigma and discrimination against people living with HIV remains strong in China, and this deters people from being tested. Where the condition remains undiagnosed, there is a far greater risk that it will be spread.

HIV treatment and care

Testing for and treatment of HIV is officially free under Chinese health policy, but in practice, hospitals and clinics often charge for the treatment of opportunistic infections associated with the disease. As a result, no matter how urgently some people need help, if they cannot pay they simply cannot access treatment.

Since 2003, MSF has been operating an HIV/AIDS centre with the Guangxi Public Health Bureau in Nanning. The centre provides confidential care and treatment focusing particularly on vulnerable groups such as injecting drug users, commercial sex workers, men who have sex with men, and migrant workers. The outpatient clinic provides treatment free of charge and MSF pays for patients who need to be admitted.

In 2009, more than 1,000 people living with HIV were under MSF care at the clinic, 900 receiving first-line antiretroviral therapy (ART), and 27 receiving second-line therapy, which is needed when a patient develops a resistance to the original treatment. Teams performed over 8,500 consultations. MSF also worked with the Centre for Disease Control to set up voluntary counselling and testing centres in the city. Of the 4,300 people who used centres in 2009, 147 tested positive for HIV.

The Nanning project will be handed over to Chinese authorities in October 2010.

Post disaster mental health

In May 2008 there was an earthquake of magnitude 8 near Chengdu in Sichuan province, southwest China. Some 80,000 people were killed, ten million made homeless and vast numbers were left mentally traumatised. Working with the Chinese Academy of Science and the Crisis Intervention Centre, MSF provided psychological care for survivors, and trained mental-health workers from November 2008 to August 2009. Teams conducted home visits and established five counselling centres in Mianzhu and Beichuan, two of the worst affected areas. Patients received between six and 20 consultations to help them to recover.

MSF has worked in China since 1988.

Chen

A 35 year old patient at the MSF clinic in Nanning tested positive for HIV in 2006.

The news was devastating. 'When I found out, I felt that life had no meaning and I had no idea what to do next,' he said. After his diagnosis, Chen was referred to the MSF centre. 'The counsellor helped me to think a lot more positively. He explained that HIV is not a disease than takes your life immediately and that if you adhere to the treatment, you can live for years.' Only one trusted friend knows about Chen's HIV status. 'There is more information about HIV/AIDS available these days, he explained. 'Things are improving, but there is still a long way to go before discrimination will be eliminated.'

© Anna Tsuji

Nanning City, China: A doctor carries out a consultation in an HIV/AIDS treatment programme centre.

GEORGIA

REASON FOR INTERVENTION • Armed conflict • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 85**

When conflict broke out between Russia and Georgia in South Ossetia in August 2008, MSF set up a programme to provide support to people who had been displaced by the violence in Georgia, and as a consequence had little if any access to healthcare.

© Julie Damond

Abkhazia, Georgia: A patient who is receiving treatment for drug resistant TB.

Nugzari

60 years old, now cured of drug-resistant TB

'I had so many side effects: I couldn't get up and I didn't leave my room because I felt ashamed. Someone who hasn't taken these drugs can't imagine how hard it is. I knew a man who went mad taking this medicine. Me too, I used to lose my patience and my wife was worried about me.'

In June 2009 the programme finished because medical needs had decreased and many of those displaced had returned home. MSF has also been working to treat drug-resistant tuberculosis (DR-TB) and HIV/TB co-infection.

Until June 2009, MSF provided healthcare services and psychological support to people in the cities of Tbilisi and Gori who had been forced to flee their homes. About 10,000 consultations were carried out. Most of the people seen were suffering from depression, anxiety, post-traumatic stress disorder and psychological problems.

TB treatment success

The Georgian Ministry of Health opened a new TB hospital in Tbilisi in March 2009 and this, combined with a project that started in 2008 known as the National Tuberculosis Plan (NTP), has strengthened the country's fight against DR-TB. Therefore, MSF started to hand over its project in Zugdidi to the government in 2009. The transfer should be complete by September 2010. More than 50 new patients with DR-TB were admitted in 2009 and 80 per cent of them adhered well to the treatment despite the debilitating side effects. This success rate was due to a home-based approach that patients found easier to follow.

In Abkhazia MSF continued to support the national TB programme, providing treatment for patients with DR-TB and life-prolonging antiretroviral therapy for those co-infected with HIV. This project will also be handed over to the national programme.

Outreach programme

A health access programme for vulnerable people in Abkhazia, which started in 1993 and at its peak had 6,000 patients, was also reduced in size as the Ministry of Health's willingness to take responsibility increased. In 2009, some 100 people, mainly homebound and bed-ridden, were registered on the programme.

MSF has worked in Georgia since 1993.

INDIA

REASON FOR INTERVENTION
- Armed conflict
- Endemic / Epidemic disease
- Healthcare exclusion
- Natural disaster

Field Staff 533

Providing healthcare to a growing population of more than a billion people poses great challenges to the Indian health authorities and there are huge disparities in services between the different states.


© Cristina De Middel

Mumbai, India. A doctor checks the progress of a patient with multi-drug-resistant TB.

In 2009, MSF responded to epidemics and natural disasters, and treated diseases such as tuberculosis (TB) and HIV/AIDS. The poorest and most remote parts of the country often have inadequate medical facilities, poor healthcare infrastructure, low-quality health standards, and a lack of medical staff.

Up to three million people are living with HIV in India, according to the World Health Organization. The MSF Antiretroviral Centre in Mumbai offers HIV care to patients who require treatment that is not yet available in the public sector. This includes patients who experience severe side-effects to the most commonly used medication, and those who are co-infected with TB. In 2009, MSF provided more than 400 patients with antiretroviral therapy.

Providing basic healthcare

In the northeastern state of Manipur, where political and social violence is common, MSF runs four clinics providing basic healthcare, HIV/AIDS and TB treatment and counselling and maternity services. In 2009, MSF teams carried out more than 40,600 consultations, including treatment for HIV-positive pregnant women to prevent transmission of the disease to the child.

In Chhattisgarh State, tens of thousands of people were forced to move into government-run camps, or into the dense forests in the south of the state because of the conflict between Maoist rebels and government forces. MSF provided healthcare to people living in the camps, and in other settlements in the Andhra Pradesh region. MSF conducted more than 55,000 consultations.

In Jammu and Kashmir, MSF carried out basic healthcare and psychosocial counselling to a population traumatised by over 20 years of violence. MSF has worked to increase awareness of psychosocial problems and in 2009 more than 5,800 people were treated on the mental health programme. MSF also provided support to six clinics in Kupwara, conducting more than 20,500 consultations.

Healthcare for kala azar and malnutrition

In the Vaishali district in Bihar state, MSF treated more than 2,000 patients for the deadly parasitic disease kala azar. In Darbhanga, teams cared for children aged between six months and five years who were suffering from acute malnutrition.

Emergency response

In 2009, MSF assisted the state governments of Meghalaya and Tripura in response to outbreaks of meningitis. MSF also responded to the Cyclone Aila emergency in West Bengal State, distributing relief items and setting up a medical surveillance system in the worst-affected districts to prevent possible outbreaks of disease. In October, MSF responded to the floods in Andhra Pradesh and distributed relief items to 60,000 flood victims.

MSF has worked in India since 1999.

Jukelha

A 40 year old mother of six, who has kala azar.

'I was really sick. I had fever and pain and I didn't feel like eating. However, after my third dose of treatment I began to feel much better. I couldn't even walk when I first came here. My mother had to help carry me to the bus. I'm from a village about seven and a half miles away from this health centre. I have to come every day for the treatment. MSF staff told me about the sand flies and the disease. I didn't know anything about this but I know that other people got sick from it in our village. Our neighbour got sick from it six months ago and he came here for treatment too.'

INDONESIA

REASON FOR INTERVENTION • Natural disaster **Field Staff 11**

MSF first started working in Indonesia in October 1995, when it provided emergency aid to the victims of a devastating earthquake in Kerinci, Sumatra.

Since then, MSF responded to various natural disasters and epidemics until March 2009, when it withdrew due to the Indonesian government's increased capacity to deal with natural disasters. Before the withdrawal, MSF had worked throughout Indonesia including in former conflict zones such as Aceh and Ambon. Teams provided treatment and medication for diseases such as malaria, tuberculosis and HIV/AIDS, as well as general healthcare, surgery, vaccination campaigns, sanitation programmes and training of staff.

After the Asian tsunami in 2004, MSF refurbished 28 health facilities, conducted more than 40,000 medical consultations and provided 2,000 individual counselling sessions.

In 2008 it was clear that the Indonesian government's capacity to deal with natural disasters had considerably increased. Most internal conflicts had been resolved or had subsided and a large proportion of the previously displaced people had been able to resettle. Therefore the MSF projects were handed over to local authorities and partners, a process that was completed by March 2009.

Sumatra earthquake

On September 30, a powerful earthquake hit the Indonesian island of Sumatra leaving more than 1,000 people dead. MSF returned temporarily to provide survivors with emergency medical assistance via mobile clinics in some of the most neglected rural areas, as well as water and sanitation facilities and psychological care. Teams distributed essential relief items such as hygiene kits, kitchen utensils, blankets, mats and plastic sheeting to 1,600 families.

MSF has worked in Indonesia since 1995.

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MSF staff walk through an area destroyed by the earthquake that struck the island of Sumatra in September 2009.

KYRGYZSTAN

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 52

The prevalence of TB is still 20 to 30 times higher in prisons than it is in the general population: 500 new cases of this infectious disease are registered each year despite recent prison reforms.

Around two-thirds of those infected have drug-resistant forms of the disease (DR-TB) that require a particularly long and difficult treatment programme. In recent years, MSF teams have put greater emphasis on ensuring that ex-prisoners are able to continue their treatment correctly after release.

MSF works with the Ministry of Health, the prison authorities and international organisations including the International Committee of the Red Cross to support the treatment of TB in prisons. In 2009, teams treated more than 400 prisoners for TB including 92 patients for the drug-resistant form. MSF teams organised training sessions and supplied drugs, constructed laboratories and refurbished the prisons' hospitals and the patients' living quarters.

With TB, one of the challenges is in maintaining continuity of treatment, because once interrupted, there is a risk that drug-resistance could develop. In Kyrgyzstan, one out of three prisoners with TB is released before treatment is complete. Outside the prison system, former inmates often struggle for the bare necessities of life, and so do not see the continuation of their medication as their highest priority. Furthermore they may not have the money to reach the nearest TB facility.

In 2007 MSF opened a 'social support' office in the south of the country to help ex-prisoners. In 2009, social workers and a network of volunteers supported around 100 former inmates to continue their TB treatment, through counselling, provision of food parcels and transport money.

To highlight the poor living conditions of prisoners and to fight against the disease, MSF organised a photography exhibition in the capital Bishkek to raise awareness about the issue and to reduce the stigma surrounding it.

An important step in the fight against TB in Kyrgyzstan was made when the country's application to the Global Fund's Round 9 of financing was approved in 2009. It included funding for medication for multi-drug resistant forms of TB (MDR-TB) and for systems to be set in place to ensure that former prisoners can adhere to their treatment after their release. However, this financial aid was put on hold because of an audit investigation, and now an adequate supply of drugs is jeopardised because of a lack of funding.

MSF has worked in Kyrgyzstan since 2005.

Ruslan

An ex-prisoner who suffered drug-resistant TB

'It was like a nightmare; you can't imagine how difficult it was to take those drugs. You want to sleep but you can't, you feel dizzy, you feel nauseous... you vomit, but you don't feel any better. I took the drugs even though I felt awful, but my former cell-mate couldn't keep going: for him the side-effects were too much. I was released in May 2008, right in the middle of my treatment. While I was in prison, the social workers explained to me how I could continue treatment in the civilian sector. But when I got to the hospital, the doctors looked at me with suspicion. "Ex- prisoner... drug dealer," they said. But after a while, because of my good behaviour, their attitude towards me changed.'

A doctor talks to a prison inmate with TB.

An HIV patient is visited by a staff member who is also HIV positive and on ART treatment.

MYANMAR

REASON FOR INTERVENTION
- Endemic / Epidemic disease
- Healthcare exclusion
- Natural disaster

Field Staff 1,189

A health crisis, exacerbated by devastating diseases such as malaria, HIV/AIDS and tuberculosis (TB) has developed in Myanmar.

The government spends just 0.3 per cent of its GDP on healthcare, the lowest percentage worldwide, and international aid to the country remains completely inadequate at just $3 per person per year.

MSF has been working to provide antiretroviral therapy (ART) to people with HIV/AIDS and to treat those with TB and malaria.

Malaria is one of the biggest killers in Myanmar because there is so little access to effective and affordable diagnostic tools and drugs. In 2009, MSF treated approximately 160,000 people for malaria in Rakhine State.

Prevalence of TB is also high: the latest government figures report 134,000 known cases. Because the national TB programme is underfunded, there are sometimes interruptions in the supply of medicines. Patient's treatment is in turn interrupted, which increases their drug-resistance and reduces the effectiveness of the drugs. MSF continued to treat patients co-infected with HIV and TB throughout the year, and in July initiated the country's first multi-drug-resistant TB programme in Yangon in collaboration with the Ministry of Health.

HIV/AIDS kills thousands of people every year in Myanmar because so little antiretroviral therapy (ART) is available. As many as 76,000 people are living with HIV, but only 20,000 people receive treatment, mostly from MSF. In Shan, Kachin and Rakhine states and in Yangon, the country's largest city, MSF runs 17 HIV clinics, nine health centres and more than 30 malaria field posts. MSF also provides TB and HIV treatment and general healthcare programmes in both the rural and urban parts of the Dawei and Myiek districts in the south of the country. The programmes offer help to 700,000 people and target in particular more vulnerable people such as migrant workers and fishermen in the area. Last year, MSF supplied more than 14,300 people with ART.

Throughout 2009, MSF continued to lobby strongly for an increased response from the government and the international community to address the HIV/AIDS crisis.

The MSF mental health programme that assisted victims of the 2008 cyclone 'Nargis' closed in May, as emergency needs diminished. Between January and May 2009, 17,000 people received counselling.

MSF has worked in Myanmar since 1992.

Tin

A 29 year old mother living in Dawei, is HIV-positive and has TB.

It took Tin a month to find diagnosis and treatment for TB. After visiting two private clinics, she went to an MSF clinic and received free TB care.

'I was feeling very tired and couldn't work,' she said. 'My mother is taking care of me now and MSF's counsellor visits me regularly. I need to go to the clinic once a month and if I can't afford the transport cost, MSF covers this for me. MSF also gives me food such as rice, beans, salt and oil. It helps a lot and I have gained some weight and I feel better. They explained about TB with a chart and told me it's very important to take my treatment until the end. When I got to the MSF clinic, they screened all the family members for HIV and TB. It turned out that my four-year-old daughter also has TB, and is also HIV-positive. She has been taking TB treatment for two months now.'

NEPAL

REASON FOR INTERVENTION • Armed conflict **Field Staff 101**

Between 2002 and 2009, MSF teams provided healthcare to people still affected by the conflict between government forces and the Communist Party of Nepal which lasted from 1996 until 2006, and by the resurgence of violence that accompanied a chaotic peace process.

MSF worked where help was most needed, including in general and reproductive healthcare and water and sanitation provision.

Despite Nepal's struggles with political stability since the peace process, MSF is now leaving the country as government agencies and developmental organisations start to take a longer-term approach to covering the people's health needs. Capacity-building and training on the job are consequently key objectives in the remaining MSF projects.

Teams worked to increase knowledge about reproductive health and called for better access to good-quality public health services. Through a number of national radio announcements and education at local level, MSF also addressed the issue of oxytocin misuse. The drug, used to stimulate contractions in pregnant women, is widely misused. This can result in foetal and neonatal deaths, and in ruptures of the uterus. The drug can be used safely in small doses if the baby is overdue, but in Nepal it is common to take high doses to try to induce a birth prematurely, especially to make the birth take place on a religiously significant date.

In May, MSF handed over programmes in the isolated mountainous Kalikot district. Up until then MSF had offered general healthcare, tuberculosis treatment, and emergency services with a special focus on care for pregnant women and children under five. In 2009, MSF carried out more than 10,000 consultations and assisted with 192 deliveries.

In December, MSF handed over its last remaining programme in the Terai region of Nepal, which provided medical services, emergency consultations, maternal healthcare, and treatment of acutely malnourished children. In the areas affected by internal unrest, MSF used mobile clinics in the most neglected areas and transferred patients needing more care to its facility at Gaur District Hospital. MSF carried out more than 10,000 consultations and assisted more than 1,300 deliveries.

In the areas where it worked, MSF leaves behind an improved level of care for mothers and newborns, and better trained staff.

Since 2002, MSF provided more than 30,000 consultations, antenatal care to 6,000 women and treated around 2,000 malnourished children.

MSF has worked in Nepal since 2002.

© Corbino

Kalakot, Napal. A patient receives treatment for injuries to his hands.

Ranjana

23 years old

She was brought into Gaur District Hospital in the Rautahat district by her husband. She was about to deliver her first baby and was experiencing complications. On examination, MSF doctors discovered that her uterus had ruptured. Doctors realised that Ranjana had taken oxytocin, a drug available over the counter that is used to stimulate uterine contractions. Ranjana and her baby survived, but she lost so much blood that she needed to have a blood transfusion and her uterus had to be removed.

PAKISTAN

REASON FOR INTERVENTION • Armed conflict • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 819**

In 2009 there was a rapid escalation of violence across the country as fighting intensified and attacks on civilian buildings increased.

More than two million people have been displaced by the armed conflict in the North West Frontier Province (NWFP) and in the Federally Administered Tribal Areas (FATA). Despite the difficulties, MSF offered emergency medical and relief services in more than 12 sites in NWFP, FATA and Balochistan province. This included healthcare to people wounded or displaced by fighting, and maternal and child healthcare in some of the poorest areas of the country.

A mother and daughter in their tent in a refugee camp having fled violence in Malakand.

In February, two MSF medical technicians were killed as they travelled in an MSF ambulance on their way to pick up civilians injured in fighting in the Swat District of NWFP. This direct attack and the continuing increase in hostilities in the area led MSF to withdraw from the Swat District. Later in the year, travel restrictions prevented MSF teams from providing medical support to communities displaced by fighting in South Waziristan.

Critical care for displaced people

Local health structures in districts hosting displaced families were overwhelmed by patients, particularly in Mardan where around one million displaced people settled as they fled fighting in Swat. MSF supported referral hospitals, health centres and mobile clinics. In Mardan District alone between June and September, MSF provided emergency medical care to more than 3,200 people, treated 880 hospitalised patients and provided more than 16,000 consultations. During the cholera season, MSF set up five treatment facilities in the region and treated 4,500 patients. An additional 56,000 medical consultations were carried out throughout the year for displaced people living in Lower Dir, Charsadda and Peshawar.

MSF teams also distributed basic relief items to thousands of displaced families and provided tents, latrines, and water and sanitation facilities to five camps hosting around 23,000 displaced people.

Trauma treatment

Throughout the year, nearly 5,300 trauma patients were cared for in the emergency room of the main referral hospital of Lower Dir, where MSF teams treat on average 4,000 patients each month. MSF also worked in all departments of Dargai Hospital in Malakand District, where surgical teams carried out more than 880 surgical interventions with Ministry of Health staff. Teams also support Darband rural hospital of Mansehra District and, in June 2009, started providing medical consultations to the neighbouring Kala Dhaka tribal area where the parasitic disease cutaneous leishmaniasis is endemic. In Kurram Agency, MSF donated medical material to three hospitals to help treat war-wounded, and carried out more than 2,000 paediatric consultations each month in Alizai and Sadda hospitals.

Improving mother and baby care

Pakistan has one of the highest infant and maternal mortality rates in the region. Women and children tend to be most affected by the shortage of medical staff and unaffordable health services, particularly in remote rural areas. MSF strives to have female medical staff to provide healthcare to women patients in nearly all of its medical activities. In Balochistan in particular, teams have developed an extensive mother-and-child healthcare programme. In Kuchlak, Chaman and in the eastern districts of Nasirabad and Jafarabad, teams carried out 18,000 antenatal consultations, helped with 4,000 deliveries and treated nearly 5,000 malnourished children. An additional 110,000 consultations were also carried out.

MSF has worked in Pakistan since 2000.

Patient story

Woman displaced by fighting in Bajaur

'My husband was killed in crossfire. I was preparing a meal for him when my neighbour told me that he had died .... I was very worried for my children and wanted to leave but I did not know how or where to go and there was continuous shelling. After a few days one of my neighbours agreed to come with us, so we left home and took nothing except the clothes we were wearing. We walked for a day and a night until we found some families already travelling in trucks. We joined them and reached Peshawar by truck.'

PAPUA NEW GUINEA

REASON FOR INTERVENTION • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 79**

Lae, Papua New Guinea. Outreach workers talk to the community about the problem of domestic violence which particularly affects women and children.

The people of Papua New Guinea are caught in a self-perpetuating cycle of violence. The rapid development of the country in recent years has had the unintended consequence of aggravating existing tensions.

For the most part, it is women and children who bear the brunt of this, suffering rape and other forms of violence - that creates an urgent need for both medical care and psychosocial support.

In addition, infectious diseases claim many lives, there are serious public health risks from endemic diseases such as malaria, and an emerging HIV/AIDS epidemic. Healthcare provision however, remains limited.

In the coastal city of Lae, MSF worked in collaboration with the Ministry of Health to provide care for survivors of sexual and domestic violence. MSF also began integrating medical care with psychosocial care and in 2009 more than 2,500 people received counselling.

In the Southern Highlands, MSF has been supporting the district hospital of Tari to address the physical and psychosocial needs of survivors of domestic and other types of violence. MSF also managed the operating theatres and water and sanitation facilities in the hospital. Psychological counselling and support for emergency obstetric patients were also provided.

In December, the international team was temporarily withdrawn after some members were threatened in the Tari hospital, though national staff continued to work with Ministry of Health doctors. International staff began to return at the end of the year. Overall, more than 650 medical procedures were performed throughout the year, including more than 240 major surgeries, and more than 150 people received counselling.

Cholera outbreak

MSF set up several emergency centres to treat the first cholera outbreak to have affected Papua New Guinea in 50 years. Teams helped train hospital staff to implement a cholera intervention programme and treat patients.

MSF has worked in Papua New Guinea since 2009.

PHILIPPINES

REASON FOR INTERVENTION
- Armed conflict
- Natural disaster

Field Staff 76

Mindanao Island in the southern Philippines has been at the heart of an armed conflict between Philippine government forces and the Moro Islamic Liberation Front since the 1970s. In the summer of 2008, between 400,000 and 500,000 people fled the area to escape the violence, and despite the announcement of a ceasefire in July last year, some 300,000 people remain displaced. The country can barely cope with such numbers of displaced people.

MSF provided medical care via mobile clinics and supported existing health structures for an estimated 70,000 displaced people in five camps in Region XII and in the Autonomous Region in Muslim Mindanao Region. Teams focused on helping people who were particularly vulnerable or not well-served by local medical centres.

Throughout 2009, MSF provided almost 43,000 consultations including 1,500 for pregnant women.

In March, MSF psychologists started a mental health programme to help the many people who were suffering from psychological problems and showing psychosomatic symptoms due to stress. In collaboration with the psychiatric unit in Cotabato hospital in the Mindanao Region, MSF started treating patients with severe mental health disorders. More than 2,100 patients received psychological support and psychiatric treatment.

Natural disasters

In September and October last year, the Philippines were hit by a series of typhoons that caused widespread damage and floods in and around the capital Manila, and on the northern island of Luzon.

MSF helped improve living conditions in the camps for those who had been displaced, by building latrines and strengthening hygiene and sanitation services. Mobile clinics were used to reach people in need of medical care in the camps and surrounding areas. Teams also used boats to reach parts of the city where people had been cut off by the floodwaters. In total, 4,300 consultations were carried out.

In northern Luzon, MSF intervened in Ilocos Norte, Cagayan, Pangasinan and Tarlac provinces and conducted more than 3,400 consultations. In Rosales, where water from local dams flooded and destroyed the surrounding area, MSF helped by distributing relief items, including plastic sheeting, hygiene and construction kits. MSF also assisted the victims of landslides caused by weeks of heavy rain in Benguet.

MSF has worked in the Philippines since 2008.

Manlia, Philippines. An MSF team registers people staying at a temporary camp set up after several typhoons and tropical storms.

Ramon

30 years old

'Everything happened so quickly. It was terrifying. I was in my house when suddenly I heard a bomb exploding. At first, I didn't realise what was happening, but later I realised that a bomb had fallen on my house. Outside, everybody was running around, and some people were looking at me strangely. I felt very tired and I was in a lot of pain so I lay down. Later, some people told me that I had been covered with blood and that they had thought I was dead. However, someone was able to feel my heart beating and so they brought me to the health centre. I had two pieces of shrapnel in my stomach. The doctors then transferred me to the general hospital in Cotabato where I stayed for nine days.

'Later, when I was back with my family, I went to the MSF mobile clinic to get some drugs. The doctor advised me to meet a psychologist, which I did. Then I realised that I was still in shock because of what had happened and that I needed support. Now, my wounds still hurt me and I very often think about what I've been through, but I am feeling better.'

SRI LANKA

REASON FOR INTERVENTION • Armed conflict **Field Staff 347**

Menik Farm camp, Sri Lanka: A nurse treats people displaced by the war between Sri Lankan security forces and the separatist Tamil Tigers.

Rajasekaran

29 years old, married with two children

'After doctors told me I would never be able to walk again, I lost all hope. I spent my days lying in a hospital bed, which caused painful pressure sores that became infected. I was embarrassed that I was unable to control my bladder and bowel movements and that I was entirely dependent on others and could not provide for my family.

'I signed up to the MSF rehabilitation programme for patients with spinal-cord injuries in November and now no longer feel so depressed about my future. After physiotherapy, nursing care, and medication, I am now out and about in my fitted wheelchair, can wash and dress myself and go to the bathroom alone. I hope to continue my work as a motor mechanic and learn more English.'

The decades-long civil war between the Sri Lankan security forces and the separatist Tamil Tigers (Liberation Tigers of Tamil Eelam) came to an end in May 2009.

During the final phase of the bitter conflict, tens of thousands of civilians were trapped on a narrow strip of beach and jungle in the northeast of the country with little or no access to healthcare.

In 2009, surgical teams worked in hospitals in the north of the country to treat those who had escaped the war zone. MSF also helped to provide clean water in government-run camps for 300,000 displaced people and provided supplementary feeding for around 10,000 undernourished people.

From mid-April till the end of May, thousands of people managed to escape the conflict area. Many needed medical assistance after months of limited access to it, and others needed treatment for severe injuries inflicted by shrapnel, gunshots or landmines. Hospitals in the area treated as many civilians as they could, but the numbers were overwhelming. On April 21st, in just one 36-hour period, more than 400 patients were treated for life-threatening conditions in Vavuniya hospital. Overall, MSF treated almost 4,000 war-wounded between February and June.

More than 150 MSF staff supported patients, many of whom had been separated from their families. Medical teams also cared for more than 60 patients with spinal-cord injuries who needed rehabilitation.

Many displaced people were malnourished, so in February, MSF started to distribute supplementary food daily to every child under five years old, as well as to pregnant and lactating women and the elderly. In August, at the peak of its activity, the programme reached more than 26,000 people.

In late May, MSF was authorised to open a 160-bed referral hospital in Vavuniya with an inflatable operating theatre and surgical facilities. It was set up just outside the government-run Menik Farm camps that house hundreds of thousands of people displaced by the conflict. Between May 2009 and January 2010, there were more than 4,200 admissions. Teams performed more than 1,600 surgical procedures and more than 13,500 consultations. A further 850 people were treated for war-related injuries, and 200 patients began receiving psychological support after conflict-related trauma.

Towards the end of the year, people detained in the government camps were released, and medical needs decreased. By the end of 2009, around 100,000 people remained in the camps and government health facilities were able to cope, so activity at the MSF hospital was scaled down. It was closed in January 2010.

Throughout the year, MSF also supported surgical, emergency and obstetric treatment for patients at the Ministry of Health hospital at Point Pedro in Jaffna district. Healthcare needs in the district on the northern tip of the island started to increase in October, because around 70,000 people who had been displaced by the war returned. MSF performed more than 2,000 emergency consultations and 1,300 surgical interventions. The hospital psychological support team carried out 430 consultations.

MSF has worked in Sri Lanka since 2007.

THAILAND

REASON FOR INTERVENTION • Endemic / Epidemic disease • Healthcare exclusion **Field Staff 85**

For decades Thailand has been a magnet for economic migrants and asylum seekers fleeing poverty or political unrest in the surrounding regions.

The country introduced a Universal Health Coverage Scheme in 2001, and although the national healthcare scheme was extended to include registered labour migrants, it does not cover those who are undocumented. These people make up more than three-quarters of the total migrant population and usually cannot afford treatment. MSF has been working to help such migrants, and has been continuing to give medical assistance to displaced people and marginalised ethnic minority groups.

Cross-border activities

MSF continued to support people living in New Mon State (Myanmar) throughout 2009. Along the border with Thailand, the area enjoys semi-autonomy and has its own health authority but it lacks drugs and equipment. The Mon people live in small, scattered and remote villages. The MSF programme focuses mainly on treating and preventing malaria, which is endemic here. Teams train village malaria workers and support local health centres. In 2009, MSF distributed more than 1,400 bed nets and carried out 3,700 consultations.

In March 2009, drawing on its experience in New Mon State, MSF began training Thai medical staff operating in the remote areas of Kayah State, eastern Myanmar, near the border with Thailand. These staff have direct contact with isolated ethnic minorities hiding in the jungle who have no access to healthcare. MSF also donated malaria treatment and diagnosis kits.

Hmong refugees

Having worked in the refugee camp for four years, MSF ended its activities in May 2009 because the Thai army attempted to empty the camps by forcibly repatriating the Hmong people to Laos. In addition, the army increased restrictions on access to medical treatment and food to pressurise refugees to return, which reduced MSF's ability to work.

MSF repeatedly denounced the Thai and Laotian government's policy of forced repatriation and called for an independent third party (the UN High Commission on Refugees – UNHCR) to be involved to help guarantee the refugees' rights and safety upon their return to Laos.

Before leaving, MSF had conducted 11,200 consultations, mainly for diarrhoea and respiratory and skin infections, and provided psychological support to people suffering from stress, anxiety and depression. MSF also provided family planning and immunisation programmes for pregnant women and children.

After MSF's departure, camp activities were handed over to a local non-governmental organisation with the support of UNICEF. At the end of 2009, the Thai government forcibly repatriated more than 4,000 Hmong from the camp, without involving UNHCR.

HIV handover

2009 marked the end of MSF's HIV/AIDS projects with the handover in July of its last programme in Phang Nga, southern Thailand.

MSF has been working in Thailand since 1976.

Mae La refugee camp in Thailand, at the border to Myanmar, which houses more than 30,000 refugees.

YH

22 years old

She used to live in the forests of Xiangkhouang province in Laos. She fled to Thailand in May 2005 after five cousins and two sisters were killed during attacks on her family. She lives with her husband and their three-year-old daughter in Huai Nam Khao.

'I lived all my life in the forest in Laos. Lao and Vietnamese soldiers chased us all the time. Soldiers killed my family members. Sometimes the planes attacking us would drop bombs that produced a poisonous, yellow-coloured gas. We would have to run and hide among the trees. I saw a lot of people die. During one attack, one of my younger sisters breathed in poisonous gas and she passed out. My mother had to carry her.

'My husband decided we could no longer stay in the forest and that we should come to Thailand. All we had when we arrived was my husband's Hmong knife that he used to dig for roots. We started to receive food from MSF. Ever since we fled Laos our life has improved because we have had food to eat and we don't have to hide from attacks. But I am so afraid that we will be sent back to Laos. I don't want to be sent back to Laos to be killed. Everyone is saying we are going to be sent back.'

TURKMENISTAN

REASON FOR INTERVENTION • Healthcare exclusion **Field Staff 57**

Despite the fact that Turkmenistan is rich in oil and gas reserves, many people lack access to good-quality basic healthcare.

The government actively promotes an adherence to international healthcare standards in order to uphold a façade of prosperity while the true picture of public health concerns remains hidden, and healthcare workers are unable to provide adequate care.

The existence of HIV/AIDS is often denied by authorities, and the relatively high prevalence of communicable diseases such as tuberculosis (TB) and sexually transmitted infections do not receive adequate attention in the health centres.

MSF worked in Magdanly District Hospital in the east of the country supporting paediatric and reproductive healthcare from 2004 until September 2009. The project supported more than 1,600 hospitalised children and assisted more than 780 deliveries. However, having come to a limit of what could be achieved in this programme, MSF decided to close the project in September 2009.

MSF had planned to start a new project to treat Multi-Drug Resistant Tuberculosis (MDR-TB) and HIV co-infected patients. So far, MSF has not been granted permission to start or be involved in a comprehensive MDR-TB programme, despite the fact that Turkmenistan has no such programme in place and that drug-resistance rates are comparatively high. Negotiations have been slow: they started in summer 2008 and continued until the end of 2009. Therefore, MSF closed its operational presence in December 2009, but stays committed to reengaging and assisting the Turkmen population as soon as an agreement can be reached.

MSF has worked in Turkmenistan since 1999.

UZBEKISTAN

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 95**

The incidence rate of tuberculosis (TB) in Uzbekistan is one of the highest in the world.

This is most evident in the Autonomous Republic of Karakalpakstan in the northwest of the country.

MSF's project in this region sees high rates of drug-resistant tuberculosis (DR-TB). However, the appropriate tools for diagnosis and treatment are only available from international organisations such as MSF. Throughout 2009, MSF focused on improving infection control and supplying patient care and treatment. Great concern still remains however, regarding the high proportion of people who fail to finish the treatment programme for DR-TB, which requires a long course of medication with difficult side effects.

Nukus, Uzbekistan. A doctor holds in her hand a sample of the daily dosage of medication needed to combat multi drug-resistant TB.

MSF's experiences in Uzbekistan highlight the insufficiency of current diagnostics and treatment methods in treating DR-TB properly. MSF has called on governments and international organisations on several occasions to increase their research and development activities. The National Tuberculosis Programme in Uzbekistan has admitted that it is unable to tackle the DR-TB epidemic alone.

In 2010, MSF will begin to establish comprehensive TB care, providing diagnostics and treatment for all patients in all districts of Karakalpakstan, together with the Ministry of Health.

MSF has worked in Uzbekistan since 1997.

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San Francisco de Asis hospital, Columbia. Carmen, 31 years old and her husband Moyses caring for their newborn son.

AMERICAS

© Anna Surinyach

A child being tested for Chagas.

BOLIVIA

REASON FOR INTERVENTION • Endemic / Epidemic disease **Field Staff 36**

One hundred years after the discovery of Chagas, a potentially fatal parasitic disease, access to diagnosis and treatment is still limited in Bolivia and there is almost no treatment offered to people over 15 years old.

MSF is treating both adults and children and is lobbying for wider access to treatment in the country. MSF launched a 'Break the Silence' advocacy campaign in 2009 to call on governments of all countries where Chagas is endemic to fight the disease.

In October 2009, MSF started working in rural Cochabamba in the heart of Bolivia, one of the areas in the country with a higher rate of Chagas. MSF is working with the rural communities on the prevention, diagnosis and treatment of the disease. Of the 700 adults and children who were tested here for Chagas, more than 300 tested positive. Two thirds of these people completed the 60-day treatment successfully.

In Cochabamba there is a high presence of vinchuca beetles that can be found in people's homes and which transmit the disease to humans. MSF is working to implement a new strategy of insect control and is raising awareness among the population of the possible risks.

MSF also supports a programme in the capital of the Cochabamba department in collaboration with the Ministry of Health. The programme works to integrate assistance for Chagas patients into the national public health system.

Laura

39 years old and lives in Cochabamba town.

Seven years ago she found out she had Chagas disease but the parasite had already seriously damaged her heart and she needed a pacemaker. 'I could barely walk a block without getting tired. I went to the doctor and I had a blood test and a full check-up and they found out I had Chagas. From that moment I kept worrying about the disease.
I went to MSF and the doctor said it was too late to receive treatment, so there was no option but to get a pacemaker fitted.'

MSF has worked in Bolivia since 1986.

BRAZIL

REASON FOR INTERVENTION • Social violence / Healthcare exclusion **Field Staff 51**

Approximately 170,000 people live in Complexo do Alemão, which is a conglomerate of eleven poor communities in Rio de Janeiro, Brazil. Like hundreds of other slums in Rio, it is controlled by heavily armed groups that traffic drugs in the area.

Violent clashes can erupt at any time, anywhere, as a result of police incursions or fighting between rival groups. Besides physical wounds, the effects of the violence also leave psychological scars. MSF offered emergency medical care and psychological support to the residents from 2007 until the end of 2009, when a local organisation took over the activities.

After a series of violent clashes between police forces and armed groups in 2007, during which residents caught in the cross-fire had no access to emergency medical care, MSF started a project in Complexo do Alemão. Even in peaceful times, ambulances do not enter slums such as these, leaving residents with little or no life-saving assistance. The MSF project aimed at providing much-needed help right inside the community, where no other medical service was available, even at times when violence was at its peak. To enable rescues and referrals, MSF converted a van into a basic ambulance narrow enough to go through the alleyways and roadblocks. In two years, MSF provided 19,000 medical consultations and undertook 650 emergency rescues using the customised ambulance.

Having established a presence inside the community, MSF teams recognised a much less visible facet of the violence: the psychological scars it leaves on both adults and children. Although mental health services were part of the project from the start, they have become a crucial component of the assistance provided. Through individual consultations, a team of psychologists helped residents cope, and many for the first time in their lives took the opportunity to express their suffering in a professional and confidential environment.

Between 2007 and 2009, MSF gave more than 3,000 psychological consultations to 1,300 patients in the area. Psychosomatic complaints, depression and anxiety are the most common symptoms found in adults, whereas in children aggressiveness, behavioural problems and learning difficulties are common. Half the patients seen by MSF's psychologists had a story of violence to tell. More than one third had been in a situation of conflict, and one in five patients reported that a family member of theirs had been killed.

After two years of activities, MSF ended its presence in Complexo do Alemão at the end of 2009. The decrease in violent clashes in the community and the creation of new health services nearby that are available for all residents meant MSF's emergency role was no longer needed. By the end of 2009, negotiations were in place with a local organisation willing to take over the services established by MSF, ensuring continued medical and psychological care for the residents of Complexo do Alemão.

MSF has worked in Brazil since 1991.

Complexo do Alemo, a poor area of Rio de Janeiro controlled by armed drug dealers. Here, MSF supports the population trapped by violence.

Patient story

A patient at the MSF clinic.

'My brother was killed in the community when he was 16 years old and ever since I have suffered from depression. There were times when I didn't want to leave the house, I didn't want to talk to anybody, I was completely isolated. Twice, I wanted to kill myself. Then I lost my daughter in an accident. I just wanted to die. It was during one of these crises that I found out there were psychologists here at the clinic and I was able to find the support I needed to carry on living.'

COLOMBIA

REASON FOR INTERVENTION
- Armed conflict
- Healthcare exclusion
- Natural disaster

Field Staff 327

The conflict between guerrilla groups and government forces has been going on for 40 years in Colombia.

Paramilitary groups that were supposedly demobilised have re-emerged in many areas across the country. Many people have moved from rural areas to towns to escape the insecurity, but end up living in poverty with little access to care. MSF has been providing healthcare to those affected by the conflict as well as treating people with Chagas disease and offering maternal care.

Conflict

Armed conflict escalated in Nariño, and according to official figures there were 12,400 displaced people between January and September, by far exceeding the country's response capacity. MSF mobile teams worked to improve access to healthcare for people affected by the armed conflict and provided treatment to those who were displaced. MSF conducted more than 5,000 medical consultations overall.

Maternal care

More than 2,600 babies were born under MSF care in the main hospital in Quibdó, the capital of Chocó department, in 2009. Since this is the referral hospital for complicated obstetric cases, 60 per cent of the deliveries involved Caesarean sections. MSF also provided training for hospital staff, and medical equipment. Elsewhere teams set up fixed health posts to supplement mobile clinic activities. By maintaining a regular presence in some isolated villages on the riverbanks, MSF is able to offer better-quality medical care, improve patient follow-up and stabilise emergency cases before referring them. Overall, 6,300 consultations were carried out.

Emergency response

In the Tumaco municipality southwest of Colombia, the river Mira overflowed its banks in February, disrupting the lives of 30,000 people. Teams provided emergency healthcare in the most isolated areas and supplied medicine to the main hospital in Tumaco town.

Back in 2007 MSF opened a trauma centre in Buenaventura in response to increasing levels of violence in the shantytown. As the situation evolved, the centre broadened out its services to cover general healthcare needs and introduced a mobile clinic service. However by 2009 demand for the facility had decreased so the mobile service finished and efforts concentrated instead on the health centre, which in 2010 may be relocated to another area where the needs are greater.

Healthcare provision

MSF runs a boat-ambulance that serves riverbank villages. In 2009 more than 14,500 riverbank consultations were carried out. In December, the fixed health post and mobile clinic activities on the San Juan river were handed over to the municipality and MSF was able to focus its activities on the Baudo river.

More than 6,300 consultations were carried out in the department of Norte de Santander, where MSF managed two clinics and several rural mobile clinics. These included sexual and reproductive healthcare, mental healthcare and care for survivors of sexual violence. Nearby in the Bajo Atrato area, MSF also provided healthcare services including nutrition surveillance and mental healthcare to a vulnerable and isolated community. MSF handed over the mental health centre it was running in

A young girl sits on an examination table, having received treatment for a wound to her forehead.

Florencia, the capital of the department of Caquetá last year, although teams continue to conduct mental health consultations in other administrative centres and provide mental health support in rural areas.

MSF provided more than 8,000 consultations in the Cauca and Putumayo departments, including medical and psychological healthcare and promotion and prevention consultations. The programme supported the health network in both departments by training staff, supplying materials and refurbishing medical facilities. At the end of the year, MSF handed over the activities in Cauca to the local authorities.

The disease Chagas is endemic in most Latin American countries and, if left untreated, can lead to serious health problems and eventually death. The Arauca department in the northeast of the country on the border with Venezuela has one of the highest rates of Chagas in the country, with an estimated eight per cent of the community infected. MSF carried out nearly 15,000 consultations via mobile clinics in rural and urban areas last year.

MSF has worked in Colombia since 1985.

Manuel

40 years old, shop-owner in a rural part of the Nariño district

'Our life here is quiet; nothing usually happens. However, a few months ago, several uniformed men arrived looking for a criminal they thought was in the district. They entered the houses kicking the doors open and forcing people out. Everybody was very scared; nobody understood what was happening. They seized me and took me to the bush because they thought I was collaborating with the criminal. They threatened me with a gun and then a chainsaw to make me talk. I cannot remember how long I was detained, but I could not make them understand that I didn't know anything. When I was finally released I left the area because I was scared. Nearly all of us fled, but what could we do so far from our land? Some people returned, but I couldn't, I was frightened. Then, when I saw MSF was coming, I returned and managed to talk through my experience with them.'

© Juan Carlos Tomasi

Sexual violence is a huge problem in Guatemala, with 10,000 rapes reported in 2009.

GUATEMALA

REASON FOR INTERVENTION • Healthcare exclusion **Field Staff 33**

According to the World Bank, about 51 per cent of Guatemalans live on less than two US dollars a day and 15 per cent on less than one US dollar.

Social development indicators such as infant mortality, chronic child malnutrition and illiteracy are among the worst in the hemisphere. Violent crime, including murder, rape and armed assault, presents further serious challenges with an average of 20 people being killed every day. In 2009, 10,000 cases of rape were reported to the Ministry of Justice.

Such a climate left national authorities with few resources to devote to survivors of sexual violence. To address this, MSF set up a programme providing urgently needed treatment in the capital Guatemala City in 2007. The centre now provides medical and psychological assistance to 100 new patients every month. Through education and information initiatives, teams are also making the authorities, the medical community and the Guatemalan public aware that sexual violence is a medical emergency and that effective treatment is available.

MSF works in local clinics in the two most violent districts, supporting the main referral hospital in Guatemala City and teams also run a mobile clinic. As a result of the local education campaigns and national lobbying, MSF's services are now successfully integrated into the public health system. One of the future challenges is to persuade patients to come to the clinic as soon as possible after an attack. Many treatments, including anti-HIV medication are effective only if administered within 72 hours of the assault. Although patients who were attacked by individuals unknown to them usually seek treatment early, victims of interfamilial sexual violence tend not to seek help until much later.

MSF has worked in Guatemala since 1984.

Maria

She was abducted by a criminal gang in Guatemala City, taken to a house and raped. Having managed to escape, she made her way to the MSF clinic and arrived distressed and badly shaken. 'I was terrified, I didn't want to live,' she explained. 'MSF gave me pills to protect me from HIV and injections to prevent other sexual diseases.' Psychologists also helped Maria find coping mechanisms to deal with the mental trauma.

HAITI

REASON FOR INTERVENTION •Social violence / Healthcare exclusion **Field Staff 849**

Political stability in Haiti, however weak, was achieved with the election of a new government in 2006. However, 2009 was characterised by rising food prices, chronic unemployment, and a dysfunctional healthcare system.

Slum dwellers in the capital Port-au-Prince continued to live in deplorable conditions. Haiti has the highest level of maternal mortality in the western hemisphere (67 deaths for every 10,000 live births). Poverty, in combination with a mostly privatised healthcare system, has compromised maternal healthcare for women living in slum areas. MSF was one of the main public healthcare providers in Port-au-Prince before the earthquake in January 2010, providing obstetric, emergency and trauma care to the inhabitants.

Women's health

In 2009, a surge in the number of births prompted MSF to move its maternity hospital in Port-au-Prince to a larger facility known as Maternité Solidarité. To avoid any duplication of public health services, MSF focused on helping women who were experiencing complications, and transferred those with straightforward pregnancies to government-run centres in the city. MSF also managed the provision of antenatal care in three slum locations in the capital, carrying out 1,500 consultations a month. Since the emergency obstetric programme was opened in 2006, more than 40,000 babies have been delivered, clearly indicating the huge need for maternity care in the slums.

Emergency trauma care and training

At Martissant Emergency Centre, MSF provided life-saving medical care in one of the most poverty stricken neighbourhoods of Port-au-Prince, where 400,000 people live. Opened in 2006, the project was created to respond to medical needs resulting from the high level of armed violence in the Martissant area. Today, although armed violence has decreased, the medical needs remain huge. In 2009, MSF teams performed more than 97,000 medical consultations for nearly 48,000 patients. Over 60 per cent of the new patients were victims of trauma, such as car accidents, and one in ten was wounded as a result of violence.

In Martissant, patients with severe medical needs were stabilised and those requiring surgery or specialised treatment were transferred to other medical structures, including MSF facilities in Port-au-Prince, Maternité Solidarité and Trinité Trauma Center. Referrrals to public medical structures were difficult because the lack of personnel, poor organisation and high cost of services meant that many patients were left without the medical care that they urgently needed. To increase the capacity of Martissant Emergency Centre, the number of beds in the centre was increased from 13 to 35 and short term hospitalisation was also provided.

MSF provided comprehensive trauma care at its 75-bed hospital called the Trinité Trauma Center. Here MSF introduced a programme for internal fixation, a technique that enables injured patients to walk again within a couple of weeks, instead of months. After the procedure patients were transferred to Pacot Rehabilitation Center for physiotherapy and follow-up consultations. In 2009, nearly 10,000 patients were treated in the emergency room of Trinité and over 4,260 underwent surgery.

MSF has worked in Haiti since 1991.

© Espen Rasmussen

Port-au-Prince, Haiti. A nurse looks after a premature baby in MSF's maternity hospital known as Solidarité.

HAITI: THE 2010 EARTHQUAKE RESPONSE

As the first reports came in about the destruction caused by the earthquake that struck Haiti on January 12, within hours its consequences became devastatingly clear, and MSF, who was already in the country, launched its largest emergency effort in the organisation's history.

A patient, who has suffered two broken legs, is cared for just outside Carrefour Hospital which partially collapsed in the earthquake.

MSF has been working in Haiti since 1991. Immediately prior to January 12, MSF was running three programmes - a maternity project, a trauma and rehabilitation centre, and an emergency stabilisation programme - all necessitated by the cumulative impact of decades of violence and instability in a place with limited medical and governmental capacity. In the best of times, life in Haiti was precarious, but the earthquake brought unprecedented conditions. In a matter of moments, hundreds of thousands of people were killed or injured and millions were rendered homeless. The organisations that would usually coordinate a disaster response - the Haitian government and the UN - were badly hit themselves.

At the same time there were hundreds of thousands of people in desperate need of help. As Dr. Jeanne Cabeza, a medical coordinator for MSF in Haiti wrote, "Five minutes after the quake, people were banging on our door." A trickle of patients quickly became a deluge. "Within a few hours, there were hundreds of people in need of surgery," Cabeza recounted.

She and her colleagues worked through the night, attending to crush wounds, fractures, concussions, and other injuries. Care was given in courtyards or in the streets in front of MSF structures which had all partially collapsed. Car headlights were used to illuminate procedures. Sheeting was hung from trees and an old shipping container that had served as a pharmacy was cleared out to create adhoc operating theatres. Veteran MSF staff likened it to doing surgery in a war zone when everyone is injured at the same time.

Simultaneously, MSF offices around the world mobilised, launching what Dr. Greg Elder, deputy operations manager for Haiti, later described as "the single most concentrated response by MSF." Personnel, medication, medical supplies, and even an inflatable hospital were soon on its way. When congestion at the Port-au-Prince airport delayed arrival, MSF re-routed cargo through the Dominican Republic and lobbied coordinating bodies to give priority to aircraft carrying life-saving emergency medical equipment which they did after some days.

Within a week, MSF sent more than 250 metric tonnes of medical and material equipment to Haiti. The next week another 260 tonnes arrived. In total, over the first seven weeks, nearly 1,200 tonnes of supplies were flown, driven, and carried by boat into Haiti. Putting it to use were waves of medical and logistics personnel. Before the earthquake, there were some 800 people working in MSF's projects in Haiti, the vast majority of them Haitian. By the end of the February, that number was above 3,300. Collectively, four months after the earthquake struck, MSF was running approximately 20 medical facilities and several mobile clinics and 15 operating theatres. Teams had assisted some 137,000 patients, performed more than 7,600 surgeries, distributed roughly 28,000 tents and 40,000 hygiene and kitchen kits, and carried out nearly 70,000 mental health consultations.

The national healthcare system before the earthquake was very weak, and now it's worse off. Estimates put the number of wounded between 200,000 and 300,000. MSF must therefore continue to respond to immediate needs while also planning for the future. "More than one million people are still living in deplorable conditions, beneath tents or plastic sheeting, without a clear sense of what's ahead in the coming months," Stefano Zannini, MSF's head of mission in Haiti, said in May. "In the meantime, the rains are intensifying, flooding the sites several times a week where earthquake victims live."

It is already clear that MSF will be making a very substantial commitment to Haiti for at least the next 18 months. Beyond that there are still likely to be more specific gaps in provision that require a longer term presence. This ongoing commitment is very large by MSF's global standards. As a rough guide, MSF multiplied its activities by a factor of five after the earthquake. And in 2011 the work will still be around three times more than it was before the disaster.

MSF would like to pay tribute to the seven Haitian staff who were killed in the earthquake, and to those staff who were injured or lost relatives. Their bravery and commitment will not be forgotten.

HONDURAS

REASON FOR INTERVENTION • Armed conflict • Social violence / Healthcare exclusion **Field Staff 41**

Homeless young people living on the streets in the capital Tegucigalpa are very vulnerable. Their living conditions are dangerous and they are often the targets of violence. Last year more than 500 homeless people under the age of 24 were murdered. They have little or no access to healthcare.

MSF runs a therapeutic day-care centre in Comayaguela that provides medical, psychological and social support in one of the poorest areas in the city. In 2009, the centre saw on average 220 young people on a regular basis and the MSF team recorded over 8,000 therapeutic visits, including over 2,000 medical interventions. Many suffered from respiratory infections, skin conditions, dental problems, injuries resulting from violence, and HIV/AIDS.

Some patients show symptoms too severe to be treated in the day-care centre. In 2009 MSF referred to national hospitals 37 people suffering with depression, psychotic episodes, severe drug or alcohol withdrawal symptoms, or who had attempted suicide.

In 2009 MSF implemented a new model of care for those with drug or alcohol addiction. The service helps people to confront their addiction, which is often the first step to recovery.

Maria

She was seven when she was raped. At the age of eight, she ran away from home. Since then, she has been in juvenile detention centres 18 times, has worked as a prostitute and was addicted to drugs and alcohol. However, since starting at the day-care centre, she has never missed a session and has stopped taking drugs and alcohol.' When you stop the drugs, you start having responsibilities. It becomes not enough to sit and feel sorry for yourself.' With the support of the MSF psychologist, she is now more stable.

MSF has worked in Honduras since 1988.

© Marion Jaros

Tecucigalpa, Honduras. Young homeless people sleeping on the street.

© Yuri Kozyrev / Noor

Island of Lesvos, Greece. Undocumented migrants, many of whom have fled unstable regions including Afghanistan, Iraq, Somalia and Palestine, live in extremely precarious conditions.

EUROPE & THE MIDDLE EAST

FRANCE

REASON FOR INTERVENTION • Healthcare exclusion **Field Staff 11**

Many asylum seekers and non-French speaking people have problems accessing medical and psychological care in France.

Many migrants have escaped violence and deprivation in their home countries only to find themselves homeless and destitute in France. Undocumented asylum seekers are extremely vulnerable, and may be susceptible to psychological disorders as a result of the stress of their experiences. In 2009, MSF continued to provide asylum seekers with medical assistance, psychological care and social support.

MSF runs a centre in Paris that offers psychological care to people in distress who have come to France seeking asylum and protection. There are a variety of reasons why asylum seekers have difficulty accessing psychological care and services, including their undocumented status, the language barrier, and the nature and intensity of their psychological distress.

Psychotherapy is complemented with medical care, legal referrals and advice. Since the centre opened in 2007, more than 690 people have received care and more than 11,000 consultations have been given. Psychological care is essential if mental health is deteriorating: of the patients attending the centre, 41 per cent reported that they had experienced suicidal thoughts.

Healthcare on Mayotte Island

In May, MSF opened a healthcare centre in a shantytown in the capital of the French island territory of Mayotte in the Indian Ocean. Free healthcare was given to people living in precarious conditions, many of whom are migrants (mostly from the Comoros) who have no valid papers or are waiting to receive them. Among those waiting for their papers are people who were born in Mayotte but are unable to prove it. MSF teams noted two significant obstacles to obtaining medical treatment: first, those without papers are afraid of being arrested and expelled, and second, healthcare is not free and most people cannot afford to pay for it.

MSF gave more than 10,000 consultations in the healthcare centre, 35 per cent of which were for children under the age of five. An additional 340 were conducted in remote villages. The main medical complaints were upper respiratory tract infections and gynaecological problems. Doctors also checked the children's vaccination and nutritional status, and 1,500 people were seen for accidental injuries.

MSF has worked in France since 1987.

Many migrants and refugees in Paris have to sleep rough on the streets.

GREECE

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 17

Patra, Greece. A young migrant in the makeshift Afghan migrant's camp.

Patient story

'My entire family, my parents, my three brothers and my sister were killed when a bomb fell on our house. I went to answer the phone and then the bomb fell. The roof collapsed over the room my family was sitting in. There was a lot of dust. I could see their hands under the debris. I could not see their faces. I only saw the face of my youngest brother. Here, I need to be able to go outside the cell because inside I think of the bad things that happened at home.'

Palestinian boy, aged 16,
Pagani detention centre, Greece

In recent years, the number of undocumented migrants arriving in Greece has been increasing. In 2009, more than 36,400 people were arrested at the Turkish border trying to gain access to Greece.

Often, these people come from countries such as Afghanistan, Pakistan, Iraq, Somalia and Palestine and are trying to escape conflict and instability. Migrants often endure poor living conditions and are not entitled to access the national public healthcare system except in emergencies, when they must pay for care. Throughout 2009, MSF worked in a makeshift migrant's settlement in the city of Patra and in three detention centres for undocumented migrants.

Assistance to migrants in Patra

Patra is the main exit port for migrants hoping to reach Western Europe. Many leave hidden in trucks in an attempt to reach Italy. Between May 2008 and August 2009, MSF ran a clinic here in a shantytown, and organised mobile clinics in other locations to assist the migrants. MSF offered healthcare and psychosocial support and worked to help improve living conditions. More than 8,000 patients were examined and referrals were made to hospitals. The most common medical complaints were dermatological problems, upper respiratory infections and injuries, and most of these were related to the poor living conditions endured by the migrants. MSF psychologists frequently identified symptoms of depression, anxiety disorders and post-traumatic stress disorder. The MSF project was closed in September 2009 following the demolition of the makeshift migrant settlement by Greek authorities and a resulting decrease in the migrant population in the area.

Detention in Greece

In August 2009, after negotiations with the Greek authorities who had closed a detention centre on the island of Lesvos in 2008, MSF started new psychosocial support programmes in three detention centres in Pagani, Venna and Filakio. MSF psychologists provided support to undocumented migrants via individual or group counselling sessions. Most of the migrants come from unstable regions, and many of them have had traumatic experiences on their journey to Europe. Furthermore, detention in the camps, which involves difficult living conditions, overcrowding, confinement, and the threat of forced repatriation, can increase the pressure on their mental health. Unaccompanied minors, children, women and victims of torture are especially vulnerable.

In Pagani, overcrowding led to a dramatic deterioration of living conditions and people began to protest. The number of migrants detained in a facility with an official capacity of 275 was often more than 800, and reached up to 1,200. There was often only one functioning latrine for up to 200 people. During periods of overcrowding many migrants had to sleep on dirty mattresses, on floors that were covered with stagnant water from overflowing showers. The migrants were rarely allowed to go outside and families were split up.

In Venna and Filakio migrants faced shortages of food, clothes and hygiene items, and outdoor access was irregular and insufficient. In Filakio migrants regularly complained about inhumane treatment from police officers, including verbal and physical abuse.

MSF raised concerns with authorities regarding the poor living conditions in detention centres, the limited provision of medical care, the absence of mental health services, the inadequate care of unaccompanied minors, and the absence of a follow-up system for people with medical problems. The Pagani detention centre closed in November 2009, following repeated MSF appeals to the authorities to address the humanitarian emergency taking place there.

MSF has worked in Greece since 2008.

ITALY

REASON FOR INTERVENTION • Healthcare exclusion • Natural disaster **Field Staff 33**

Italy has long been a destination or a transit country for migrants and asylum seekers, often escaping conflict or deprivation. The organisation Fondazione ISMU estimated the number of undocumented migrants living in Italy to be nearly 422,000.

In 2009, the Italian government introduced stricter immigration policies, which have worsened the situation for migrants, increased stigma and hampered their access to healthcare. Last year MSF focused on responding primarily to the medical and humanitarian needs of seasonal migrant workers in southern Italy. MSF also continued to speak out about the difficult living conditions of migrants in order to put pressure on the authorities to improve their situation and increase their access to healthcare.

The Italian government has introduced policies to crack down on unofficial immigration, resulting in an increasingly hostile environment for undocumented migrants. The new law has criminalised unlawful entry into the country and people who are living there without visas. The maximum period in detention centres for undocumented migrants has been extended from two to six months, despite the fact that longer periods of detention are likely to contribute to a further deterioration in detainees' physical and mental health. MSF assessed 21 detention centres for migrants and reception centres for asylum seekers, and found overcrowding, poor living conditions and a serious lack of healthcare provision.

Border controls have been tightened, resulting in migrants taking longer and more precarious journeys in smaller boats to avoid being detected.

Over the past seven years, MSF has set up 35 clinics providing healthcare and psychological care to undocumented migrants in six Italian regions which are gradually being handed over to local health authorities. The clinics were integrated into the country's national health services and respected the migrants' wish to be anonymous.

In Puglia and Calabria in 2009, teams carried out more than 700 consultations and distributed hygiene kits and other essential items to seasonal migrant workers. MSF ran four clinics in the Campania region and assisted more than 1,600 migrants. In April, MSF provided psychological care to victims of the earthquake in the Abruzzo region. Between 2003 and 2009 in Lampedusa, a frequent entry point for migrants and refugees, teams provided migrants with medical assistance. However, last year there was a sharp decrease in the number of migrants due to a new agreement between Italian and Libyan governments to reinforce border patrols. As a consequence, MSF closed the project.

MSF has worked in Italy since 1999.

Turin, Italy. Migrants at their residential block which is surrounded by bars.

Patient story

'I come from Côte d'Ivoire. I have been in Italy for two months. After crossing the Libyan Desert, I was put in prison for six months without any explanation. I lived in a cell measuring five by ten metres with 20 other people. There was no toilet and we could hardly ever go out. Then I travelled to Sicily on a boat. It was a horrible journey: there were more than 15 people, we didn't have food or water, some were throwing up. Now I have come to Italy to pick tomatoes. They pay us three to four Euros a box. If all goes well I earn € 30 a day here, but I don't work every day. I live in a shack and I sleep on a mattress on the floor. I didn't think I would have such a bad life in Italy.'

MALTA

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff (this figure is integrated with those of Italy)


© Julie Remy

A Somali woman and her baby who have to stay in a detention camp in Malta.

Malta's location in the Mediterranean has made it a common port of arrival for thousands of migrants and asylum seekers who set off from the coast of Libya towards Europe.

They are then kept for up to 18 months in detention centres where they face overcrowding, inadequate sanitation and poor living conditions. This environment often has damaging effects on their physical and mental health. MSF has been treating patients both within and outside the detention centres.

Between January and October 2009, more than 1,150 migrants and asylum seekers landed in Malta, more than half of whom were Somali. Many were already suffering from psychological problems as a result of their often traumatic experiences in their home countries and their journeys to Malta. Most migrants have spent days on boats exposed to the sun and rain, unable to move, and with limited supplies of food and water; conditions that can cause skin, gastrointestinal, urinary and musculoskeletal health problems. Poor living conditions in the detention centres and uncertainty about the future also contribute to a high incidence of mental health problems.

At the start of 2009, teams were providing medical and psychological care for migrants inside two detention centres known as the Safi and Lyster Barracks. By March 2009, nearly 20 per cent of conditions diagnosed by medical staff were respiratory problems linked to exposure to cold and lack of treatment for infections. After repeated attempts to push authorities to take steps to improve matters, MSF withdrew from the centres, and in April published a report exposing the appalling conditions endured by migrants in Maltese detention centres.

After further negotiations with the Maltese authorities, MSF established a temporary programme inside the detention centre in Takandja. Here, between June and December, MSF provided more than 1,600 medical consultations. By the end of the year, MSF was phasing down the activities in Takandja.

In 2009, MSF also ran a clinic in Hal Far in the south of Malta, where migrants and asylum seekers outside the detention centres could have access to medical and psychological care. After their release from detention, migrants and asylum seekers are given a place in one of 15 open centres on the island. Although they can move freely and begin to build a new life on the island, integration into Maltese society remains difficult. Living conditions are still poor, as many centres are overcrowded and lack adequate water and sanitation facilities. MSF teams organise health and hygiene promotion activities in the open centres.

Throughout 2009, MSF provided more than 4,200 medical consultations and more than 780 mental health consultations for migrants and asylum seekers in Malta, both in detention centres and at the clinic in Hal Far.

MSF has worked in Malta since 2008.

MOLDOVA

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 8

Transnistria, a politically isolated region in Moldova, has received little aid in the past despite the enormous assistance Moldova receives from international institutions to tackle the country's HIV/AIDS epidemic.

MSF is assisting people living with HIV in this region where prevalence is four times higher than it is in the rest of the country. Before this intervention there was no treatment available.

In early 2007, MSF, together with the Ministry of Health and local authorities, set up the first HIV/AIDS programme in the region. Patients started receiving antiretroviral therapy (ART) at the new department in the main hospital in the capital, Tiraspol. Activities were extended to weekly visits to Bender Hospital to treat patients co-infected with TB, to Slobozia at the region's only facility for HIV patients, and to Ribnitza in the north of the country to give weekly consultations in the city's clinic.

MSF began providing treatment within the prisons, where the prevalence of HIV is as much as 13 times higher than it is among the general population. The prevalence of HIV/TB co-infection is also much higher. The programme has now expanded to cover the entire prison system.

In February 2009, MSF handed over all activities to the national authorities. Some 850 patients, representing more than half of all HIV cases registered in the region, are now on the programme.

With its work in the prisons and in the public HIV hospitals, MSF was able to demonstrate that it is possible to work in Transnistria and provide much-needed medical assistance to those most in need.

MSF has worked in Moldova since 2007.

RUSSIAN FEDERATION

REASON FOR INTERVENTION • Armed conflict • Healthcare exclusion **Field Staff 14**

The situation in the three republics of the North Caucasus region of the Russian Federation remains volatile.

Nearly every day there are attacks and violent incidents, and the insecurity worsened during the latter half of the year when the number of suicide bomber attacks increased alarmingly. MSF has been providing support to hospitals and through clinics and has been raising awareness of the mental health problems caused by the conflict.

Medical situation and priorities

Healthcare needs vary across the North Caucasus regions in Russia. For MSF, the priorities are to provide treatment for tuberculosis (TB), to offer psychosocial support, and help vulnerable groups such as displaced people and illegal migrant workers who have experienced neglect or violence. Prevalence of all strains of TB remains high, particularly in Chechnya where the entire health infrastructure was ruined during the war. Furthermore, there is an irregular supply of TB drugs, the necessary diagnostic tools are not yet in place, and infection control measures are unsatisfactory. In the region of Ingushetia in the south of the country, the mental health of the population is also becoming a serious concern. Intense insecurity coupled with political instability has exacerbated chronic psychological problems.

Throughout 2009, MSF doctors continued to offer free paediatric care in two clinics in Grozny in the south, and to provide women with free healthcare in two clinics in the nearby Staropromyslovsky district. Together these clinics gave consultations to more than 1,500 women every month, many of whom were displaced or from low-income, rural families. MSF also supplied drugs and medicines to a hospital in Grozny and to regional health centres in three mountainous villages.


© Lana Abramova

Ingushetia, Russian Federation.
A paediatrician checks the health of a child in a camp for internally dispaced people.

After several years' absence, MSF returned to Dagestan, again in the south, to provide treatment for migrant workers and internally displaced people in a health centre there.

MSF has started to hand over its support for the TB programmes in the more stable northern area of Chechnya as mental health activities respond to acute psychosocial needs and support patients with chronic conditions. In July 2009, MSF also ended its surgery and physiotherapy programme in the main hospital in Grozny, since fewer patients required treatment for injuries and chronic disabilities than during the war.

Access to the mountainous southern region remains a tough challenge due to the remote location of the communities. MSF's priority is to improve the treatment for TB, including drug-resistant forms of the disease.

MSF has worked in Russia since 1988 and the North Caucasus since 1995.

SWITZERLAND

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 10

Undocumented migrants have great difficulty accessing healthcare in Switzerland.

Although officially the Swiss Constitution guarantees access to the health system for all, thousands of people, often due to their lack of health insurance or their fear of being reported and expelled from the country, are left without proper medical care. In January 2006, MSF set up a project called Meditrina, which provided free medical consultations for these people.

Located in a small alley of downtown Zurich, the MSF Meditrina clinic provided more than 1,100 free consultations in 2009, bringing the total since the beginning of the project in 2006 to more than 3,400. Furthermore, hundreds of patients were referred to a network of medical and paramedical specialists who provided confidential consultations and medical care.

Around 50 per cent of Meditrina's patients are migrants living without documents in the Zurich area, but many others, despite their legitimate status, came to the MSF clinic because they could not or did not know how to access public healthcare. The most common conditions found in patients at the Meditrina clinic were gastrointestinal, dental and dermatological. Many patients also showed psychological disorders, often linked to their difficult living conditions. Meditrina also provided testing, counselling and longterm treatment for chronic diseases such as HIV/AIDS and tuberculosis.

After setting up and establishing Meditrina as a reliable and functioning entry point to the Swiss healthcare system for Zurich's undocumented people, MSF looked for an organisation to take over the project longterm. The Zurich branch of the Swiss Red Cross, already involved in providing care to those who need it most, took over the project at the beginning of 2010.

MSF has worked in Switzerland since 2003.

Patient story

'B', 36, from Cameroon

'Living here in Zurich as a "Sans-Papiers" is very difficult. You always fear the police will catch you, detain you and eventually send you back to your country. Meditrina people were of great help to me, they even managed to get me health insurance. They took great care of me and referred me to a doctor who can treat me in the future if necessary.'

UKRAINE

REASON FOR INTERVENTION • Healthcare exclusion **Field Staff 1**

Ukraine is often used as a transit country by migrants and refugees trying to reach the European Union (EU).

Under growing pressure to contain this movement, the country has received EU funding and technical support to implement stricter border controls and increase the capacity of detention centres for migrants. As a result, a large number of migrants and refugees without proper papers, from countries such as Afghanistan, Pakistan, Georgia, Moldova and many others, remain blocked in the country, unable to continue towards Europe or unwilling to return home. MSF has been working to improve conditions in the detention centres and has been providing the migrants with medical care.

Under national legislation, migrants arrested when trying to cross the Ukraine border into the EU illegally should be detained for a maximum of ten days. However, in reality they are often detained for much longer under conditions that fall far below basic standards and which offer limited access to healthcare.

MSF conducted an assessment in the detention centres in the Zakarpattya province near the European Union border, after reports in 2008 from the European Council of Refugees and Exiles denounced the poor living conditions there. While making the assessment MSF also repaired and installed toilets and showers to improve conditions in the detention centre.

Migrants are transferred to new Migrant Accommodation Centres (MACs) in Volyn and Chernihiv Oblast in the northeast and northwest of the country when they are released from the detention centres. MSF conducted a medical assessment in both these centres (which were built with EU financial support) and found that, although material conditions were better, the quality of medical services remained poor. People detained in these centres frequently suffer with skin diseases like scabies, as well as respiratory infections and digestive disorders such as diarrhoea, stomach-aches and nausea. They also show psychosomatic symptoms such as headaches and insomnia. However, mental health services are often nonexistent.

To share its concerns over the detention of migrants in Ukraine, MSF will launch a report with the results of the assessment and will also warn of the possible consequences of the 're-admission agreement', which came into force in January 2010. Under this agreement, all migrants without proper documents arrested in the EU after having travelled through Ukraine could be sent back to the country, resulting in increasing numbers of migrants and asylum seekers being trapped in Ukraine.

MSF has worked in Ukraine since 2009.

Chop, Western Ukraine. Illegal migrants detained in a camp.

IRAN

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 73

Zahedan, Iran. A child has their arm bandaged at the MSF supported hospital.

Iran hosts one of the highest numbers of refugees in the world. The UN refugee agency UNHCR reported more than 930,000 documented Afghan refugees in Iran in 2009, while estimates of undocumented Afghans reached two million.

MSF supplied relief aid to refugees in Zahedan, the capital of the Iranian province of Sistan-Balochistan, where refugees have been crossing the border from Afghanistan for the last 30 years. The number of 'illegal' Afghans is estimated to be around 200,000 in the city, and as many as 500,000 in the province.

In Zahedan, MSF runs three medical clinics and in 2009, carried out more than 6,700 consultations a month. A team of social workers identified people in need of medical care in the refugee community and distributed food and basic relief items to 1,290 families. Maternal and child healthcare activities were increased last year to meet the growing needs. Antenatal and postnatal care are now offered in the three clinics, and further postnatal care is provided in the community by a home-visit team that includes midwives.

In 2002, the Iranian government implemented a policy of repatriation, and the practice has continued even though conditions in Afghanistan have deteriorated. Many people are reluctant to return to Afghanistan and prefer to remain in Iran. Some even return after they have been deported in spite of the difficult living conditions imposed on the refugees. These include work restrictions, lack of educational opportunities and health services. MSF teams provide general healthcare and maternal care to the Afghan people who have little or no access to the Iranian system.

MSF has been working in Iran since 1996.

IRAQ

In Iraq, even though overall levels of violence have decreased, highly volatile areas still remain. Bombings and assassinations continue in many regions, and dozens are killed or wounded every week.

Although many health facilities function inside of Iraq, the quality of care has been undermined by a shortage of staff, and there has been no upgrading of skills since the early nineties. As in previous years, MSF could not give direct assistance to the most affected areas in 2009 due to security constraints. However MSF still worked to provide aid from more secure parts of the country or from the outside, especially Jordan.

According to the Iraqi Health Ministry, hundreds of medical employees have been killed in the course of the conflict and even greater numbers have fled the country. Iraq is critically short of nurses and of specialist doctors, including psychiatrists and psychologists. MSF has identified some of the main challenges to be the inability of hospitals in conflict zones to deal with mass casualty incidents due to deficiencies in skills and management, and a virtual absence of psychological care for patients with mental trauma.

MSF supports hospitals in different parts of the country such as Anbar, Baghdad, Ninewa and Kirkuk, by training medical staff, providing materials and supporting mental health counselling and conducting health education campaigns. MSF also established a programme in neighbouring Jordan in August 2006, from where it has been operating a reconstructive surgery project for the Iraqi war-wounded, focusing on orthopaedics, facial reconstruction and plastic surgery. In 2009, MSF remotely supported nine Iraqi hospitals from Amman that had been severely affected by the violence.

In 2009, some of the remote hospital support was closed as the security situation had largely improved in Iraq, permitting MSF to open a mental health counselling unit in Baghdad in September, followed by a similar unit in Fallujah in December. The units are located within Ministry of Health hospitals and seconded staff provide the counselling services. Over 175 patients were treated during the last quarter of 2009.

REASON FOR INTERVENTION • Armed conflict **Field Staff 289**

For the first time since returning to Iraq in 2008, MSF was able to establish an international team in the southern part of the country. There, in Basra General Hospital, MSF provided technical support and training on anaesthesia, post operative care, hygiene and sterilisation throughout 2009. In addition, MSF is currently participating in the rehabilitation of the emergency operation theatre in this 600 bed hospital, as well as focusing on improving emergency response capacity and better management of emergency surgical cases.

MSF is directly supporting the emergency units of four hospitals in the Ninewa and Kirkuk governorates in northern Iraq through continuous medical supplies and training of medical and paramedical staff, such as the training to manage mass casualty situations. MSF provides emergency response support to hospitals after violent incidents and is engaged in health education campaigns aimed at the prevention of communicable diseases. Campaigns promoted water treatment and personal hygiene, while others focused on raising awareness of leishmaniasis and on preventing swine flu (H1N1). In the Kurdish North of Iraq, MSF is also giving psychological support to persons displaced due to conflict

In Jordan, by the end of 2009, the reconstructive surgery programme lead by MSF in Amman treated nearly 900 wounded patients. The project has developed with the help of a small group of doctors in Iraq, who identified patients and organised their transfer to Amman, based on the specialist care we are able to provide (orthopedic, maxillo-facial and plastic). Treatment and follow-up are complex, requiring months of hospitalisation in a specialised environment. Beyond the complex surgery, MSF provides physiotherapy and psychological care to patients in need.

In the governorate of Kurdistan, MSF started a project in 2007 in the Sulaymaniyah teaching hospital, in order to respond more quickly to the wounded victims from the north of Iraq, and to improve the quality of care given to severely burnt patients. After two years working to improve the quality of care in the burn unit, MSF handed over this project to the authorities at the end of 2009. Despite the difficulty in improving survival rates in such a medical context (due to the high number of severe burns), progress was made in pain management, infection control and palliative care.

MSF is continually assessing the possibility of providing further medical assistance to the Iraqi people and weighs this possibility against maintaining staff security.

MSF's current intervention in Iraq started in 2006.

© Khalil Sayyad

Basra General Hospital, Southern Iraq. A team of medical staff operate on a patient.

LEBANON

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 21

Bourj el-Barajneh district of Beirut, Lebanon. Staff give out brochures to help raise awareness of mental health issues.

In Lebanon, 17 per cent of the population suffer from mental health problems according to a recent national survey, but few have access to treatment.

The problem is even more acute among people living in refugee camps, whether they are Palestinians who have lived there for decades, or more recently displaced people from Iraq. In December 2008, MSF opened a mental health centre in Bourj el-Barajneh, in the southern suburbs of Beirut, near a large Palestinian refugee camp. As well as providing psychological and psychiatric assistance, MSF has also started activities to promote the integration of mental healthcare within existing healthcare services for Palestinians and Lebanese communities.

Bourj el-Barajneh is a suburb of the Lebanese capital Beirut. It is home to a mix of Lebanese people, Palestinian refugees who have lived in camps since 1948, and recently arrived Iraqi refugees. Following a 2008 study on medical needs in Lebanon, MSF decided to start a new project that would provide mental health services to the poor and most vulnerable people living in this area.

The first full year of operations for this three-year programme was 2009. Throughout the year, between the MSF Mental Health Community Centre in Bourj el-Barajneh and the United Nations Relief and Works Agency clinic in the Palestinian refugee camp, MSF psychologists, psychiatrists and nurses carried out 2,300 consultations. Patients were mostly of Palestinian and Lebanese origin, and some were Iraqi refugees. Depression was the most commonly observed mental health problem, followed by anxiety disorders, psychosis, epilepsy and personality disorders. Further diagnoses included drug and alcohol abuse, bipolar disorder and dementia.

At first, the MSF team encountered difficulties in convincing people to come and consult mental health specialists, since mental health disorders are very much stigmatised in the communities. In order to challenge this, health education sessions were regularly held in the refugee camp and at the nearby MSF centre, and MSF community health workers regularly visited marginalised and disadvantaged patients' families.

As yet, mental health is not seen as a primary public health concern in Lebanon. There are only about 50 registered psychiatrists in the country. MSF has therefore been pushing for a better integration of mental healthcare within the existing healthcare services, and has been promoting its community-based mental healthcare approach during meetings with Lebanese health authorities and other partners.

MSF has worked in Lebanon since 2008.

Salwa

A Lebanese mother of four, who is married to a Palestinian man

'A few months ago, following the advice of a friend, I went to the MSF Mental Health Community Centre. I knew I could get free psychological support there. Session after session, I started feeling better and I even started participating in the centre's activities. I was lucky enough to meet other women suffering with the same problems, and I did not feel alone any more. My life has turned in a new direction. Today, I am able to talk about my psychological problems and to accept them, without fear of other peoples' opinions. I am happy I could find somebody to talk to who enabled me, for the first time, to believe in myself.'

PALESTINIAN TERRITORIES

REASON FOR INTERVENTION • Armed conflict **Field Staff 206**

The conflict that followed the rise to power of Hamas in the Gaza Strip in June 2007 and the continuing Israeli-Palestinian conflict have resulted in many deaths and injuries.

The Palestinian people have been badly affected physically and mentally, but not enough post-operative services such as physiotherapy and psychological care are available. MSF is working to remedy this while trying to adapt its operations to the volatile situation in the Palestinian Territories.

In June 2007, internal clashes within the Gaza Strip divided the Palestinian Authority into the Fatah government based in Ramallah and the Hamas government in Gaza. Internal clashes persist, continuing to claim victims.

The Israeli-Palestinian conflict continues. In response to rocket attacks against Israel, the Israeli army launched a large-scale offensive on December 27, 2008. 'Cast Lead' was characterised by intensive air raids and bombing, paving the way for a ground offensive launched on January 3, 2009. Twenty-two days of war left about 5,300 injured, and nearly 1,300 Palestinians, including 300 children, dead.

Emergency intervention

In response to the Israeli offensive, MSF supported the hospitals in Gaza with donations of medical equipment and medicine. Due to the intensity of the bombing and the lack of security, emergency activities were restricted, and though MSF's post-operative care centre in Gaza city remained open, few patients were able to reach it.

On January 18, Israeli forces announced a ceasefire. A surgical team and 21 tons of equipment (including two inflatable hospitals) were then able to enter Gaza City. In the days immediately following, MSF opened an emergency surgical centre to care for the influx of wounded people who needed operations. Between January and July, when this programme ended, more than 500 operations were performed.

Psychological care was also strengthened, with a special focus on local emergency staff such as ambulance crews and doctors, who endured much during the war.

Post-conflict programmes in the Gaza Strip

MSF has been providing post-operative care and physiotherapy to the war-wounded at its three health centres and through mobile teams. More than 120 patients are still being cared for within this programme. A microbiology programme was also set up to improve the care of wound infections and research resistance to antibiotics. In 2009, more than 1,900 people received treatment: three times as many as in 2008.

In 2009, improved local paediatric services and the arrival of new aid workers helped to strengthen the only specialised paediatric hospital in the Gaza Strip. From January until the end of the programme in September, more than 9,000 children under 12 years old were seen.

The psychological effect of the Israeli offensive in January has been substantial, especially on children. Additional MSF staff were brought in to help cope with the influx of patients. 400 new patients, more than half of whom were under 12 years old, received psychological support.

The West Bank

In Nablus, MSF runs a programme for people suffering from trauma related to the conflict. In 2009, more than 300 new patients received psychotherapy, and MSF psychologists carried out 2,100 consultations.

Hebron

MSF is also working in Hebron on the southern West Bank, operating a psychosocial programme for the victims of the ongoing violence.

MSF has worked in the Palestinian Territories since 1989.

© Frederic Sautereau

A psychologist greets a child at a centre for post-traumatic stress, which is often brought on by the experience of war.

SYRIA

REASON FOR INTERVENTION
• Healthcare exclusion
Field Staff 2

Approximately 4.7 million Iraqis have sought refuge outside their country and, according to the latest figures from the UN refugee agency UNHCR, the number of registered Iraqi refugees in Syria is around 215,000.

However many thousands more remain unregistered. Most of these people live in precarious conditions and cannot afford to pay for medical care.

In August 2009, MSF started a healthcare project in Damascus, Syria, in partnership with a local organisation which is known as the Migrant's Office. The aim of the project is to provide free healthcare and mental health support to the unregistered refugees and migrants and the underprivileged residents of the city.

With the support of MSF, the clinic provides primary healthcare services, prenatal consultations and mental healthcare. In the first six months, more than 2,800 patients received medical care, including 400 pregnant women, and 280 people were given psychological support.

In Syria there are also migrants and refugees from other countries, such as Afghanistan, Somalia and Sudan who live in poor conditions. Some 2,000 undocumented migrants from Afghanistan and Somalia live in Damascus with little or no access to medical care. MSF intends to increase the services provided in the Migrant's Office clinic to meet this growing demand.

MSF has worked in Syria since 2009.

YEMEN

REASON FOR INTERVENTION • Armed conflict **Field Staff 248**

In August, the conflict between the armed group Al-Houthi and Yemeni armed forces broke out again in the northern governorate of Saada.

This war was the most intense in recent years, and caused the displacement of at least 150,000 people. This is in addition to 100,000 others who had already been displaced by previous wars (UNHCR, 2009). MSF has been working to provide care for displaced people, migrants and refugees.

Conflict

Dealing with the consequences of the Saada war in northern Yemen was a priority for MSF in 2009. Health structures throughout the governorate were affected, and most of them had to interrupt their activities or became very difficult to access. Therefore, MSF worked to provide healthcare to rural communities while also helping the Yemeni authorities and other relief organisations to cope with the medical needs caused by the displacement of more than 150,000 people in neighbouring governorates.

A family share a meal in a refugee camp in Yemen.

Despite difficult safety conditions and logistical challenges, MSF set up an emergency programme for displaced people seeking refuge in the northern village of Mandabah in Saada, providing water and medical care for more than 10,000 people. More than 1,500 consultations were carried out.

In Al Talh and Razeh hospitals, not far from the city of Saada, more than 31,000 consultations were carried out and 2,100 people were hospitalised. More than 550 children were admitted to the nutritional programme and 700 women were assisted in giving birth. However the insecurity caused regular interruptions to MSF's work.

Another consequence of the violence in Sadaa was the massive displacement of civilians to neighbouring Governorates. According to the UN refugee agency UNHCR, about 90,000 displaced people had grouped in the Hajjah governorate. MSF found that eight per cent of children under five years old were severely malnourished in the al-Mazraq camp. Teams opened a nutrition intervention programme in the area and, within two months, more than 550 children had received treatment.

Many migrants, refugees and asylum seekers from the Horn of Africa continue to seek refuge in Yemen. The harsh conditions of their journeys and sea accidents cause hundreds of deaths, and the state of health of those who do manage to reach the Yemeni coast is often poor. Around 9,000 people received medical assistance from MSF in Abyan and Shabwah governorates in the south of the country.

MSF has worked in Yemen since 2007.

© Juan Carlos Tomasi

COUNTRY CLOSURES

BELGIUM

MSF worked in Belgium for 20 years, between 1989 and 2009. MSF closed its last project when socio-medical consultations in Antwerp ended in April 2009.

Over the years programmes to ensure access to healthcare for those most in need were implemented in four cities: Verviers, Liège, Brussels and Antwerp. In 2008, MSF provided more than 3,900 consultations for more than 1,000 patients in Antwerp. In May 2009, the Antwerp programme was handed over to the organisation Medecins du Monde, which had already taken over the MSF project in Brussels in 2008.

In November 2009, after closing its healthcare programmes, MSF returned to set up a refugee camp in the centre of Brussels in order to highlight the political gridlock around the reception and accommodation of asylum seekers in Belgium. The camp was meant to be a symbolic act and not intended to serve as an alternative to the accommodation provided by the government. However over the course of five days, more than 270 people stayed at the camp.

Although MSF no longer has operational programmes in Belgium it continues to work there via its national headquarters in Brussels to raise awareness of MSF's work, to fundraise for MSF programmes worldwide and to recruit staff as required.

FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that is also private and not-for-profit.

It is comprised of nineteen main national sections 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. Additionally, there is the international office in Geneva and a branch office in South Africa.

The search for efficiency has led MSF to create ten specialised organisations - called "satellites" - in charge of specific activities such as humanitarian relief supplies, epidemiological and medical research studies, and research on humanitarian and social action. These satellites, considered as related parties to the national sections, include: MSF-Supply, MSF-Logistique, Epicentre, Fondation MSF, Etat d'Urgence Production, MSF Assistance, SCI MSF, SCI Sabin, Artze Ohne Grenzen Foundation and MSF Enterprises Limited. As these organisations are controlled by MSF, they are included in the scope of the Financial Statements presented here.

The figures presented here describe MSF's finances on a combined international level. The 2009 combined international figures have been set up in accordance with MSF international accounting standards, which comply with most of International Financial Reporting Standards (IFRS). The figures have been jointly audited by the accounting firms of KPMG and Ernst & Young, in accordance with international auditing standards.A copy of the full 2009 Financial Report may be obtained from the International Office upon request. 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 2009 calendar year. All amounts are presented in millions of Euros.
Note: Figures in these tables are rounded, which may result in slight differences in addition.

AFRICA

	in million €
Democratic Republic of the Congo	49.7
Sudan	32.9
Zimbabwe	20.7
Somalia	18.6
Niger	17.4
Kenya	14.6
Nigeria	14.5
Central African Republic	12.6
Chad	12.4
Ethiopia	11.0
Malawi	8.8
Mozambique	7.6
Uganda	6.9
Liberia	6.7
South Africa	5.7
Burkina Faso	5.3
Sierra Leone	4.8
Guinea	4.4
Mali	4.0
Swaziland	2.7
Burundi	2.2
Djibouti	1.6
Cameroon	1.5
Zambia	1.3
Other countries**	2.4
Total	**270.3**

ASIA AND THE MIDDLE EAST

	in million €
Iraq	10.1
Pakistan	9.0
Myanmar	8.5
India	8.5
Sri Lanka	5.9
Palestinian Territories	5.2
Yemen	3.6
Cambodia	3.0
Philippines	2.9
Bangladesh	2.5
Papua New Guinea	2.5
Afghanistan	2.3
Iran	2.3
Georgia	2.0
Indonesia	2.0
Thailand	1.9
Uzbekistan	1.9
China	1.6
Armenia	1.4
Jordan	1.4
Nepal	1.2
Other countries**	2.7
Total	**82.4**

THE AMERICAS

	in million €
Haiti	12.8
Colombia	8.8
Brazil	1.4
Other countries**	2.4
Total	**25.4**

EUROPE

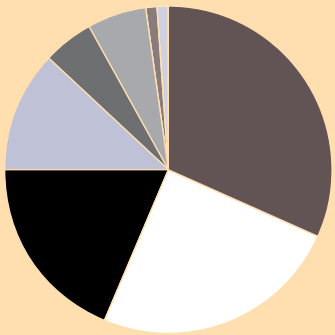
	in million €
Chechnya / Ingushetia / Dagestan	5.1
Italy	1.3
Other countries**	2.6
Total	**9.0**

** 'Other countries' combines all the countries for which programme expenses were below one million Euros.

Where did the money go?

Programme expenses* by nature

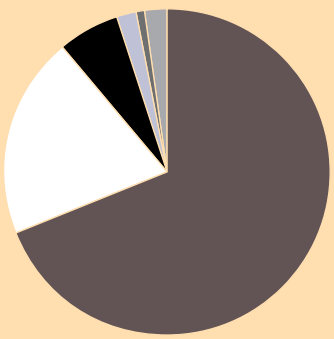
National staff	31%
International staff	25%
Medical and nutrition	19%
Transport, freight and storage	12%
Operational running expenses	5%
Logistics and sanitation	6%
Training and local support	1%
Consultants and field support	1%



Programme expenses* by continent

Africa	69%
Asia	20%
Americas	6%
Europe	2%
Oceania	1%
Unallocated	2%

* Project and coordination team expenses in the countries



INCOME

	2009		2008	
	in million €	*in percentage*	*in million €*	*in percentage*
Private	572.4	86%	587.4	87%
Public institutional	77.9	12%	67.7	10%
Other	15.1	2%	20.3	3%
Total Income	**665.4**	**100%**	**675.5**	**100%**

HOW WAS THE MONEY SPENT?

	2009		2008	
	in million €	*in percentage*	*in million €*	*in percentage*
Operations*	462.4	75%	494.9	76%
Témoignage / Awareness raising	21.7	4%	24.7	4%
Other humanitarian activities	6.4	1%	7.2	1%
Total Social mission	**490.5**	**80%**	**526.8**	**81%**
Fundraising	87.4	14%	81.2	13%
Management, general and administration	38.9	6%	40.2	6%
Other expenses	**126.3**	**20%**	**121.6**	**19%**
Total Expenditure	**616.8**	**100%**	**648.2**	**100%**
Net exchange gains/losses	2.9		-4.7	
Surplus/(deficit) after exchange	**51.5**		**22.5**	

* = Programme and HQ support costs

BALANCE SHEET (year-end financial position)

	2009		2008	
	in million €	*in percentage*	*in million €*	*in percentage*
Cash & equivalents	433.3	80%	375.6	77%
Other current assets	68.5	13%	73.3	15%
Non-current assets	36.6	7%	37.0	8%
Total assets - Net	**538.4**	**100%**	**485.9**	**100%**
Permanently restricted funds	2.5	0%	2.5	1%
Unrestricted funds	475.5	89%	423.8	87%
Other retained earnings	-9.8	-2%	-13.9	-3%
Retained earnings and equities	**468.2**	**87%**	**412.4**	**85%**
Current liabilities	70.2	13%	73.5	15%
Total liabilties & retained earnings	**538.4**	**100%**	**485.9**	**100%**

HR STATISTICS

	2009		2008	
	no. of Staff	*in percentage*	*no. of Staff*	*in percentage*
Medical pool	1,239	26%	1,052	23%
Nurses and other paramedical pool	1,459	31%	1,452	31%
Non-medical pool	2,046	43%	2,113	46%
Total international departures (full year)	**4,744**	**100%**	**4,617**	**100%**
International staff	2,015	9%	2,029	8%
National staff	20,447	91%	23,944	92%
Total field positions	**22,462**	**100%**	**25,973**	**100%**
First time departures (full year)	**874**	**18%**	**1,142**	**25%**

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 2009, 88.3% of MSF's income came from private sources. More than 3.8 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF include, among others: ECHO, the governments of Belgium, Canada, Denmark, Germany, Ireland, Luxembourg, Spain, Sweden and the UK.

Expenditure

Expenditures are allocated according to the main activities performed by MSF. 'Operations' includes programme-related expenses as well as the headquarters' support costs devoted to operations. All expenditure categories include salaries, direct costs and allocated overheads.

Permanently restricted funds may either be capital funds, where the assets are required by the donors to be invested, or retained for actual use, rather than expended, or they may be the minimum compulsory level of retained earnings to be maintained by some of the sections.

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, including the conversion difference.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. As of the end of 2009, 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, and the sustainability of long-term programs (e.g. ARV treatment programs), as well as the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

Unspent temporarily restricted funds are unspent donor-designated funds, which will be spent by MSF strictly in accordance with the donors' desire (e.g. specific countries or types of interventions).

The complete Financial Report is available on www.msf.org

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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, healthcare exclusion and natural disasters. MSF combines the provision of emergency medical care with a commitment to speaking out about the suffering people endure and the obstacles encountered in providing assistance. MSF offers assistance to people based only on need and irrespective of race, religion, gender or political affiliation.

Today MSF has national sections in 19 countries. In 2009 over 22,000 doctors, nurses and other medical professionals, logistical experts, water and sanitation engineers and administrators provided medical aid in over 65 countries.

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COVER PHOTO
Mobile clinic, Masisi, DRC. A staff member carries out a consultation on a 43 year old woman who suffered rape at gun-point. She received medication and psychological support.