

INTERNATIONAL ACTIVITY REPORT 2012



THE MÉDECINS SANS FRONTIÈRES CHARTER

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

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

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

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

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

The country texts in this report provide descriptive overviews of MSF's operational activities throughout the world between January and December 2012. Staffing figures represent the total full-time equivalent positions per country at the end of 2012.

Country summaries are representational and, owing to space considerations, may not be comprehensive. For more information on our activities in other languages, please visit one of the websites listed on p.100.

The place names and boundaries used in this report do not reflect any position by MSF on their legal status. Some patients' names have been changed for reasons of confidentiality.

CONTENTS

2 MSF PROGRAMMES AROUND THE WORLD

4 THE YEAR IN REVIEW

Dr Unni Karunakara, International President
Jérôme Oberreit, Secretary General

8 OVERVIEW OF ACTIVITIES

10 GLOSSARY OF DISEASES AND ACTIVITIES

14 ADAPTATION AND INNOVATION: KEYWORDS FOR MSF'S MEDICAL ACTION

16 AFGHANS TRAPPED AS WAR RAGES ON

18 FINDING REFUGE?

22 'TEST ME, TREAT ME': THE BURDEN OF DRUG-RESISTANT TUBERCULOSIS AND THE PUSH FOR BETTER TREATMENT

25 ACTIVITIES BY COUNTRY

95 SPECIAL REPORTS 2012

96 FACTS AND FIGURES

100 CONTACT MSF



4 The year in review



14 Adaptation and innovation



16 Afghans trapped as war rages on

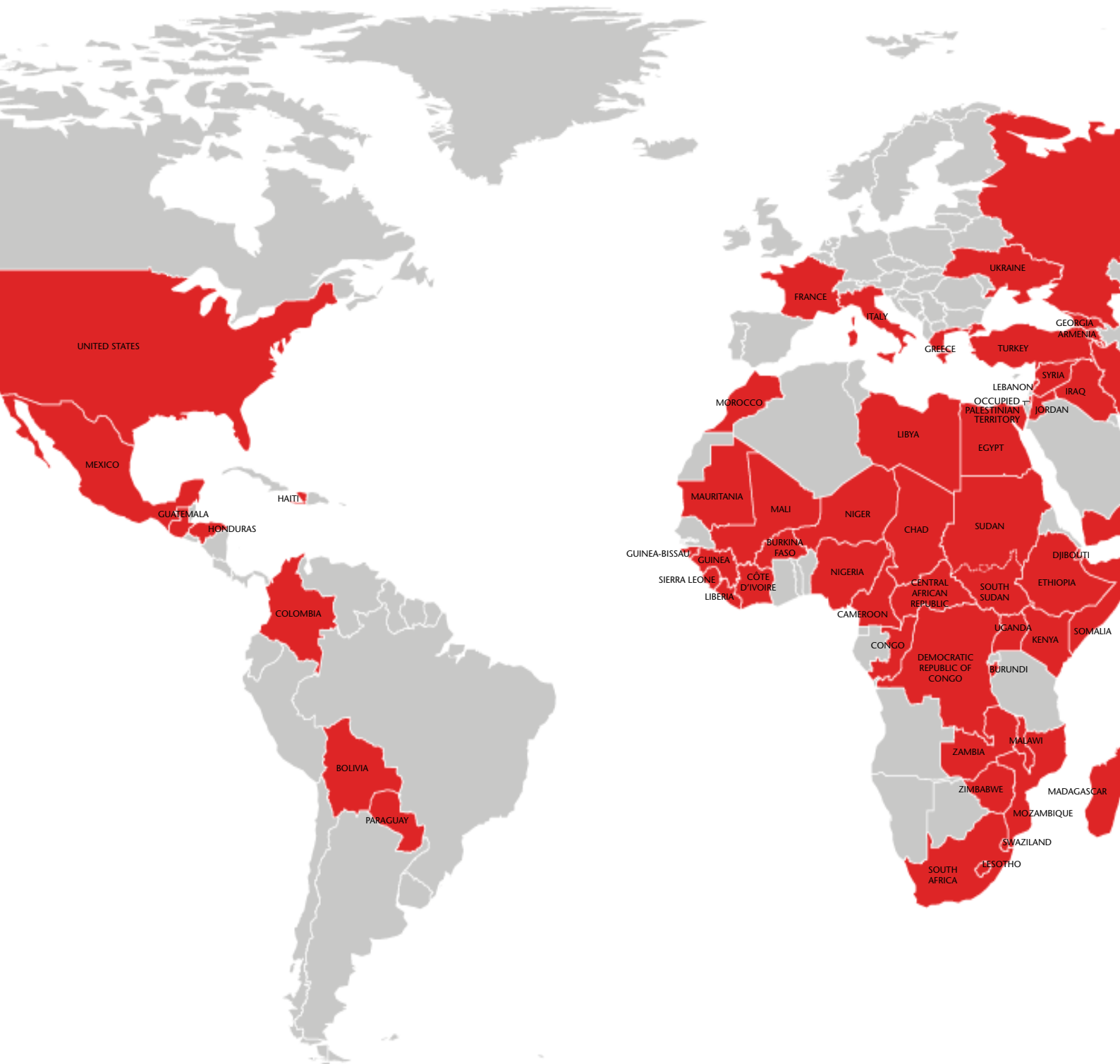


18 Finding refuge?



25 Activities by country

MSF PROGRAMMES AROUND THE WORLD





THE YEAR IN REVIEW

Dr Unni Karunakara, International President
Jérôme Oberreit, Secretary General

At the end of 2012 our colleagues Montserrat Serra and Blanca Thiebaut were still being held hostage after their abduction from a refugee camp in Dadaab, Kenya on 13 October 2011. This is one of the longest-running kidnappings in the history of Médecins Sans Frontières (MSF).

Insecurity has had a significant impact on our activities this year, and many teams continued to work in unpredictable and

unstable situations. Seven MSF staff were detained in Myanmar in June, and two of them remain in detention. Two members of staff were kidnapped in North Kivu, in the Democratic Republic of Congo (DRC) in April. Several hours later, they were released unharmed. Armed men entered Huth health centre, in Yemen, and threatened MSF staff. Daynile hospital, on the outskirts of Mogadishu, Somalia, was damaged by shellfire. We have not always been able to respond to people's needs as we intended.

Challenges to delivering healthcare in conflict zones

In Syria, conflict intensified. Extreme violence, the collapse of the health

infrastructure and the displacement of millions of people led to massive needs, but MSF has been frustrated at serious blockages to providing care. According to authorities, by early 2013, 57 per cent of public hospitals in Syria had been damaged, but lack of authorisation from the government, limited cross-border access and the severe constraints caused by insecurity have all restricted the provision of humanitarian assistance. Beginning with donations of drugs and medical supplies, our teams managed to expand activities over the year, setting up hospitals in Aleppo and Idlib governorates. But we have been forced to limit operations to opposition-controlled



A man is examined by an anaesthetist at the MSF clinic in northern Syria before undergoing surgery to remove a bullet lodged in his abdomen.

© Nicole Tung



This nine-year-old boy's legs were injured when a grenade exploded in his house. He received surgery at Virunga hospital in Goma, the Democratic Republic of Congo.

areas of the country and neighbouring countries. We are concerned about what the constraints on humanitarian assistance will mean for the people of Syria in the future.

In eastern DRC, MSF continued working in hospitals, health centres and clinics across North and South Kivu, Orientale and Katanga provinces, despite escalating violence. In this country where health needs are extreme even where the context is stable, our programmes include basic as well as specialist medical services, mental healthcare and assistance to victims of sexual violence. We carried out 1.6 million outpatient consultations, adapting activities as people were forced to move in search of safety.

Conflict in northern Mali and the warring parties' restrictions on movement made it very difficult for people to get to health facilities. In an effort to improve access to treatment, MSF supported hospitals and health centres in remote locations as well as urban areas such as the city of Timbuktu.

In March, MSF opened a maternity hospital in Khost, Afghanistan, a province that borders Pakistan and the highly volatile tribal areas. Some 100 births were being assisted per week, but then in April the hospital was targeted in a bomb attack, and seven people were wounded. We suspended activities.

Several months of talks and assurances of support resulted in the reopening of the hospital at the end of the year (see pages 16–17 for more on healthcare in Afghanistan).

Attacks on health workers and health facilities and the lack of respect for medical action are having consequences that reach far beyond the direct victims. At MSF, we are collecting data on these attacks in order to assess their impact. This analysis will increase awareness of the need to respect medical activity and, it is hoped, help us to develop effective responses.

Inadequate response to the needs of the displaced

In 2012, MSF saw huge growth in the need for support for people forced to leave their homes. Unfortunately, we also saw a slow and piecemeal response to that need. The crises of the past year have revealed that we must get the balance of assistance right: between the delivery of humanitarian relief and more specialised medical services.

Fighting in Sudan led to a serious refugee crisis in South Sudan, with 170,000 people fleeing across the border. MSF set up field hospitals, clinics and feeding centres, carrying out more than 8,000 consultations each week. But the impact of healthcare is limited in the absence of essentials such as water, food and

shelter, and in view of the needs and lack of broader response we realise that we should have done more to meet basic needs.

Syrians who had fled to neighbouring countries also lacked access to the basics. As winter approached, refugees were still in shelters without heating. Fuel was hard to obtain. Half the refugees in Lebanon were not receiving the healthcare they needed. MSF ran assistance programmes in Lebanon, Turkey, Jordan and Iraq, but had grave concerns about the conditions for the 2.5 million people estimated to be displaced within Syria, to whom access was restricted.

Even in Dadaab, Kenya, where the refugee population is the size of a big city and there are adults who have lived their entire lives in the camps, agencies and organisations have not been able to adapt to a rapidly changing situation, and this has consequences for morbidity and mortality rates. We have taken lessons from the challenges of this year, as we do from every new setting in which we work, to improve our response. (See pages 18–21 for more on refugee response.)

Flooding affects hundreds of thousands worldwide

Typhoons in the Philippines caused flooding on several different occasions over the year, and MSF delivered emergency assistance,

supplying relief items and providing medical care. Similar activities were carried out when major flooding hit northern Cameroon and eastern Nigeria. Teams set up mobile clinics, built latrines and provided safe drinking water when the Pakistani province of Balochistan and southeastern parts of Sudan were severely flooded.

Improving how we deliver care

We need to constantly consider whether our care results in the best outcomes for people, whatever the setting.

Take maternal health: most maternal deaths occur just before, during or after delivery, and are caused by complications that often cannot be predicted. But skilled birth attendants can prevent some 80 per cent of maternal deaths. High-quality emergency obstetric services, postnatal services and aftercare for unsafe abortions are all critical to bringing down maternal mortality. Concerned at the lack of recognition of the importance of such services, MSF has engaged more in the provision of emergency obstetric care. Our teams assisted some 185,000 births in 2012, and around one in ten of these were by caesarean section.

Our approach to HIV is changing too. In KwaZulu-Natal, South Africa, we are focusing on getting more people tested,

initiating treatment earlier and making sure patients can access treatment and care close to home. The aim of models such as the decentralisation of treatment and care (including diagnostics) is to maximise the impact on patients' health, as well as reduce the spread of the virus, since treatment significantly lowers the risk of transmission. Our team in Swaziland is improving lab facilities and capacity in local clinics in preparation for the implementation of a similar 'test and treat' approach, but there are many more challenges for us to address. Paediatric HIV, co-infection with other diseases, opportunistic infections, the abandonment of people with HIV in places where prevalence is considered 'not so high': these issues are invisible in wealthy countries, but require urgent attention in the places where we work.

Despite progress in reducing mortality from malaria, 660,000 people still die from the disease every year, most of them African children. In Koutiala, Mali, and Moissala, Chad, areas where the disease is hyperendemic, MSF introduced chemoprevention during the peak malaria season. Teams systematically administered antimalarial treatment to children between three months and five years of age. The number of simple malaria cases treated in the following weeks fell sharply: by 66 per cent in Koutiala and 78 per cent in Moissala.

This is a positive step, but the lethal impact of malaria means that it must remain a priority. Strains of malaria that are resistant to current medication are already a concern in southeast Asia, and there are to date no real alternative treatment options. MSF is looking at how new programmes can tackle drug-resistant malaria.

Drug-resistant tuberculosis: a health emergency

Drug resistance has already reached crisis point for tuberculosis (TB). Data on the prevalence of drug-resistant TB (DR-TB) have shocked doctors tackling the disease: in Uzbekistan, 65 per cent of MSF's TB patients were found to have DR-TB. But since only a minority of patients have access to testing for resistance, this is just the tip of the iceberg. The introduction of a test that can detect resistance has nearly quadrupled diagnoses of DR-TB in just one MSF programme in Zimbabwe.

For the 20 per cent of people with DR-TB who have access to treatment, what follows is two gruelling years of taking pills and injections, with severe side effects. Treatment is so harsh that some choose to stop, accepting what they know will be a death sentence.

This is an emergency. Hundreds of thousands of people urgently need better



A Syrian refugee cradles her baby in a room in a ramshackle home on a cattle ground in Tripoli, Lebanon.

© Michael Goldfarb



© Ron Haviv/VII

A 16-year-old girl who has MDR-TB undergoes treatment at home in Tajikistan. Her treatment involves taking up to 20 pills a day.

diagnostics. They need treatment regimens that are effective, take less time and are not toxic (see pages 22–24 for more).

Not-so-routine vaccination

The 'Decade of Vaccines' – a collaboration including the WHO, UNICEF and private foundations – was launched in 2010, but two years later the number of children who have not received the basic package of immunisations has actually grown, from 19 to 22.4 million. Large sums are being invested in vaccines, yet the impact is not obvious. Hundreds of thousands of children are still dying from preventable diseases every year.

Children living where roads are poor, where there is no electricity or where there is insecurity, are all at risk of missing out on immunisation. This is because most vaccines must be kept refrigerated from production to administration, need more than one dose, and require a skilled health worker to administer those doses. These constraints make it very difficult to reach remote populations.

Vaccine funding must be invested in making vaccine programmes work: in developing new technologies and simpler tools, adapting delivery and cutting costs.

Ultimately, our objective is, as always, to enable access to medical attention to everyone who needs it, no matter who or where they are.

Our frustrations with the limitations of the medicines and tools available, and the limitations of access and response, do not stop us. Thanks to the ongoing support of millions of people around the world, our independence and impartiality have allowed us to bring important assistance to people in crisis. We continue to strive to improve that assistance.

Thank you.

OVERVIEW OF ACTIVITIES

Largest country programmes based on project expenditure

1. Democratic Republic of Congo	6. Kenya
2. South Sudan	7. Sudan
3. Haiti	8. Chad
4. Niger	9. Ethiopia
5. Somalia	10. Zimbabwe

The total budget for our programmes in these 10 countries is 324 million euros, **52 per cent** of MSF's operational budget.

Staff numbers

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

1. Democratic Republic of Congo	2,782
2. Haiti	2,582
3. South Sudan	2,415
4. Somalia	1,990
5. Niger	1,593

Outpatient consultations

Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.

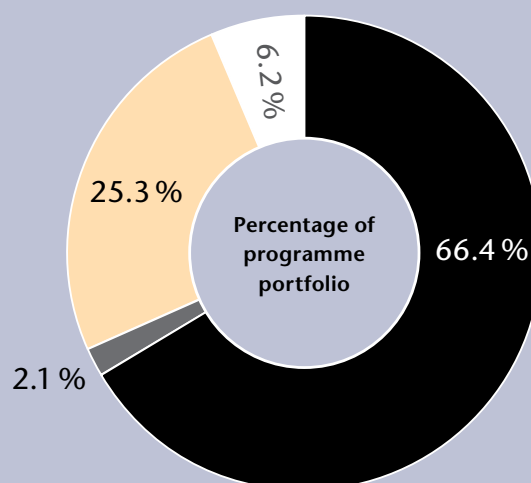
1. Democratic Republic of Congo	1,674,000
2. Niger	878,000
3. South Sudan	869,300
4. Somalia	624,200
5. Central African Republic	590,400
6. Myanmar	406,800
7. Kenya	335,900
8. Afghanistan	332,300
9. Pakistan	298,000
10. Guinea	210,200

Programme locations

Number of programmes

■ Africa	247
■ Europe	8
■ Asia*	94
■ Americas	23

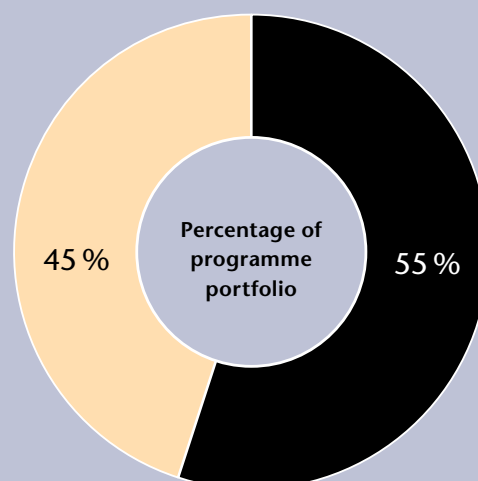
* Asia includes the Middle East and the Caucasus



Context of intervention

Number of programmes

■ Unstable	205
■ Stable	167



2012 ACTIVITY HIGHLIGHTS

- **8,316,000**
Outpatient
Number of outpatient consultations
- **472,900**
Inpatient
Number of admitted patients
- **1,642,800**
Malaria
Total number of cases treated
- **276,300**
Therapeutic feeding
Number of severely malnourished children admitted to inpatient or outpatient feeding programmes
- **71,500**
Supplementary feeding
Number of moderately malnourished children admitted to supplementary feeding centres
- **310,500**
HIV
Number of HIV patients registered under care at end 2012
- **279,600**
Antiretroviral treatment (first-line)
Number of patients on first-line antiretroviral treatment at end 2012
- **4,670**
Antiretroviral treatment (second-line)
Number of patients on second-line antiretroviral treatment at end 2012 (first-line treatment failure)
- **13,100**
PMTCT – mother
Number of HIV-positive pregnant women who received prevention of mother-to-child transmission (PMTCT) treatment
- **11,900**
PMTCT – baby
Number of eligible babies born in 2012 who received post-exposure treatment
- **185,400**
Births
Number of women who delivered babies, including caesarean sections
- **78,500**
Surgical procedures
Number of major surgical procedures, including obstetric surgery, under general or spinal anaesthesia
- **36,400**
Violent trauma
Number of medical and surgical interventions in response to direct violence
- **10,600**
Sexual violence
Number of patients medically treated for sexual violence
- **29,000**
Tuberculosis (first-line)
Number of new admissions to tuberculosis first-line treatment
- **1,780**
Tuberculosis (second-line)
Number of new admissions to tuberculosis second-line treatment
- **169,600**
Mental health (individual)
Number of individual mental health consultations
- **21,700**
Mental health (group)
Number of group counselling or mental health sessions
- **57,400**
Cholera
Number of people admitted to cholera treatment centres or treated with oral rehydration solution
- **690,700**
Measles vaccinations
Number of people vaccinated against measles in response to an outbreak
- **26,200**
Measles treatment
Number of people treated for measles
- **496,000**
Meningitis vaccinations
Number of people vaccinated against meningitis in response to an outbreak
- **3,430**
Meningitis treatment
Total number of people treated for meningitis

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

GLOSSARY OF DISEASES AND ACTIVITIES

Chagas disease

Chagas disease is found almost exclusively in Latin America, although increased global travel and migration have led to more cases being reported in North America, Europe, Australia and Japan. Chagas is a parasitic disease transmitted by triatomine bugs, which live in cracks in the walls and roofs of mud and straw housing. It can also be transmitted through blood transfusions or to the foetus during pregnancy and, less frequently, through organ transplants. A person with Chagas often feels no symptoms in the first, acute stage of the disease. Then the chronic stage is asymptomatic for years. Ultimately, however, debilitating complications develop in approximately 30 per cent of people infected, shortening life expectancy by an average of 10 years. Heart failure is the most common cause of death for adults.

Diagnosis is complicated, requiring laboratory analysis of blood samples. There are currently only two medicines available to treat the disease: benznidazole and nifurtimox, which were both developed over 40 years ago. The cure rate is almost 100 per cent in newborns and infants, but as the gap between the date of infection and the beginning of treatment lengthens, the cure rate declines.

The treatment currently used can be toxic and can take longer than two months to complete. Despite the clear need for more efficient and safer medication, there are few new drugs in development.

MSF admitted 1,440 new patients to Chagas treatment programmes in 2012.

Cholera

Cholera is a water-borne, acute gastrointestinal infection caused by the *Vibrio cholerae* bacterium. It is transmitted by contaminated water or food, or direct

contact with contaminated faeces. In non-endemic areas, large outbreaks can occur suddenly and the infection can spread rapidly. Most people will suffer only a mild infection, but the illness can be very severe, causing profuse watery diarrhoea and vomiting that can lead to severe dehydration and death. Treatment consists of a rehydration solution – administered orally or intravenously – which replaces fluids and salts. Cholera is most common in densely populated settings where sanitation is poor and water supplies are not safe.

As soon as an outbreak is suspected, patients are treated in centres where infection control precautions are taken to avoid further transmission of the disease. Strict hygiene practices must be implemented and large quantities of safe water must be available.

This year, MSF has for the first time successfully used oral cholera vaccines in the context of an outbreak, in addition to the usual outbreak response measures.

MSF treated 57,400 people for cholera in 2012.

Health promotion

Health promotion activities aim to improve health and encourage the effective use of health services. Health promotion is a two-way process: understanding the culture and practices of a community is as important as providing information.

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

HIV/AIDS

The human immunodeficiency virus (HIV) is transmitted through blood and body fluids and gradually breaks down the immune system – usually over a three- to ten-year period – leading to acquired immunodeficiency syndrome, or AIDS. As the virus progresses, people begin to suffer from opportunistic infections. The most common opportunistic infection that leads to death is tuberculosis.

A simple blood test can confirm HIV status, but many people live for years without symptoms and may not know they have been infected with HIV. Combinations of drugs known as antiretrovirals (ARVs) help combat the virus and enable people to live longer, healthier lives without their immune systems deteriorating rapidly. ARVs also significantly reduce the likelihood of the virus being transmitted.

As well as treatment, MSF's comprehensive HIV/AIDS programmes generally include education and awareness activities, condom distribution, HIV testing, counselling and prevention of mother-to-child transmission (PMTCT) services. PMTCT involves the administration of ARV treatment to the mother during pregnancy, labour and breastfeeding, and to the infant just after birth.

MSF provided care for 310,500 people living with HIV/AIDS and antiretroviral treatment for 284,300 people in 2012.

Kala azar (visceral leishmaniasis)

Largely unknown in the developed world, kala azar – Hindi for 'black fever' – is a tropical, parasitic disease transmitted through bites from certain types of sandfly. It is endemic in 76 countries, and of the estimated 200,000–400,000 annual cases, 90 per cent occur in Bangladesh, India, Ethiopia, South Sudan, Sudan and Brazil. Kala azar is characterised by fever, weight loss, enlargement of the liver and spleen, anaemia



© Lynsey Addario/VII

This baby has just been delivered by caesarean section at the Gondama referral centre, Sierra Leone.

and immune-system deficiencies. Without treatment, kala azar is almost always fatal.

In Asia, rapid diagnostic tests can be used for diagnosis of the disease. However, these tests are not sensitive enough for use in Africa, where diagnosis often requires microscopic examination of samples taken from the spleen, bone marrow or lymph nodes. These are invasive procedures requiring resources that are not readily available in developing countries.

Treatment options for kala azar have evolved during recent years. Liposomal amphotericin B is becoming the primary treatment in Asia, either alone or as part of a combination therapy. This is safer and involves a shorter course of treatment than previously used medication. However, it requires intravenous administration, which remains an obstacle to its use in local clinics. In Africa, the best available treatment is a combination of pentavalent antimonials and paromomycin, which requires a number of painful injections.

Co-infection of kala azar and HIV is a major challenge, as the diseases influence each other in a vicious spiral as they attack and weaken the immune system.

MSF registered 5,860 new patients for kala azar treatment in 2012.

Malaria

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

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

In 2012, MSF also used a seasonal chemoprevention strategy for the first time, in Chad and Mali. Children up to five years of age took oral antimalarial treatment monthly during the peak season for the disease.

MSF treated 1,642,800 people for malaria in 2012.

Malnutrition

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

Malnutrition in children can be diagnosed in two ways: it can be calculated from measurements of weight and height, or by measurement of the mid-upper arm circumference. According to these measurements, undernourished children are diagnosed with moderate or severe acute malnutrition.

MSF uses ready-to-use food (RUF) to treat malnutrition. RUF contains fortified milk powder and delivers all the nutrients that a malnourished child needs to reverse deficiencies and gain weight. With a long shelf-life and requiring no preparation, these nutritional products can be used in all kinds of settings and allow patients to be treated at home, unless they are suffering severe complications.

continued overleaf ►

continued **Glossary of diseases and activities** ➤

In situations where malnutrition is likely to become severe, MSF takes a preventive approach, distributing nutritional supplements to at-risk children to prevent their condition from deteriorating further.

MSF admitted 276,300 malnourished patients to nutrition programmes in 2012.

Measles

Measles is a highly contagious viral disease. Symptoms appear between 10 and 14 days after exposure to the virus and include a runny nose, cough, eye infection, rash and high fever. There is no specific treatment for measles – patients are isolated and treated with vitamin A, and for any complications: these can include eye-related problems, stomatitis (a viral mouth infection), dehydration, protein deficiencies and respiratory tract infections.

While most people infected with measles recover within two to three weeks, between 5 and 20 per cent die, usually due to complications such as diarrhoea, dehydration, encephalitis (inflammation of the brain) or severe respiratory infection.

A safe and cost-effective vaccine against measles exists, and large-scale vaccination campaigns have significantly decreased the number of cases and deaths. However, coverage remains low in countries with weak health systems and in areas where there is limited access to health services, leaving large numbers of people susceptible to the disease.

MSF treated 26,200 patients for measles and vaccinated more than 690,700 people against the disease in 2012.

Meningococcal meningitis

Meningococcal meningitis is an infection of the thin membranes surrounding the brain and spinal cord. It can cause sudden and intense headaches, fever, nausea, vomiting, sensitivity to light and stiffness of the neck. Death can follow within hours of the onset of symptoms. Up to 50 per cent of people infected will die without treatment.

Six strains of the bacterium *Neisseria meningitidis* (A, B, C, W135, X and Y) are known to cause meningitis. People can be infected without showing symptoms and transmit the bacteria when they cough or sneeze. Suspected cases are diagnosed through the examination of a sample of spinal fluid and treatment consists of

specific antibiotics. However, even with treatment, 5 to 10 per cent of patients will die and as many as one in five survivors may suffer from after effects, including hearing loss and learning disabilities.

Meningitis occurs throughout the world, but the majority of infections and deaths are in Africa, particularly across the 'meningitis belt', an east-west geographical strip from Ethiopia to Senegal, where epidemics are most likely to be caused by meningitis A. A new vaccine against this strain provides protection for 10 years and even prevents healthy carriers from transmitting the infection. Large preventive vaccination campaigns have now been carried out in Benin, Burkina Faso, Cameroon, Chad, Ghana, Mali, Niger, Nigeria, Senegal and Sudan.

MSF treated 3,430 patients for meningitis and vaccinated 496,000 people against the disease in 2012.

Mental healthcare

Traumatising events – suffering or witnessing violence, the death of loved ones or the destruction of livelihoods – are likely to affect a person's mental wellbeing. MSF provides psychosocial support to victims of trauma in an effort to reduce the likelihood of long-term psychological problems.

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

MSF staff held 191,300 individual and group counselling sessions in 2012.

Relief items distribution

MSF's primary focus is on providing medical care, but in an emergency teams often distribute relief items that contribute to psychological and physical survival. Such items include clothing, blankets, bedding, shelter, cleaning materials, cooking utensils and fuel. In many emergencies, relief items are distributed as kits – cooking kits contain a stove, pots, plates, cups, cutlery and a water container so that people can prepare meals, while a washing kit includes soap, shampoo, toothbrushes, toothpaste and laundry soap.

Where people are without shelter, and materials are not locally available, MSF distributes emergency supplies – rope and plastic sheeting or tents – with the aim of ensuring a roof, and some level of security and protection. In cold climates more substantial tents are provided, or teams try to find more permanent structures.

MSF distributed 61,000 relief kits in 2012.

Reproductive healthcare

Comprehensive neonatal and obstetric care form part of MSF's response to any emergency. Medical staff assist births and perform caesarean sections where necessary, and sick newborns and babies with a low birth weight receive medical care.

Many of MSF's longer-term programmes offer more extensive maternal healthcare. Several antenatal visits are recommended so that medical needs during pregnancy are met and potentially complicated deliveries can be identified. After delivery, postnatal care includes counselling on family planning and information and education on sexually transmitted infections.

Good antenatal and obstetric care can prevent obstetric fistulas. Obstetric fistulas are injuries to the birth canal, and are most often a result of prolonged, obstructed labour. They cause incontinence, which can lead to social stigma. Around two million women are estimated to have untreated obstetric fistulas; there are between 50,000 and 100,000 new cases each year. A number of MSF programmes carry out specialist obstetric fistula repair surgery.

MSF held more than 784,500 antenatal consultations in 2012.

Sexual violence

MSF offers patients who have suffered sexual violence medical care, treatment to prevent the development of sexually transmitted infections, emergency contraception if needed, and psychological, social and legal support. In settings where the rate of sexual violence is high, such as in conflict zones and refugee or displaced persons camps, dedicated teams provide assistance. Staff also work with the community to raise awareness, provide information about the care that MSF provides and offer social and legal support.

MSF treated more than 10,600 patients for sexual violence-related injuries in 2012.

Sleeping sickness (human African trypanosomiasis)

Generally known as sleeping sickness, human African trypanosomiasis is a parasitic infection transmitted by tsetse flies that occurs in sub-Saharan Africa. It attacks the central nervous system, causing severe neurological disorders or even death. More than 95 per cent of reported cases are caused by the parasite *Trypanosoma brucei gambiense*, which is found in western and central Africa. The other 5 per cent of cases are caused by *Trypanosoma brucei rhodesiense*, which is found in eastern and southern Africa.

During the first stage, the disease is relatively easy to treat but difficult to diagnose, as symptoms such as fever and weakness are non-specific. The second stage begins when the parasite invades the central nervous system and the infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, convulsions and sleep disturbance. At this stage, accurate diagnosis of the illness requires a sample of spinal fluid.

Nifurtimox-eflornithine combination therapy, or NECT, is now the World Health Organization recommended protocol. NECT is much safer than melarsoprol, the drug that was previously used to treat the disease, and which is a derivative of arsenic. Melarsoprol causes many side effects and can even kill the patient. It is hoped that the new molecules currently under clinical trial will lead to the development of a safe, effective treatment for both stages of the disease that can be administered orally.

MSF admitted 2,000 new patients for sleeping sickness treatment in 2012.

Tuberculosis

One-third of the world's population is currently infected with the tuberculosis (TB) bacillus. Every year, about nine million people develop active TB and 1.5 million die from it.

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

Diagnosis of TB depends on a phlegm sample, which can be difficult to obtain from children. A new molecular test that can give results after just two hours and detect a certain level



Blood samples at the MSF lab at Anka hospital, Nigeria.

of drug resistance is now being used, but it is costly and still requires a phlegm sample, as well as a reliable power supply.

A course of treatment for uncomplicated TB takes a minimum of six months. When patients are resistant to the two most powerful first-line antibiotics, they are considered to have multidrug-resistant TB (MDR-TB). MDR-TB is not impossible to treat, but the drug regimen is arduous, taking up to two years and causing many side effects. Extensively drug-resistant tuberculosis (XDR-TB) is identified when patients show resistance to the second-line drugs administered for MDR-TB. The treatment options for XDR-TB are limited.

MSF treated 29,000 patients for TB and 1,780 for MDR-TB in 2012.

Vaccinations

Immunisation is one of the most cost-effective medical interventions in public health. However, it is estimated that approximately two million people die every year from diseases that are preventable by a series of vaccines recommended for children by the World Health Organization. Currently, these are DTP (diphtheria, tetanus, pertussis), hepatitis B, *Haemophilus influenzae* type b (Hib), BCG (against tuberculosis), human papillomavirus, measles, pneumococcal conjugate, polio, rotavirus, rubella and yellow fever – although not all vaccines are recommended everywhere.

In countries where vaccination coverage is generally low, MSF strives to offer routine vaccinations for all children under five as part of its basic healthcare programme.

Vaccination also forms a key part of MSF's response to outbreaks of measles, yellow fever and meningitis. Large-scale vaccination campaigns involve awareness-raising activities regarding the benefits of immunisation as well as the set-up of vaccination posts in places where a community is likely to gather. A typical campaign lasts between two and three weeks and can reach hundreds of thousands of people.

Water and sanitation

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

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

MSF distributed more than 197,000,000 litres of safe water in 2012.

ADAPTATION AND INNOVATION: KEYWORDS FOR MSF'S MEDICAL ACTION

Dr Marc Gastellu Etchegorry took up the position of International Medical Secretary at Médecins Sans Frontières (MSF) in September 2012. He shares his views on the current challenges to MSF's humanitarian medical action.

The objective of MSF's medical teams is to bring emergency aid to people affected by armed conflict, epidemics, healthcare exclusion and man-made or natural disasters. Delivering healthcare in such contexts is often a challenge and requires adaptation and innovation.

Making choices in conflict situations

In armed conflict, the situation is never static: as it evolves, front lines move, entire populations are displaced, medical teams and infrastructures shift. If we are to make a useful assessment of medical needs and priorities, these transformations must all be taken into account – and when possible, anticipated.

The difficulties of providing medical assistance are particularly acute when medical teams are harassed by armed authorities or groups that deny assistance to anyone they consider to be an enemy, as well as to the people they believe would help the 'enemy' – including women, children and the sick and injured.

In a context like Syria today, where humanitarian assistance and humanitarian workers are targeted by fighters, and where the risks of deploying staff are high, medical activities cannot always be fully implemented; action must be hidden and minimal, and it is a challenge to maintain the quality of medical care. Because of the risks to patients and medical teams, our work is mainly oriented towards lifesaving acts such as war surgery and acute medical emergencies.

But war injuries are not the sole medical emergencies during conflict. When a health system collapses, many diseases and

medical conditions do not get treated or prevented; maternal health programmes, immunisation and treatment for infectious as well as non-communicable diseases are all essential services that save lives (even if not immediately). However, their implementation requires different resources, equipment, tools, skills and networks.

Making choices is an essential part of adaptation. We must choose our activities so that we cover vital needs, take into account operational and medical constraints, and keep in mind that the aim of our presence and our

action is to address gaps in access to health services, and show where there is deliberate willingness by armed forces to harass or deprive people of essential healthcare.

Camp settings: ensuring the basics are in place

Massive displacement of a population poses different challenges. People fleeing fighting or abuse take few belongings with them. They rapidly – if not immediately – become destitute and dependent on national or international assistance. As the delivery of



High blood pressure is a common condition among the patients at Timbuktu hospital, where MSF began working after conflict broke out in northern Mali.



A doctor accompanies a pregnant woman to the car that will take her to the MSF field hospital in Jamam refugee camp, South Sudan.

aid tends to be slow and insufficient, living conditions deteriorate, often very quickly. The absence or scarcity of essentials such as water, food or shelter leads to high rates of illness and death, which healthcare providers struggle to contain.

The benefit of healthcare is very limited if these basic needs are not met. Consider the crisis in South Sudan in 2012, when tens of thousands of Sudanese refugees arrived at makeshift camps with limited water supplies. In such cases, MSF must widen the scope of its activities, delivering safe water, providing shelter and blankets and preventing malnutrition. Once basic needs are met, medical care can resume its full value; programmes can be developed that meet more sophisticated medical needs and adapt to the health priorities of the population.

The thousands of people who fled recent conflicts in North Africa and the Middle East revealed new epidemiological profiles, with a particularly high prevalence of non-communicable diseases such as diabetes, hypertension and epilepsy. Before conflict, patients had access to sophisticated diagnosis and treatment through well-developed medical systems, but now these same patients are desperately seeking treatment.

Again, we must adapt our medical activities: to the resources available, to the main causes of illness and mortality, to a potential deterioration in living conditions and to potential increases in the number of refugees or displaced people. Continuous observation and assessment are essential, as such situations nearly always remain volatile. The immediate response to basic needs must be balanced with a longer-term approach to non-communicable diseases.

Healthcare where resources are scarce

In stable situations, adaptation may be slower, but it is no less necessary. Our medical teams regularly have to diagnose illnesses and treat patients with resources that are inadequate for the conditions in which they operate. Access to health services is restricted, resulting in late diagnosis and difficulties in follow-up. Poor transport often makes supplies unreliable. Electricity can be intermittent or non-existent. Skilled personnel are usually scarce.

In some domains, significant progress has been made. Today the treatment options for malaria are effective and diagnostic tests are easy to use in remote health posts (although we have to anticipate the development of drug-resistant strains of the disease). Elsewhere, progress is far from sufficient.

Tuberculosis, HIV, hepatitis, meningitis and the vast majority of non-communicable diseases are difficult to diagnose at the point of care and treatment regimens are often long and complex, with many side effects.

Innovation is crucial. Diagnostic tools that are easier to use, treatment regimens that are simpler and more effective, and new, less complex models of care are all indispensable if we are to improve the quality and relevance of our medical action.

Our technical knowledge and innovation must influence our programmes and our care, and so must epidemiological surveillance and study. Dynamic analysis and interpretation of the medical and political environments are also essential in order to adapt our projects to needs and ensure the relevance of our response.

MSF treats individuals, not diseases, and it is hard to define priorities beyond the patient. We do know that when healthcare is hard to reach, patients often visit medical facilities late and are unlikely to come back soon. We have learned that if we miss an opportunity for diagnosis and treatment, we may have lost the chance to cure someone. Access to quality health services is essential. To improve access, innovation and adaptation are crucial.

AFGHANS TRAPPED AS WAR RAGES ON

After over 10 years of military intervention in Afghanistan, the focus of the media is increasingly on the timeline of NATO troop withdrawal and transition. Lost in the headlines is the harsh reality for Afghans trapped in a war that is still raging.

The continuing insecurity in Afghanistan has many serious consequences for people's lives and livelihoods, not least the negative impact on the availability and accessibility of critical health services.

People are trapped, unable to access the healthcare they need. Many rural health clinics are dysfunctional. The number of public hospitals has increased, but many still do not operate well and are overburdened with patients. Qualified health staff have left insecure areas and there is an overall lack of highly trained personnel, in particular women doctors and nurses. Insecurity impedes the delivery of drugs and medical

supplies and prevents entire communities from travelling freely to reach secondary health facilities. There is a private health sector, but private clinics are too expensive for most people.

Health indicators in Afghanistan are among the worst in the world, and the breakdown of essential health services is bound to grow more pronounced the longer the conflict goes on.

Médecins Sans Frontières (MSF) first worked in Afghanistan in 1981, but withdrew in 2004, when five members of its team were killed. After an absence of five years, MSF returned to the country in mid-2009. Between 2009 and 2010,

it started supporting all services at a district hospital in the east of Kabul, and working in the provincial hospital in Lashkargah, Helmand. By the end of 2011, MSF had opened a private trauma centre in Kunduz, providing surgical care to victims of conflict as well as patients with injuries from other causes. A private maternity hospital was opened in Khost in early 2012.

Meeting health needs?

A major challenge facing MSF today is that our four programmes are offering secondary level surgical care in a setting where access to basic health services is missing. What is more, the four projects are all located in provincial capitals – where we have managed to negotiate our security with all parties – when we know that there are also pressing needs outside the main cities and the walls of our hospitals, in rural areas where the war is very present.



© Camille Cillardéau

As well as surgery and other specialist services, MSF staff at Boost hospital, Lashkargah, run a nutrition programme for children.



MSF staff meet to prepare for the reopening of the maternity hospital in Khost, which was closed after an explosion inside the hospital.

However, we have to make choices on where we can work. Being impartial means that we base these choices on the needs of the patients – a principle that is enshrined in both international humanitarian law and medical ethics. Our choices follow independent needs assessments and are always driven by the imperative to provide good-quality healthcare free of charge for a population that has lived through 30 years of war. But they are also defined by our own resources, security constraints and access issues.

Strict neutrality must be observed in order for patients to trust that the care they receive is determined only by their medical needs, without any underlying political or military agenda.

Negotiating access

For MSF, the only way to work in conflict settings is through directly negotiated access with all armed groups and with the acceptance of the community: this is also achieved through the provision of quality healthcare and respect for culture and tradition.

All warring parties must agree not to interfere with the medical choices of MSF or with the patients MSF treats, and not to target health facilities. In return, MSF promises that its resources will be used for medical purposes only, and not to benefit the military effort of any warring party.

In Afghanistan, warring parties include the Afghan army and police, the American army, the British army in Helmand, the German army in Kunduz and various opposition groups such as the Taliban. It is crucial to ensure MSF interacts with all these armed groups in exactly the same way. MSF is able to do so because of its independence – especially its financial independence – which puts it in the position of being able to refuse money from any government and thereby ensure that its neutrality is accepted.

However, this pragmatic approach still has its limitations. One place that illustrates the difficulties of working in Afghanistan and the limits of negotiated access and community acceptance is Khost province.

Considered the homeland of the Haqqani network opposition group, and located at the border with the volatile Pakistani tribal areas, maternal and neonatal health indicators for Khost province are considered among the worst in the country. Qualified Afghan medical staff from other provinces are reluctant to work there and few international organisations are present.

In March 2012, MSF opened a maternity hospital in Khost. However, after six weeks, during which time 600 babies were delivered, a bomb exploded inside the hospital, injuring seven people.

Activities were suspended and extensive discussions and negotiations were reinitiated with all parties. Through this process, there was a strong demonstration of support for MSF as well as reassurances by the local community and all relevant parties that enabled the hospital to be reopened at the end of December, despite an increasingly complex security environment.

In spite of the reassurances of acceptance by the government, the opposition and the community, in such a fluid context zero risk is an illusion. The strengthening of our internal security measures, such as body search for all patients, caretakers and staff, has been a necessary step.

We still face difficult choices in terms of balancing the risks we run and the medical impact we can have. As long as the safety and security of patients, medical staff and facilities is maintained, MSF remains committed not only to continuing but also to expanding its activities in Afghanistan, in order to meet the increasing medical humanitarian needs in an uncertain future.

In 2012, MSF carried out more than 332,000 consultations, assisted 16,500 births and conducted 7,200 surgical procedures at its programmes in Kabul, Khost, Kunduz and Helmand, Afghanistan (see pages 26–27).

FINDING REFUGE?

Millions of people fled their homes in 2012. The contexts differed – people escaping violence or natural disaster, gathering in makeshift camps, disused buildings, in the desert, the bush or the city – but most have had one thing in common. The assistance they received was minimal.

Even worse, in all too many cases, the response has been conditional. People who have fled their homes empty-handed have had to wait for formal registration as refugees before receiving aid, and this can take time.

Displacement seems to force the acceptance of inhuman, degrading conditions, in which survival is all people can hope for. Shortages of water, shelter, food and healthcare are commonplace, and it is not standard practice to adapt assistance to changing contexts and changing needs.

In 2012, MSF teams provided humanitarian medical assistance to refugees and displaced people in more than 30 countries. They set up hospitals, health centres, mobile clinics, nutrition programmes, safe water distribution and sanitation systems. At times, our assistance was not adapted to needs; frequently, it was limited by external constraints; and in all cases it was able to meet only a fraction of the total need. (For more on MSF's response to refugees and the displaced see the individual country reports, pages 26–94.)

As well as increased risk of disease, restricted access to clean water means that refugees do not have the dignity of bathing in privacy (camp near Sittwe, Rakhine state, Myanmar).



Many refugee camps are in places where even the fittest would struggle to survive. Yet people who arrive empty-handed, exhausted and under extreme stress, are obliged to do what they can with a bare minimum of assistance, or nothing at all. Assistance often arrives late and poorly adapted to needs. Extreme overcrowding at the refugee camps in Dadaab, Kenya, has meant that thousands of new arrivals from Somalia have had to set up makeshift shelters.



© Lynsey Addario/VII



© Michael Goldfarb

Syrian man

Deir Zenoun camp, Lebanon

"The sanitary conditions in the camp are very bad. We have no sewage system so we dig ditches. When it rains, the sewage runs between the tents. It can come inside or get very close to where people are living. The smell is affecting us. The children have rashes on their skin and they feel nauseous. When it rains, the tents are flooded. There are no stoves for heat, and most people don't have any wood, so they burn plastic to warm themselves. The situation is extremely dire."

Temporary, emergency solutions must be revisited when it proves impossible to return home soon. Public structures used as shelters must be modified for their new purpose, and preparations made for seasonal changes. For Syrian refugees facing a harsh winter in 2012, however, there was little to protect them from the cold. These two boys are tending a fire in their new home in Lebanon. A family of 20 rent two rooms on a cattle ground. Water must be drawn from a nearby well.

Both the quantity and quality of water are a problem in many camps. It is mainly women and children who fetch water, and they are often expected to travel long distances to deserted sites and then carry back huge containers. These Malian refugees are collecting water at a point set up at Mbera camp in Mauritania.

© Lynsey Addario / VII



© Florian Lens

Sudanese woman

El Fuj, South Sudan

"When we arrived in El Fuj [border crossing-point between Sudan and South Sudan], we stayed there for one week. We were very tired from walking and not eating. We were given a little bit of food and then came here 12 days ago. We have not been given anything here. We have no plastic sheeting, no food. We are eating leaves from the trees, but it is not enough. People are getting sick. There is not enough water. There was a food distribution today, but we have not received anything. I have seven children and no food to give them."

Refugees are often hungry when they arrive, if not malnourished. But food supplies have been inadequate in places supposed to offer safety. MSF surveys in Batil camp, South Sudan, found child mortality rates in July to be double the emergency threshold, with more than 10 per cent suffering from severe malnutrition. These children are receiving therapeutic food at MSF's nutrition programme in Doro camp, South Sudan.

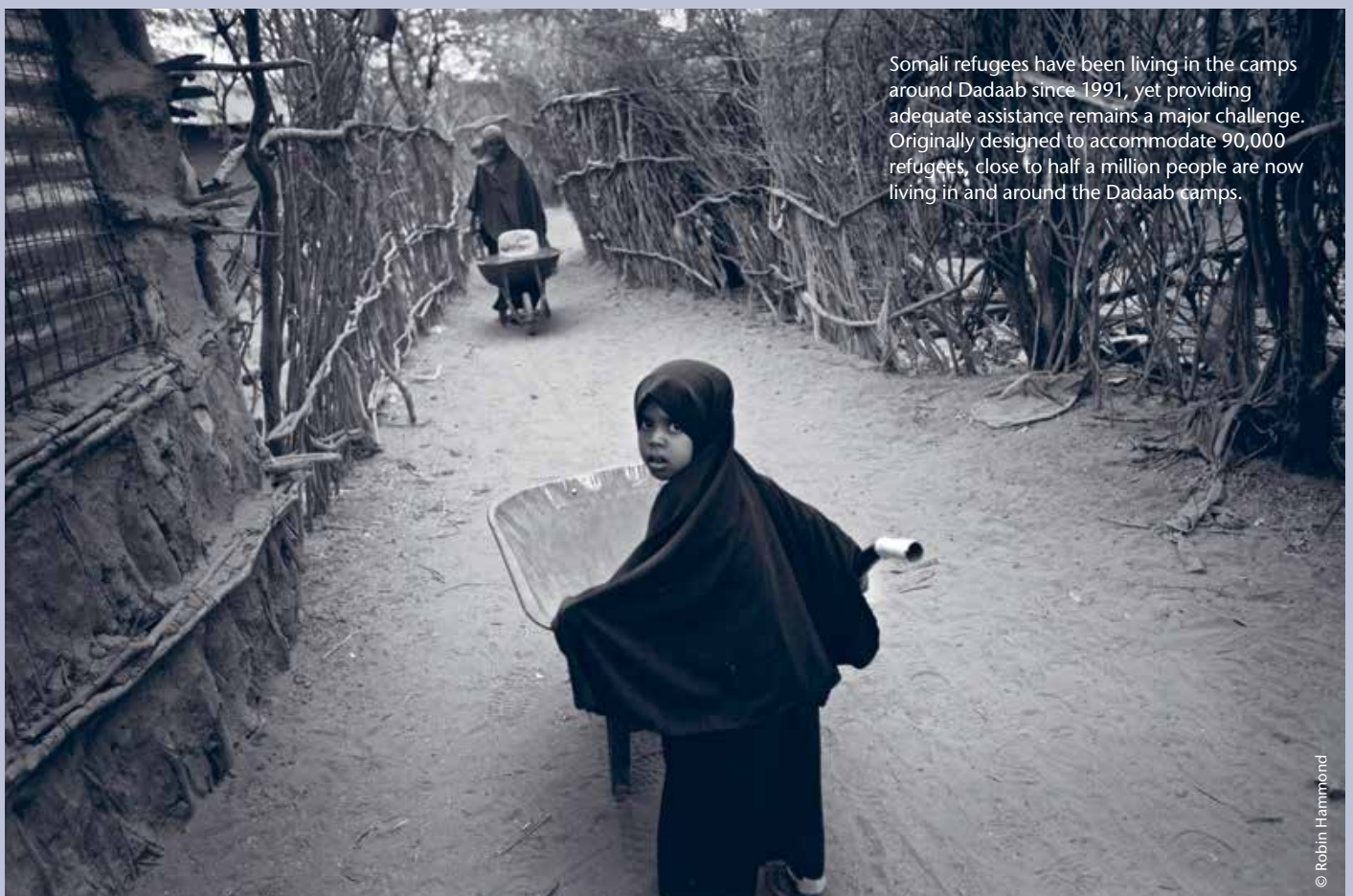


This patient is receiving care at MSF's field hospital in Yida camp, South Sudan, having been found unconscious in the bush outside the camp.

© Camille Lepage

Without adequate water, sanitation, shelter or food, diarrhoea, respiratory infections, skin diseases and malnutrition become more common and there is a heightened risk of epidemics. Healthy people become far more vulnerable to disease, while the young, old and injured need special assistance.

Medical services in refugee camps tend to focus on immediate emergencies like these, but if other conditions, including those requiring secondary or tertiary care, or chronic diseases like diabetes or hypertension, are not treated, they can become life-threatening.



Somali refugees have been living in the camps around Dadaab since 1991, yet providing adequate assistance remains a major challenge. Originally designed to accommodate 90,000 refugees, close to half a million people are now living in and around the Dadaab camps.

© Robin Hammond

A swift and comprehensive approach is vital if displaced people are to receive the assistance they need. Water, sanitation, shelter, food and medical services must all be available and of adequate quality. As MSF nurse Chiara Burzio said while working in Jamam camp, South Sudan: "There are solutions for all these problems. It's just that more needs to be done – fast."

'TEST ME, TREAT ME': THE BURDEN OF DRUG-RESISTANT TUBERCULOSIS AND THE PUSH FOR BETTER TREATMENT

Baby Shirinmo crawls busily across the waiting room of Dushanbe's paediatric tuberculosis (TB) hospital, in Tajikistan, but she breathes in gasps, with a rattling sound. Shirinmo is just nine months old and has been diagnosed with multidrug-resistant tuberculosis (MDR-TB).

"Shirinmo is not the youngest child we have seen with TB, but she is the youngest patient we have diagnosed with MDR-TB," says Dr Christoph Hoehn, who works for the Médecins Sans Frontières (MSF) TB programme in Tajikistan, where 30 children and adolescents are currently receiving treatment for MDR-TB.

Globally, our TB programmes are seeing alarming numbers of people arriving at the clinic with drug-resistant forms of the disease, including people who have not had TB before. This is grave cause for concern, as it means that the strains that are considerably tougher to treat – including MDR-TB and extensively drug-resistant TB (XDR-TB) – are being directly transmitted from person to person.

Improved diagnosis, but inadequate treatment

The ability to diagnose MDR-TB is improving. A new test called Xpert MTB/Rif has reduced the time it takes to detect drug-resistant forms of TB from two weeks to just two hours. This test is being rolled out across MSF programmes: 46 devices are now being used across 41 sites in 23 countries.

But what about treatment? Without it, MDR-TB kills, yet fewer than one in five people with the disease have access to care.

So few people are diagnosed and put on treatment that there is no lucrative market to entice multiple manufacturers to produce the drugs and ensure both a steady supply of medicines and the competition that will bring prices down. A full course of treatment costs at least US\$ 4,000 per person, and drug stockouts are not uncommon.

Crucially, the treatment regimen itself is a major barrier to scale-up. Patients must endure two years of up to 20 pills a day,

as well as eight months of daily painful injections. In total, a person will need to swallow nearly 15,000 pills before they finish their treatment.

Furthermore, the side effects are severe and incapacitating: often people feel constantly nauseous, suffer hallucinations, become depressed or psychotic, and can even go deaf. After all this, only 53 per cent of patients in MSF's care are cured. Globally, the figure is much the same – around 48 per cent. It is unacceptable that the treatment is so ineffective.

New hope

Some MSF centres – including one in Swaziland – are looking at implementing a new regimen in an attempt to make today's treatment less arduous for both patients and caregivers. It reduces treatment time to just nine months; but this is not enough. More needs to be done.

At the end of 2012, the US Food and Drug Administration approved a new drug called bedaquiline. This is a major milestone: it is the first new drug for TB to be approved in 50 years. Another drug will soon follow: delamanid, which is also active against resistant forms of TB, is expected to be approved in 2013.

For the first time in decades, there are a number of TB drugs in development. This brings an unprecedented opportunity – and responsibility – to improve and scale up MDR-TB care. MSF has committed resources to tackle the disease and find ways to overcome barriers to scale-up. But what exactly needs to be done? And what role can MSF play?

Research new treatment regimens

With two brand-new drugs to work with, there is an urgent need for research to develop treatment regimens that are



© George Butler

Illustrator George Butler visited MSF's MDR-TB project in Mumbai and drew a series of intimate drawings of the patients. Here, a 12-year-old girl and her mother, who both have MDR-TB, are talking to a doctor. The young girl had to drop out of school because of her illness, but after two months of treatment is now back in class.

shorter, less toxic and, most importantly, much more effective. MSF is advocating for drug manufacturers to make the new drugs accessible to researchers and affordable for all countries with a high burden of TB. MSF is also pushing for governments and researchers to start working together in earnest to determine the most effective way of introducing these new drugs so that treatment can be dramatically improved for people with MDR-TB.

Test all TB cases for drug resistance

Countries with a high burden of MDR-TB must ensure that all people with TB undergo testing to determine exactly which drugs will work for them, so that those with drug-resistant forms of the disease can start taking the correct treatment much sooner. This will prevent further drug resistance from developing, and reduce the spread of resistant strains.

Meanwhile, research and development for an easy-to-use test that can detect both drug-sensitive and drug-resistant strains of TB on the spot is still urgently needed. For such a test to work in high-burden countries, it should be affordable, and not require electricity.



© George Butler

Patients at MSF's clinic in Mumbai see a doctor, nurse and counsellor on each visit. A psychologist and psychiatrist are available for patients suffering from the side effects of treatment, which can include severe depression and psychosis.



© George Butler

For patients already weakened by the disease, treatment for MDR-TB is excruciating. The side effects of the drugs include nausea, body aches, rashes and even permanent deafness. Patients can become depressed or psychotic. Only half of patients who start treatment are cured.

Scale up and fund MDR-TB treatment now

With better, shorter treatment regimens in the pipeline, countries must prepare now for increased numbers of patients receiving MDR-TB care. Scaling up now will save lives, and will set up the infrastructure and systems necessary to handle greater numbers of patients in the future. To achieve this, MSF is advocating for donors and the Global Fund to Fight AIDS, TB and Malaria to commit the funds needed for treatment scale-up, and to ensure funding for TB becomes a priority.

Develop better diagnostics and treatment for children

The needs of children continue to be neglected. Current methods to diagnose children – who have difficulty producing the samples of sputum (phlegm) needed to conduct tests – are invasive, and still end up missing nine in ten cases. Research into methods that use samples that are easier to collect, like urine, blood or stools, is urgently required. So, too, are better treatment regimens; with no paediatric formulations available for MDR-TB drugs, children must take crushed adult formulations, which carries a risk of under- or over-dosing. More effort needs to be put into pushing for the development of better paediatric drug formulations.

Listen to people with MDR-TB

It is the people with MDR-TB who are most able to provide information and insight into what is needed to improve treatment. Until now, opportunities for them to speak up about their needs, and to call on donors, funding bodies and policy-makers to make improved diagnosis and treatment a priority have been extremely limited.

But MSF is working to change this. The 'Test Me, Treat Me' manifesto has been written and signed by people with MDR-TB and their treatment providers. The manifesto demands better treatment, immediate scale-up of treatment, and the funding that will help achieve this. People with MDR-TB are also making themselves heard through 'TB&Me', a series of blogs.

We have an historic opportunity for change. If we can secure the political will, funding and research, the ability to tackle this epidemic successfully will finally be within reach.

In 2012, MSF provided treatment to 1,780 people with DR-TB in countries across the world, such as Armenia, Swaziland, Uganda, Kyrgyzstan, Myanmar and Colombia. MSF is a large provider of DR-TB care, but the number we reach is a small fraction of the estimated 630,000 cases globally of DR-TB.



© George Butler

Gopal lost his job after he was diagnosed with MDR-TB. After 14 months of treatment, which involved a combination of painful injections and taking up to 20 pills a day, he is back at work and happy to be able to cook again.



First patient cured of MDR-TB in Zimbabwe

In her home on the outskirts of Zimbabwe's capital city, Harare, 48-year-old Mary Marizani says that, having conquered MDR-TB, she now faces another challenge: "I have my appetite back and now I am eating everything in sight."

Mary first showed symptoms of TB in 2006, after caring for four members of her family who had the disease. After eight months of treatment, and without screening to confirm whether it had been successful,

she was taken off TB medication by her doctor, who declared she "looked much better".

Over the following months, Mary was in and out of hospital with fever and a dry cough that would not shift. She grew thinner and thinner, her condition got worse and – having already lost half her body weight – she took the advice of a neighbour and went to a clinic where MSF was treating patients with TB.

She was diagnosed with a drug-resistant strain of TB, but no treatment was available at the time. When MSF launched its MDR-TB programme in Epworth, near Harare, in 2010, Mary was the first patient.

Treatment came just in time. "Just two days before the MSF doctors came to tell us the good news – that she would go on a new course of drugs – my mother had coughed up half a bucket of blood. It was terrible, I thought she was going to die," says Mary's daughter, Shorai.

In Zimbabwe, there is massive stigma around TB. Mary says, "Most of my family deserted me for two years while I was on MDR-TB treatment. My own relatives didn't come to visit me when I was on death's doorstep. The only family I had left was MSF and my two children.

"I felt like I had bugs crawling on the inside of my head," says Mary about the treatment, which made her vomit, lose her appetite and hallucinate. "I had to pass through hell to get to heaven."

But Mary was able to see the treatment through to the end, with the support of MSF staff. At the end of 2012, MSF was treating 40 MDR-TB patients in Zimbabwe, and Mary provides inspiration for the other patients at Epworth.





© Isabel Corthier

A patient at MSF's three-week fistula surgery camp in Warrap state, South Sudan. Obstetric fistulas are debilitating injuries to the birth canal that cause incontinence and often lead to social stigma.

ACTIVITIES BY COUNTRY

26	AFGHANISTAN	40	DEMOCRATIC REPUBLIC OF CONGO	61	LIBERIA	79	SIERRA LEONE
28	ARMENIA	42	ETHIOPIA	61	LIBYA	79	SRI LANKA
28	BAHRAIN	44	FRANCE	62	MALAWI	80	SOMALIA
29	BANGLADESH	44	GEORGIA	63	MALI	82	SOUTH AFRICA
30	BOLIVIA	45	GREECE	64	MAURITANIA	83	SUDAN
30	BURKINA FASO	46	GUATEMALA	65	MADAGASCAR	84	SOUTH SUDAN
31	BURUNDI	47	GUINEA	65	MEXICO	86	SWAZILAND
31	CAMBODIA	48	HAITI	66	MOROCCO	87	SYRIA
32	CAMEROON	50	GUINEA-BISSAU	67	MOZAMBIQUE	88	TAJIKISTAN
32	CHINA	51	HONDURAS	68	MYANMAR	88	TURKEY
33	CENTRAL AFRICAN REPUBLIC	52	INDIA	69	OCCUPIED PALESTINIAN TERRITORY	89	UGANDA
34	CHAD	54	IRAN	70	NIGER	90	UKRAINE
36	COLOMBIA	54	ITALY	72	NIGERIA	90	UNITED STATES
37	CONGO	55	IRAQ	74	PAKISTAN	91	UZBEKISTAN
37	CÔTE D'IVOIRE	56	KENYA	76	PAPUA NEW GUINEA	91	ZAMBIA
38	DJIBOUTI	58	JORDAN	77	PARAGUAY	92	ZIMBABWE
38	DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA	58	KYRGYZSTAN	77	PHILIPPINES	94	YEMEN
39	EGYPT	59	LEBANON	78	RUSSIAN FEDERATION		
		60	LESOTHO				

AFGHANISTAN

Conflict in Afghanistan continues to limit access to quality healthcare services.

People in need of healthcare must often travel long distances, across insecure areas, to reach public medical facilities. A lack of trained medical staff, particularly female doctors and nurses, further restricts access for many. Médecins Sans Frontières (MSF) is expanding its work at several hospitals, aiming to meet some of the most urgent needs. (For more on access to healthcare in Afghanistan, and the challenges to delivery, see pages 16–17.)

Trauma care in Kunduz

The trauma centre run by MSF in Kunduz is unique in northern Afghanistan, providing free, high-quality surgical care to victims of general trauma such as those resulting from traffic accidents, as well as people with conflict-related injuries. Before the hospital opened, most people with life-threatening injuries had to travel to the capital, Kabul, or to Pakistan for treatment.

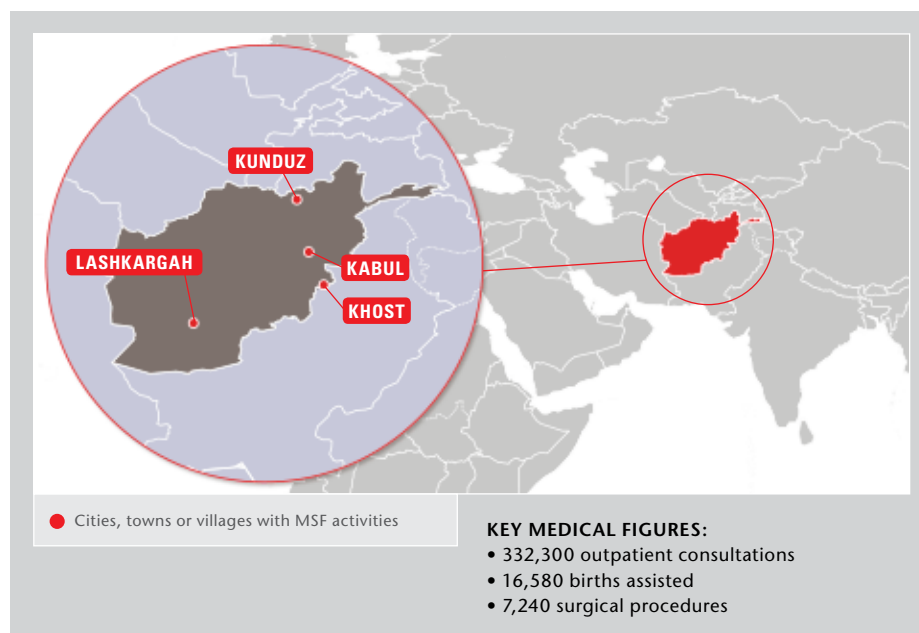
MSF developed the trauma centre in 2012 with a new emergency room, including more beds for resuscitation and observation. The centre now has a new, larger outpatient clinic, better physiotherapy services and improved infection control and sterilisation procedures, in preparation for the introduction of internal fixation in orthopaedic procedures. Staff in the intensive care unit also implemented new protocols.

When multiple patients arrive at a health facility at the same time, emergency medical staff use triage so that those with the most critical needs get immediate attention. This type of 'mass casualty response' is a significant part of MSF's work in Afghanistan, and took place on average once per month in 2012 in Kunduz, sometimes involving large numbers of people with life-threatening injuries. During civil unrest in February, 50 patients were brought to the hospital: more than 15 were severe, urgent cases. In August, 20 people were seriously injured in an explosion in the north of the province, and in September staff tended

to 33 casualties from a bus collision. Over the year, 10,000 patients were treated in the emergency department and surgeons carried out 1,500 operations.

Ahmad Shah Baba hospital, Kabul

The population of Kabul has swelled to more than three million as people migrate or are displaced due to conflict, and refugees return from Pakistan. MSF began working in Ahmad Shah Baba clinic in eastern Kabul in 2009, upgrading it to a district hospital with an emergency department, operating theatre, outpatient clinic, maternity ward and tuberculosis



Mohammad, 70, was sitting in front of his shop in Lashkargah when a bomb exploded. He has various wounds and is still in shock.

Abdullah*

40 years old, Helmand province

Our houses are destroyed. Our children are hurt. Even our wounded are helpless. One is putting bombs under our feet. The other is dropping them on our heads. Where can we go?

Vaccination is needed everywhere, but there is a war in Afghanistan. There is no peace. Sometimes it's quiet, but then the fighting starts again. What we need is a proper clinic in a safe place.

We had to leave our homes. It's been one year since we've been to our village.

Two months ago we arrived in this new place. Still there is fighting. This is our reality – still there is war.

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



© Francois Dumont/MSF

A three-year-old boy and his younger sister in the emergency room of Boost hospital. The children sustained head injuries when a bomb in Lashkargah caused the wall of their house to collapse.

clinic. In 2012, emergency obstetric care, including surgery, was extended to offer services round the clock. Staff developed mental health and health promotion services to complement medical care at the hospital, particularly in maternity, nutrition, emergency and outpatient services. A system was put in place to register complaints, in order to increase transparency and improve communication with patients.

Boost hospital, Lashkargah

MSF continued to support one of the only two functioning referral hospitals in southern Afghanistan, Boost hospital in Lashkargah. It provides surgery, internal medicine, and maternity, paediatric and emergency services. Staff in the outpatient clinic saw over 7,000 patients per month, many of whom had travelled long distances to obtain medical assistance.

The number of patients has grown as people have learned about the hospital and its services. The total number of surgical procedures increased to more than

3,000, over a third of them trauma-related orthopaedic operations.

The hospital also has an inpatient unit specialising in care for severely malnourished children, where some 900 children were treated.

By the end of the year, the hospital was equipped with 250 beds, and an extension to the paediatric and neonatology departments was completed with MSF support. About 2,000 people were admitted to the hospital each month, a 15-fold increase in patients since MSF started work in this hospital in 2009.

Ensuring safety at Khost maternity hospital

Khost, near the border with Pakistan, is a very insecure province, with minimal medical services. The one general hospital, located outside the city of Khost, is understaffed. As a significant proportion of the surgical staff is male, women are deterred from seeking healthcare.

In March, MSF opened a maternity hospital in the city centre, staffed only by female doctors and nurses. Equipped with 56 beds,

the hospital has the capacity to assist more than 1,000 women to give birth every month and to deal with obstetric emergencies.

Just six weeks after it opened, the hospital was targeted in a bomb attack. The explosion wounded seven people and MSF suspended activities because of the security risks to staff and patients. After several months of extensive talks with community leaders and other relevant parties, MSF was assured of support and safety for its medical activities and reopened the hospital at the end of December. Before the incident, the team assisted over 600 births. MSF continues to enforce a strict no-weapons policy at all locations where it works.

ARMENIA

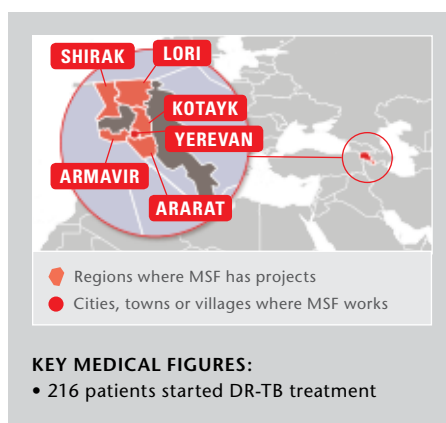
In the capital Yerevan, as well as in more remote areas of the country, Médecins Sans Frontières (MSF) teams are committed to improving access to treatment for drug-resistant tuberculosis (DR-TB).

Treatment is not universally available, and those who can access it have to adhere to a gruelling regimen, which can involve painful side effects, for up to two years. DR-TB is much harder to cure than drug-sensitive TB, and without appropriate support, many patients find it impossible to complete the treatment.

The MSF DR-TB programme in Yerevan, Armavir, Kotayk, Ararat, Lori and Shirak provides not only medication but also counselling and social support to help patients adhere to treatment.

Renovation and new facilities

In 2012, MSF signed an agreement with health authorities to begin improving ventilation in the DR-TB ward of Armenia's main TB hospital, Abovyan, in Yerevan. Improved ventilation and infection control



will help reduce retransmission of the disease among patients. It was also agreed that a palliative care unit will be set up, so that people for whom treatment is failing can still receive care to alleviate their suffering.

Focus on children with DR-TB

Detection of DR-TB in children is difficult, as they find it hard to cough up enough sputum for laboratory diagnosis. In 2012, MSF began to focus specifically on this issue, and in June launched a three-year study to improve understanding of infection patterns among children with DR-TB. The study has already yielded results: 23 children were diagnosed and began treatment in 2012.

Mariam

a student from Yerevan

When I was diagnosed with DR-TB, alarming thoughts began to swirl in my head. How could I accept the fact that I couldn't go back to my husband? That I couldn't have a baby for many years?

I had to take about 15–20 tablets, as well as injections. I had hardly started treatment when I began to feel terribly bad. I was vomiting, losing my appetite. I couldn't see or hear properly, had strange noises in my ears, felt a heaviness on my back. It was difficult to breathe.

The doctors said I had to get used to these feelings if I wanted to be cured. I was thinking this kind of experience couldn't possibly be 'treatment'. I wanted to escape from the hospital.

Mariam did leave hospital, but she returned and finally completed treatment in September 2012. You can read the rest of her story at blogs.msf.org/tb

No. staff end 2012: 93 | Year MSF first worked in the country: 1988 | msf.org/armenia

BAHRAIN

Despite authorities' efforts at reforms, recommended by the Bahrain Independent Commission of Inquiry after the violence of 2011, many people are still not seeking medical care in public hospitals.



The healthcare system in Bahrain is of excellent quality, but it is still grappling with the consequences of being caught up in political unrest. Médecins Sans Frontières (MSF) had sought to assist people unable to access medical attention, but its first aid post was closed in July 2011.

An MSF team remained in the country until March 2012, aware that hundreds of people were still not going to public hospitals for treatment. In March, staff were refused entry to the country, and activities had to be suspended.

Hoping to return to Bahrain, MSF staff worked from Dubai, in the United Arab Emirates, submitting proposals for activities to the Bahraini Ministry of Health. These included providing technical support in emergency preparedness and mental healthcare, as well as accompanying patients to health facilities to ensure that they and staff act in compliance with universally recognised medical ethics.

In May, MSF held a mental health workshop in Dubai, attended by medical professionals from the Bahraini government and opposition. MSF personnel were allowed into the country from June 2012, but negotiations to launch activities failed. MSF's principal concerns are comprehensive mental healthcare and patients' access to services.

No. staff end 2012: 1 | Year MSF first worked in the country: 2011 | msf.org/bahrain

BANGLADESH

The vast majority of the estimated 300,000 Rohingya refugees in Bangladesh are unregistered and living in deplorable conditions.

In 2012, there were around 30,000 registered refugees living in Kutupalong camp, in Cox's Bazaar. Some were fleeing renewed violence in Myanmar, while others sought protection from exploitation elsewhere in Bangladesh. Many have been struggling to survive in the area for years.

Médecins Sans Frontières (MSF) runs a clinic for local Bangladeshis and refugees just outside the makeshift camp, although MSF's presence has been challenged by the government. Staff provide basic healthcare, including maternal and mental health services. The clinic also has a small inpatient unit, a stabilisation unit for severely malnourished children, a diarrhoea treatment centre and an ambulance for hospital referrals. MSF continues to advocate for improved living conditions for the Rohingya.

Assisting children and women in Dhaka

In the Dhaka slum of Kamrangirchar, MSF teams run two health centres offering basic

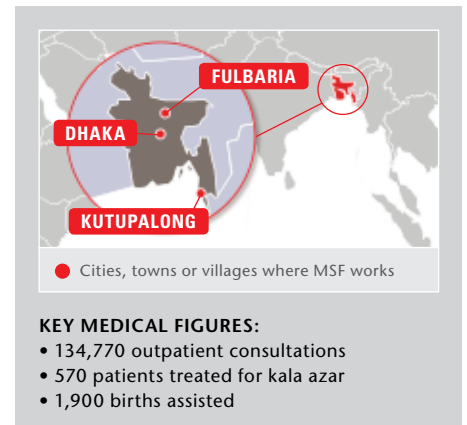
medical care and child and maternal health services. More than 40,000 paediatric consultations were carried out over the year.

It is not uncommon for girls between the ages of 10 and 15 in Kamrangirchar to marry and become pregnant soon afterwards. However, information about the elevated health risks for this age group during pregnancy and childbirth is seriously lacking. Staff at both centres have begun providing specialist services to adolescent girls and young women.

Kala azar programme

Kala azar, also known as visceral leishmaniasis, is a deadly tropical disease transmitted by sandflies. It is the second-biggest parasitic killer worldwide, after malaria. Some 90 per cent of cases occur in just seven countries, and Bangladesh is one of them.

At MSF's kala azar programme in Fulbaria, the team has been using liposomal amphotericin B



to treat the disease since 2010. This is safer and more effective than previous treatments, and takes just one day. In 2013 the Ministry of Health approved treatment with liposomal amphotericin B nationwide and is in the process of changing its national protocol.

No. staff end 2012: 354 | Year MSF first worked in the country: 1985 | msf.org/bangladesh



An MSF staff member gives food rations to a family in Kamrangirchar.

BOLIVIA

The prevalence of Chagas disease in Narciso Campero province, Bolivia, is more than 40 per cent in the general population, but doubles to 80 per cent for people aged over 45.

Access to treatment, however, is difficult: most health facilities charge fees, and people tend to live a long distance from centres offering diagnosis and treatment.

Screening is vital because Chagas can be deadly. Although people may live for years without symptoms, the disease can ultimately cause debilitating complications. Heart failure is the most common cause of death for adults.

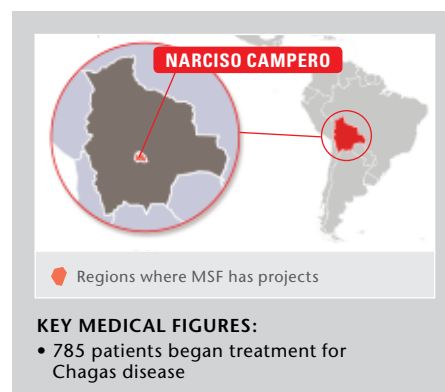
These complications require complex clinical treatment, which is not usually available locally. New, simpler models of care are needed so that patients can get the treatment they need at their local health centre.

No. staff end 2012: 67 people worked in Bolivia and Paraguay, which is run as a joint programme | Year MSF first worked in the country: 1986 | msf.org/bolivia

Médecins Sans Frontières (MSF) staff carry out screening and treatment for Chagas in the communities of Aiquile, Omereque and Pasorapa, in Narciso Campero province, and offer training to health staff. In 2012, MSF signed an agreement with the Bolivian organisation Puente de Solidaridad and the local hospital, which allows patients with heart and intestinal complications to be referred to the hospital for specialist treatment free of charge.

Production of medication guaranteed

In 2011, benznidazole, the most commonly used medicine for Chagas, became unavailable when the world's sole manufacturer of the drug, based in Brazil, ceased production. After intensive lobbying, production of the medicine resumed and delivery has been guaranteed for 2013. In November, MSF introduced a paediatric formulation of benznidazole for younger patients, developed by the non-profit research and development organisation, the *Drugs for Neglected Diseases initiative* (DNDi).



Angel

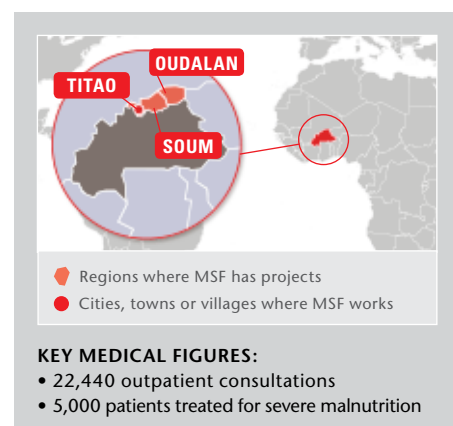
55 years old, lives in Chujllas, a small rural community in Cochabamba department.

I wasn't feeling well. I had some palpitations when I was sleeping. I went to the hospital in the town of Aiquile for a diagnosis. The results were that I had Chagas. But it was impossible for me to keep going to Aiquile for treatment. Six months went by and a friend told me that MSF was coming to Chujllas. "This is very important," I said, "we mustn't miss this opportunity."

The whole community met with the doctors. By that time I didn't feel like working or even eating. I started treatment. I recovered. I hope others follow the treatment, as I am feeling very well now.

BURKINA FASO

By the end of 2012, an estimated 38,000 Malians had fled to Burkina Faso to escape conflict.



The region at the border with Mali is arid, and resources are scarce. Médecins Sans Frontières (MSF) started offering emergency assistance to refugees in Mentao camp, Soum province, in February. The team then moved on to set up activities in four

camps near Deou, Oudalan province, as more refugees arrived there and other organisations took care of services in Mentao camp. Staff at Deou supported a health post and conducted mobile clinics, offering basic healthcare, including antenatal care, treatment for malnutrition and vaccinations. Patients were mainly suffering from malaria and respiratory infections.

Closure of malnutrition programme

In 2012, the Titao nutrition programme closed, following a consistent decrease in admissions over the past few years. Opened in 2007, the programme offered treatment for malnutrition at 11 outpatient feeding centres and Titao hospital. In the hospital, MSF treated patients for malaria and provided basic healthcare to children under 14 years of age. More than 4,500 patients were treated for malnutrition in 2012, and 830 were treated for malaria.

Fatima

from Mali

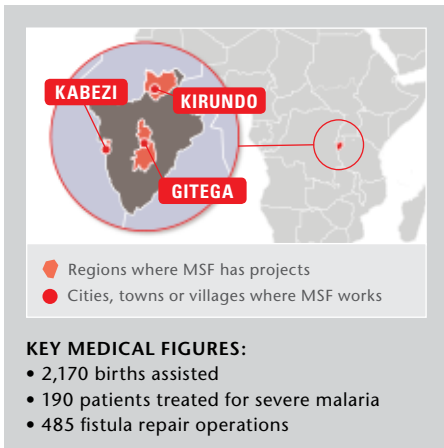
We are a population who fled war, who fled insecurity in northern Mali. We have been chased away by the army; a lot of people have died. We fled, abandoning everything. I am with my children. We have nothing. We are living in the open air here.



MSF provides health consultations to Malian refugees at camps in Oudalan province.

No. staff end 2012: 178 | Year MSF first worked in the country: 1995
msf.org/burkinafaso

BURUNDI



Obstetric services have been provided free of charge in Burundi since 2006, but equipment, referral systems and skilled staff are all lacking.

These gaps in services result in many maternal deaths. In Kabezi, Bujumbura Rural province, Médecins Sans Frontières (MSF) runs the Centre for Obstetric Emergencies, or CURGO, which provides free 24-hour care. Three ambulances transport women in need of emergency services from 24 health centres: on average, 250 women per month were admitted in 2012. According to MSF figures, this model of care – a referral system and emergency obstetric services – has resulted in 74 per cent fewer maternal deaths in Kabezi district compared with the national average.

Obstetric fistula care

Obstetric fistulas are injuries to the birth canal, most often a result of prolonged, obstructed labour. They cause incontinence, which can lead to social stigma. At the Urumuri health centre in Gitega, MSF offers fistula repair surgery, physiotherapy and psychosocial support. The team also works to raise awareness of the condition within

the country through medical staff training and a telephone information line, among other measures.

Severe malaria

National health statistics show that malaria accounts for over half of all medical consultations in Burundi, and it is the cause of more than a third of deaths in children under the age of five. In September MSF opened a severe malaria programme in Kirundo province, where over 300,000 people suffered from the disease in 2011. Staff in Kirundo hospital and 34 health centres in the province focus on diagnosis and introducing artesunate injections as the first choice of treatment at facilities. Artesunate is more effective, requires a shorter period of treatment, is easier to administer and has fewer side effects than other drugs.

No. staff end 2012: 282 | Year MSF first worked in the country: 1992 | msf.org/burundi

CAMBODIA

Tuberculosis (TB) is one of the most serious public health challenges facing Cambodia.

TB is spread through the air by an infected person coughing or sneezing. It is an opportunistic infection that takes advantage of weakened immune systems.

Searching for TB

In Kampong Cham hospital, MSF offers treatment for both drug-sensitive and drug-resistant TB (DR-TB). DR-TB is much harder to treat because it is a form of the disease against which first-line drug regimens have failed.

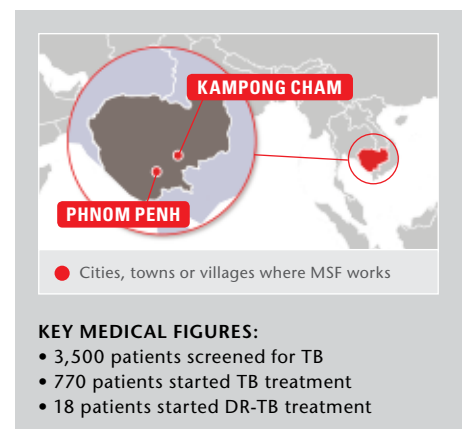
A priority is to improve detection of the disease, and actively look for and test people who may have it. MSF invites individuals patients have had contact with, such as family members, to be tested, and works with hospital staff, particularly in the paediatric ward, to identify patients who

may have TB. The team carries out regular awareness-raising activities to help increase knowledge and understanding of TB and reduce the stigma surrounding the disease.

These activities, as well as the completion of a new laboratory, have all contributed to a significant growth in patient numbers. Each month MSF staff now conduct around 1,000 consultations inside Kampong Cham hospital's TB ward. The team also makes home visits to DR-TB patients who have difficulty getting to the hospital, and a telephone hotline is available for anyone with an urgent enquiry. The overall number of patients is expected to double in 2013.

Handover of services in Phnom Penh prisons

Since February 2010, MSF has been working in three prisons in the capital Phnom Penh.



Teams provide care and treatment for HIV and TB. The programme is in the process of being handed over to a number of national organisations. Most support will stop by July 2013, although staff will remain to care for patients with HIV.

No. staff end 2012: 129 | Year MSF first worked in the country: 1979 | msf.org/cambodia

CAMEROON

The north of Cameroon was affected by a measles epidemic at the beginning of the year and severe flooding at the end.

The people in the north are especially vulnerable to outbreaks of disease as the health infrastructure is so poor. After measles broke out, Médecins Sans Frontières (MSF) set up a dedicated unit in the hospital in Garoua, capital of North region. Most patients were under five years of age, and suffering from malnutrition and respiratory complications. At the end of April the unit was handed over to the Ministry of Health.

Between March and April, MSF also delivered training to staff in 102 health facilities in 22 districts of North and Extreme North regions and donated measles treatment kits for some 1,835 patients.

In September, flooding displaced thousands of families in the Extreme North. MSF set up a health centre and mobile clinic in the camp of Kousseri, and improved the provision of sanitation and safe water.

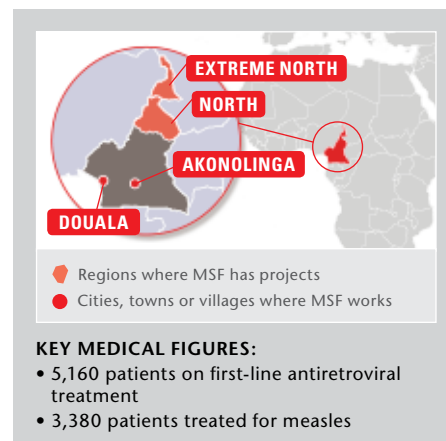
Buruli ulcer

People infected with Buruli ulcer develop sores that can cause irreversible deformities, which can restrict movement, and lead to secondary infections and long-term disability. The bacteria causing Buruli is related to leprosy but very little – not even the mode of transmission – is known about the disease.

The MSF team at the Buruli Pavilion inside the district hospital of Akonolinga carries out testing, treatment (with antibiotics and dressings), surgery and physiotherapy for patients suffering from this neglected disease. The staff also treat other chronic wounds and HIV in patients who are co-infected with Buruli and HIV, caring for around 100 people every year.

HIV

In Nylon district hospital and Soboum health centre in the city of Douala, MSF trained hospital staff and provided medicines and other supplies for the treatment of



5,000 HIV patients. MSF is increasing access to viral load testing – which is used to determine how patients are responding to treatment – by subsidising the test. MSF also continues to advocate for more patients to receive the improved first-line treatment for HIV, based on the drug tenofovir.

Natasha

24 years old, was admitted to the Buruli programme in 2007. Five years later, she talks about her experience.

In 2000, I noticed I had a little spot on my left ankle. I thought it was a mosquito bite. Several days later, a wound formed. My parents put a dressing on it and it healed. But months later the same wound reappeared, and it didn't heal. In fact it got bigger. I spent four long months with a traditional healer. My wound did not heal.

In the meantime, MSF arrived in Akonolinga. A nurse persuaded us to come to the hospital. The first operation went

smoothly, but when I went to have the dressing changed, I nearly fainted. The sore was even bigger. I was certain it wouldn't heal. I was convinced I would never walk again despite everything the nurses said.

But I continued my treatment and after a bit more than a year I was discharged. One year after leaving hospital I was even able to run again. Not as fast as before, admittedly, but I could run.

No. staff end 2012: 96 | Year MSF first worked in the country: 1984 | msf.org/cameroon

CHINA

In 2012, Médecins Sans Frontières (MSF) provided assistance after southern parts of China were flooded.

China is frequently hit by flooding, landslides, typhoons and earthquakes. While the authorities' response to such natural disasters is improving, there are sometimes gaps in emergency assistance, especially in the delivery of adequate food and materials for the survival of those affected.

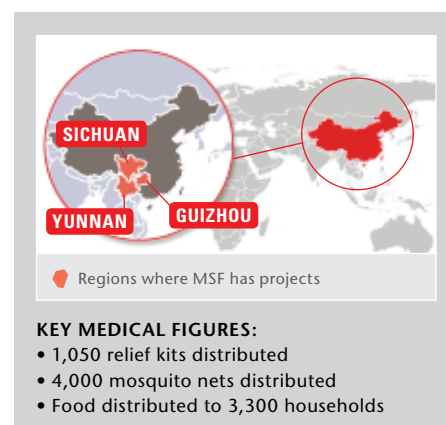
In 2012, an MSF team delivered relief items such as blankets and food, plastic sheeting and cooking kits to several thousand households in Yunnan, Guizhou and Sichuan provinces.

Innovative HIV care

Although treatment for HIV and AIDS is being scaled up in China, available resources do not meet the increasing demand, which has led to problems in accessing quality treatment and care.

It was agreed in 2012 that MSF would support the implementation of comprehensive antiretroviral (ARV) treatment services for HIV patients in five pilot clinics in three provinces of the country.

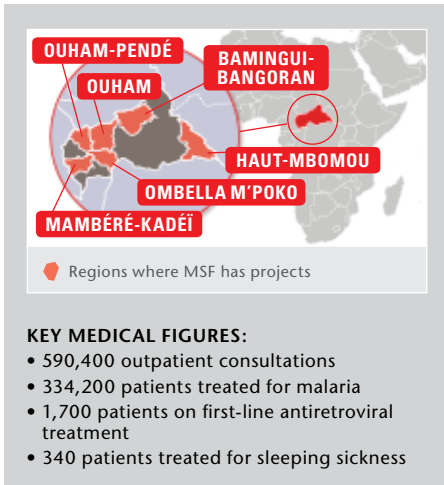
Local organisation AIDS Care China (ACC) will lead the programmes, and MSF will provide technical assistance in the clinical management of HIV patients. The aim is to demonstrate that a new model of



comprehensive treatment, incorporating counselling, can result in better outcomes for patients. MSF will also supply ARV drugs.

No. staff end 2012: 12 | Year MSF first worked in the country: 1986 | msf.org/china

CENTRAL AFRICAN REPUBLIC



Conflict across large areas of the Central African Republic at the end of 2012 increased health needs and further destabilised the fragile health system.

A military campaign by an alliance of rebel forces, Séléka, took a number of major towns and territory in eastern and central regions. By early 2013, Séléka forces had reached the gates of the capital Bangui.

Thousands of people fled into the bush, and hospitals and health posts were abandoned. Médecins Sans Frontières (MSF) teams, already working in five regions across the country, continued activities and launched extra mobile clinics to attend to the medical needs of the displaced. An emergency surgical team began work in Kaga-Bandoro, in the north, and donations were made to hospitals and clinics in locations affected by violence.

Urgent health crisis

The conflict only exacerbated medical needs, which were already huge even in stable areas of the country. The health system suffers from a lack of qualified staff and there are few public facilities outside the capital. Shortages of essential medicines are frequent and many people cannot afford



Tens of thousands of people come to MSF's Paoua hospital, Ouham-Pendé, each year. Basic healthcare is difficult to access and mortality rates in parts of the country are up to five times the emergency threshold.

to pay the fees required for treatment. In short, a large proportion of the population does not have access even to the most basic healthcare, and mortality rates are above emergency levels.

MSF teams work with the Ministry of Health in seven hospitals and more than 30 health posts, providing a wide range of services: basic and specialist healthcare, maternity and paediatric services, surgery, HIV and TB care, and treatment for neglected diseases, including sleeping sickness (human African trypanosomiasis).

Malaria is one of the main causes of death in the country, and is a major priority for MSF programmes. The goal is to boost prevention and offer diagnosis and treatment in more locations.

Testing new tools for sleeping sickness

The Central African Republic is one of the few countries where sleeping sickness remains a problem. Sleeping sickness attacks the central nervous system and

is deadly if untreated, but both diagnosis and treatment are complex and difficult to administer. In Batangafo, in Ouham, MSF is using a new rapid diagnostic test for the disease and participating in clinical trials of a new oral treatment for last-stage sleeping sickness developed by the not-for-profit research and development organisation, the *Drugs for Neglected Diseases initiative* (DNDi).

The mobile sleeping sickness team screened more than 4,500 people for the disease in the southeast of the country. Access to the region has been difficult for some years due to attacks by the Lord's Resistance Army, but in 2012 MSF was able to reach more people as many left Zémio, in Haut-Mbomou, and returned to their home villages to start farming again.

No. staff end 2012: 1,300 | Year MSF first worked in the country: 1996 | msf.org/car

CHAD

Malnutrition, meningitis and malaria were among the recurring health emergencies faced in Chad in 2012.

Internal strife has diminished since 2010, and the main public health problem for Chadians today is a lack of quality health services or, in most cases, an absence of health services altogether.

Médecins Sans Frontières (MSF) teams continued programmes designed to meet the neglected medical needs of women and children, and responded to malnutrition and other emergencies.

Widespread child malnutrition

Immunisation rates are very low and the country is regularly affected by outbreaks of preventable disease, which increase the exposure of young children to malnutrition.

In 2012, MSF treated more than 23,000 children for severe malnutrition in different areas of the Sahel strip, which runs across the middle of Chad. Two regular programmes run nutrition activities, and four additional short-term nutrition programmes were opened in places where the existing capacity to tackle malnutrition was overwhelmed. MSF handed over these emergency programmes to other associations and the Ministry of Health at the end of the peak of the crisis.

In Biltine, Wadi Fira region and Aboudeia, Salamat region, 5,180 children were treated for malnutrition at two inpatient feeding centres and 20 outpatient feeding centres. In and around Yao, Fitri district, Batha region, MSF ran an emergency nutrition programme from April to September. Staff at the hospital in N'Djamena Bilala in Fitri ran a 30-bed paediatric ward for children suffering severe malnutrition and other diseases, and teams screened for and treated malnutrition in 27 surrounding villages. Staff also carried out 1,330 paediatric consultations and ensured

routine immunisation for 6,300 children. In June, MSF opened one inpatient and 10 outpatient feeding centres in Bokoro, Hadjer Lamis, which treated 3,800 children.

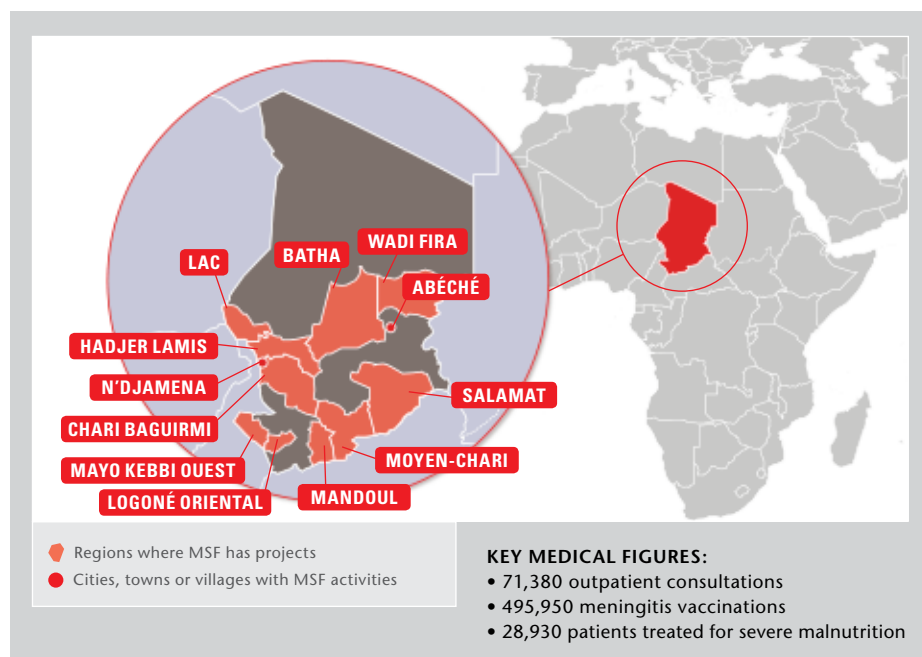
An MSF team has worked at Massakory hospital, Hadjer Lamis region, since 2010. Staff offer emergency medical care for children up to 15 years old and provide treatment for children under five with severe malnutrition with complications. In 2012, 8,530 patients were treated for malnutrition and over 1,000 for malaria. A nutrition programme operated in six health zones, where teams also monitored for common diseases. More than 17,000 children were also vaccinated against measles and 182 patients were treated for meningitis.

Meningitis outbreaks

Chad lies in a swathe of countries across Africa that see recurrent outbreaks of meningitis, an infection of the thin membranes surrounding the brain and spinal cord. Meningitis can cause headaches, fever, nausea, sensitivity to light and can lead to disability or death.

When meningitis epidemic thresholds were passed in early 2012, MSF launched vaccination campaigns in districts in the regions of Batha, Salamat, Mayo Kebbi Ouest, Mandoul and Hadjer Lamis. Some teams were able to use a newer vaccine, which offers 10 years of protection against the disease.

Teams treated hundreds of patients for the disease in Am Timan and Aboudeia, Salamat



A nurse treats a severely dehydrated child at MSF's mobile feeding centre in Angara village, Biltine district.



© Florian Lems/MSF

A nurse carries out a consultation at MSF's outpatient therapeutic feeding centre in Angara, Biltine district.

region and Moissala, in Mandoul. In April, MSF responded to a meningitis outbreak in Léré, Mayo Kebbi Ouest. Medical supplies were donated and a team worked with hospital staff to provide patient care and staff training. More than 700 treatment kits were donated to health centres and staff led awareness sessions in the villages and through local radio broadcasts.

Malaria prevention and treatment

A quarter of all deaths in Chad are attributed to malaria and it is the most common cause of death for children. Cases of the mosquito-borne disease peak from July to November.

In Moissala, Mandoul region, MSF has trained healthcare workers to diagnose and respond to simple malaria. They treated 39,500 people for the disease, while staff in clinics treated another 20,000. MSF donated drugs and medical supplies and ran an inpatient malaria ward for children in the district hospital, treating 2,100 children.

A new preventive strategy was also implemented. Between July and October, teams distributed antimalarial medicine to children once per month in two health

zones of Moissala district. In the eight weeks following the first distribution of the medicine, staff in the health centres recorded a 78 per cent reduction in the number of patients with simple malaria.

Specialist services for women and children

In Am Timan, Salamat region, MSF supports the district hospital with an emphasis on emergency services for women and children. On top of treatment for malnutrition, the team offers reproductive healthcare and emergency obstetric care, including an HIV–TB programme and prevention of mother-to-child transmission of HIV. Ante- and postnatal consultations are held in six health zones and therapeutic feeding programmes in nine health zones. In 2012, teams conducted 20,790 antenatal consultations and assisted 1,870 births.

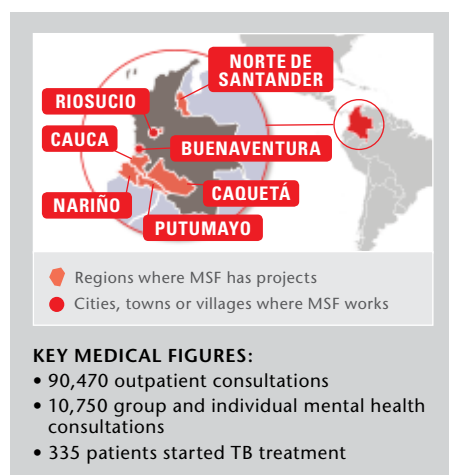
Women who have sustained an obstetric fistula, damage to the birth canal most often caused by obstructed and prolonged labour, suffer physical pain, incontinence and rejection by their families and communities. MSF runs a women's health village in Abéché, Ouaddai region, where patients can stay for their weeks-long treatment and receive nutritional support

and counselling. Surgery and post-operative care is carried out at the regional hospital, in collaboration with the Ministry of Health. In 2012, 166 women received this surgery.

Assisting refugees from the Central African Republic

Some 20,000 refugees from the Central African Republic have lived for several years in camps in the Moyen-Chari region of Chad. Heavy rains caused flooding in the camps in October and the refugees had to be relocated. MSF carried out 8,000 medical consultations, built 100 latrines and provided clean water and blankets, mosquito nets, water containers and soap to some 4,000 families.

COLOMBIA



Colombians living in conflict zones have to contend not only with chronic violence but also with geographical, cultural, administrative and financial barriers to healthcare.

In the southern departments of Cauca, Nariño, Caquetá and Putumayo, Médecins Sans Frontières (MSF) operated mobile clinics and fixed health posts throughout the year, offering basic healthcare and vaccinations, sexual and reproductive healthcare, including family planning and antenatal care, and referrals for emergencies.

People traumatised by regular exposure to violence rarely have access to public mental health services. MSF provides psychological assistance through clinical consultations, counselling sessions and community work. Staff saw a steady growth in the number of patients using services, carrying out 5,400 mental health consultations and providing medical and psychological care to nearly 200 victims of sexual violence. Group activities to promote good health and raise awareness of mental health issues reached 38,400 people.

Violent attacks by armed groups forced people to leave their homes in seven separate incidents. MSF distributed medical supplies and relief items to local health facilities and provided direct medical and psychological care to a total of 16,000 people.

Meeting health needs in Buenaventura

Thousands of people live in slum conditions in the Pacific seaport of Buenaventura. Tuberculosis (TB) is one of several public health concerns. MSF supports the National TB Control Programme in the detection and treatment of the disease, including the more difficult to treat drug-resistant TB. By the end of the year, 285 new patients had begun treatment, and 60 were undergoing treatment for drug-resistant TB.

An MSF health facility also offers treatment for victims of sexual violence, sexual and reproductive healthcare for teenagers

and medical care for children. More than 13,000 consultations were held. As this facility is more easily accessible for patients, activities were concentrated here and a second clinic in the island part of the city was closed in February.

Work to ensure a safe water supply and prevent disease in the areas of Los Angeles and Pampalinda was completed at the end of the year.

Programme closures

The Chagas programme in Norte de Santander was closed in September, after 10 years of activity. Patient numbers had fallen: of 2,250 screened for Chagas in 2012, 43 were diagnosed with the disease and received treatment. Patient care was handed over to the Ministry of Health, while the Pan American Health Organization took over the monitoring of the programme.

In July, MSF handed over the River Atrato programme, based in Riosucio, to the Ministry of Health. The team had been providing basic and mental healthcare, reproductive healthcare and assistance to victims of sexual violence through a clinic, as well as mobile outreach to four communities.

MSF continues to advocate around three main issues of concern in Colombia: healthcare access, the effects of conflict on mental health and the urgent need for mental health support, and awareness of and treatment for sexual violence.



Drug-sensitive and drug-resistant tuberculosis are public health concerns in Colombia.

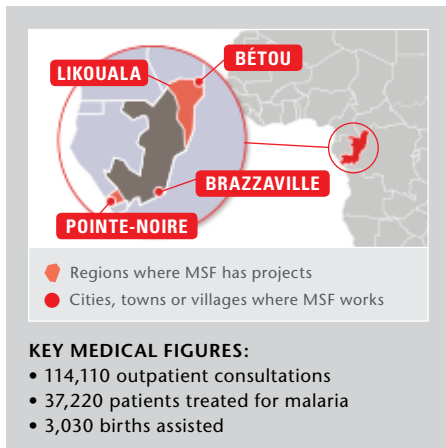
Alicia*

received mental health support from MSF in Cauca department.

Look, this is all so hard ... The day you least think about it, there are combats or explosions in our town. All the time there has been this anxiety. That is what produces my poor health. Before, I didn't feel the pain that I now feel. Now, every day I feel bad. I can't sleep ... One feels bad, and one thinks: until when do you have to live in this situation? If I had somewhere to go, I would go, but regrettably I don't.

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

CONGO



At the beginning of the year, according to the UN refugee agency, an estimated 59,000 refugees from the Democratic Republic of Congo (DRC) remained in Bétou district, in Likouala, afraid to go home.

At Bétou hospital, Médecins Sans Frontières (MSF) has strengthened capacity to meet the needs of refugees and local residents. The team has opened new services including obstetrics, a nutrition programme and a laboratory, and reorganised hospital departments for surgery, outpatients and emergency medicine. The majority of roughly 2,600 outpatient visits per month were children, most of whom had respiratory infections or malaria. In addition, staff provide emergency assistance to refugees along the Ubangi River.

MSF also works with national control programmes for tuberculosis (TB) and HIV. In 2012, 77 HIV patients and 97 TB patients were registered for treatment supported by MSF.

Explosions in Brazzaville

On 4 March, explosions in a munitions depot in Congo's capital Brazzaville caused serious damage. Two hundred people died, over 1,000 were injured and 15,000 became homeless.

MSF treated wounded at two public hospitals, setting up triage tents at the University Hospital to prioritise patients in need of urgent treatment and donating medical equipment for surgery.

Over 1,000 displaced people in two camps received medical and psychological care. MSF also managed safe water provision and sanitation and monitored for cholera and measles at five other locations. The emergency response ended in June.

New treatment for yaws

The indigenous Aka pygmies in northern Congo have scant access to healthcare. These remote communities are still affected by yaws, a contagious but curable skin infection that, untreated, can cause permanent disfigurement and disability. The World Health Organization has a new recommended treatment protocol for yaws, which requires just a single oral dose of azithromycin. The MSF team in Congo was the first to implement this protocol, travelling to Aka communities in the forest and treating 17,500 people.

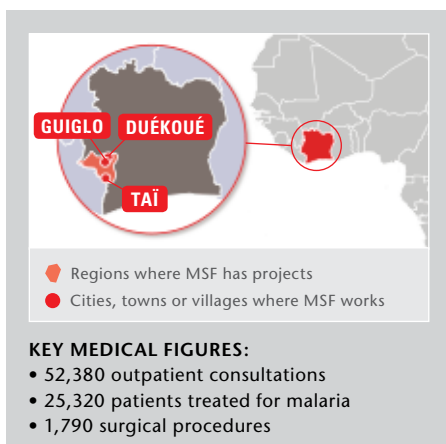
Cholera in Pointe-Noire

Following torrential rains in November, cholera broke out in December in the city of Pointe-Noire. MSF set up a cholera treatment centre in Loandjili hospital and helped health authorities put preventive measures in place. A draft response plan was presented to local and national authorities.

No. staff end 2012: 220 | Year MSF first worked in the country: 1997 | msf.org/congo

CÔTE D'IVOIRE

As the conflict following the disputed presidential election subsided and the humanitarian situation improved, Médecins Sans Frontières (MSF) gradually handed activities back to returning Ministry of Health staff.



A team remained at the hospital in the western town of Duékoué throughout 2012. They took care of surgical emergencies, internal medicine, and maternal and paediatric services. In July, staff in the emergency department treated 56 casualties from an attack on a camp for displaced people.

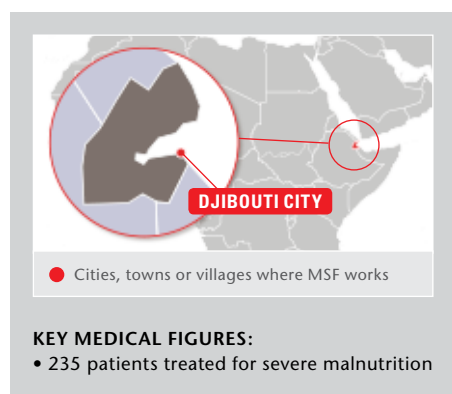
MSF started working in Taï, to the south of Duékoué, at the end of 2011. Staff support Ministry of Health teams in the outpatient, maternal and paediatric services of a 20-bed facility, which sees more than 2,000 outpatients every month.

Handover of medical activities

MSF support for health services in and around the town of Guiglo came to an end. The team at Boléquin hospital left in January. MSF left the Nikla dispensary, where staff ran a feeding programme that accommodated 20 inpatients, at the end of March. Activities at the health centre in Guinkin, where the team was holding up to 1,200 consultations each month, were handed over to the Ministry of Health a few months later.

No. staff end 2012: 369 | Year MSF first worked in the country: 1990 | msf.org/cotedivoire

DJIBOUTI



The nutrition programme in Djibouti was handed over to the Ministry of Health in 2012.

With an extremely hot and dry climate and poor crop capacity, inadequate food supply is a chronic issue for the vast majority of Djiboutians. Children need essential nutrients for normal growth and development and are most vulnerable to the effects of malnutrition. For this reason, Médecins Sans Frontières (MSF) opened an emergency inpatient feeding centre for children in Djibouti in 2008.

MSF's lobbying for the implementation of a preventive approach to malnutrition has resulted in the health ministry distributing



A child is screened for malnutrition using a MUAC (mid-upper arm circumference) band during a visit by an MSF outreach team.

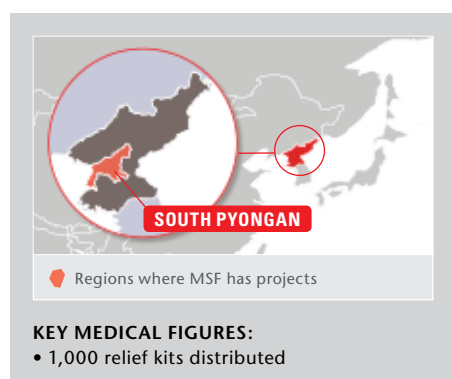
ready-to-use supplementary food. This high-protein formulation contains all the nutrients children need and is proven effective in preventing malnutrition.

The team also gave technical support to the Ministry of Health so they could develop their own specialised nutrition programme.

Staff training, medicines and medical equipment were provided. The ministry constructed a nutrition treatment centre and MSF handed over its programme in April. In four years, MSF teams treated 10,600 children for severe malnutrition.

No. staff end 2012: 31 | Year MSF first worked in the country: 2008 | msf.org/djibouti

DPR KOREA



Torrential rains led to devastating floods in the Democratic People's Republic of Korea in mid-2012, which displaced thousands of people.

Médecins Sans Frontières (MSF) assisted in the response. A team undertook an assessment of 13 health facilities in the flood-affected area, including a local hospital, pharmacy and both urban and rural health centres.

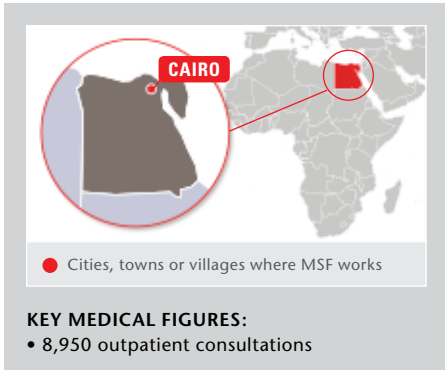
Staff delivered medical kits to help health workers in South Pyongan province care for some of the thousands of people caught

up in the emergency. These kits contain everything needed to meet medical needs in the weeks following a natural disaster.

In addition, teams distributed relief items to some of the communities affected, including blankets, water containers and plastic sheeting to provide temporary shelter. Tons of rice and more than a million water purification tablets were also donated.

No. staff end 2012: 2 | Year MSF first worked in the country: 1995 | msf.org/dprk

EGYPT



Vulnerable groups in Egypt, including migrants and people in poor, remote areas, do not have access to critical health services.

Mothers and children in some isolated settlements and rural areas lack access to the specialist services they need. In August, Médecins Sans Frontières (MSF) opened a mother and child clinic in Abu Elian, a rural settlement in El Marg district, on the outskirts of Cairo. Until then, it had been more than an hour's journey to the closest medical facility, and transport and treatment costs posed barriers to care. Staff in Abu Elian carried out nearly 9,000 consultations. Most of the children they saw were suffering from respiratory tract infections, intestinal parasites, skin diseases or diarrhoea. A 24-hour emergency referral system is in place for pregnant women, with MSF providing transport and covering hospital costs.

Many of the refugees and migrants living in Cairo and throughout Egypt have experienced violence and have almost no access to health services. MSF opened a clinic for women in Nasr City, in Cairo, offering mental healthcare and treatment for victims of violence, and treated more than 430 people.

Strengthening capacity for tuberculosis care

In September, MSF staff in Qalyubia governorate trained 20 doctors and 20 nurses from the Ministry of Health in tuberculosis (TB) care, focusing on infection control of this communicable and potentially deadly disease.



A paediatrician examines a young patient at the newly opened mother and child clinic in Abu Elian.

Emergency assistance in Gaza and southern Sinai

When the 'Pillar of Defence' military operation was launched on Gaza in November, MSF donated close to five tons of medicines and medical supplies to the Gaza Ministry of Health and to El-Arish hospital, the Egyptian referral hospital that received some of the wounded.

Expanding treatment for hepatitis C

According to government data, there is an alarming prevalence of hepatitis C in the country, with a national average of one in every five people infected. In rural areas, prevalence for certain age groups reaches up to 55 per cent and 38 per cent for men and women, respectively, and public health facilities are having difficulty meeting medical needs. Passed primarily through contact with infected blood, hepatitis C is a chronic disease affecting the liver that can cause serious health problems, including cirrhosis and liver failure. MSF is awaiting approval for a new model of care that can be implemented with the Ministry of Health in remote areas.

Mona*

brought her daughter to the mother and child clinic at Abu Elian.

My two-year-old daughter suffered from a lung infection for months. I sought help in other healthcare facilities, but the infection persisted. Now I tell all the people I know that since I brought my daughter to the MSF clinic, she received proper healthcare and I haven't needed to bring her again.

Earlier, when a child would get a fever, the mother would wait for a week before seeking medical care at a healthcare facility. More mothers in the area are now bringing their children to this clinic; they know it is easily accessible for them and free.

**Name has been changed.*

No. staff end 2012: 63 | Year MSF first worked in the country: 2010 | msf.org/egypt

DEMOCRATIC REPUBLIC OF CONGO

KEY MEDICAL FIGURES:

- 1,674,000 outpatient consultations
- 407,600 measles vaccinations
- 434,300 patients treated for malaria
- 90,470 patients admitted to hospital
- 4,040 patients treated after incidents of sexual violence

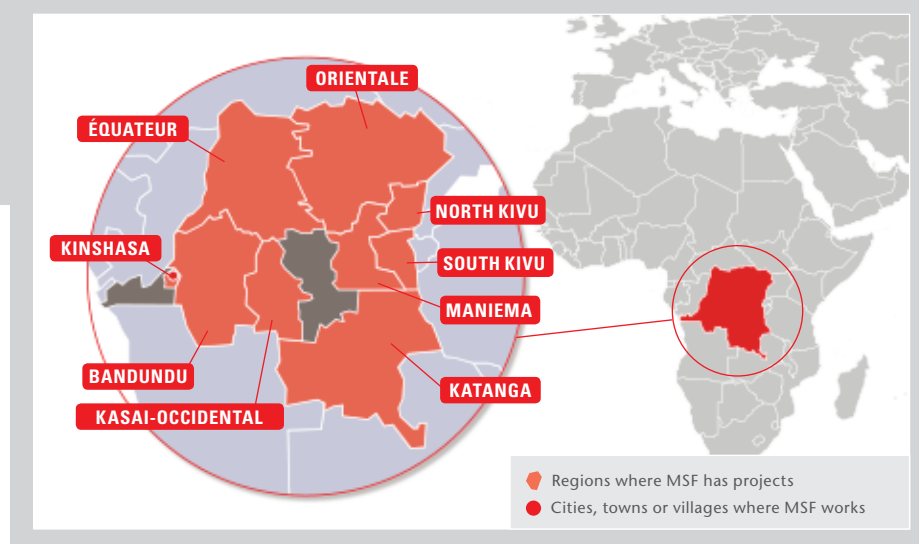
Most people in the Democratic Republic of Congo (DRC) are suffering a desperate lack of healthcare: many health facilities are barely operational. Escalating violence in the east has increased the already high level of medical need.

In 2012, a newly formed armed group, M23, attacked Rutshuru in North Kivu province before occupying the provincial capital of Goma for several days. Hundreds were injured and thousands were forced to flee, again: they abandoned Kanyaruchinya displaced persons camp, heading to neighbouring camps or further south.

Médecins Sans Frontières (MSF) continued to run services at Rutshuru hospital throughout the violence, although with a reduced team. From July to December, staff provided basic healthcare, nutritional care, maternity services and assistance to victims of sexual violence at Kanyaruchinya health centre, and set up a cholera treatment centre. In November MSF started work in Mugunga III camp, offering basic healthcare, nutritional support, measles vaccinations and treatment for victims of sexual violence. Surgical staff operated on 60 war-wounded in Virunga hospital, Goma.

Comprehensive healthcare in North and South Kivu

MSF fully resumed activities in Masisi hospital in North Kivu in 2012: services had been reduced after a member of staff was injured in a security incident in 2011. The team supports all services at the 160-bed hospital, and provides basic healthcare at two health centres and mobile clinics. Comprehensive services are also provided in Mweso, Kitchanga and Pinga.



In South Kivu, MSF supports basic and specialist services in hospitals and health centres in Kalonge, Minova, Shabunda, Kimbi Lulenge and Baraka.

In Lubutu, Maniema province, MSF's hospital programme has reduced mortality significantly. In March MSF handed over to the Ministry of Health after the team demonstrated that high-quality, easily accessible health services can be offered at almost the same cost as that defined by the Ministry of Health.

Insecurity limits medical activities

In April, two staff members were abducted in Nyanzale, near Rutshuru. They were returned unharmed after several hours but medical activities – including both basic and specialist services, and assistance to victims of sexual violence – in Nyanzale were closed, and the number of staff at Rutshuru was reduced.

Pinga, also in North Kivu, was repeatedly the scene of armed conflict, and when residents, including MSF staff, had to flee, MSF services were interrupted. Heavy fighting between the army and a Mai-Mai group, which expanded its influence in the region over the year, meant that an emergency response to high rates of malaria in Walikale was suspended for several weeks.

In South Kivu, staff who had been working in six health facilities and running mobile clinics in Hauts Plateaux, Uvira were evacuated in February due to armed conflict, though MSF continued to supply the facilities with

medicines. When the MSF compound in Baraka was robbed and staff intimidated, services continued, though with fewer personnel.

Assisting the displaced in Katanga

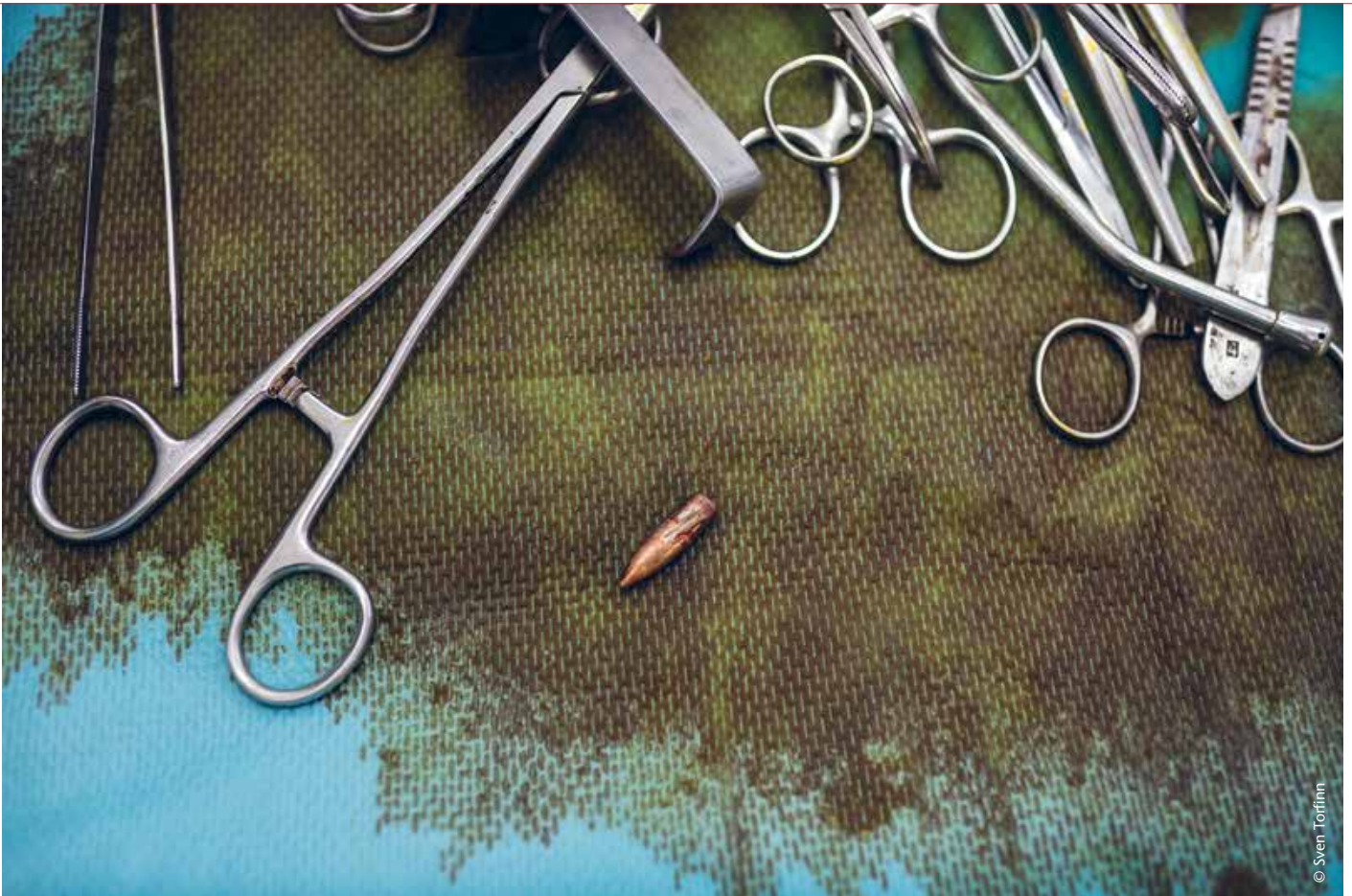
Until August, a team in Kalémie in Katanga province provided basic healthcare, maternity services, nutritional support and water in two camps for people who had fled conflict in South Kivu.

Fighting flared up in Katanga itself between the army and Mai-Mai militias. MSF provided basic and specialist health services to the displaced in Mitwaba between April and August, and in Dubie from March. Longer-term programmes providing comprehensive health services in Shamwana saw a decrease in inpatients as fighting hindered access to the hospital. Displacement prevented follow-up for many patients.

Assisting victims of conflict in Orientale province

In Geti, Ituri district, MSF provides basic and specialist services, paying particular attention to maternal and child health, although insecurity hampers activities. More than 820 patients, two-thirds of whom were under five years of age, were admitted for emergency treatment.

In Bunia, MSF provides financial, human and logistical resources to two Congolese organisations (SOFEPADI and EPVI, or Hope for Life) offering women's health services, family planning and HIV treatment.



An AK47 bullet, removed from a young woman by surgeons at Virunga hospital, Goma.

MSF also supports the emergency department of Dingila hospital in Bas-Uélé. In 2012, 1,070 patients were admitted, more than half of whom were suffering from malaria. In Niangara in Haut-Uélé, a team continued to support the general hospital as well as three health centres, where activities were expanded to offer mental health services and routine vaccinations. The programme in Dungu was handed over to health authorities in December, following an improvement in the security situation and a reduction in the number of trauma patients.

Sleeping sickness

Three-quarters of all reported cases of sleeping sickness (human African trypanosomiasis) are in DRC, yet testing for the disease has declined significantly. In Ganga-Dingila and Ango, Bas-Uélé, MSF worked with Ministry of Health staff in the hospital and in mobile teams, screening some 60,000 people and treating 1,070 for the disease. A further 100 patients in Bandundu and Kasai-Occidental provinces received treatment through a mobile programme, which closed in December. MSF's programme in Doruma in Haut-Uélé was handed over to the Ministry of Health as the number of cases had fallen below the emergency threshold.

HIV care

Only 15 per cent of people living with HIV in DRC have access to the antiretroviral

(ARV) treatment they need, one of the lowest coverage rates in the world. In Kinshasa, staff at MSF's Centre Hospitalier de Kabinda have treated a large number of patients arriving in later stages of the disease with serious complications. Some 4,700 patients are receiving ARV treatment in Kinshasa, and many people attend MSF's other HIV programmes across the country.

Malaria

Malaria is the leading cause of illness and death in DRC. In 2012, an outbreak struck several regions of Orientale, Équateur and Maniema provinces. Unusually high numbers of cases of serious malaria required hospitalisation. MSF teams set up treatment and intensive care units, supplied drugs to health facilities and organised the transfer of seriously ill patients to hospital. Between June and September, MSF treated tens of thousands of patients, the majority children under five years of age. A team also brought short-term support following malaria outbreaks in North Kivu and Katanga.

Measles

At the beginning of the year, there was a measles epidemic in the areas of Dungu and Faraje, Orientale province. MSF vaccinated 37,400 children and treated 61 patients. When another massive epidemic broke out in October, MSF carried out a major vaccination campaign. Teams also responded

to measles in Katanga, South Kivu, Bandundu and Équateur provinces.

Cholera

MSF responded to outbreaks of cholera in DRC throughout the year, treating a total of 1,160 patients in Ituri district, Orientale; 1,550 in and around Goma, North Kivu, where the team also organised patient transfers to MSF-supported hospitals and donated medicines to other health facilities; and 300 in Lubumbashi, Katanga. Staff also managed a treatment centre in Kalémie hospital and assisted in responding to outbreaks in Bandundu and South Kivu provinces.

Ebola outbreak in Haut-Uélé

Ebola, a haemorrhagic fever transmitted through bodily fluids, broke out in Isiro in Haut-Uélé in August. There is no known cure for Ebola and the mortality rate fluctuates from 30 to 90 per cent. MSF assisted the response, treating 18 patients and providing psychosocial support.

ETHIOPIA

Despite significant economic progress in the country, medical care remains beyond reach for many Ethiopians, particularly in remote and conflict-affected areas.

Tens of thousands of refugees are also in need of health services. By the end of 2012, an estimated 170,000 Somali refugees had arrived in southern and eastern parts of Ethiopia, escaping conflict and the effects of 2011's severe drought. People fleeing violence in Sudan and South Sudan have entered Ethiopia from the west. Médecins Sans Frontières (MSF) continued to provide medical assistance to refugees and communities around the camps, as well as to other people without access to health services, throughout the year.

Refugee assistance

Refugees are medically screened and receive measles vaccinations upon arrival at the reception site at the southern border town of Dolo Ado in Liben zone, Somali region. Further medical care, including outpatient consultations, surgery, ante- and postnatal services, vaccinations and treatment for tuberculosis (TB), is available at the MSF-supported health centre.

For part of 2012, MSF also ran basic healthcare and nutrition programmes in five refugee camps in Liben zone. Approximately 30,000 children per month were screened for malnutrition. Children were also diagnosed and treated for pertussis (whooping cough), kala azar and diarrhoeal diseases. Staff handed activities over to the Ethiopian authorities.



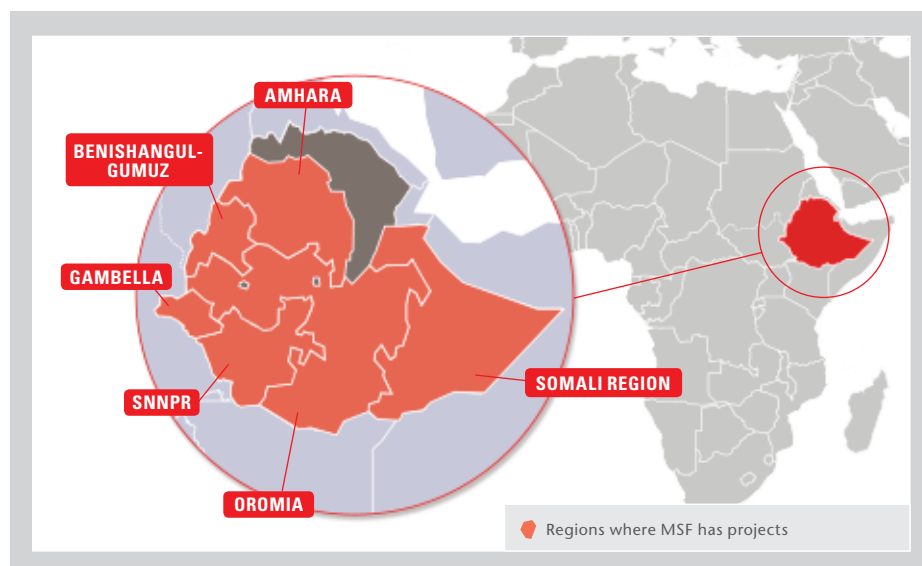
MSF teams at the Bambasi camp vaccinated children against measles and opened a treatment centre for malnutrition.

To assist the many refugees with symptoms of mental distress, MSF carried out 1,090 individual counselling consultations and more than 400 follow-up sessions. Outreach teams conducted 14,840 education sessions to raise awareness of the psychological suffering among the refugees and suggest ways to strengthen resilience in their communities.

In the far west of Ethiopia, MSF supported the Regional Health Bureau to meet the increased needs for basic and specialist medical care following the arrival of refugees from South Sudan. Staff carried out more than 60,000 consultations at Mattar health centre and at mobile clinics, which are run by car or boat, depending on the season.

When Ethiopian authorities transferred 12,000 Sudanese refugees from the Ad-Damazin camp, near the Sudan–Ethiopia border, 80 kilometres east to Bambasi, in Benishangul-Gumuz region, roughly one out of four children was found to be malnourished. MSF teams treated 500 people for malnutrition, immunised 3,500 children against measles and distributed food rations to 4,000 people. MSF has been providing emergency healthcare to Sudanese refugees in Benishangul-Gumuz since 2011, but direct access to camps has proven difficult to obtain and MSF continues to negotiate with the authorities.

In March, a mobile medical team conducted consultations in and around the border town of Moyale, which is partly in Oromia region, for Kenyans fleeing intercommunal clashes. MSF also supported health facilities with additional medical staff, drug donations and training in management of common illnesses. The programme was closed in May, when most of the refugees had returned to Kenya and it was clear that local authorities could manage the basic needs of those remaining.



KEY MEDICAL FIGURES:

- 203,250 outpatient consultations
- 1,400 patients began TB treatment
- 2,160 births assisted

Basic and specialist health services in Somali region

The provision of healthcare in Somali region is limited, owing to lack of development, a dearth of trained medical personnel and conflict between government forces and armed anti-government groups. MSF runs a health clinic in West Imey and another in East Imey, providing basic and maternal healthcare, an inpatient clinic, treatment for TB and kala azar, as well as mobile clinics. With health services for the largely nomadic population now more firmly established, activities will be handed over to the Regional Health Bureau in early 2013.

In an area known as Ogaden, in the northeast of Somali region, MSF continues to assist at the hospital in the town of Degehabur with emergency obstetric care, antenatal consultations, treatment for malnutrition, and medical and psychological care for victims of violence. MSF staff also support Wardher hospital, particularly in treatment for TB and malnutrition, reproductive healthcare – including assistance for victims of sexual violence – and vaccinations. Another team works in Danod health centre. Since January 2011, MSF has conducted mobile clinics in Ogaden, providing basic healthcare, but these activities were limited in the second part of the year due to security restrictions imposed by authorities.

Sidama mother and child healthcare

Responding to a lack of access to healthcare in parts of Sidama, a zone in the Southern Nations, Nationalities and Peoples Region (SNNPR), MSF opened a programme in 2010 focused on the health of mothers and children under five years of age. Activities include ante- and postnatal consultations, a 24-hour emergency service, medical and psychological care for victims of violence, surgery and treatment for obstetric fistula and referrals. Obstetric fistulas are injuries to the birth canal, and are most often a result of prolonged, obstructed labour. They cause incontinence, which can lead to social stigma.

A maternity waiting home was also opened to accommodate women with obstetric complications so that they have rapid access to skilled emergency care. More than 50,000 women and 34,000 children received care in the Sidama programme in 2012. The team is also training Ministry of Health staff.



Nearly 40,000 Sudanese people who fled fighting in Blue Nile state now live in camps in Ethiopia.

Decentralising care for TB

TB is the second-most common cause of death in Ethiopia, after malaria. There are indications that cases of drug-resistant TB (DR-TB) – which requires two years of gruelling treatment that can cause severe side effects – are on the rise.

MSF is assisting the federal Bureau of Health in the launch of a decentralised DR-TB treatment model in the eastern city of Dire Dawa, which will offer care on an outpatient basis. MSF has provided medical advice, donated specialised diagnostic equipment and designed modifications for the hospital as well as patients' homes. These refurbishments will significantly reduce the risk of patients passing on the disease to family members and allow them to live at home during their treatment.

Kala azar and HIV

Kala azar, or visceral leishmaniasis, is a parasitic disease transmitted by the bite of a sandfly, and is almost always fatal if not treated. It receives very little attention from the medical community, however. In Abdurafi, Amhara region, MSF works with the Ministry of Health to treat patients with kala azar, including those co-infected with HIV. MSF pays particular attention to groups most vulnerable to these diseases, such as migrants and sex workers.

Badoo

40 years old

I had my baby in the bush where I live, as I've done with all my previous children. A traditional birth attendant delivered my baby girl but soon after I became very sick. I had a very high fever and was shaking uncontrollably. I felt like all the energy was leaving my body. I had been cut very badly and became infected. I found it painful to pass urine and the pain made me want to be sick. My family put me on a donkey cart and it took two hours to get here.

I have been in the hospital two days and the staff check my blood pressure, have given me medicine and put me on an oxygen machine. The doctor says I look better now and I feel like I'm getting a little more energy.

I feel like now I am here I will be OK. I was in a lot of pain but every day I feel a little bit better. If I had stayed in the bush and not come to hospital, I don't know what would have happened to me.

FRANCE

The vast majority of patients seen by the staff at the Médecins Sans Frontières (MSF) programme in Paris are asylum seekers who live on the streets or in temporary accommodation.

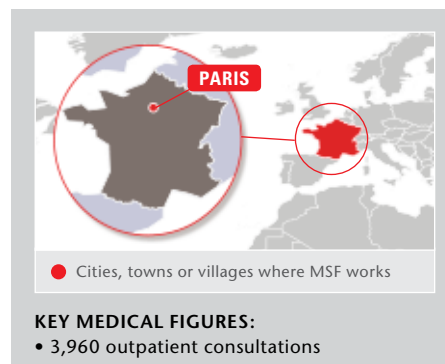
Most have no health insurance, and it is extremely hard for them to access any kind of medical care. The difficulties are compounded for people who cannot speak French, and who do not have a residence permit.

MSF's health centre offers medical, psychological and social care through a multidisciplinary staff of nurses, doctors, psychologists and social workers. Many patients – particularly those receiving psychological care – have suffered repeated

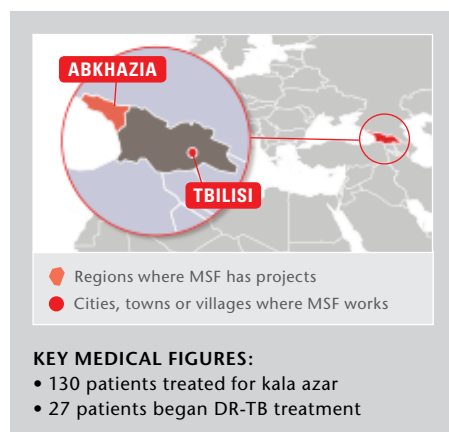
traumatic experiences both at home and in exile. In 2012, the team saw around 100 new patients. As well as medical consultations, staff carried out more than 2,100 psychological consultations. Nearly 900 patients received social assistance.

In addition to providing direct medical and social assistance to those in need, MSF's goal is to ensure that barriers are removed, so that vulnerable people can access care in the public system.

No. staff end 2012: 13 | Year MSF first worked in the country: 1987 | msf.org/france



GEORGIA



People in Georgia who contract kala azar, or visceral leishmaniasis, now have greater access to quality care and shorter, more tolerable treatment.

Kala azar is a parasitic disease that is almost always fatal without treatment. It is transmitted through bites from infected sandflies. Symptoms include fever, weight loss, enlargement of the liver and spleen, anaemia and immune-system deficiencies. It is a neglected disease, and treatment until recently has been painful, requiring multiple injections which caused toxic side effects.

The disease is mainly found in Bangladesh, India, Ethiopia, Sudan, South Sudan and Brazil. However, incidence of kala azar has steadily risen in Georgia. Around 180 people are diagnosed with the disease each year, many of them children.

In 2011, Médecins Sans Frontières (MSF) began working with Tbilisi's Parasitological Hospital to improve detection of kala azar with rapid diagnostic tests, and to introduce a better drug, liposomal amphotericin B, to treat it. This treatment regimen is far easier for patients: they receive the drug for four days and need only remain in hospital for a maximum of 10 days rather than the month that was required with the previous medication.

After completing staff training, the MSF team handed over the kala azar programme to the national authorities in 2012, with a final donation of liposomal amphotericin B.

Tuberculosis programme handover

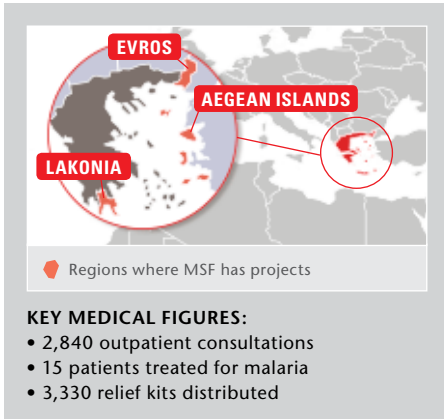
Since 2010 MSF has run a TB programme focusing on the treatment of patients with multidrug-resistant TB (MDR-TB) in the autonomous republic of Abkhazia. MDR-TB is a strain of the disease that does not respond to standard TB drugs. Treatment takes up to two years and often causes painful side effects. MSF continues to treat patients while it assists with the development of the Abkhazian National TB Programme, which will manage all activities in future.

Access to care in Sukhumi

In 1993, during the civil conflict in Abkhazia, MSF began a programme delivering medical services to a community in Sukhumi who were without access to healthcare. During 2012, MSF continued to provide medical care, including surgery and eye care, to 64 patients.

No. staff end 2012: 44 | Year MSF first worked in the country: 1993 | msf.org/georgia

GREECE



Migrants arriving in Greece, including asylum seekers, face prolonged detention of up to 18 months.

Access to medical care is limited to emergencies, and new migration policies have resulted in mass arrests of migrants and their detention in sub-standard 'pre-removal centres'.

During 2012 Médecins Sans Frontières (MSF) provided medical assistance to migrants and refugees arriving at the land border with Turkey (Evros region) and on

the eastern Aegean islands (Agathonisi, Lesbos, Leros, Samos, Simi), as well as to people in detention centres.

Most people came from countries affected by conflict, and their medical complaints were mainly a consequence of the gruelling journeys and poor conditions they had endured. MSF medical staff treated injuries, skin and respiratory infections, gastrointestinal problems, frostbite and exhaustion. They also provided treatment for chronic conditions such as diabetes and heart disease.

Basic relief items such as hygiene kits and sleeping bags were regularly distributed to people on arrival and in the detention centres of Evros, and necessities such as dry clothes provided to those who needed them.

In December, teams extended medical services throughout the region of Eastern Macedonia and Thrace, making regular visits to detention centres as state medical teams had withdrawn. Migrants' health had been affected by the length of their detention in sub-standard and overcrowded conditions. Staff treated patients for medical problems such as scabies, skin infections and gastrointestinal complaints.

Reappearance of malaria

Malaria has reappeared in Greece after almost 40 years. MSF supported the Hellenic Centre for Disease Control and Prevention team and local health facilities for seven months, working in the municipality of Evrotas, in Lakonia, contributing to prevention, epidemiological surveillance, clinical management, laboratory diagnosis and vector control.

Samira*

17 years old, Lesbos

In the Ghazni region of Afghanistan where we used to live, my father was killed, and my mother and two sisters were raped. I was the only one spared, so we decided to flee. We walked for months through mountains in the dark and the cold. We reached Lesbos island in extreme exhaustion. Here we feel safe; we received help from MSF and the local population.

At the border with Iran they separated us from one of our sisters: they put her in another truck and since then we've lost track of her. We want to go and live in a peaceful place, where our lives won't be at risk.

*Name has been changed.

No. staff end 2012: 16 | Year MSF first worked in the country: 1991 | msf.org/greece



Detained migrants in southern Greece are registered in Poros (Evros), where MSF provided medical care.

GUATEMALA

In four years, the percentage of female patients seeking assistance at the Médecins Sans Frontières (MSF) sexual violence treatment programme within 72 hours of being assaulted has increased from 17 to 64 per cent.

Timely treatment means patients can receive prophylactic medication to prevent the transmission of sexually transmitted diseases, including HIV.

For years, victims of sexual violence have received very little support in Guatemala, and have rarely known where to look for help. Recently, some positive changes have been introduced: survivors of sexual violence are now able to receive medical attention before a crime is reported, and medical staff in public health facilities have begun to offer treatment.

MSF completed the handover of its programme to the Ministry of Health in 2012, having provided 24-hour services to victims of sexual violence since 2008. Teams had worked in five locations: a health centre and two clinics on the outskirts of Guatemala City, the emergency department of the city's general hospital, and in the

Public Ministry, where assaults are reported. The provision of services in the Public Ministry means that victims of assault who seek justice can access medical care directly.

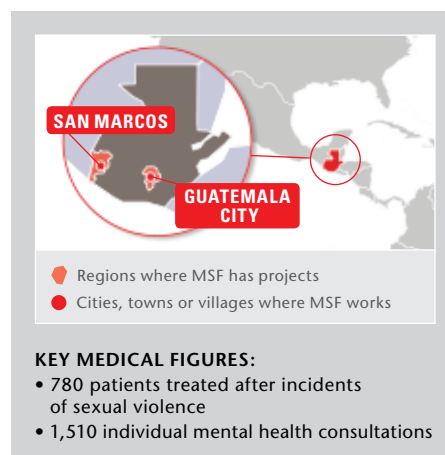
The teams provided medical, psychological and social care to nearly 4,000 patients over the course of the programme, and carried out more than 11,000 follow-up consultations. MSF also worked to influence policies and practices, including advocating the availability of 24-hour healthcare.

In 2010, the Ministry of Health adopted a national protocol on the treatment for victims of sexual violence, facilitating access to healthcare, and in 2011 asked MSF to train its staff to implement this protocol. MSF provided training for 450 health professionals in 28 healthcare facilities.

Earthquake response

A 7.2 magnitude earthquake hit Guatemala's Pacific coast on 7 November, destroying hundreds of homes.

MSF donated medicines to health centres in affected districts of the department of San Marcos. The team also provided psychological first aid – initial support and counselling in the immediate aftermath of a traumatic event – to survivors suffering panic attacks. In the district of San Juan Ostuncalco, in Quetzaltenango department, more than 300 displaced families received hygiene kits.



Claudia

17 years old

I was on my way to class, I was going to do my practical work, when they made me get into the car. They abducted and attacked me. They left me with only my trousers and shirt.

My mother's friend told us about a hospital we could go to. We went there and spoke with a woman. That's how we got in contact with MSF for the first time.

I think the hardest time of all was the moment I discovered I was pregnant. I remember the first day I put on maternity trousers and I cried so hard. I was ashamed to be seen outside. Some people helped me, but lots of people blamed me and said bad things about me. So I got angry ... angry with them ... angry with God who let this happen to me.

This has been a long, difficult and often bitter journey. I don't think the government is paying the attention it should to sexual abuse. It's not because it isn't happening – it's because they pay more attention to killers, as their crimes are more visible and everyone knows it's happening.

For more on MSF's inner-city programmes, including Guatemala City, visit the Urban Survivors website: www.urbansurvivors.org

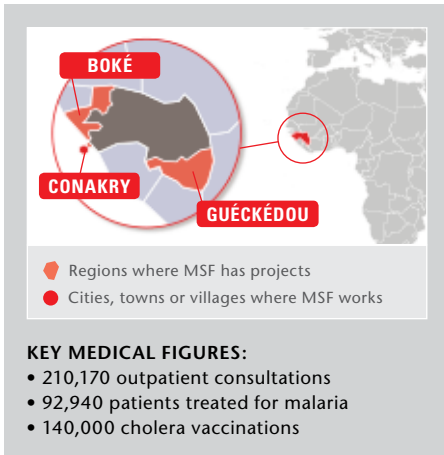


A member of staff leads a patient to her consultation in the Zona 1 health centre, Guatemala City.

No. staff end 2012: 23 | Year MSF first worked in the country: 1984 | msf.org/guatemala

GUINEA

Although the prevalence of HIV in Guinea is relatively low compared with other countries in west Africa, many people cannot access treatment early and this impacts on their health.



Supporting 5,800 patients on antiretroviral (ARV) treatment in the capital, Conakry, Médecins Sans Frontières (MSF) has become a significant provider of HIV/AIDS care in the country. Staff offer diagnosis, treatment and psychosocial support at five health centres across the city, as well as at an outpatient clinic in Matam district.

Teams also provide basic health services to pregnant and breastfeeding women and children under five at three centres in Matam. In 2012, staff carried out 57,000 consultations for children under five and assisted 7,000 births.

MSF handed over the HIV programme in Guéckédou after activities had been integrated into the district hospital. MSF will supply ARV drugs for 1,670 patients until the end of March 2013 and the Ministry of Health has committed to ensuring continuity of treatment from then.

Responding to cholera emergencies

In response to a cholera outbreak in Boffa prefecture, in Boké region, MSF vaccinated over 140,000 people between April and June. This was the first time an oral vaccine was used as a preventive measure against cholera before an outbreak turned into a fully fledged epidemic. Staff responded to another cholera outbreak in Conakry in June, treating more than 50,000 people across four temporary treatment centres.

The team also conducted preventive water, sanitation and educational activities to help control the spread of this water-borne disease.

Malaria

Malaria is a leading cause of illness and death in Guinea. In Guéckédou, MSF supports malaria prevention and treatment activities in the local district hospital, six health centres and nine health posts, and trains medical staff. In 2012, 77,000 people received malaria treatment, almost a third of them cared for by MSF-trained community health workers.

David*

25 years old, from Matam

I've been very sick for more than eight months. I went to a lot of health centres and hospitals here in Conakry. I tried everything, even traditional medical treatments. No one ever suggested an HIV test. Coming here, I was tested, and then told the news. Nobody knows in my family except my uncle, who accompanies and supports me. These last months have been physically and emotionally exhausting.

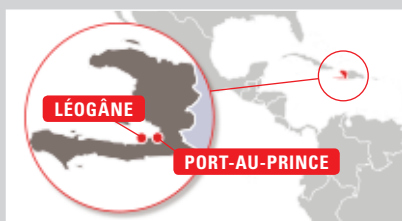
**The patient's name has been changed.*

No. staff end 2012: 366 | Year MSF first worked in the country: 1984 | msf.org/guinea



Rehydrating fluids are administered to patients at Donka cholera treatment centre, Conakry.

HAITI



KEY MEDICAL FIGURES:

- 24,980 patients treated for cholera
- 16,820 surgical procedures
- 14,890 births assisted

Reconstruction has been slow since the 2010 earthquake, and many Haitians continue to rely on humanitarian aid for emergency medical care.

Delays in disbursements and in the realisation of planned projects mean the reconstruction of the health system is far from complete. Access to healthcare was a problem for vast numbers of people even

before the disaster: fees were unaffordable and there were few adequately equipped public hospitals. Médecins Sans Frontières (MSF) continues to fill gaps in emergency care with more than 500 beds in four hospitals. Teams also provide treatment for cholera, a potentially deadly water-borne disease, which according to Haitian authorities had affected 638,000 people and killed almost 8,000 by the end of 2012.

Maternal healthcare

Pregnant women in Haiti often find themselves in a precarious situation in emergencies. MSF runs a 130-bed obstetric and neonatal emergency hospital in the Delmas 33 neighbourhood of Port-au-Prince, offering free, round-the-clock emergency care for women experiencing complications, including common hypertensive disorders such as pre-eclampsia. In 2012, 7,980 patients were admitted to the hospital and teams assisted 6,360 births.

In addition, the hospital provides a full package of reproductive healthcare services including family planning, prevention of mother-to-child transmission of HIV, neonatal

and postnatal care and mental health counselling. A 10-bed cholera centre has also been set up inside the hospital for pregnant women who have contracted the disease.

Emergency surgery in the capital

In February, MSF opened the Nap Kenbe – Creole for ‘staying well’ – surgical centre in Tabarre, eastern Port-au-Prince. Teams provide emergency trauma, orthopaedic and abdominal surgery for victims of gun crime and domestic violence as well as people injured in road accidents. Of almost 1,200 patients in 2012, 18 per cent had suffered violent trauma and 72 per cent were victims of accidents.

MSF continued to work out of the 130-bed Drouillard trauma hospital close to the Cité Soleil slum in the north of the city. This facility is equipped with an emergency department, operating theatres and intensive care and burns units, and provides physiotherapy and mental health services. In 2012, hospital staff cared for 19,700 emergency patients and carried out 8,000 surgical procedures, treated 480 people with burns and provided medical and psychological support to 150 victims of sexual violence.



Many of the patients at MSF's burns unit in Drouillard hospital, Cité Soleil, are young children injured in domestic accidents.



© Emilie Régnier

Mothers bring their sick children for diagnosis and treatment at Chatuley, Léogâne. Originally a tent hospital treating earthquake survivors, MSF has since built a 160-bed container hospital.

Martissant emergency and stabilisation centre

The only MSF facility that remained intact after the earthquake was the 35-bed Martissant clinic for paediatric care, maternity services and internal medicine. A 100-bed cholera treatment centre remained open until June. MSF closed its mental health programme at Martissant at the end of the year. In total, more than 61,200 patients received treatment at the facility in 2012.

Chatuley hospital, Léogâne

The 160-bed container hospital run by MSF in the city of Léogâne, close to the earthquake's epicentre, is the only facility in the region offering free 24-hour care for medical and surgical emergencies. Some people travel from Port-au-Prince for medical attention there. Facilities include a laboratory, radiology, physiotherapy and mental health services and a special outpatient department for pregnant women and children under five. In 2012, staff assisted 6,600 births and carried out 3,600 surgical procedures – most of these

were for women requiring caesarean sections and victims of road accidents. The cholera treatment unit is the only facility treating patients suffering from cholera-associated medical complications.

Cholera response

Cholera can cause rapid dehydration and death if untreated and is commonly found in areas with unsafe water and poor sanitation control. Unhygienic living conditions and a lack of healthcare have exacerbated the cholera crisis that began in the country in 2010. Public cholera treatment centres remain inadequate throughout Haiti and the overall response to the crisis is limited because of reduced international funding. In 2012, MSF treated close to 25,000 people with cholera in Port-au-Prince and Léogâne. Patient numbers increased after hurricanes Isaac and Sandy, when rains caused open sewers to overflow and led to the spread of contaminated water, but the peak period was in April and May, during the rainy season. Teams continued preventive

measures, including distribution of hygiene kits, water chlorination and education and awareness activities. MSF was still treating more than 500 people for the disease per week at the end of the year.

Completion of anaesthesia training

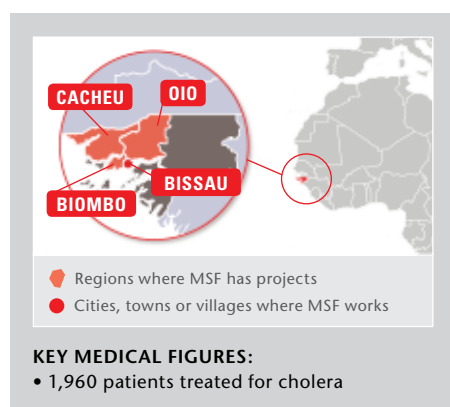
In September, MSF completed the training of nurses in anaesthesia. In the absence of other educational institutions providing such training, this course equips nurses with the critical skills they need in the management of obstetric and surgical emergencies.

No. staff end 2012: 2,582 | Year MSF first worked in the country: 1991 | msf.org/haiti

GUINEA-BISSAU



A young woman, five months pregnant with her first child, recovers from cholera at the MSF treatment centre in Bissau.



An outbreak of cholera gradually escalated to a health emergency in Guinea-Bissau.

Cholera, a communicable, water-borne disease that can cause rapid dehydration and sometimes death, is a recurring health issue in Guinea-Bissau. Outbreaks can be triggered by heavy rainfall and flooding in areas with inadequate water and waste management.

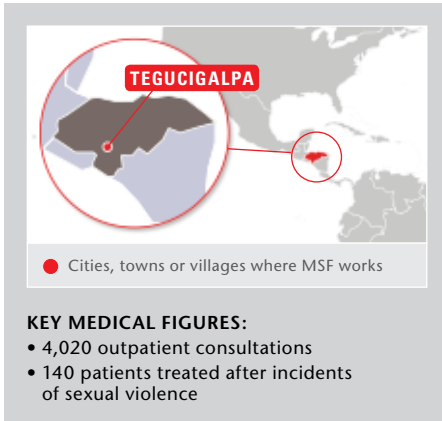
A team from Médecins Sans Frontières (MSF) worked with the Ministry of Health to establish a national programme on cholera preparedness in 1999. Since then, emergency teams have provided support during major cholera outbreaks in 2005 and 2008.

At the end of August, the Ministry of Health began to record an increase in the number of cases of cholera. MSF started assisting an emergency response in the capital Bissau and affected areas of Biombo, Oio and Cacheu regions in October.

Teams set up a 60-bed cholera treatment centre in Bissau and treatment units in the other areas. MSF also supported health centres in the management of patients with cholera by opening isolation units, providing treatment and medical supplies, improving hygiene and sanitation inside facilities, training health staff and raising awareness among the population of the disease and how it is transmitted.

MSF proposed using a new, two-dose oral cholera vaccine, which had recently been used in other countries. As cholera vaccinations had never been carried out in the country before, the proposal had to pass through a complex approval system, and approval was given too late for vaccination to have an impact on the epidemic in 2012. However, the government has agreed to implement a preventive cholera vaccination campaign in 2013.

HONDURAS



Violence is widespread in the Honduran capital of Tegucigalpa, but very few victims seek medical attention, fearful of their aggressors and deterred by the many barriers to accessing healthcare.

Each week, Médecins Sans Frontières (MSF) teams visit more than 20 sites in the capital's most violent neighbourhoods, offering assistance to people who would otherwise be unlikely to receive medical attention. Social workers, medical staff and psychologists provide preventive care, first aid and psychological support. Patients in need of further medical and psychological attention are referred to four health centres supported by MSF, where staff ensure that comprehensive treatment is available.

Tegucigalpa University Hospital is the only public hospital in the city with the capacity to treat victims of trauma, and violence-related admissions have doubled over the past five years. The overwhelming number of people in need of urgent care due to violence poses an enormous burden on an already overstretched medical system, particularly emergency departments. MSF staff hope that treating and documenting the needs of the people they see will encourage the Honduran authorities to recognise the need for a firm commitment to address this issue and implement an appropriate response.

Marco

30 years old

I left home when I was around 11 years old. I have always lived on the street. One takes refuge on the streets when there's no other option.

I got into a fight. Both of us were armed, and we exchanged gunfire. We both got injured. And that's how my foot got injured. The truth is that there is so much meanness here on the streets that one person doesn't hesitate to harm another. I have seen a lot of my friends die on the streets.

I was taken to the hospital. Many homeless people die at the hospital, because they don't receive the attention they deserve or aren't treated in time. After hours of waiting, I called MSF because they always help you out. They took care of me at the hospital. I'm getting better now.

For more on MSF's inner-city programmes, including Tegucigalpa, visit the Urban Survivors website: www.urbansurvivors.org

No. staff end 2012: 34 | Year MSF first worked in the country: 1974 | msf.org/honduras



A homeless man in Tegucigalpa receives an eye examination from an MSF health worker. Teams go into city streets daily to assess medical needs.

© Spencer Platt/Getty Images

INDIA

KEY MEDICAL FIGURES:

- 119,500 outpatient consultations
- 640 patients began TB treatment
- 1,990 patients treated for kala azar

Many people in India still cannot access the medical services they need, despite significant economic development within the country.

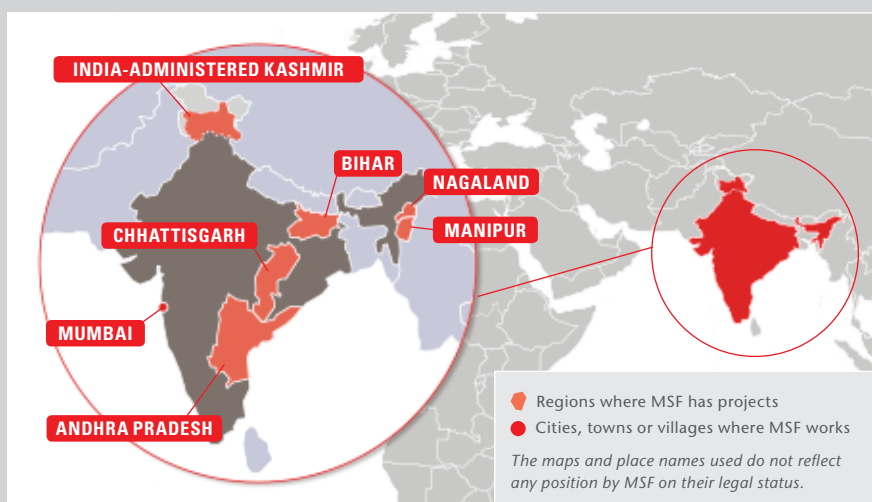
Drug-resistant tuberculosis (TB) is a major health problem. Drug-resistant forms of TB are much more difficult to treat, requiring at least two years of medication, which can cause serious side effects. Although growing public awareness of the issue has led authorities to increase access to treatment, the national health system's response remains underdeveloped.

Médecins Sans Frontières (MSF) has HIV and TB clinics in Manipur, where 17 new patients began treatment for multidrug-resistant TB (MDR-TB) in 2012. Patient numbers increased significantly when a fourth clinic was opened near the border with Myanmar in April.

A long history of insurgency, poor infrastructure and a scarcity of staff mean specialist health services are almost non-existent in the far northeastern regions of the country. MSF supports basic and specialist healthcare, including TB services, in Mon district hospital in Nagaland.

In Mumbai, an MSF team specialises in HIV treatment for people who cannot access the

care they need through the public system. Staff offer medical and psychosocial care to people with HIV who need second- or third-line treatment or alternative first-line treatment, and people who are co-infected with MDR-TB or extensively drug-resistant TB or hepatitis B or C. Research into treatment options and models of care is an important component of the Mumbai project.



A patient undergoing treatment for MDR-TB, photographed outside his home near Churchandpur, Manipur.

Supporting victims of conflict

In southern Chhattisgarh state, MSF provides comprehensive basic healthcare through weekly mobile clinics to people caught in the long-running conflict between the government and Maoist opposition groups. Patients requiring specialist care are referred to facilities in Andhra Pradesh. In the town of Bijapur, MSF's mother and child health centre offers immunisations and basic healthcare, and staff work with the district hospital to perform emergency obstetric surgery and diagnose TB.

In the disputed region of Kashmir, mental healthcare continues to be the main medical need. MSF staff focused services on counselling in five urban areas, while basic healthcare and mental health activities in the rural areas of Kupwara district came to an end in April. The team carried out two emergency mental health programmes, offering counselling, after violence in Srinagar in 2012.

Researching better treatment options in Bihar

Bihar state has one of the highest incidences of kala azar (visceral leishmaniasis) in the world. Kala azar is transmitted by infected sandflies and without treatment it is almost always fatal.

In 2007, MSF introduced liposomal amphotericin B treatment to the kala azar programme in Vaishali district, which covers five health centres and Sadar district hospital. This treatment is more effective and more rapid than previous regimens, but also more expensive. In August, the team began a three-year project with the not-for-profit research and development organisation *Drugs for Neglected Diseases initiative* (DNDi) to examine the safety and effectiveness of more affordable treatment options based on liposomal amphotericin B.

In Biraul subdistrict of Darbhanga, Bihar, MSF has managed five feeding centres since 2009. Negotiations with the state government in 2012 will lead to the expansion of MSF's model for community-based management of malnutrition throughout Darbhanga in 2013: for the first time in India, treatment for children with severe malnutrition will be integrated into the state's public health system, from the community level and basic health facilities up to the intensive care unit that MSF will build at the district hospital.



MSF helped Saliyet, a patient receiving treatment for HIV and MDR-TB in Churhandpur, Manipur, build a room of his own outside his brother's home.

Gopal*

Mumbai

I was working as a cook when I was first diagnosed with drug-resistant TB. The treatment involved six months of injections every day. It was very difficult – every day there was pain. After that I had to take 15 to 17 different tablets every day. I used to just stay at home. It has been six months now since I finished my treatment. Now I am free of tension and I want to earn money and live life properly. My family are happy because I've got my job back and I'm able to support them.

** The patient's name has been changed. Gopal is one of the patients featured in the article on TB, pages 22–24.*

IRAN

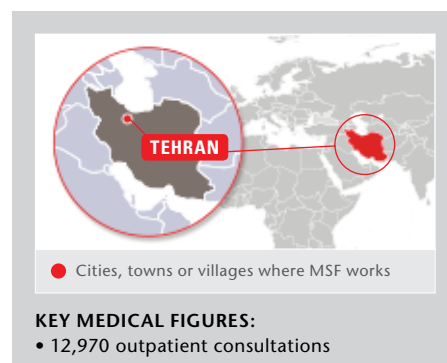
Authorities in Iran have been improving social and medical services in the capital Tehran, but many people living in the poorest neighbourhoods remain unable to access them.

In April, Médecins Sans Frontières (MSF) opened a health centre for women and children under five years of age in Darvazeh Ghar, a district where many do not have the identity papers they need to use the country's healthcare system.

Social stigma is another obstacle to accessing healthcare. Drug users, women with sexually transmitted diseases and newborns who are suffering withdrawal symptoms because their mothers were drug

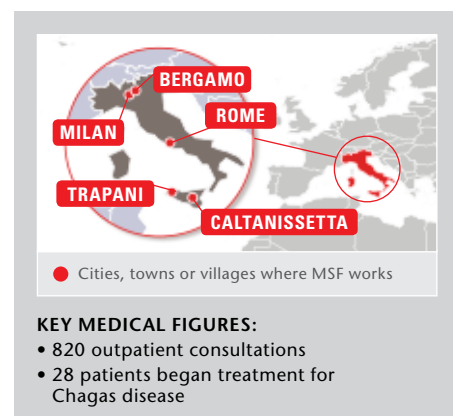
users are often not welcome in medical centres. Many are particularly susceptible to HIV, hepatitis C and tuberculosis, diseases which pose a serious public health concern.

Since the health centre opened, staff have been seeing around 1,000 patients per month. The team offers general medical and gynaecological consultations, as well as ante- and postnatal care. Patients requiring emergency treatment are referred to the Ministry of Health hospital.



No. staff end 2012: 84 | Year MSF first worked in the country: 1990 | msf.org/iran

ITALY



Screening and treating Chagas disease

Some migrants have been diagnosed with Chagas, a parasitic disease transmitted by the bite of an insect most prevalent in Latin America and almost unknown in Italy. MSF shared its knowledge of the disease with the Ministry of Health and other parties involved in migrant health. In the northern city of Bergamo, in collaboration with Verona hospital and Italian association OIKOS, MSF teams met with Latin American migrants to screen for Chagas and arrange treatment. MSF is helping develop

standard procedures in Italy for the prevention, detection and treatment of the disease.

Caring for the homeless in Milan

In December, MSF opened a programme to provide medical care to homeless people discharged from hospital, most of whom have chronic diseases like diabetes and hypertension, and require follow-up. Some patients were also suffering from conditions exacerbated by the cold, such as bronchitis and respiratory tract infections.

No. staff end 2012: 5 | Year MSF first worked in the country: 1999 | msf.org/italy

Gaps in healthcare persist for migrants and asylum seekers arriving in Italy.

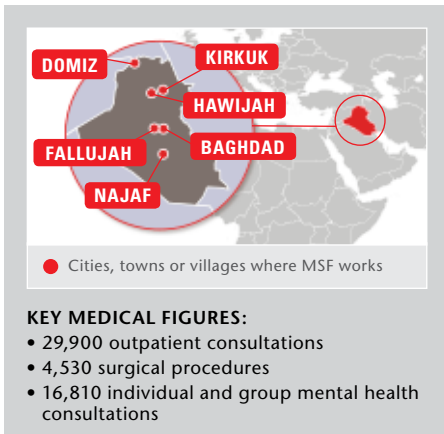
Migrants without papers are detained for up to 18 months in Centres for Identification and Expulsion. Health services, which have been subcontracted to private firms, lack coordination. Tuberculosis (TB) and other neglected diseases are poorly diagnosed and treated, despite national protocols.

In the centres in Caltanissetta, Milan, Rome and Trapani, Médecins Sans Frontières (MSF) worked with the Ministry of Health, the Ministry of Foreign Affairs and private entities managing the centres to improve the quality of care. A mobile medical team advised and trained medical personnel working at the centres to detect and treat TB.



A woman takes a blood test for Chagas disease in Bergamo. Symptoms of the disease may not show for years.

IRAQ



Activities in Iraq were expanded in 2012 to provide assistance to Syrian refugees.

Tens of thousands of Syrians settled in the north of the country over the course of the year. Since April, Médecins Sans Frontières (MSF) has been the main healthcare provider in Domiz refugee camp. The team delivers basic medical services and mental healthcare.

Emergencies are referred to the nearest hospital. Staff also distribute relief items such as hygiene kits, and ensure access to safe water and adequate sanitation in the camp.

Emergency surgery in Hawijah

MSF's surgical team continued to support the emergency department of Hawijah general hospital, keeping the operating theatre open round the clock and performing more than 300 emergency procedures a month.

Mental health services growing

Through its mental health services in Baghdad and Fallujah hospitals, MSF aims not only to provide care to people suffering psychologically from violence and insecurity, but also to reduce the stigma attached to mental health issues more broadly in society. Some 3,800 people received treatment in 10,700 counselling sessions, and the Ministry of Health is rolling out services based on the MSF model to other health facilities. In addition, a telephone helpline has been set up so that people can contact mental health staff more easily.

Kidney dialysis programme handed over

Having increased the capacity of Kirkuk general hospital's dialysis unit from 22 patients in 2010 to 100 in 2012, MSF handed services over to the Ministry of Health. During 2012, the surgical team carried out 26 operations on patients with kidney disease. Staff also provided training and worked with the hospital more generally to improve sterilisation, infection control and pharmacy management.

New approaches in obstetric and neonatal care

Half of all babies in Najaf governorate are born in Al-Zahra hospital, the main referral centre for obstetrics, gynaecology and paediatrics. The MSF team works closely with hospital staff to build capacity, offering bedside training to bring neonatal mortality rates down. New infection control measures are being implemented to reduce the incidence of sepsis – a severe response to bacterial infection – which is a primary cause of death. Specialists in obstetrics and neonatology set up meetings to introduce improved practices, and worked to build partnerships between medical institutes.

No. staff end 2012: 304 | Year MSF first worked in the country: 2003 | msf.org/iraq



A Syrian refugee speaks with a doctor about her child's health at the clinic in Domiz camp.

KENYA

KEY MEDICAL FIGURES:

- 335,900 outpatient consultations
- 12,930 patients on first-line antiretroviral treatment
- 1,500 patients began TB treatment
- 350 patients treated after incidents of sexual violence

Healthcare needs are great in Kenya's urban slums and refugee settlements, where poor living conditions put people at increased risk of contracting communicable diseases.

Refugee camps and urban slums are overcrowded and characterised by a lack of basic services such as water and sanitation. Accessing healthcare is a challenge, particularly for people with chronic or neglected diseases such as HIV and tuberculosis (TB).

Healthcare in Dadaab

Located on a desert plain in northeastern Kenya, Dadaab is the largest refugee complex in the world. The population, mainly Somalis fleeing conflict and drought in their country, is approaching half a million. In addition to the original camps of Dagahaley, Hagadera and Ifo, there are two new camps – Ifo extension and Kambios – which were set up to accommodate the growing numbers of refugees who started to arrive in 2011. In December 2012, the Kenyan government announced the cessation of refugee reception, registration and documentation in urban centres in

an effort to relocate refugees and asylum seekers to the camps. Yet the camps are ill-equipped to meet people's basic needs.

Médecins Sans Frontières (MSF) has been the sole provider of healthcare in Dagahaley camp since 2009, working out of a 200-bed hospital and at four health centres, where medical services include vaccinations, antenatal consultations and mental healthcare. Staff carried out an average of 14,000 consultations and admitted 1,000 patients from the refugee and host communities to the hospital each month.

High rates of acute malnutrition were recorded in children over five years old in the camps in 2012. MSF included children up to 10 years of age in its feeding programme and lobbied for

other healthcare providers to include this age group in their annual nutritional surveys. More than 2,200 severely malnourished children were admitted for inpatient treatment over the year. There is also concern about the quality of shelter and sanitation. Poor sanitation has led to outbreaks of disease that otherwise could have been controlled: in September, MSF responded to hepatitis E and cholera outbreaks in the camps. Both diseases are transmitted mainly through contaminated water.

Since July 2012, following several security incidents in which aid workers were targeted, it has not been possible for MSF international staff to work on a permanent basis in Dadaab.

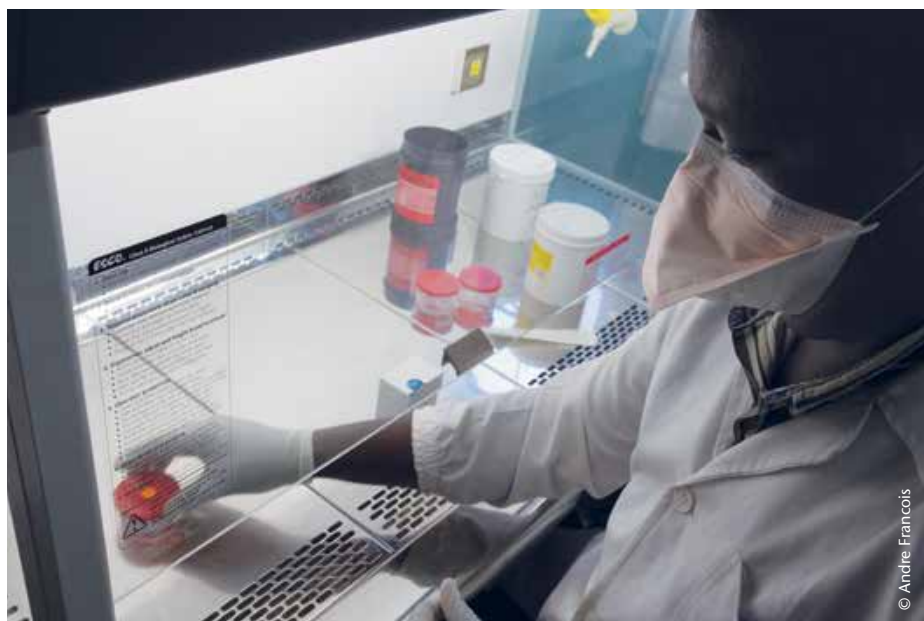
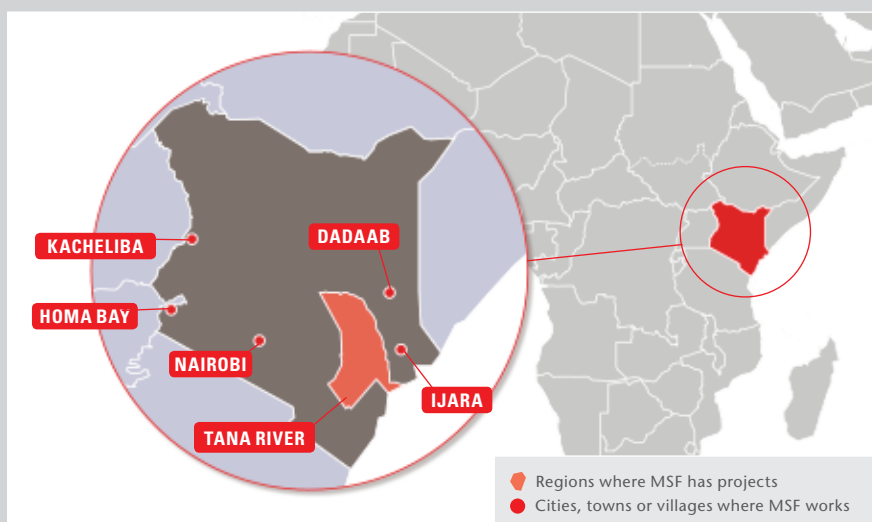
Response to violence in the Tana River area

Clashes between the two major communities in the Tana River district, the Orma and the Pokomo, caused dozens of casualties and significant displacement in August and September. MSF provided psychosocial support to more than 900 people affected by the violence, as well as medical and logistical assistance to health facilities and in the camps for displaced people.

HIV and TB

In Homa Bay, Nyanza province, MSF is providing care to over 10,500 people living with HIV/AIDS. Roughly one in four of the 4,500 people tested in 2012 were found to be HIV positive and more than 1,000 joined the HIV programme. An additional 345 patients were registered in the TB programme.

In Nairobi, MSF continues to run the Blue House clinic in the slum area of Mathare and three clinics in Kibera. A new TB diagnostic test introduced in 2011 has led to an increase



A laboratory test is used to diagnose TB and strains resistant to the primary TB drug, rifampicin, at Kibera South health centre.



Kizito (r), 49, started showing symptoms of diabetes in 2006 with frequent thirst and weight loss. By 2008 he weighed only 30 kg. He now receives free, ongoing care at the medical clinic in Kibera.

in the number of people identified with drug-sensitive and drug-resistant TB. MSF provides a range of services in Kibera, including HIV diagnosis and treatment, maternal and paediatric care, and treatment for chronic diseases such as diabetes and hypertension. In 2012, cervical cancer screening was introduced for women with HIV. In total, the teams in Nairobi saw more than 10,000 patients per month.

A large health centre incorporating a 24-hour maternity unit was completed on the edge of Kibera in 2012. It will be run jointly by MSF and the Ministry of Health from the beginning of 2013.

Sexual violence

Sexual violence is a major social and medical issue in Mathare, and MSF has provided medical care and psychological support there since 2008. Each month, dozens of people, more than half of them children, come to the centre for help.

A new 24-hour sexual violence clinic was opened on the outskirts of Kibera in 2012. Each week it provides 20 to 30 victims of rape with treatment to reduce the risk of contracting sexually transmitted infections, psychological support and medical care.

Kala azar

Kala azar, a parasitic disease transmitted by sandflies, is almost always fatal without treatment. In 2012, 500 patients were treated for kala azar in Kacheliba hospital in West Pokot district, where MSF has run a programme since 2006, with a 98 per cent cure rate. In December, the programme was handed over to the Ministry of Health, which is implementing a national kala azar control programme, supported by the not-for-profit research and development organisation the *Drugs for Neglected Diseases initiative* (DNDi). Before the handover, MSF trained health workers and raised awareness of kala azar among the population through a photo exhibition in Pokot, Turkana, Merti, Wajir and Habaswein.

Handover of Ijara programme

In October, a basic healthcare programme with a focus on women and children in the Ijara district of North Eastern province was handed over to the Ministry of Health and Atlantic Global Aid, a local organisation. MSF provided reproductive healthcare and treatment for 4,800 people in 2012, and offered vaccinations and supported TB care.

No. staff end 2012: 851 | Year MSF first worked in the country: 1987
msf.org/kenya

Dickens

34 years old, is undergoing treatment for HIV and multidrug-resistant TB (MDR-TB).

I discovered that I had TB in 2008, when I was working in Tanzania. I wasn't getting better and in February 2010 I came back home. I was put on first-line medication – three tablets. I started losing weight very rapidly. It was scary. I weighed 58 kg, and within two weeks I dropped to 51. They realised that I was probably resistant. So they sent my sputum to Nairobi and the result came back that I had MDR-TB. I was referred to Homa Bay, and luckily I got into the programme and started treatment in October 2010.

I also have HIV. I take 19 tablets for MDR-TB and four tablets for HIV every day. I've not undergone many other treatments, but I don't think that there is any worse than this. We [the patients] support each other. It's important, because sometimes people feel like running away. When I got here I was very weak, I could walk only short distances. Now I weigh 60 kg, I am walking, and I am already halfway through treatment.

JORDAN

Jordan has become a place of refuge for hundreds of thousands of Syrians fleeing conflict in their country.

Médecins Sans Frontières (MSF) has been operating a specialist surgical programme in Amman for victims of conflict since 2006. The programme was initially established to offer surgery for severely injured Iraqis – adults and children burned and wounded by bombs and explosions, many requiring reconstructive and orthopaedic surgery they could not get in their home country. With increased conflict in the region, patients now come from Yemen, Syria, Libya, Gaza and Egypt.

From March, MSF visited transit camps and health facilities, in an effort to identify Syrian refugees in need of operations and

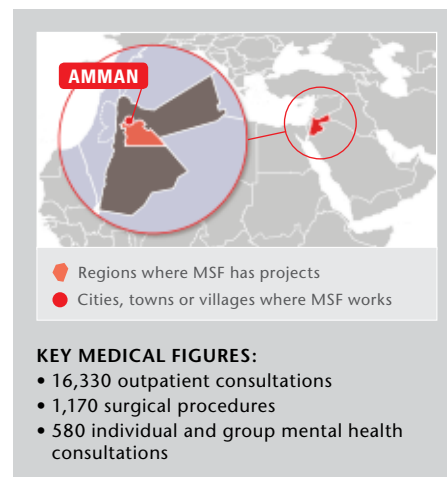
offer them surgery. As a result, the number of orthopaedic operations increased by 77 per cent over 2011. There was also an increase in Yemeni patients, with more than 100 admitted in 2012.

Expanding medical activities

Many Syrians are in need of medical care and mental health support. MSF opened an outpatient department in Amman's Jordanian Red Crescent hospital compound. Patients receive treatment for acute needs and chronic conditions such as diabetes and hypertension. More than 350 medical and surgical consultations were conducted monthly.

Physiotherapy has also been crucial for people with conflict-related injuries that could not be properly treated within Syria, and staff provide psychosocial support to help people cope with symptoms of mental health distress as well.

MSF staff working in Jordan are accounted for through programmes in Iraq | Year MSF first worked in the country: 2006
msf.org/jordan



To provide effective care, referrals for additional expertise and services are sometimes required. MSF has therefore developed partnerships with Handicap International, the Center for Victims of Torture, the Jordan Health Aid Society, UN agencies and specialist hospitals in Jordan.

KYRGYZSTAN

Kyrgyzstan has one of the highest burdens of drug-resistant tuberculosis (DR-TB) in the world, but treatment is hard to obtain.

Severe budget constraints over past decades have resulted in a deterioration of health services in general. DR-TB treatment takes up to two years and often causes severe side effects. It is expensive, and in Kyrgyzstan it is prescribed selectively, according to criteria set by the country's DR-TB Consilium, because of a chronic shortage of drugs. In October 2011, a further decrease in supply led to the suspension of the initiation of DR-TB treatment.

Decentralised model of care for DR-TB

In February, Médecins Sans Frontières (MSF) began offering comprehensive, free medical care for people with DR-TB and people co-infected with both HIV and TB in the district of Kara Suu, Osh province. The rate of DR-TB is particularly high in this region, as is the number of patients waiting for treatment.

The programme is a model for decentralisation: staff screen for TB, DR-TB and HIV throughout the district. Those who are diagnosed then receive the drugs and medical care they need, as well as psychosocial support to encourage adherence. Most people are treated as

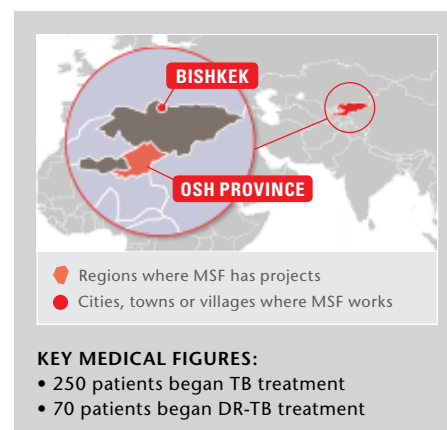
outpatients and only the most seriously ill are admitted to hospital. MSF helped renovate the TB facilities in Kara Suu to improve infection control.

High DR-TB prevalence in prisons

An MSF team is working across the capital Bishkek's detention system, screening inmates for TB. Those diagnosed with the disease are referred to the TB centre for detainees, where MSF provides treatment, counselling and social support. The team also offers nutritional support, and when patients are released – some 30 per cent are released while still on treatment – makes sure they receive psychosocial support and can continue treatment in public medical facilities.

Infection control is vital to reducing TB rates. MSF conducts awareness-raising activities and advocates for improved ventilation and living conditions, as well as early detection of TB, among prisoners.

MSF also supports the national reference laboratory with technical capacity, supplies and staff supervision and training.



Mukhtar 44 years old

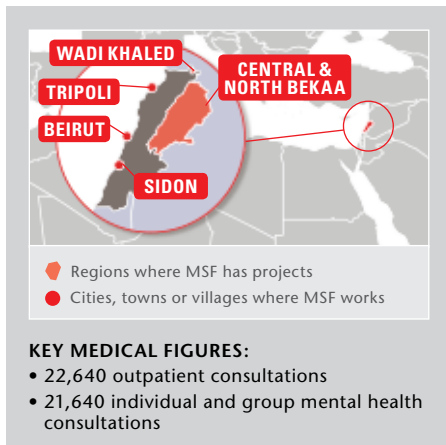
In February 2011, I felt bad, exhausted, had fever, dizziness. After many tests the doctors discovered TB. I was on treatment for six months, then they told me to go to Bishkek for treatment. I didn't have the financial means. Nobody was working at home; we were living on my mother's pension.

I had other tests, and was told that I needed nine more months of treatment. But there was no free place, so I was told to go home.

One day someone told me about the MSF project in Kara Suu. I decided to go. On 29 June I was hospitalised. Before hospitalisation I weighed 67 kg, but in hospital I reached 82 kg. I did more tests and the results were very good. On 14 September I moved to outpatient treatment, and I have since gained another 6 kg.

No. staff end 2012: 117 | Year MSF first worked in the country: 2005
msf.org/kyrgyzstan

LEBANON



Many of the 200,000 Syrians who had sought refuge in Lebanon by the end of 2012 were unable to access the healthcare they needed.

Some 63 per cent of unregistered refugees had received no assistance whatsoever, according to the Médecins Sans Frontières (MSF) study *Misery Beyond the War Zone*, conducted at the end of 2012.

The survey revealed a marked deterioration in the humanitarian situation for refugees and other displaced people in Lebanon, in large part due to very lengthy registration delays. Refugees in Lebanon are not entitled to formal assistance if they are not registered or at least enrolled in the registration process. Many live in overcrowded, substandard structures and cannot afford medical care. Local organisations and individuals within the Lebanese community have made a tremendous effort to help, but they are reaching the limits of their capacity.

The situation worsened in July, when the Lebanese government announced that a lack of funds was forcing it to stop financing refugees' medical care.

Assisting refugees in the Bekaa valley

MSF offered basic healthcare and mental health services in the north and east of the country. Teams worked at six health facilities in the Bekaa valley. In November, as needs grew and winter loomed, MSF distributed blankets and heating fuel as well as hygiene and cooking kits, and baby milk and nappies to thousands of refugees in the Bekaa valley. In Aarsal, staff provided mental health support until the end of December.

Expanding activities in Tripoli

An MSF team began working in Tripoli in February. Staff at Dar Al-Zahra hospital provided basic healthcare, as well as

treatment for chronic diseases and mental health services. In April, a mental health team started work at Tripoli government hospital, and in June MSF began to support the hospital's emergency department by training medical staff. Since November, MSF has been offering basic health services for vulnerable people in the poorest and most volatile neighbourhoods of the city.

MSF had been running a mental health programme in Wadi Khaled, but since many refugees left the town and moved to Tripoli, it was closed in September.

Assisting Palestinian refugees

Hundreds of thousands of Palestinian refugees are living long-term in overcrowded camps in Lebanon. Ein el-Hilweh, in Sidon (Saïda), is the most crowded, and the population has grown with the arrival of Palestinian refugees from Syria.

MSF provided mental health services in two UN clinics and in Al-Nidaa Al-Insani hospital. Since March, services have also been available outside the Palestinian camp in Sidon, in the Palestinian Red Crescent Society hospital and in Sidon government hospital, primarily to vulnerable Lebanese and Palestinian refugees living in unofficial gatherings outside the camp.

Mental health services at Burj el-Barajneh, in the suburbs of Beirut, which included psychiatric and psychological care, were handed over to the municipality and to the Islamic Health Society in December. Staff had worked at the MSF community mental health centre, the UN clinic, the Palestinian

Red Crescent hospital, and carried out home visits since 2009. More than 17,500 consultations were held over four years.

MSF also coordinated a primary trauma care course for emergency doctors and nurses throughout the country. More than 150 doctors were trained in various regions.

Sami*

31-year-old Syrian man, Bekaa valley

We fled Syria under shelling, with only the clothes we were wearing. My two nephews were both killed, and my sister-in-law was wounded.

We are now renting a flat in Baalbeck. We have only a mat and a few mattresses. It's cold, we need fuel for heating, and we don't have money to pay the rent. I cannot find work.

It is the first time I have come to the MSF clinic. My wife is six months pregnant. She is feeling some pain, but the doctor has reassured us that everything is going well. He also examined my mother and gave her the drugs she needs for her hypertension and ulcer.

My wife was refused a consultation at a local clinic because we are not yet registered as refugees. We were told to go to Al-Marj, 50 kilometres from Baalbeck. We are 10 people – can you imagine me taking all of them so far for registration, in the cold, in their state of health?

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



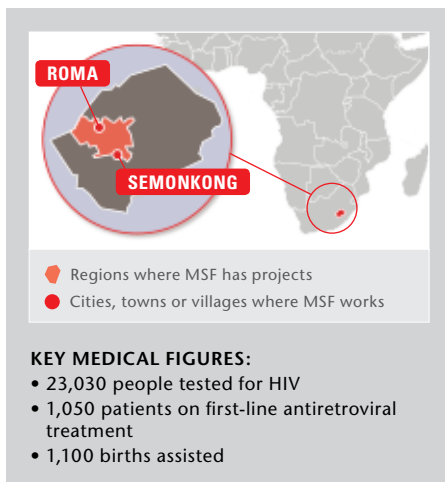
An elderly Syrian man with Parkinson's disease lives with 19 family members in two rooms in Tripoli, Lebanon.

LESOTHO



© André François

When a blizzard closed roads, and people could not travel to Semonkong, MSF staff delivered antiretroviral drugs to patients in their villages.



More than half of all maternal, infant and under-five deaths in Lesotho can be attributed to HIV.

It is not only HIV treatment that is hard to access, but healthcare in general. Only a small number of the health facilities in the country are adequately staffed.

To address the huge gaps in access to medical care, Médecins Sans Frontières (MSF) runs a programme focused on maternal and child health, integrating HIV and TB care at the same clinics. Capacity has been increased through the decentralisation of medical services to more health facilities and the shifting of some responsibilities from doctors to nurses. MSF provides support to St Joseph's district hospital in Roma, six health clinics in the lowlands and three clinics in the remote Semonkong area, where an ambulance was supplied to transport patients to St Joseph's in emergencies. MSF also trained counsellors and village health workers, who help link patients to the services they need.

Lobbying for counsellors

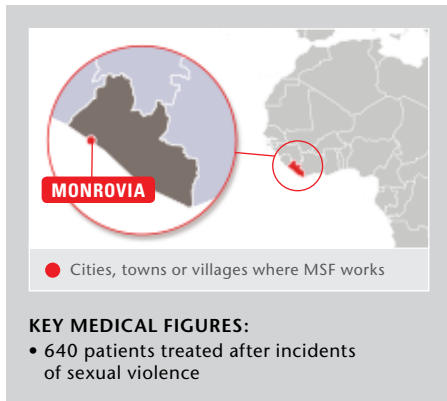
In 2012, withdrawal and delays in funding from international organisations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, resulted in a decrease in the numbers of lay counsellors at facilities. Counsellors are trained to provide one-to-one support through HIV and TB testing and to help ensure patients adhere to treatment.

They perform a critical role: without them, the workload for nurses increases and patient care is compromised. MSF lobbied strongly to ensure funding for counsellors and began working on a longer-term solution with the Ministry of Health and other partners.

Faster access to second-line treatment

An HIV patient's CD4 count is measured to determine when to initiate antiretroviral (ARV) treatment. The viral load of HIV – the amount of the virus in the blood – is measured to ascertain whether first-line ARV treatment has failed. If it has, the patient needs to be switched to a second-line drug regimen. In Lesotho, viral load tests had to be carried out abroad, and switching to second-line treatment required approval by committee at the Ministry of Health. The time taken by this process often meant the patient died before approval was obtained. In 2012, MSF received a grant from the financing initiative UNITAID to develop and implement viral load testing, as well as point-of-care CD4 testing, in eight HIV programmes in Africa, including Lesotho.

LIBERIA



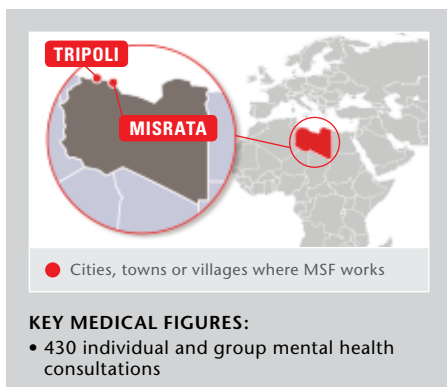
After more than two decades in Liberia, in 2012 Médecins Sans Frontières (MSF) handed over the last of its programmes to the Ministry of Health.

The final programme provided treatment and counselling for victims of sexual violence in Monrovia. Since this project began in 2010, major emphasis was placed on training Ministry of Health staff to carry out services. Between January and July, 644 patients received treatment: 12 per cent of them were under four years of age, 38 per cent were aged between five and 12 years and 41 per cent between 13 and 18 years. Only nine per cent were adults. After a gradual handover of responsibilities, MSF withdrew in July.

MSF ran emergency operations in response to the 14 years of civil conflict that raged until 2004. Teams also provided emergency healthcare for refugees from conflicts in neighbouring countries and improved access to health services more generally through the set-up and management of hospital projects in the capital Monrovia, as well as in remote areas. As the emergency phase has passed, one by one these projects have been handed over to the Ministry of Health or to organisations that can take the work forward with a long-term development approach.

No. staff end 2012: 11 | Year MSF first worked in the country: 1990 | msf.org/liberia

LIBYA



In 2012, the people of Libya were still suffering the effects of the violent conflict of the previous year.

A Médecins Sans Frontières (MSF) team began medical activities in detention centres in the city of Misrata in August 2011. Staff treated war wounds, carried out surgery and provided follow-up care such as physiotherapy.

However, doctors had been increasingly confronted with patients whose injuries had been caused by torture. After reporting 115 such cases, and with no concrete response from the authorities, in January MSF took the decision to suspend activities in the centres.



About 2,500 people from Tawergha, a pro-Gaddafi stronghold during the Libyan civil war, live at the Janzour Marine Academy displacement camp.

Mental health support for residents of Misrata continued until March. More than 150 group counselling sessions were held to assist people's recovery from the conflict.

Assisting the displaced in Tripoli

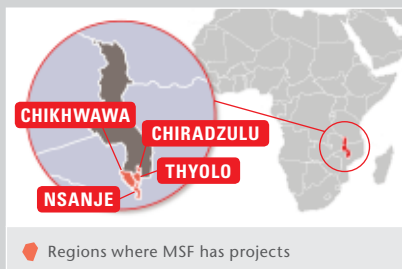
As the conflict in Libya came to an end, particular groups faced persecution. Gaddafi had recruited mercenaries from sub-Saharan Africa, and Tawergha had been used as a base for Gaddafi's forces. Sub-Saharan Africans and members of the

Tawergha ethnic minority began to seek refuge in camps in the capital Tripoli. MSF carried out basic health services and offered mental health support via mobile clinics in the camps until August.

MSF is negotiating with the new authorities to provide assistance in mental healthcare and help fill other gaps in health services in 2013.

No. staff end 2012: 23 | Year MSF first worked in the country: 2011 | msf.org/libya

MALAWI



KEY MEDICAL FIGURES:

- 67,520 patients on first-line antiretroviral treatment
- 2,640 women enrolled on PMTCT treatment

Médecins Sans Frontières (MSF) has been adopting a range of approaches to improve access to treatment for people with the disease and one programme has expanded, while another is on track for handover to the Ministry of Health.

Patient numbers increasing in Chiradzulu

Antiretroviral (ARV) treatment was introduced in the HIV programme in Chiradzulu in 2001. Implementation of the recommendations for care that the World Health Organization set out in 2009, including starting ARV treatment earlier, has meant that the number of patients has grown: in 2012, MSF had about 33,860 HIV patients, 80 per cent of whom were on ARV treatment. Some 2,600 pregnant women received prevention of mother-to-child transmission (PMTCT) services.

Such large numbers mean models of care must be simplified, but without sacrificing quality. Some tasks have been transferred from doctors to nurses, so that services can be decentralised to health centres. At the 10 centres where MSF works, teams offer antenatal care to pregnant women, including PMTCT, counselling and also integrated care for people co-infected with tuberculosis (TB), so that patients can obtain all their treatment at one facility. Furthermore, people who are in a stable condition need only attend appointments every six months: this has reduced the burden on both the patients and medical staff.

Preparing for handover in Thyolo

Around 48,000 patients have begun ARV treatment at the HIV programme in Thyolo during its 15-year history. All 24 sites in the district currently offer comprehensive HIV care, including PMTCT option B+, which puts pregnant women with HIV on lifelong ARV treatment. The objective now is to hand over all basic services to the Ministry of Health by the end of 2013 so that MSF can focus more on technical support in specialist areas such as diagnostics, including early infant diagnosis, and integrated HIV and TB care.

HIV/AIDS is the main cause of death among young adults in Malawi – those who should normally be the most productive age group in the country – according to national surveys.



At the World AIDS Day parade in Thyolo, a girl holds a sign saying 'If you get tested for HIV you will benefit from ARVs'.

With MSF's support, 30 students were enrolled in the Malamulo scholarship programme, which trains young people from rural areas in health professions, on the condition that when they qualify they return to work in rural areas of Thyolo district for five years.

Supporting HIV care in Nsanje and Chikhwawa

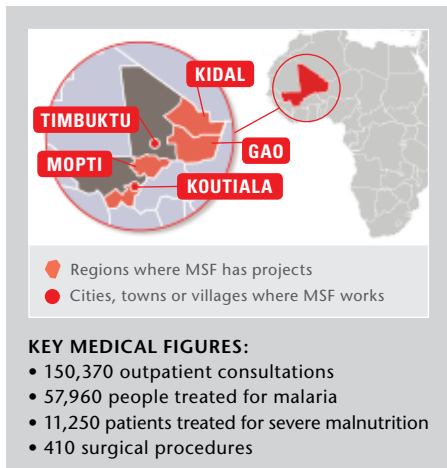
An MSF team has been supporting an innovative nationwide mentoring programme in Nsanje and Chikhwawa. Mentoring staff as they implement new clinical guidelines should help improve patient care. MSF also assisted in infection control and pharmacy management.

Kingston

25 years old and studying for a diploma in nursing and midwifery, sponsored by MSF.

When I was 15, my sister fell sick and we took her to Thekerani hospital. The queue was long and there was only one clinician. We arrived at 7 am and my sister died right there in the queue at 2 pm. It was very difficult to understand. The death of my sister was due to the shortage of healthcare workers, and I decided to become one.

MALI



Conflict erupted in the north of Mali in January. Security forces fought Tuareg opponents, who were later supported by Islamist groups. In March, a coup d'état took place in the capital Bamako.

By April the country had virtually split into two, with Tuareg and Islamist groups controlling the north and an interim government in the south. At the end of 2012, the UN estimated that 340,000 people had been displaced, while some 145,000 people, including many health workers, sought refuge in neighbouring countries. Access to healthcare, already precarious due to lack of resources and infrastructure, was reduced further.

Healthcare in conflict zones

Médecins Sans Frontières (MSF) began providing basic medical services at three health posts in remote areas of Kidal region. An MSF team then progressively took over the 65-bed Timbuktu hospital: emergency department, paediatric ward, general medicine, surgery, maternity services, pharmacy and laboratory. Staff also supported 10 health centres in the Timbuktu region, carrying out a total of 50,000 medical consultations.

In Gao region, east of Timbuktu, MSF provided basic services at two health centres from September. Staff conducted some 65 consultations each day and ran mobile clinics in rural areas. A team also took over the management of a 40-bed hospital in Ansongo, south of the city of Gao.



A boy receives antimalarial medicine as part of a new malaria prevention strategy in Koutiala.

At the end of October, MSF began supporting the referral hospital and a health centre in Douentza, central Mali, providing outpatient, inpatient and maternity care and surgery, and conducting around 500 consultations each week.

Teams also assisted Malian refugees in the neighbouring countries of Burkina Faso, Mauritania and Niger.

Medical care for children in the south

Mali lies in the Sahel region of Africa, where children suffer from seasonal malnutrition as families' food stocks run out and prices rise. In Mopti region, MSF started working at four outpatient and two inpatient therapeutic feeding centres in June, treating hundreds of children.

Staff continued to provide nutritional support and paediatric care at Koutiala hospital, Sikasso region. More than 4,800 children, most of whom had malaria, were treated at the hospital, and 4,400 with malnutrition were admitted to the inpatient feeding centre. Another 3,000 were treated at six outpatient feeding centres.

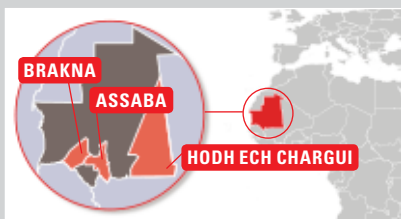
MSF supported four outlying health centres in the region with staff, supervision, drugs and logistics. A complete package of preventive and curative care was provided for children at a fifth health centre in Konseguela. More than 80,000 consultations were conducted in the five centres. Community health workers in 19 surrounding villages also detected and treated malaria, and made

referrals for medical consultations. All children aged six months to two years received supplementary food to prevent malnutrition, mosquito nets to prevent malaria, and routine vaccinations, with follow-up consultations.

New malaria prevention campaign

Between August and October, MSF ran a seasonal malaria chemoprevention campaign newly recommended by the World Health Organization, reaching more than 165,000 children in Koutiala district. Children took antimalarial medicine once per month for three months during the malaria season, with encouraging results: a 66.5 per cent reduction in consultations for simple malaria within the first weeks of distribution, and a 70 per cent reduction in children hospitalised with severe malaria.

MAURITANIA



KEY MEDICAL FIGURES:

- 91,860 outpatient consultations
- 7,350 patients treated for severe malnutrition
- 836 births assisted

Tens of thousands of refugees arrived in Mauritania's Mbera camp in 2012, escaping conflict in northern Mali.

Refugees must all enter through the village of Fassala, where they are registered before being transferred to Mbera, in the region of Hodh Ech Chargui. Conditions in the camp are poor and the assistance provided has not met people's basic needs consistently.

In late February, soon after the first refugees began to arrive, Médecins Sans Frontières (MSF) set up medical and nutritional activities in the area of Bassikounou. A team provided free basic and specialist healthcare, including antenatal care, for refugees and the local community. Medical teams ran two health posts in Mbera camp and supported two health centres: one in Mbera village and one at the border post of Fassala.

In November, an MSF nutritional and retrospective mortality survey in Mbera camp showed that nearly 17 per cent of children were malnourished, and 4.6 per cent were suffering from the most severe form of malnutrition.

In the confines of the camp, an outbreak of measles among children suffering from malnutrition could be devastating, so protecting them against the disease is a priority. MSF therefore carried out a vaccination campaign, reaching thousands of children.

Staff carried out more than 60,000 consultations, assisted 200 births and treated some 3,880 severely malnourished children at the camp.

Nutrition programmes

A particularly severe nutritional crisis was expected in the south of the country in 2012, and in April MSF teams began supporting both outpatient and inpatient feeding programmes in Boghé and Magtaa Lahjar districts of Brakna region, and in Assaba region. Needs in Brakna and Assaba turned out to be less extreme than anticipated, and staff were able to close programmes in the two regions in September and December, respectively.

No. staff end 2012: 198 | Year MSF first worked in the country: 1994
msf.org/mauritania



In July, 1,200 Malian refugees arrived at the border town of Fassala in just one day.

MADAGASCAR

Amid political uncertainty and financial difficulties, the national health budget in Madagascar was halved in 2012, exacerbating gaps in healthcare.

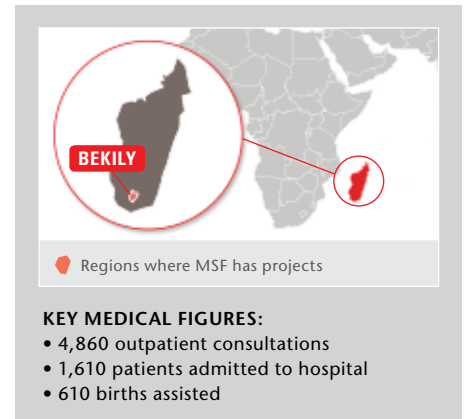
In the remote Androy region, up to 180,000 people have difficulty accessing medical care because of the distance to the nearest hospital. In 2011, Médecins Sans Frontières (MSF) began working with the Ministry of Health to improve and expand medical services.

Basic medical care and maternal and child health services are supported through a programme at the hospital in the town of Bekily. MSF has assisted renovations, delivery of medical supplies and staff training, and has increased hospital capacity from 20 to 38 beds. The team also provides clinical care for adults and children and conducts joint consultations with Ministry of Health staff in three health centres.

The number of women attending antenatal services has increased fivefold since June, thanks in part to activities to improve awareness of the importance of medical care during pregnancy. Approximately 500 women now visit the hospital each month for antenatal care and teams assist more than 50 births per month.

Treatment for schistosomiasis

Schistosomiasis, a curable disease caused by parasitic worms, is endemic in Madagascar. People become infected through contact with contaminated water when bathing or swimming. Left untreated, the parasite can eventually damage internal organs such as the spleen and liver. MSF treated 429 patients for schistosomiasis in 2012.



No. staff end 2012: 75 | Year MSF first worked in the country: 1987 | msf.org/madagascar

MEXICO

Migrants travelling through Mexico on their way to the United States are exposed to serious risks and dangers to their health.

Many migrants enter Mexico from Guatemala and Belize. From there, they embark on a perilous rail journey, during which they are at significant risk of assault, kidnapping, rape or murder.

Aiming to fill the gaps in medical services and mental health support and improve conditions, Médecins Sans Frontières (MSF) launched a new programme in the southern Mexican states of Oaxaca (at Ixtepec) in February and Chiapas (at Arriaga) in June.

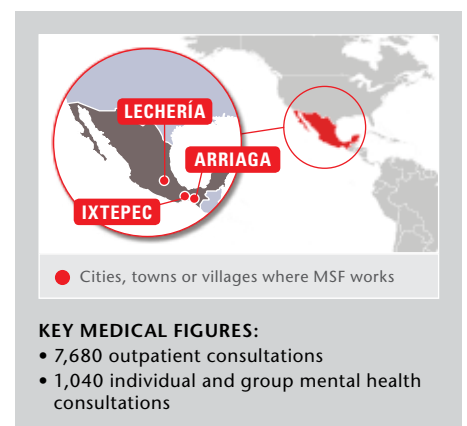
Early on, the teams made improvements to water and sanitation facilities and kitchens, so that living conditions in migrant shelters were raised to acceptable health standards. Facilities for the provision of medical and psychological services were also constructed.

Migrants are rarely able to seek healthcare, so MSF has pursued a 'proactive' search for patients, especially among vulnerable groups: women, children, unaccompanied minors, and victims of violence, kidnapping and human trafficking.

Teams see patients with conditions related to their journey: respiratory infections, skin diseases, dehydration, gastrointestinal disorders, and the physical and mental consequences of violence and sexual violence.

Spike in needs in Lechería

A total of 1,200 migrants passed through the local shelter in Lechería, Mexico state, during the first week of June – where only 70 people are normally accommodated. MSF provided healthcare and worked to improve living conditions. Conflict with



local residents forced closure of the shelter in July and the migrants moved to makeshift camps. Government agencies then offered basic healthcare and MSF teams focused on more complex health issues. MSF teams also distributed more than 6,500 hygiene kits, took care of water and sanitation and improved the electricity system in the camp.

No. staff end 2012: 31 | Year MSF first worked in the country: 1985 | msf.org/mexico

MOROCCO

There was an increase in violence against sub-Saharan migrants in Morocco in 2012, with Moroccan security forces making daily raids in the cities of Oujda and Nador.

As it has become increasingly difficult to reach Europe, Morocco has become the final destination for many sub-Saharan Africans. Without permission to work or access to basic social services, they are forced to live in unstable and insecure conditions.

Access to basic healthcare is granted by law, however, and more migrants are getting medical care in Oujda, although the situation in Nador is less positive. Médecins Sans Frontières (MSF) teams in both cities helped 2,300 migrants access services in 2012. Increased violence by Moroccan and Spanish security forces also led MSF to resume direct medical consultations. Staff treated 1,100 people for violence-related injuries.

In Nador, near the Spanish territory of Melilla, MSF ran monthly mobile clinics throughout 2012, after a year of being

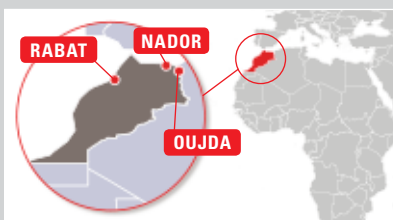
denied access to the city. The team also distributed relief items, including hygiene kits, blankets, plastic sheeting and clothing, to migrants living in forests on the outskirts of Nador and Oujda.

Activities in Nador were handed over to the Migration Division of the Archbishopric of Tangier at the end of the year.

Assisting victims of sexual violence

Migrants in Morocco have experienced alarming levels of sexual violence. MSF works with a local association, Fondation Orient Occident, assisting victims. More than 60 people received medical assistance at the centre in Oujda.

In the capital city of Rabat, MSF completed the handover of its programme to treat victims of sexual violence to the Association de Lutte contre le SIDA.



● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

- 6,010 outpatient consultations
- 330 patients treated after incidents of sexual violence
- 4,630 relief kits distributed

Sidy*

22 years old, from Mali, is living in Oujda forest

They hit me with batons. I wanted to run, but they hit me and I fell down. They started hitting me again. I tried to protect my head and they broke my arms. I've tried to cross [into Melilla] 10 times. I've been beaten three times, but this time it was very serious.

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

No. staff end 2012: 35 | Year MSF first worked in the country: 1997 | msf.org/morocco



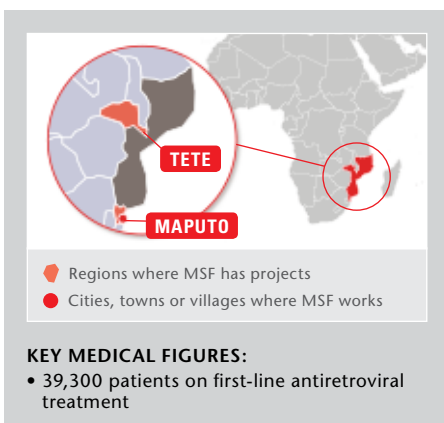
Migrants in Morocco have difficulties meeting their essential needs: shelter, food and water.

MOZAMBIQUE



An ARV treatment group meeting in Maputo. Peer groups provide social support and help people adhere to their drug regimens.

There has been progress in Mozambique's response to HIV over recent years, but still only 45 per cent of patients who need antiretroviral (ARV) treatment have access to it.



All three Médecins Sans Frontières (MSF) programmes in Mozambique provide HIV care. The teams are beginning to focus on the integration and simplification of care for specific groups of patients like children and adolescents, and gradually handing over responsibility for first-line ARV treatment in the Chamanculo and Mavalane districts of the capital Maputo to the Ministry of Health.

At the Primeiro de Maio health centre in Mavalane, children and adolescents can access tailor-made services, and pregnant women with HIV and people co-infected with HIV and tuberculosis (TB) can obtain all the medical attention they need at one point. Patients with complex conditions are referred to specialist services.

MSF is working with the Ministry of Health at one of these specialist facilities in Chamanculo, the Centro de Referencia de Alto Mae (CRAM). Here, patients suffering from the cancer Kaposi's sarcoma (an opportunistic infection of advanced stage HIV) and those in need of second- or third-line treatment receive care.

In Tete, MSF is helping local health staff to promote community and patient involvement in HIV treatment. Patients get together to offer mutual support and take turns to pick up drug refills from the health centre, and staff engage the community in improving the detection, diagnosis and treatment of TB.

Ivanilda

15 years old

My mother and brothers are HIV negative, but I have been living with HIV for five years. I was sick a few years ago, and had many blood transfusions in the hospital. My mother believes that these transfusions are the cause of my infection.

Because my health was not showing any improvement, my mother decided to accompany me to take an HIV test. I started ARV treatment in 2007. Now I go to the health facility on my own. The ARV drugs are my daily bread. If I do not take them, I feel bad.

I have always had the support of my mother and uncle. Both know about my HIV status, but they have never discriminated against me. I also find refuge and support at teenagers' monthly meetings. In these meetings I see that HIV is not only my problem, but also the problem of many children my age.

MYANMAR

In June, deadly intercommunal clashes in Rakhine state, Myanmar, triggered an official state of emergency.

An estimated 75,000 people were displaced and many houses were burned down. Another outbreak of violence in October worsened the crisis, forcing 40,000 more people from their homes. Many ended up living in makeshift camps without sufficient shelter, sanitation, food or healthcare.

Emergency teams from Médecins Sans Frontières (MSF) were able to provide basic medical care in 15 of the largest camps. They treated people suffering from skin infections, worms, chronic coughs and diarrhoea, and made sure those with life-threatening conditions were referred to hospitals.

MSF has long experience – nearly 20 years – of working in remote and neglected Rakhine state, offering basic and maternal healthcare and treatment for HIV and tuberculosis (TB). Malaria is endemic in the region and teams have treated hundreds of thousands of people from all ethnic groups, including the Rakhine community and the Muslim minority population known as the Rohingya.

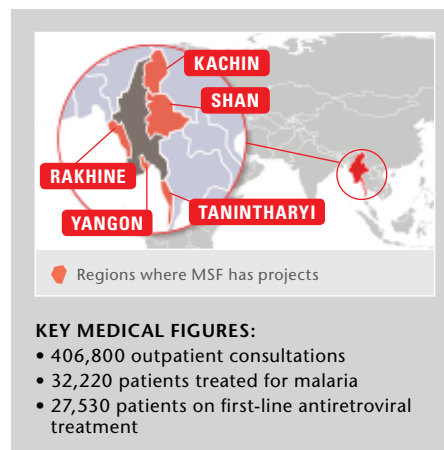
Insecurity, delayed authorisation and repeated threats and intimidation by a small and

vocal group of the Rakhine community have hindered MSF's work in 2012. With access curtailed, MSF was able to treat only 50,000 people between June and December, many of whom were living in camps in Maung Daw, Sittwe and Pauk Taw townships. Many thousands more suffered without being able to obtain the treatment they urgently needed.

Treating HIV and tuberculosis

Despite efforts to increase the healthcare budget, thousands of people throughout Myanmar have no access to medical services. Coverage for antiretroviral (ARV) treatment for people with HIV is very low: barely one in three of those needing it receives it. MSF, the leading provider of ARV medication in the country, has to make difficult choices about whom to treat.

People with HIV are more likely than the general population to have active TB. MSF runs HIV and TB programmes in the capital Yangon, in Kachin and Shan states and in Tanintharyi region. There is also a programme at Insein prison, Yangon, where 160 patients started ARV treatment and 79 started TB treatment in 2012.



The number of patients with drug-resistant TB (DR-TB), which is harder to diagnose and requires two years of arduous treatment, is growing at an alarming rate. An estimated 9,300 people contract DR-TB in Myanmar each year, but only a few hundred have received treatment. In 2012, in a pilot programme in conjunction with the Ministry of Health, MSF enrolled 82 DR-TB patients.

In February, MSF released the report *Lives in the Balance*. It highlighted the devastating impact that cancellation of Round 11 funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria would have on the efforts to scale up the provision of treatment to people with HIV and TB in Myanmar.

No. staff end 2012: 1,247 | Year MSF first worked in the country: 1992 | msf.org/myanmar

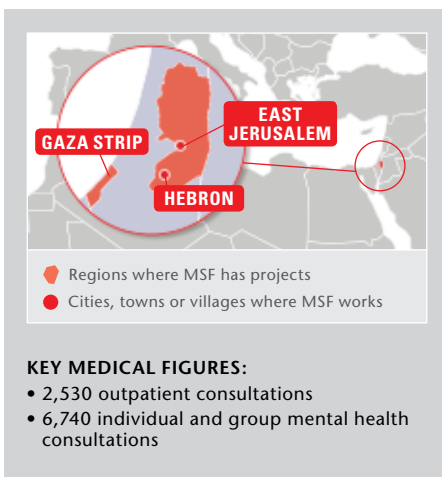


A doctor examines a child suffering from diarrhoea at an MSF clinic in a refugee camp, Pauk Taw township, Rakhine state.

OCCUPIED PALESTINIAN TERRITORY



A three-year-old boy awaits a pre-op consultation in the specialist reconstructive surgery programme in Khan Yunis.



Exposure to violence resulting from intra-Palestinian and Israeli–Palestinian conflict has medical, psychological and social consequences, but people have difficulty accessing the care they need. Médecins Sans Frontières (MSF) programmes aim to address the gaps in the Palestinian health system.

The Israeli embargo, the financial crisis and the chronic lack of cooperation between Palestinian authorities have all contributed to a deterioration in the public health system in Occupied Palestinian Territory.

Surgery in Gaza

In the city of Khan Yunis, MSF surgical teams make regular visits to Nasser hospital to carry out specialist procedures not usually available to people living in Gaza. Most patients are children with burns.

The post-operative care programme, set up to reduce the level of disability after injury, focuses on wound dressing and physiotherapy. In 2012 the team began to offer specialist hand rehabilitation, and provided training in cardiac physiotherapy.

Emergency response to operation 'Pillar of Defence'

MSF's post-operative care clinic remained open throughout Israel's military operation in November. The mobile field hospital

within the Nasser hospital compound was converted to receive the injured and conduct minor surgery, and an emergency medical team was sent to Gaza. Drugs and medical supplies were donated to the central pharmacy, and medical kits to treat the wounded were distributed to hospitals.

Mental health support

In Nablus, Hebron, MSF offers medical, psychological and social support to people affected by conflict. In 2012, the number of psychological consultations increased by 50 per cent. In East Jerusalem, where MSF provides psychological and social services, patient numbers tripled, and almost half of patients were under 18 years of age. Anxiety-related conditions, depression, behavioural issues and post-traumatic stress were all common.

No. staff end 2012: 96 | Year MSF first worked in the country: 1989 | msf.org/opt

NIGER

KEY MEDICAL FIGURES:

- 878,000 outpatient consultations
- 324,100 patients treated for malaria
- 84,950 patients treated for severe malnutrition

Including prevention and treatment of malnutrition as part of basic health services in Niger will allow many lives to be saved.

Food insecurity and nutrition crises are a chronic problem in Niger, but child mortality was reduced by 45 per cent between 1998 and 2009, according to a study in the *Lancet*. Health authorities have shown the will to make changes. They have recruited more medical personnel, and measures such as the decentralisation of nutrition programmes and the provision of supplementary treatment to prevent those at risk of developing severe malnutrition have brought improvements.

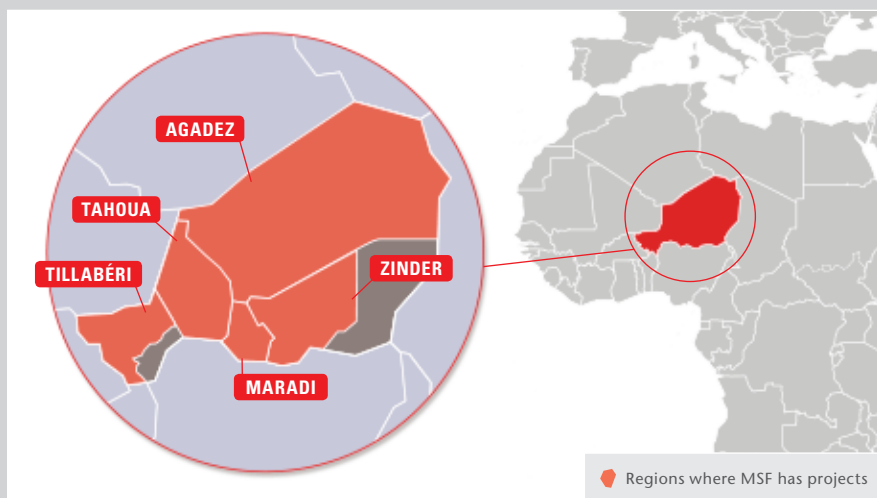
However, malnutrition rates remain high, with overall levels close to the World Health Organization's emergency threshold in 2012. There are still chronic shortages of drugs and medical supplies, and the

free services for children under five and pregnant women formally introduced five years ago have yet to be made available.

Médecins Sans Frontières (MSF) activities in Niger are mainly aimed at improving healthcare for children under five and pregnant women, focusing on early treatment and prevention, particularly of malnutrition. Teams in the regions of Zinder, Maradi and Tahoua run outpatient feeding

programmes in some 38 health centres. Patients in need of hospitalisation are cared for at inpatient feeding centres in Zinder, Magaria, Madarounfa, Dakoro, Guidan Roundji, Madoua and Bouza hospitals.

The staff in Zinder and Magaria are in the process of handing over activities to the Ministry of Health, and in 2013 expect to provide support only during the peak season for malnutrition.



Each year, hundreds of thousands of children suffer from severe malnutrition in Niger. MSF runs outpatient feeding centres at some 38 locations.

MSF handed over the inpatient feeding centre it built at Dakoro hospital in Maradi to the Ministry of Health, while the feeding programme at the centre and at eight other outpatient centres have been handed over to the organisation ALIMA/BEFEN. MSF will continue to provide paediatric and maternal care – including obstetric surgery – at Dakoro hospital, where the team assisted 13,200 births in 2012. Paediatric services also continued at the other hospitals, and MSF still supports maternity services, as well as laboratory and sterilisation departments at several of them.

Alarming rise in malaria

An extremely high incidence of malaria was reported in nearly all regions in 2012. Malnutrition and malaria peak at the same time of year (July–September) and create a vicious cycle in children: malnutrition weakens the immune system, while malaria causes anaemia, diarrhoea and vomiting, aggravating malnutrition.

Guidan Roumdji's intensive care and paediatric units, in Maradi, were overwhelmed, with an occupancy rate of 200 per cent in July. Dedicated units to treat severe malaria were set up in Dan Issa and Madarounfa, Maradi region and Madoua, Tahoua region. In Madarounfa, MSF worked with local organisation FORSANI, focusing on treatment for children under five.

When cholera struck Tahoua, the team set up treatment units in Galmi, Koumassa and Madoua, and treated 350 patients.

Improving health closer to home

The positive results of moving healthcare closer to people's homes can be seen not only in the outpatient feeding centres but also in the community health programmes that MSF runs in Niger.

When children in remote villages catch malaria, they often arrive for treatment too late, owing to a lack of access to adequate healthcare in their villages.

In Madarounfa and Madoua, MSF implemented a new strategy to improve early diagnosis and treatment of malaria for children and pregnant women: staff now provide diagnosis and treatment in rural villages.

In Zinder region, community health workers have been recruited to promote practices that will help reduce child mortality, such as improving hygiene, carrying out vaccinations and encouraging people to visit clinics. In village 'health huts', health workers screen and treat children for malnutrition, and diagnose and provide



A mother and her child peek into the health centre as they wait in line for their medical consultation, Guidan Roumdji, Maradi region.

treatment for the three main childhood killers: respiratory infections, diarrhoea and malaria. Patients in a more serious condition are referred to a health centre.

Assisting Malian refugees

Violence in Mali drove thousands of people across the border to Niger's Tillabéri region over the course of the year. MSF provided basic and specialist healthcare for the refugees and the host population, including vaccinations, maternal care and referrals. Staff carried out more than 334,000 outpatient consultations, admitted nearly 19,000 people to hospital and vaccinated over 22,000 children against measles. When cholera broke out, teams set up treatment

centres and rehydration points, and treated 2,730 patients for the disease.

In August, MSF donated basic relief kits to people affected by flooding in the region's Ouallam department.

Closure of programme in Agadez

Agadez is located on one of the main migration routes from sub-Saharan Africa to the north. MSF has been providing maternal and paediatric services in Dirkou and at eight health centres in rural areas for migrants and local communities who have difficulty accessing healthcare. The programme was closed at the end of 2012 as MSF focused its activities on the wider humanitarian needs in the country.

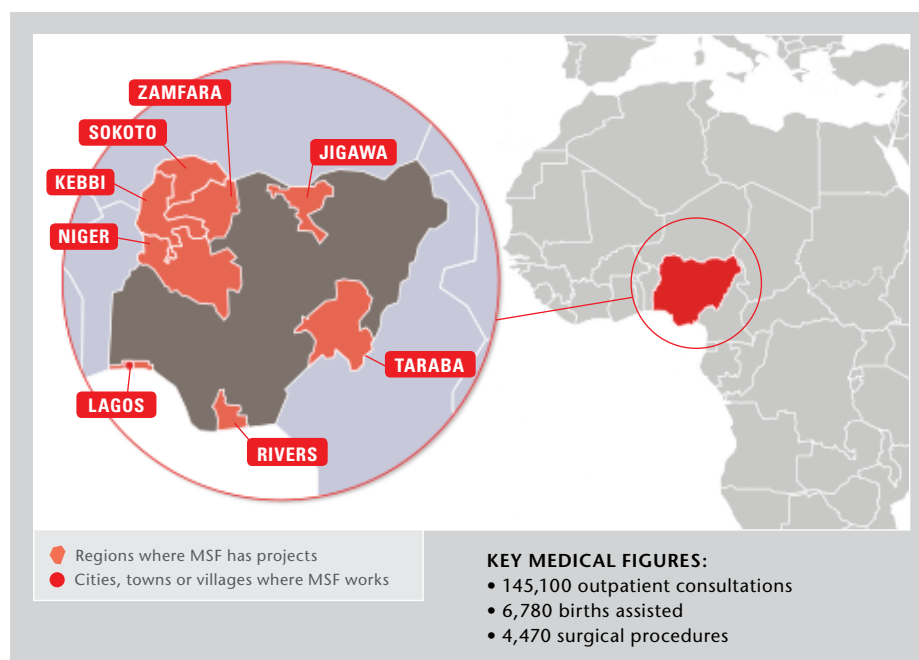
NIGERIA

Insecurity in northern Nigeria is growing, and with it comes the likelihood of increased violence, displacement and deteriorating health services.

Health services are already inadequate in this region. The response to outbreaks of disease is insufficient, nutritional crises are frequent, and many women continue to give birth without any medical assistance.

In Jigawa state, Médecins Sans Frontières (MSF) has been providing obstetric services at Jahun hospital since 2008, and close to 6,800 women gave birth there in 2012. Another 284 women underwent fistula repair surgery. Obstetric fistulas are injuries to the birth canal, and are most often a result of prolonged, obstructed labour. They cause incontinence, which can lead to stigma and social exclusion.

Further west, a team supports health centres in and around the town of Goronyo, Sokoto state. Staff offer basic healthcare, maternal care, paediatric services, vaccinations and treatment for malnutrition. They carried out more than



70,000 paediatric consultations and 28,500 antenatal consultations over the year.

The emergency team covering the northwest of the country responded to outbreaks of malaria, measles and cholera, treating tens of thousands of patients.

Villages destroyed by flooding

Heavy rains, and the opening of the dam on Lake Lagdo in neighbouring Cameroon, led to major flooding in eastern Nigeria in August. MSF set up mobile clinics to provide basic and emergency healthcare to people affected by the disaster, particularly young



A woman is measured during an antenatal consultation at Goronyo hospital.



© Olga Overbeek

Born seven weeks premature, Carlos is now five weeks and doing well in Goronyo hospital. His 15-year-old mother, suffering from malaria and a bowel perforation, died after referral elsewhere, as she was awaiting emergency care.

children and pregnant women. Hygiene kits were distributed to the displaced. As malaria rates rose, MSF also donated mosquito nets.

Lead poisoning response

A team has been treating children for lead poisoning in Zamfara state since 2010. Unsafe gold mining and ore processing practices have led to the contamination of a number of villages, and an estimated 400 children have died. MSF has treated 2,500 children for poisoning so far, but patients will need long-term follow-up.

Without environmental clean-up, treatment is ineffective, because the children will only become sick again when they return home. MSF hosted a conference on the crisis in May, but six months later, none of the key action points agreed upon at the conference had been put into effect. In early 2013, following sustained advocacy by MSF and other organisations, funds were finally released to allow for remediation of one of the contaminated villages, which will mean that medical treatment can begin for affected residents. However, the crisis will

not be fully resolved without a complete clean-up and the implementation of safer mining practices.

Trauma programme closed

Political tensions in the oil-rich Niger Delta region have eased and MSF therefore closed the trauma programme it had been running in a private hospital in Port Harcourt, Rivers state, since 2005. The last patient was admitted in October. The team carried out 9,000 emergency consultations and treated 500 victims of sexual violence during the year.

Clinics in Lagos

Health facilities are scarce in the slums of Lagos. Since 2010, MSF's clinics in Badia and Makoko have been providing free emergency care, as well as basic health services and maternal care. The floating clinic in Riverine, on the lagoon, was the first place to offer free medical services in the area. More than 19,200 people attended medical consultations through the programme. MSF withdrew at the end of 2012, and the Ministry of Health has agreed to maintain essential services.

Rabi

17 years old, celebrates her discharge from the Jahun hospital fistula repair programme.

And what of that sick woman who arrived here many days ago? What of she who suffered many days with labour pains, only to see a stillborn baby, and after her wrapper cloth always wet? What of the way that her husband turned from her, repulsed by the leaking urine, what of her family who would no longer touch the food that she cooked? What of that chair, the one everyone avoided, the one she alone would sit on?

That chair is no longer for me, because that woman is no longer me. I am now cured from my injury. With dry cloth around my hips, I am ready to return to my family. I sing because I am happy, I sing because I am free.

PAKISTAN

KEY MEDICAL FIGURES:

- 298,000 outpatient consultations
- 22,160 births assisted
- 3,730 surgical procedures

Health services in Pakistan are often unaffordable and in many regions, conflict and insecurity further restrict access.

In many parts of Pakistan sectarian violence is rife. Government forces are also engaged in military operations against armed opposition groups. Médecins Sans Frontières (MSF) programmes focus mainly on meeting urgent needs among communities affected by insecurity.

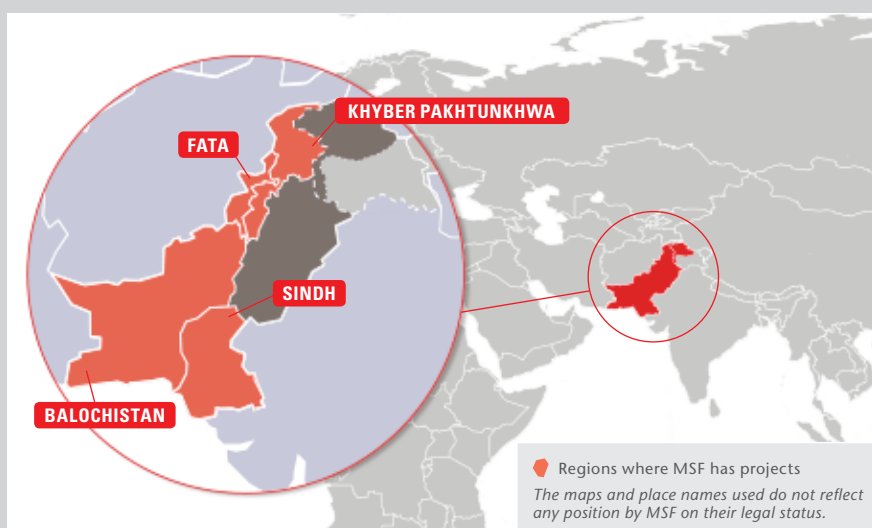
Khyber Pakhtunkhwa and FATA

In Hangu, Khyber Pakhtunkhwa, where many Afghan refugees and displaced people have settled, MSF works in the hospital's emergency department and operating theatre, and a midwife supports maternity services. The team also organises patient referral to facilities in the provincial capital Peshawar. In Timergara, MSF provides full support to the emergency department and mother and child health centre, and a new

building was constructed at the centre to accommodate growth in patient numbers. MSF operated treatment centres in Hangu and Timergara from July until October to respond to an increase in cases of acute watery diarrhoea. After more than five years supporting emergency, maternal and child healthcare in Dargai hospital, services were handed over to the Ministry of Health in August.

In Peshawar, MSF runs a 30-bed hospital specialising in obstetrics and gynaecology, and also conducts antenatal and postnatal consultations in 11 health centres in the district. Staff at the health centres were able to identify and refer high-risk pregnancies or obstetric emergencies to the hospital.

MSF programmes in Kurram Agency in the Federally Administered Tribal Areas (FATA)



Members of a mobile medical team bandage a boy's infected cut at a camp for people displaced by flooding in Sindh province.



A nurse listens to Soghran's breathing in Ranga Pur, Sindh province. The four-year-old and her mother may have tuberculosis. They will be prescribed antibiotics and return for another consultation.

are staffed by Pakistani personnel, while management is based in Peshawar, with regular visits. The team provides paediatric services at hospitals in both the Shia community of Alizai and the Sunni enclave of Sadda.

Improving access to healthcare in Balochistan

Balochistan has some of the worst health indicators in Pakistan. It is frequently affected by sectarian and interethnic violence and natural disasters. MSF is mainly focused on the needs of pregnant women and children, and carries out nutrition and health promotion activities.

MSF provides neonatal, obstetric and paediatric care in Chaman and Dera Murad Jamali hospitals. A team also supports the emergency department in Chaman. In Quetta, MSF runs a 60-bed paediatric hospital and is opening a network of basic health units across the city. Not far from Quetta, in Kuchlak, a team runs a mother and child health clinic that has a birthing unit. Patients also receive treatment for cutaneous leishmaniasis, a disease that

produces ulcers on the body, which can cause serious disability as well as social stigma. Mental health teams provide psychological and counselling services in both Quetta and Kuchlak.

Clinic opened in Karachi

In October, in partnership with local organisation SINA Health, Education and Welfare Trust, MSF opened a new clinic in Machar Colony, a settlement in Pakistan's largest city, Karachi. The clinic provides basic healthcare and emergency services, including maternal healthcare, mental health services and stabilisation for patients in a critical condition.

Response to flooding

In September, eastern Balochistan was affected by severe flooding for the third consecutive year. MSF teams set up mobile clinics providing basic health services to people who were living on the roadside or in camps, and a treatment centre for diarrhoea. Safe drinking water was provided, latrines were constructed and relief items such as washing kits were distributed.

Amina's son

was brought to the MSF nursery when he was 10 days old, weighing only 2.36 kg. He was diagnosed with tetanus.

A few days after my son was born, he started having fits and had a temperature. I delivered him under a makeshift tent near the Pat Feeder Canal.

My husband used to work on our landlord's land. But the water came and we lost everything. We have no shade, no home or land. We live on the side of the road. Thousands of families who lost their homes are now living there too.

When my son got sick, I pawned my earrings because we had nothing left to pay the doctors. However, when we came to the MSF hospital here, we were told the treatment is free, so I used the money from the earrings to buy food instead. It's been a month since I sold my earrings. Now even the food is gone.

My son has been here for 25 days now. We had thought about taking him from the hospital and going home because we didn't see an immediate change in his health. Now, though, he opens his eyes, and can slowly start to feed.

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

No. staff end 2012: 1,404 | Year MSF first worked in the country: 1986
msf.org/pakistan

PAPUA NEW GUINEA

There are high levels of domestic, sexual, social and tribal violence in Papua New Guinea, yet medical care remains inadequate. In some places it is not available at all.



● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

- 21,200 outpatient consultations
- 2,990 births assisted
- 1,190 surgical procedures

Médecins Sans Frontières (MSF) is providing comprehensive treatment and psychosocial care, with a particular emphasis on victims of domestic and sexual violence.

Local people are becoming more aware that MSF's family support centre in the Angau Memorial Hospital in Lae offers a confidential and safe space, and the team provided free, comprehensive medical and counselling services to some 6,500 patients in 2012.

MSF runs a second centre in Tari, in Southern Highlands region. As there is an enormous need for emergency medical care – often after assault – the team also offers emergency surgery at Tari hospital.

Violence is viewed as a police issue and the medical condition of victims is frequently overlooked in Papua New Guinea. Advocacy and training are critical aspects of MSF's activities. Teams conducted training on responding to the physical and mental health needs of victims of domestic and sexual violence at hospitals and health centres in all but two of the country's 22 provinces.

Improving access to healthcare in Bougainville

Decades of conflict have weakened the health system in the Autonomous Region of Bougainville and MSF is helping refurbish several facilities. Construction of a six-bed tuberculosis ward and accommodation for caregivers at Buin health centre were completed in 2012. MSF also carried out significant renovations and upgrades to the health centre's water and sanitation, laboratory and pharmacy infrastructure.

A maternity waiting home in Buin provides accommodation for women in their final weeks of pregnancy, so they are close to the health centre when they go into labour and do not have to travel for long periods on poor roads during an emergency.

Staff support clinical care, including maternal healthcare, at Buin health centre and five health facilities in the area. Patient numbers increased following an awareness campaign conducted in local communities and improvements to the referral system.

Rachel

Lae

He can bash me up badly. He can use iron, knives to threaten me. How can I fight him? He is a man and he has more strength than me.

He called me one time and was threatening me, saying, "I'll break your arms, I'll break your legs." That evening he came and surprised me and was chasing me around my big sister's house. He went to my workplace and my boss told me, "You're new here, and seems like you are facing this problem. You are not going to work." So I lost my job.

When I share my problems with the counsellors, I feel free. If I can stand in public and tell everyone, it's good for me. They know I've gone through it and it can help them too.

No. staff end 2012: 201 | Year MSF first worked in the country: 1992 | msf.org/png



A woman at MSF's clinic in Lae has been beaten by her husband. She has several knife cuts on her legs and back, and bruises on her face and chest.

PARAGUAY

Chagas disease is endemic in Paraguay, yet diagnosis is still not integrated into basic health services.

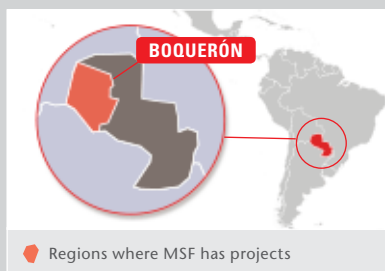
In many cases, this is because health facilities do not have the necessary equipment or staff to carry out testing. Chagas is a parasitic disease transmitted by the vinchuca beetle. Awareness and testing are crucial because Chagas can be deadly. Although people may live for years without symptoms, the disease can ultimately cause serious, even fatal, heart

and intestinal problems. Since 2010, a Médecins Sans Frontières (MSF) team has been diagnosing and treating Chagas in Boquerón, one of the three departments that make up the Paraguayan Chaco. Health services are limited in the semi-arid Chaco region, where the climate is harsh and many communities are completely isolated when it rains.



Children learn about the vinchuca beetle during Chagas awareness activities in Boquerón.

No. staff end 2012: 67 people worked in Paraguay and Bolivia, which is run as a joint programme
Year MSF first worked in the country: 2010 | msf.org/paraguay



KEY MEDICAL FIGURES:

- 590 patients began treatment for Chagas disease

MSF is based in Mariscal Estigarribia, a small town of just 5,000 inhabitants, and works in the regional hospital as well as at health posts in the towns of Teniente Martínez, Pedro P. Peña, Pirizal, La Patria and Laguna Negra.

Mobile teams travel to remote communities to inform people how Chagas is transmitted and explain the symptoms and the treatment that is available, returning later to carry out testing and diagnosis.

Chagas drug production assured

Following intensive lobbying, production of benznidazole, the most commonly used medicine for Chagas, which is only produced by one manufacturer in Brazil, resumed after coming to a halt in 2011. Delivery has been guaranteed for 2013.

PHILIPPINES

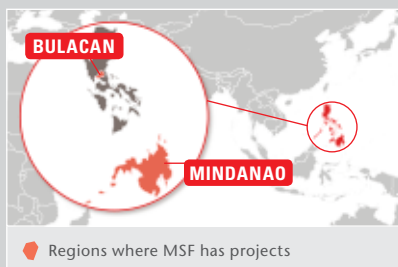
Typhoons wreaked havoc in different parts of the Philippines on three occasions in 2012.

Typhoon Washi hit the northeast coast of the island of Mindanao in December 2011, killing nearly 1,400 people and injuring thousands more.

Around 10,000 homes were destroyed. Between 9 January and 24 February, Médecins Sans Frontières (MSF) mobile teams carried out 5,400 medical consultations in the Mindanao cities of Iligan and Cagayan de Oro and treated some 240 children for severe malnutrition.

In August, typhoons Kai Tak and Saola caused severe flooding. Between 13 August and 18 September, MSF carried out 1,900 consultations and distributed 2,600 hygiene kits to families in the municipalities of Hagonoy and Calumpit in Bulacan province, north of the capital Manila. In collaboration with local authorities, MSF also distributed water purification tablets and water containers, and assisted in the removal of 6,400 tons of debris.

Typhoon Bopha, which hit the southern Philippines on 4 December, was by far the most powerful of the year. In some areas, all the health posts were destroyed and regional hospitals badly damaged.



KEY MEDICAL FIGURES:

- 7,330 outpatient consultations
- 240 patients treated for severe malnutrition

MSF launched mobile clinics in some of the most affected coastal areas, such as Cateel and Baganga on Mindanao island. The medical team began consultations in December, and assistance continued into 2013.

No. staff end 2012: 1 | Year MSF first worked in the country: 1987 | msf.org/philippines

RUSSIAN FEDERATION

A health crisis persists in the north Caucasus region, exacerbated by devastating illnesses such as tuberculosis (TB).

Years of war, the destruction of the health system and social stigma associated with TB have contributed to a lack of diagnosis and treatment in the north Caucasus, especially for drug-resistant TB (DR-TB).

Médecins Sans Frontières (MSF) has worked with the Chechen Ministry of Health to implement a comprehensive TB programme in the republic, including rapid diagnosis and treatment for people with DR-TB, those not responding to standard first-line drugs for TB. Patients receive counselling and practical support to help them complete their lengthy, isolating and often arduous treatment. The MSF team is developing a special focus on children, as well as on HIV–TB co-infection.

Improving cardiac care

One in six people in Chechnya has heart disease but the scale and quality of medical services do not meet the needs for acute coronary syndromes and other cardiovascular emergencies. In Grozny, Chechnya's capital, MSF is working to improve the cardiac

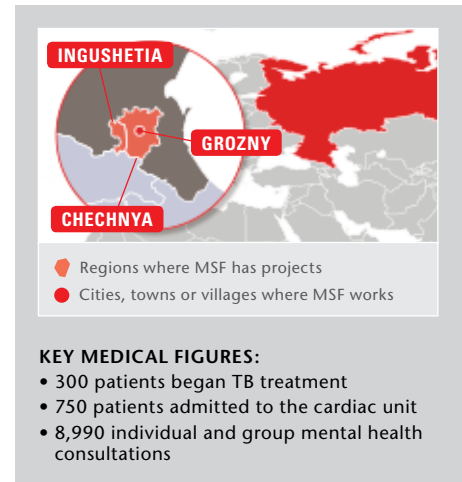
unit in the Republican Emergency Hospital through staff training and the purchase of medical equipment and essential medicines for carrying out specialist treatment. The number of patients receiving emergency care rose to almost 750 in 2012, as the unit increased its capacity.

Attention to mothers and children

MSF has provided medical care for women and children through three outpatient clinics in Grozny and rural areas in northern and southern Chechnya since 2007. After a total of 15,700 paediatric consultations and 8,800 gynaecological consultations, MSF closed the programme at the end of 2012, because of decreasing patient numbers and low levels of disease.

Mental health support in Ingushetia ends

Since 2002, MSF teams have provided psychological support to communities in the remote, mountainous regions of Chechnya and Ingushetia, where violent conflict has had a serious impact on people's mental health. Counsellors have worked



with individuals suffering from anxiety, mood-related problems and grief caused by psychological and physical violence, abuse and the deaths of loved ones.

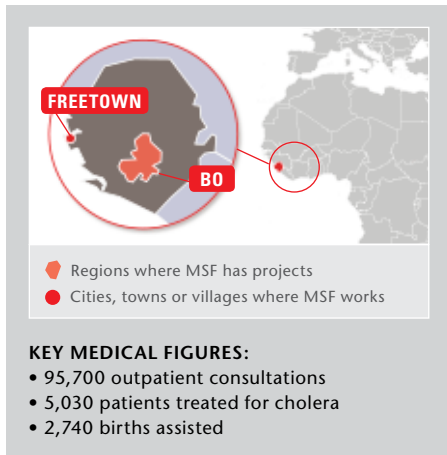
The programme in Chechnya continues. Services in Ingushetia, however, ended in September. Following extensive discussions with the government of the republic, senior officials in Ingushetia thanked MSF for its efforts but indicated that further assistance through this programme was no longer required.

No. staff end 2012: 189 | Year MSF first worked in the country: 1992 | msf.org/russianfederation



An MSF doctor and his Ministry of Health counterpart examine a patient at the Grozny Republican TB hospital.

SIERRA LEONE



An ambulance referral system and access to 24-hour emergency obstetric care has drastically reduced maternal deaths in Bo district, Sierra Leone.

The government introduced a policy of free healthcare for children under five and pregnant and breastfeeding women in 2010, but real improvements in access for these groups have not yet been achieved. Many health facilities are understaffed, underequipped and lack medical expertise, and high numbers of preventable maternal and child deaths in the country are a result of a lack of access to healthcare.

In Bo, Médecins Sans Frontières (MSF) runs a 220-bed obstetric and paediatric hospital, the Gondama referral centre. Five ambulances transport pregnant women and children from nine community health centres. Another ambulance refers patients with complications from Gondama to the capital Freetown. Yet another is a specialised ambulance that brings patients to the Lassa fever unit at Kenema hospital. Lassa fever is a viral haemorrhagic fever that affects several organs in the body.

A study published by MSF in November showed that the rate of maternal deaths in Bo district is now 61 per cent lower than in the rest of the country.

Cholera emergency

Between July and September, MSF responded to a cholera outbreak that was concentrated in Freetown, and provided treatment for 5,000 patients across four treatment centres. MSF also supported the Ministry of Health to treat 427 patients at Bo government hospital.

Jenneba

26 years old

This is my third pregnancy. I have had two miscarriages before. Last night I felt pain, so an ambulance picked me up from the health centre and took me to Gondama. The nurse in the ambulance held my hand and talked to me nicely during the ride. The nurses at the hospital examined me and said that I wasn't in labour yet. I am still in pain and very worried about what is happening. If I lose this baby, I am worried that my husband will leave me.

Jenneba's son was born by caesarean section 10 days later.

No. staff end 2012: 556 | Year MSF first worked in the country: 1986 | msf.org/sierraleone

SRI LANKA

Three years after the devastating civil war ended, Médecins Sans Frontières (MSF) has handed over its last remaining activities in Sri Lanka.

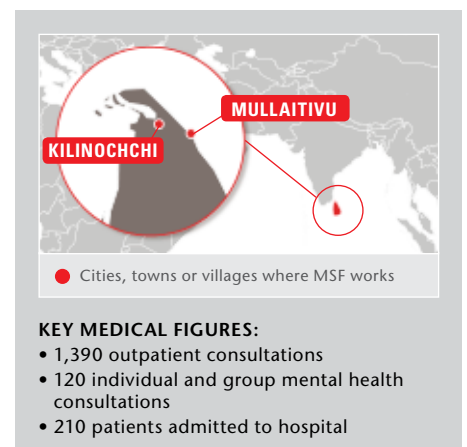
In Mullaitivu hospital, a team had been assisting in the provision of emergency care, surgery and gynaecological and obstetric services. Staff also held weekly mobile clinics at five sites, providing access to health services for isolated communities. These activities came to an end in June.

Mental health services handed over

Physical scars may have healed, but the mental health of those traumatised by war and distressed by resettlement still needs to be addressed. MSF mental health staff worked at the main district hospitals in Mullaitivu and Kilinochchi as well as at other sites in the districts. Mobile teams travelled to more distant villages to offer care to people unable to travel.

MSF also developed community-based psychosocial services in schools. Before leaving Kilinochchi, staff provided training to 10 psychological support officers and 10 field assistants.

The Ministry of Health has committed to continuing the development of community-based psychosocial services. In late 2011, the ministry and the Sri Lanka College of Psychiatrists launched a media campaign to raise awareness of mental health issues and to increase access to expert medical care. MSF's programme in Mullaitivu has been handed over to international non-governmental organisation World Vision, which has a long-term operational plan for the north of the country, while a local organisation has taken on activities in Kilinochchi.



No. staff end 2012: 73 | Year MSF first worked in the country: 1986 | msf.org/srilanka

SOMALIA

KEY MEDICAL FIGURES:

- 624,200 outpatient consultations
- 41,100 patients admitted to hospital
- 30,090 patients treated for severe malnutrition
- 58,620 routine vaccinations
- 2,750 surgical procedures

Despite some improvements in security during 2012, the majority of people in Somalia are still living in crisis.

Two decades of civil war have inflicted violence, displacement and loss of livelihood on the people of Somalia. Médecins Sans Frontières (MSF) continues to work in areas controlled by the government as well as areas held by opposition groups.

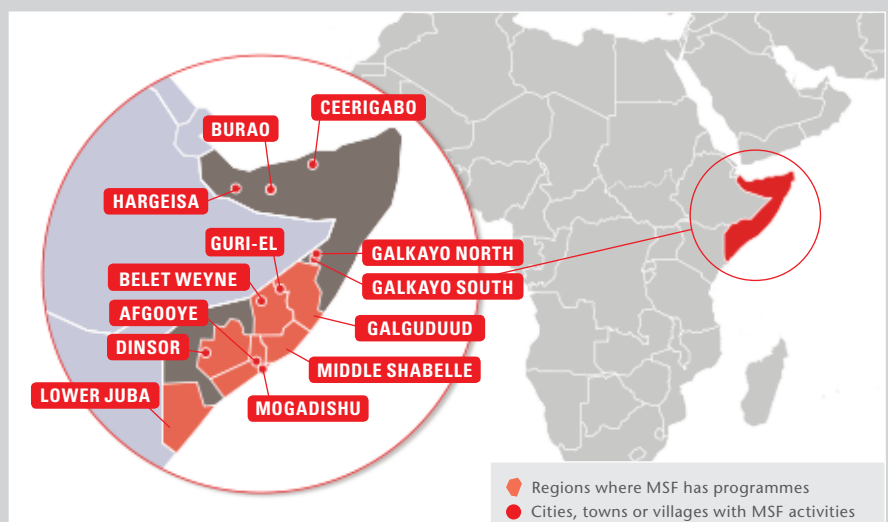
Most of the country's healthcare infrastructure has been destroyed, leaving only one doctor in the country for every quarter of a million people. The nutritional crisis of 2011 in south and central Somalia further damaged coping mechanisms and caused massive internal displacement as people searched for food and security.

At the beginning of the year, MSF decided to put on hold any opening of new non-emergency projects in Somalia until the safe release of its two colleagues, Blanca Thiebaut and Montserrat Serra, abducted from the Dadaab refugee camps in Kenya on 13 October 2011 and held against their will in Somalia.

Basic healthcare in the capital

Access to food, water, sanitation, health services and shelter is irregular and insufficient in Mogadishu, where an estimated 369,000 displaced people are living. Although the number of attacks, bombs and targeted assassinations has decreased, they remain frequent.

Children are suffering particularly and there is an urgent need for preventive activities such as vaccination, as well as lifesaving emergency care. MSF supports a children's hospital in the city, running a general ward, inpatient feeding programme and isolation units for measles and acute watery diarrhoea. Two mobile teams travelled further afield to carry out consultations, referrals and routine vaccinations. Some 6,300 children received nutritional support, 945 were admitted for inpatient treatment and 2,480 were vaccinated against measles.



On the outskirts of the city, MSF manages 60 beds in Daynile hospital. Medical services include an emergency department, surgery, intensive care and paediatric inpatient units, a nutrition programme and maternity services. At the end of March, fighting between pro-government forces and Al-Shabaab drove MSF to close the hospital. It was reopened in September.

Three health clinics located in Mogadishu's Wadajir, Dharkenley and Yaaqshiid districts provide medical consultations and care for pregnant women and children to help meet the increase in need since displaced people have arrived in the areas. A mobile nutrition programme visited six camps for the displaced in Wadajir.

Teams also ran medical clinics in the city's Rajo, Refinery and Jasiira camps and opened two more in Howlwadaag and Xadaar in

March and April, respectively. In July and August, the clinics in Rajo, Refinery and Howlwadaag were closed. A 40-bed hospital near Jasiira camp admitted 2,000 inpatients over the year.

During a cholera outbreak in Mogadishu between May and August, teams treated 350 people for the disease.

Malnutrition in the Afgooye corridor

The Afgooye corridor, linking Mogadishu and the town of Afgooye, is an increasingly dense settlement of displaced people. MSF supports the 30-bed community hospital in Afgooye, the only health facility covering the needs of 180 villages. The hospital offers outpatient consultations, emergency services, maternity care and an outpatient feeding programme. In 2012, staff carried out consultations with 25,640 people.



An outreach team gives a health promotion talk to a group of women in Hamarweyne, near Mogadishu.



A health worker carries out nutrition screening at the Warshadaha outpatient feeding centre, Mogadishu.

In November, MSF medical staff visited 34 camps, which host some 18,000 people. The team screened 1,530 children and treated more than 400 for malnutrition. They vaccinated against polio, diphtheria, tetanus, measles and pertussis (whooping cough), and all children under five years of age were given albendazole, to treat worms, as well as vitamin A. Staff returned in December for follow-up.

Comprehensive care in Dinsor

In Bay region, MSF facilities in Dinsor offer inpatient care, a nutrition programme, maternity services, treatment for kala azar, a TB programme and outpatient services.

Mother and child programmes in Middle Shabelle

During the second half of 2012, Jowhar and Balcad were on the front line of conflict and access became a challenge for the delivery of supplies and supervision visits. MSF staff support the maternity hospital in Jowhar, and offer mother and child healthcare, including nutrition and vaccinations, through four clinics in Kulmis, Bullo Sheik, Gololey and Mahadaay. Tuberculosis (TB) is also treated in Mahadaay and Gololey. MSF runs a mother and child programme at the clinic in Balcad.

Galkayo North and South

MSF has worked in the divided city of Galkayo, capital of Mudug province, for over a decade. Teams support paediatric and TB services in a clinic in Galkayo North, which is located in Puntland, a self-declared independent republic. A new maternity ward was opened in the clinic in December. In Galkayo South, administered by the state of Galmudug, a hospital team receives patients from both sides of the regional armed conflict. Comprehensive services include emergency, maternity and paediatric care, TB treatment and surgery.

Lower Juba

MSF continues to run essential health programmes throughout Lower Juba region. In Marere, a hospital offers outpatient services, reproductive health and emergency obstetrics, surgery and TB treatment. Mobile teams travelled to sites where displaced people had recently settled, offering basic healthcare and treatment for malnutrition. In Jilib, a health centre housing a measles isolation unit and providing cholera treatment offers services around the clock. MSF also runs an inpatient nutrition programme for children under five in the port town of Kismayo, the capital of

the region. The team opened emergency treatment units in response to outbreaks of measles and cholera during the year.

Programme closures

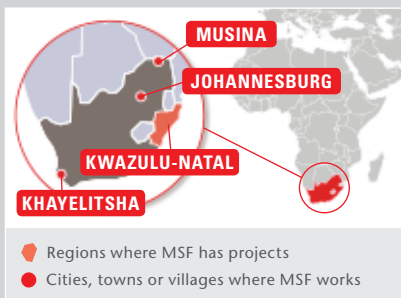
In May, due to worsening security conditions, MSF made the difficult decision to close its basic healthcare programmes in Dhusa Mareb and Hinder, Galguduud. The 108-bed hospital in Belet Weyne, Hiraan region, was closed at the end of the year. Activities in Guri-El hospital, Galguduud region, will be handed back to the community in January 2013.

Healthcare in Somaliland

In the self-declared republic of Somaliland, staff are ensuring better access to healthcare and improving water and sanitation systems in Hargeisa, Mandheera and Burao (Burco) prisons. Support is also given to psychiatric patients in the Berbera mental health clinic.

An MSF team works with the Ministry of Health at Burao general hospital in the Togdheer region of Somaliland, focusing on inpatient care. In 2012, emergency staff dealt with more than 10 incidents involving the arrival of numerous casualties. When flash floods affected the region, MSF made donations to health facilities in Buhoodle.

SOUTH AFRICA



KEY MEDICAL FIGURES:

- 31,800 patients tested for HIV
- 21,320 patients on first-line antiretroviral treatment
- 210 patients began DR-TB treatment

An estimated 5.6 million people are living with HIV in South Africa, the highest number of people in any country in the world.

KwaZulu-Natal province has the highest HIV prevalence in the country, and Médecins Sans Frontières (MSF) has a programme in KwaZulu-Natal with ambitious aims to increase testing and treatment coverage and initiate treatment earlier.

The team tested more than 23,000 people through its mobile one-stop shop in 2012, almost triple the number for 2011. This was in part a result of work with community leaders and traditional healers to gain acceptance for testing and treatment. The vast majority of the 2,000 patients enrolled in HIV care were started on antiretroviral (ARV) treatment.

In 2012, the South African Department of Health announced that it was shifting gradually to a single daily pill for HIV patients. It also announced that it will offer this same fixed-dose combination ARV treatment to all pregnant women throughout pregnancy and breastfeeding to prevent mother-to-child transmission of HIV. These two moves will make treatment easier for patients and simplify care.

Expansion of adherence clubs in Cape Town

In the township of Khayelitsha, near Cape Town, MSF continued to provide support through mentoring and operational research on HIV and tuberculosis (TB) treatment, and created more adherence clubs in community sites outside health facilities and patients' homes.

Instead of attending one-to-one appointments at the health centre, adherence club members go to meetings every two months for a check-up and drug refill, and to talk to other patients. MSF's analysis found that 97 per cent of club members stayed in care, while the figure was 85 per cent for patients who qualified for club membership but remained in mainstream clinic care. By the end of the year, there were 180 clubs, with more than 4,500 members, at nine health facilities in Khayelitsha. The Western Cape Department of Health has also set up more than 400 clubs.

Incidence of drug-resistant tuberculosis (DR-TB), a form of TB that demands two years of treatment, which can have painful side effects, is particularly high in Khayelitsha. Close to 200 patients, including those with multidrug-resistant TB and extensively drug-resistant TB, were started on treatment at their local clinic in 2012. This pilot project has contributed to changing South African health policy towards decentralised management of DR-TB, which is critical to addressing the DR-TB epidemic.

Assisting migrants

Many of the estimated one and half million Zimbabweans living in South Africa cannot access the services they need. In Musina, on the Zimbabwe border, MSF mobile clinics offer basic healthcare, and testing and treatment for HIV and TB, at night shelters and outside the offices of the Department

of Home Affairs. The teams have developed a model of care for TB and HIV that is adapted to the lives of the migrant farm workers, who frequently move from place to place.

In Johannesburg, the MSF team assisting migrants living in slum buildings in the city centre shifted attention to focus on improving living conditions. Staff helped residents clean up buildings and facilitated improved sanitation and access to clean water.

Bongiwe Vutuza

Not anyone can join the club. In order to join a club you must be taking your treatment and not miss any dates. I wanted to join the club because in a club everything becomes easy. Everything goes quickly. It's not like at the clinic where you arrive at seven in the morning and then go home at four. When you arrive at the club your treatment is always ready for you. The people we work with, Sis Ntosh and Sis Fanelwa, are friendly. If you have a problem you can go to them. If I'm not feeling well, I can ask the facilitator and they refer me to a doctor. And if we have a problem we can talk about it in the group. I only take 45 minutes, from 8:00 to 8:45. Neighbours don't see that I go to the clinic. At the club they try and assist with the privacy of patients.



Hundreds of adherence clubs are helping HIV patients stick to treatment in South Africa.

© Samantha Reinders

SUDAN

Armed groups have extended their presence across Sudan's regions of North and South Darfur, and peace agreements do not seem to have had a noticeable effect on people's lives.

Conflict has also affected tens of thousands of people living in South Kordofan and Blue Nile states.

Health services are scarce across much of the country – they are even more limited for people living in conflict zones – and the government does not allow humanitarian organisations access to areas controlled by opposition groups.

The Shaeria area in South Darfur experiences intermittent unrest. Médecins Sans Frontières (MSF) provides services at the Ministry of Health hospital, particularly maternal care and nutrition, as well as in three clinics, offering a lifeline to people living in remote villages. However, medical activities faced more obstacles during 2012 as South Darfur was divided into two states, South Darfur and East Darfur, resulting in fewer resources in each state, and making administrative procedures more complex.

In North Darfur, teams continued to provide comprehensive health services at facilities in Tawila and basic healthcare in five centres in Dar Zaghawa. In Kaguro, there were problems in the delivery of medical supplies, and MSF continued to negotiate for improved access to healthcare for residents and displaced people.

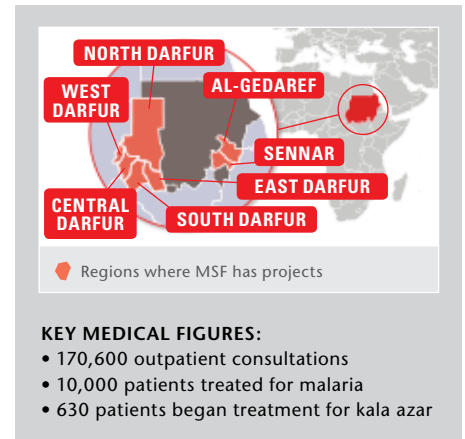
As the situation stabilised in Shangil Tobaya, where MSF had been providing basic health services since 2004, the programme was handed over to the Ministry of Health. Assistance in 2012 focused on the provision of healthcare in the displaced persons camp.

Yellow fever response

The Sudanese health authorities began responding to an outbreak of yellow fever in Darfur at the end of the year, and MSF offered medical and logistical assistance. Yellow fever is a viral haemorrhagic fever, named for the jaundice suffered by many people with the disease. Although most people who contract the disease recover within days, up to 50 per cent will develop more serious symptoms, which can be fatal. MSF teams in Al-Geneina and Zalingei treated patients and donated drugs and medical supplies. Staff in five localities of North and Central Darfur also took part in a vaccination campaign that reached a total of 750,000 people.

Kala azar programme extended

Sudan has one of the highest rates of kala azar (visceral leishmaniasis) in the world. Transmitted by female sandflies, the disease is almost always fatal if left untreated, but



timely diagnosis and treatment nearly always bring a cure.

In January, MSF trained medical staff in Azaza Damos, Sennar state, in kala azar diagnosis and treatment, and mobile teams visited the surrounding area to screen people for the disease. MSF has supported the hospital in Tabarak Allah, Al-Gedaref state, since 2010, focusing on screening and treatment of the disease. Additional support is given for the treatment of patients with kala azar who also have tuberculosis or HIV.

Thousands displaced by flooding

Heavy rains in August led to flooding. Teams in Al-Gedaref and Sennar distributed relief kits and plastic sheeting to people made homeless by the rising waters. In Al-Mafaza, Al-Gedaref, MSF delivered drinking water, built latrines and showers, and trained health staff in the diagnosis and treatment of acute watery diarrhoea. In Al-Dinder, Sennar, staff conducted mobile clinics and vaccinated children against measles. Measles vaccination was also carried out, alongside nutritional screening in Mazmun, where MSF supported the hospital's nutrition programme.

No. staff end 2012: 1,031 | Year MSF first worked in the country: 1979 | msf.org/sudan



The MSF hospital in Kaguro, North Darfur, serves a population of some 100,000 people.

SOUTH SUDAN

The massive influx of refugees into South Sudan caused Médecins Sans Frontières (MSF) to launch one of its biggest emergency programmes of 2012.

Conflict in Sudan's Blue Nile and South Kordofan states led to the arrival of thousands of refugees in Unity and Upper Nile states during the first half of the year. But the land is inhospitable: in the dry season water is scarce and the baked clay is extremely hard to drill, while in the rainy season it is a flood plain and only accessible by air. There is virtually no scope for agriculture or grazing animals. In Maban county, Upper Nile state, an estimated 110,000 refugees in four camps became entirely dependent on humanitarian organisations. However, their response failed to meet refugees' basic needs, and in some camps mortality levels had reached double the emergency threshold by July.

MSF called for more humanitarian assistance as teams ran three field hospitals and seven outreach clinics across the camps, carrying out up to 8,000 medical consultations per week and caring for people suffering from the effects of lack of food and water and long journeys on foot. Staff provided treatment for malnutrition, skin and respiratory infections and diarrhoea. MSF also addressed the issue of water supply, managing boreholes and hand pumps.

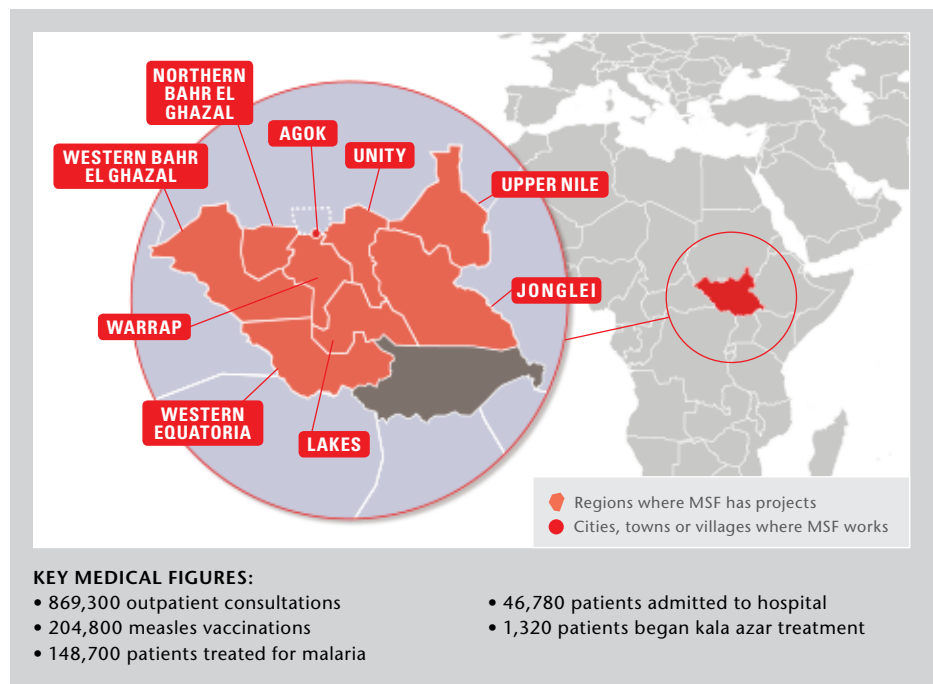
A team worked in Yida refugee camp in Unity state, where the population quadrupled to 60,000 people between January and July. MSF offered inpatient and outpatient care, and operated four feeding centres.

By September, death rates had been brought under the emergency threshold. However, the camps were soon faced with an outbreak of hepatitis E – a potentially fatal virus transmitted through contaminated water.

The refugees remain entirely dependent on humanitarian assistance.

Violence and displacement in Jonglei state

Brutal intercommunal clashes continued to cause widespread displacement in Jonglei. People escaped deep into the bush, only to become vulnerable to malaria, diarrhoea and respiratory diseases.



In central Jonglei, MSF runs a hospital in Pibor town and two outreach clinics in the villages of Lekwongole and Gumuruk. The repercussions of an exceptionally bloody attack on Lekwongole and Pibor in December 2011, in which hundreds of men, women and children were killed or wounded and two MSF medical facilities were damaged and looted, persisted into 2012. People were coming from the bush weeks after the attack, seeking treatment for badly infected wounds.

Further attacks resulted in severe damage to MSF facilities in Lekwongole and Gumuruk in August and September. Again, tens of thousands of people fled and staff ran a makeshift clinic in the bush, providing basic and emergency healthcare. In total, MSF carried out more than 32,000 medical consultations across the three facilities in 2012. The resurgence of a rebel militia in this part of Jonglei state led to an increased military presence and almost daily clashes in the area by the end of the year.



A clinician examines a young patient at the field hospital in Doro refugee camp, Upper Nile state.

In northern Jonglei, MSF runs a hospital in Lankien and an outreach clinic in Yuai. After Pieri village was burned down, the residents never returned. MSF therefore handed over the clinic, focusing instead on mobile medical assistance. Staff carried out 100,000 consultations and also treated 30,000 patients for malaria and 1,000 patients for kala azar (visceral leishmaniasis) during outbreaks in 2012.

Abyei

A region contested by Sudan and South Sudan, Abyei is prone to conflict and population displacement. MSF runs a hospital in Agok, 40 kilometres south of Abyei, providing a wide range of services, including reproductive healthcare and treatment for severe malnutrition, as well as a tuberculosis (TB) ward and emergency surgery.

In April, casualties from an air raid in Abiemnom in Unity state were brought to Agok hospital, where staff carried out lifesaving surgery. MSF also distributed relief items to people displaced by the attack, vaccinated children and conducted medical consultations.

A team ran mobile clinics in nine locations that are only accessible during the dry season. In November, they began mobile medical activities for the nomadic Misseriya population in the northern Abyei area. This was the first time MSF had been able to reach the area since July 2010.

The Abyei teams conducted a total of 29,200 consultations, helped deliver 860 babies and treated more than 3,500 children for malnutrition.

Basic and specialist health services

In Unity state capital Bentiu, MSF runs a feeding programme. Staff also supported the hospital personnel to treat people wounded in cross-border fighting. Towards the end of the year, the team started to offer TB care so that patients do not have to travel to the programme in Leer for treatment.

In 2012, the number of cases of kala azar in Unity state was far higher than in recent years: 740 patients with the disease were treated by MSF at Leer hospital. The team also treated 5,200 people for malnutrition, enrolled 630 patients on TB treatment, and provided support for TB care at the clinic in Koch.

In Nasir, Upper Nile state, MSF runs a hospital providing a full range of medical services, including surgery. The team regularly responded to violent trauma incurred during cattle raids and tribal clashes.



Refugees wade through mud to reach a water distribution point in Batil camp, Upper Nile state.

At Yambio hospital, Western Equatoria state, MSF offers paediatric, outpatient, inpatient and maternity services. Staff carried out more than 23,100 consultations and treated 13,970 children for malaria. Ten health posts were supported with staff training and drug supplies. When the area was hit by flooding, the Yambio team distributed relief kits to over 1,000 families.

In Northern Bahr El Ghazal, MSF runs the 250-bed Aweil civil hospital, focusing on maternal healthcare and paediatrics, including malnutrition. From July to December, MSF mobile clinics responded to a malaria outbreak and treated nearly 12,000 people. The paediatric mortality rate in the hospital decreased from 20 per cent at the beginning of 2009 to 5 per cent by the end of 2012.

A small MSF hospital in Gogrial town, Warrap state, provides basic healthcare and emergency surgery. In 2012 staff carried out 37,000 outpatient consultations and launched emergency responses to a measles outbreak and a spike in malnutrition. In December, 47 women received fistula repair surgery. Obstetric fistulas are injuries to the birth canal most often caused by prolonged or obstructed labour. They cause pain and incontinence, which can lead to social stigma.

Malaria response in Lakes state

In Lakes state, MSF launched a malaria response from October to December in

Rumbek town, Rumbek North, Ciubeit and Yirol. Teams supported health facilities by donating 30,000 rapid diagnostic tests and providing 20,000 mosquito nets and medicine to treat 7,350 patients.

Priscilla*

was among the first wave of refugees to arrive in Maban county from Sudan.

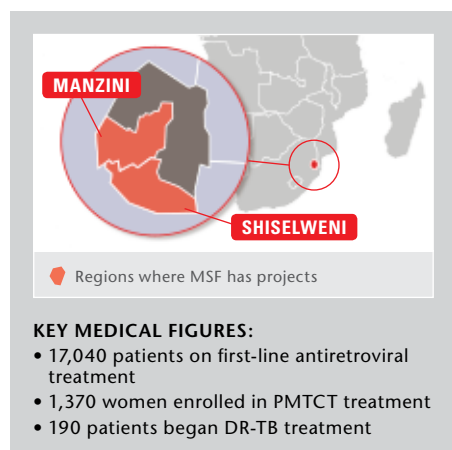
There is hunger here because there is not enough food. It's even worse if children are sick because they are malnourished. There is water, but just not enough for all these people. Surviving in this camp is not easy.

We fled the first fighting, still in the rainy season. Along the way, we were moving, but we could not race. It took us over two weeks to escape. We drank water from rivers. Many people got sick along the way, especially from malaria. As we fled, we passed through villages that were half empty. Some had already left, but others came with us when they saw us running.

Once we arrived at the border crossing-point, we felt safe. We stayed there two or three weeks. For the first time, people started to feel the pains they had not felt so far because they were so concentrated on running and saving their lives.

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

SWAZILAND



Swaziland is at the epicentre of a dual HIV and tuberculosis (TB) epidemic, and is registering a disproportionately high number of deaths.

A key strategy taken by Médecins Sans Frontières (MSF) and the Ministry of Health is the decentralisation of HIV and TB care. Testing and treating patients at local health posts relieves them of the burden of travelling and helps ensure better adherence to treatment. It also leads to more patients being tested and treated.

Given that 80 per cent of people with TB are also co-infected with HIV, the integration of treatment for these diseases, so people need only visit one health facility, is critical.

Despite some successes in scaling up care, field results across the world still show that limited impact has been made on the drug-resistant TB (DR-TB) epidemic. MSF in Swaziland is looking to identify new approaches for multidrug-resistant TB and extensively drug-resistant TB that are shorter, more tolerable, effective and feasible to scale up.

Treatment as prevention in Shiselweni

Research has shown that starting people with HIV on antiretroviral (ARV) medication as a matter of course not only helps protect their health, but also decreases transmission of the virus. However, most patients do not begin ARV treatment until their CD4 count (a measure of immune system functioning) drops to a certain threshold.

MSF and the Ministry of Health will implement a pilot 'treatment as prevention' programme in Shiselweni, a region particularly hard hit by the epidemic. The pilot will start with the 'test and treat' of all pregnant women in the district, putting



An MSF staff member carried out an HIV test during a community testing campaign in Nhletsheni, Shiselweni.

patients who test positive for HIV on ARV treatment straightaway, before working with all HIV-positive adults. Preparations for this ambitious programme were completed in 2012, with care decentralised to 22 clinics and three specialist health facilities in Shiselweni.

Collaborating with healers

Traditional healers are commonly consulted in Swaziland, but many people visit healers who cannot provide effective care for HIV or TB. MSF has collaborated with 170 traditional healers in Shiselweni, sharing medical knowledge and best practices for treatment. As a result, the healers – many of whom have now been tested for HIV and screened for TB themselves – are identifying and referring more patients to clinics.

Improving TB treatment access in Mankayane

Renovation of Mankayane hospital's TB ward and outpatient department was completed and inaugurated by the Minister of Health and the Queen of Swaziland. MSF also decentralised treatment for TB and DR-TB to four health facilities in the Manzini region. The success rate for treatment improved from 62 per cent in 2010 to 75 per cent in 2012 and the first multidrug-resistant TB patients successfully completed their drug regimens.

Expanding care in Matsapha

In Swaziland's bustling industrial centre, Matsapha, in Manzini region, MSF provides comprehensive and integrated services so patients do not need to go to separate clinics for HIV, TB and general medical

needs (including ante- and postnatal care and immunisations for children). The addition of rapid testing and treatment for DR-TB and treatment for victims of sexual violence has made the centre a complete one-stop facility.

Albert Zondo

is a traditional healer from Mnyatsi, in Shiselweni.

I can cure illnesses that I recognise. If I don't understand the illness, I do not hesitate to refer them to Western medical facilities. For me the main objective is ensuring that the patient recovers. I am not too concerned about how.

So when a patient presents any of the vital symptoms of HIV or TB I connect them to the local MSF expert client, who then links the patients with a clinic.

I got very sick in 2004. After resisting for a long time, I eventually agreed to test for HIV and try western medication. I was diagnosed with HIV and initiated on ARVs at Mankayane hospital.

My counsellor strongly advised me never to mix my medication with traditional medication. How could I turn my back against my own medicine? This felt like disloyalty to who I was. But I took the treatment as instructed and I soon saw the improvement in my health.

ARVs have worked for me. I will not keep people on treatment that will not help them. That would be wrong. My fellow traditional healers have never questioned what I do.

SYRIA

Conflict intensified across Syria in 2012: an increasing number of casualties was reported, while access to medical care was reduced and the aid provided fell far short of what was needed.

Medical attention for the direct victims of violence is not the only problem: prevailing insecurity, the targeted destruction of health facilities and the collapse of the health system mean that many people cannot access the routine or emergency healthcare they need. As the year went on, the humanitarian situation in the country deteriorated.

Caring for the victims of conflict

Despite not receiving government authorisation to deliver medical assistance, Médecins Sans Frontières (MSF) decided to work in the country, in opposition-held areas. Two hospitals were set up in Idlib governorate and a third was opened in Aleppo.

A 15-bed trauma surgery unit was set up in a house in Idlib in June. It includes an operating theatre, emergency department and resuscitation room. In November, the team began to provide post-operative physiotherapy. By the end of the year, 665 surgical procedures had taken place and 2,230 patients had received emergency treatment.

The hospital team in the region of Jabal Al-Akrad, also in Idlib, first worked in a cave, and then in a converted farm, where

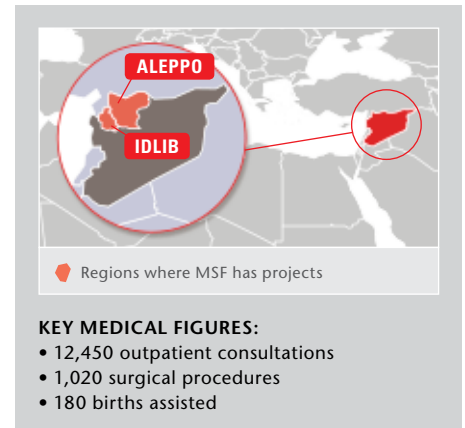
they set up an outpatient department, emergency department and operating theatre. The team had seen more than 7,200 patients by the end of the year. Staff also distributed basic relief items to people displaced by conflict.

The hospital in Aleppo governorate not only treats the war-wounded but also offers obstetric and all other kinds of emergency care, as well as basic health services. Staff performed on average 70 surgical procedures each month.

Expanding medical services

As access to health services worsened, MSF extended activities to basic healthcare, vaccinations and maternal care. In the Deir Ezzor area, a number of patients who faced interruptions in treatment for chronic illnesses such as asthma, diabetes and cardiovascular disease received the medication they needed.

In addition, MSF donated tons of medicines and medical supplies to health facilities in Aleppo, Homs, Idlib, Hama, Deraa and Damascus governorates. In September, a large donation of medical supplies and relief items was made to the Syrian Arab



Red Crescent in Damascus. Teams also distributed relief items – including hygiene and cooking kits, and food and blankets – to the displaced and to local residents.

At the end of the year, despite repeated requests, MSF still had not received government permission to work in the country.

Refugee assistance

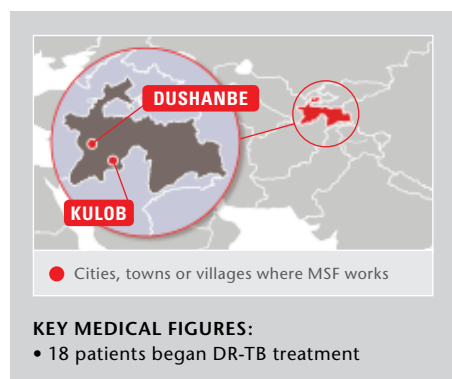
By the end of 2012, hundreds of thousands of Syrian refugees were living in neighbouring countries. MSF programmes provided medical assistance and relief in Iraq, Jordan, Lebanon and Turkey (see reports on these countries for more details).

No. staff end 2012: 123 | Year MSF first worked in the country: 2009 | msf.org/syria



A baby just delivered by caesarean section at a hospital in northern Syria is cleaned and wrapped by the head nurse.

TAJIKISTAN



A new programme for children with tuberculosis (TB) has been launched in Tajikistan.

General poverty and gaps in the healthcare system mean there is no access to treatment for TB for certain groups in Tajikistan, despite high rates of the disease in the country. Until recently, children with drug-resistant tuberculosis (DR-TB) – those for

whom first-line treatment fails – did not receive the more intensive, potentially lifesaving treatment needed for this form of the disease.

A Médecins Sans Frontières (MSF) team has begun working on a paediatric TB programme in the capital Dushanbe and the city of Kulob. The goal is to improve both access to and the quality of treatment for children with drug-sensitive TB and DR-TB, and demonstrate that comprehensive care is feasible. TB is highly contagious, so family members of paediatric patients are also tested and treated.

Whenever possible, MSF treats children and their family members as outpatients. The team provides children with nutritional and psychological support and organises educational and developmental activities for those who have to be admitted to hospital. When patients are no longer infectious, staff encourage schools to allow them to return to the classroom. Stigmatisation is an issue, and MSF is working to increase TB

awareness and public support for the needs of children with TB, while advocating for wider access to quality treatment.

Rukshona

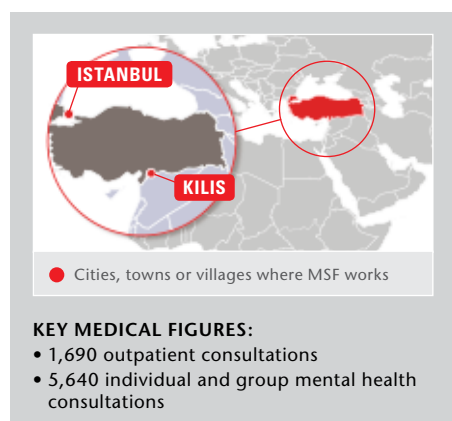
11 years old, is the first patient to start treatment for MDR-TB at the paediatric TB hospital in Dushanbe.

I was diagnosed with MDR-TB in November, five months after I started showing signs of being ill. When I arrived at hospital, I had severe malnutrition too, and I have HIV.

It's my grandfather who convinces me to take the treatment; I am being treated at home – a local doctor visits me every day. But the hospital staff say I need to spend several months in hospital if I am to make a full recovery. We are nervous of returning to the hospital, because we are gypsies, and we don't always get treated in the same way as other people.

No. staff end 2012: 38 | Year MSF first worked in the country: 1997 | msf.org/tajikistan

TURKEY



The number of Syrian refugees in camps in Turkey had reached an estimated 143,000 at the end of 2012.

According to national estimates, another 60,000 were living in urban areas. Authorities were reaching the limits of their capacity.

In the southern province of Kilis, Médecins Sans Frontières (MSF), working with local organisation Helsinki Citizens' Assembly, provides humanitarian relief and medical services to people living in the camps and the surrounding area, focusing mainly on mental healthcare.

People in an 'irregular administrative situation' are particularly vulnerable, because they either do not hold a passport or have not been officially registered as refugees, and are not therefore immediately

accounted for in any relief distributions or provision of services.

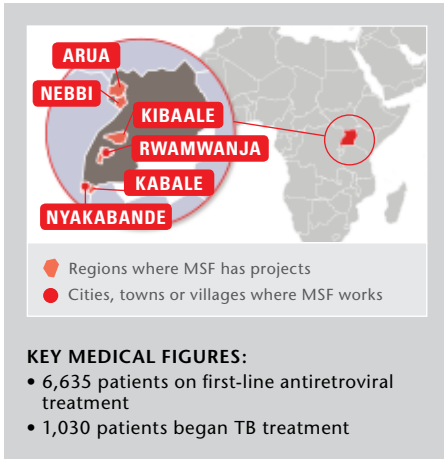
Assisting migrants in Istanbul

Hundreds of thousands of undocumented migrants are thought to be living in Istanbul. Many live and work in crowded and unsafe conditions, suffer from stigma or experience violence. MSF provides mental healthcare to people with elevated risks to their health and mental wellbeing who would otherwise not have access to such services. A team of psychologists, community health workers and translators offers psychosocial support and facilitates patients' referral to other services.

No. staff end 2012: 35 | Year MSF first worked in the country: 1999 | msf.org/turkey

UGANDA

Outbreaks of cholera, Ebola and Marburg haemorrhagic fever all occurred in Uganda over the course of the year.



From March to May, Médecins Sans Frontières (MSF) responded to a cholera outbreak in several locations across the Nebbi district of Northern region, treating 600 patients for the disease, which causes profuse diarrhoea and can lead to severe dehydration and death.

Between July and October, teams provided medical care to refugees from the conflict in North Kivu, Democratic Republic of Congo (DRC). Staff provided technical expertise for the management of severe malnutrition, treating 500 children at the Nyakabande and Rwamwanja camps in Western region.

Teams also provided technical expertise for the management of Ebola and Marburg haemorrhagic fever in August and October, respectively. There is no specific treatment for either of these diseases, and fatality rates vary significantly. MSF was in charge of the Ebola ward in Kagadi hospital, Kibaale district, after the outbreak was declared in July. Teams managed patient care and worked in collaboration with Ministry of Health staff to stop the epidemic.

HIV and TB programme

Arua regional referral hospital is the base for a long-standing MSF HIV and TB programme, though HIV treatment is now

available in 42 centres in Northern region. A significant proportion of patients are from DRC, where access to antiretroviral (ARV) treatment is very limited. By the end of 2012, more than 6,600 people were receiving ARV medication from MSF and nearly 900 patients co-infected with TB were undergoing treatment for both diseases.

Fifi

27 years old

I came from Bunia in DRC, 200 miles from here. I come here to get ARV drugs but transport is too expensive, so I've stayed with my sister in Arua for the past six months. Every two months I come here to collect my free treatment from MSF. My six-year-old daughter tested HIV positive first – that's how I found out I was sick too. She stays with me; we are both under treatment. In the community, there are people that accept us and others that stigmatise. In Bunia there is no free treatment and I cannot work at the moment.

No. staff end 2012: 456 | Year MSF first worked in the country: 1986 | msf.org/uganda



Health workers responding to the Ebola outbreak prepare to start work at Kagadi hospital.

UKRAINE



KEY MEDICAL FIGURES:

- 190 patients began DR-TB treatment
- 48 patients on first-line antiretroviral treatment

Drug-resistant forms of tuberculosis (TB) pose a serious public health threat in Ukraine, yet a comprehensive response is not yet being implemented.

The prevalence of all forms of TB and drug-resistant TB (DR-TB), as well as HIV, is far higher in prisons than among the general population.

After overcoming difficulties importing the necessary medicines for the programme, in June 2012 Médecins Sans Frontières (MSF) began treating patients at the hospital for prisoners with TB and three pre-trial detention centres in the eastern region of Donetsk.

The team provides treatment, as well as psychological support, to patients with DR-TB, and those co-infected with HIV. It can be difficult for patients to adhere to their regimen, as it lasts at least two years, and the medication often causes severe side effects. Counselling is therefore an important part of the programme. When patients are released from prison, MSF staff make sure that they have access to services and drugs so that they can continue treatment.

Andriy*

31 years old

I grew up in Artyomovsk, a small town outside Donetsk, in eastern Ukraine. Unfortunately, I am infected with drug-resistant tuberculosis. I was studying to become a builder, but I got into a drunken fight one night and ended up in jail.

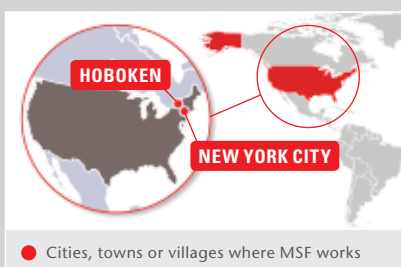
Inside prison, MSF started to provide me with DR-TB treatment. When I got out of prison, my mother had died and my sister had sold my flat. I had nowhere to go. MSF will provide me with treatment until I am cured, and has also arranged for me to stay at the Artyomovsk TB dispensary until I can find a place to live.

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

Staff have also been working to improve lab facilities, infection control and drug supply at the detention centres.

No. staff end 2012: 52 | Year MSF first worked in the country: 1999 | msf.org/ukraine

UNITED STATES



KEY MEDICAL FIGURES:

- 1,000 people received emergency medical and mental healthcare

Hurricane Sandy thrashed the United States' east coast on 29 October, causing massive destruction and displacing many residents.

Despite the government's comprehensive emergency response, Médecins Sans Frontières (MSF) found that medical services were lacking in two key areas: evacuation centres and apartment blocks in New York and New Jersey. Many elderly, disabled or chronically sick people were confined in high-rise blocks without electricity, water or access to their medicines.

Teams of returned field workers and staff from MSF's New York office offered medical and mental healthcare at the FDR High School in Brooklyn, the Susan E. Wagner High School in Staten Island, and the Wallace Public School, St Matthew's Church and Saints Peter

and Paul Church in Hoboken, New Jersey. Working with information provided by local community groups and other organisations, MSF staff also visited people in their homes to address their health needs.

The main goal was continuity in medical care, as the vast majority of patients had chronic conditions such as diabetes, heart disease, hypertension and upper respiratory tract infections. Pharmacies were damaged and closed, so teams identified pharmacies in neighbouring communities that could provide the necessary medicines. MSF handed over activities to government agencies and other organisations.

Staff responded to the emergency on a volunteer basis and are therefore not accounted for | Year MSF first worked in the country: 2012 | msf.org/unitedstates

UZBEKISTAN

Despite high rates of drug-resistant tuberculosis (DR-TB) in Uzbekistan, most people who have the disease are undiagnosed and go without medical care.

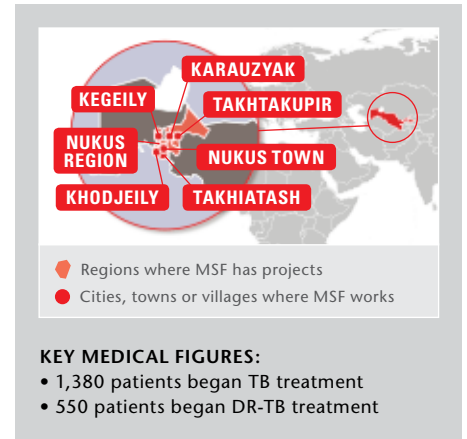
In the Autonomous Republic of Karakalpakstan, Médecins Sans Frontières (MSF) is helping address gaps in TB diagnosis and treatment, focusing on the provision of quality medical care for patients with DR-TB, who do not respond to the standard first-line regimen of drugs that can cure drug-sensitive TB.

MSF is also introducing new approaches, such as using rapid diagnostic tests and treating people as outpatients so they do not always have to be hospitalised.

TB medication can have powerful side effects such as headaches and nausea,

which can cause patients to interrupt or discontinue their regimens. MSF helps patients medically manage side effects and provides counselling to see them through treatment. The programme also supports patients with education, transportation, food packages and financial aid.

In 2012, MSF expanded its programme of comprehensive TB care to the districts of Kegeily and Nukus Town, while TB care in the districts of Takhtakupir and Karauzyak was handed over to the Ministry of Health in June.



No. staff end 2012: 160 | Year MSF first worked in the country: 1997 | msf.org/uzbekistan

ZAMBIA

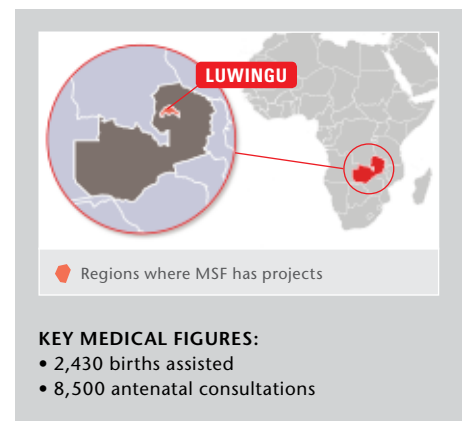
Only four out of ten women giving birth at healthcare facilities in Zambia's Northern province have a skilled health worker present, according to national health authorities.

The situation is worst in rural areas. Luwingu district, Northern province, is a remote and isolated place, where many deaths related to pregnancy and childbirth are preventable. Delays in referrals, long distances to health centres and a lack of qualified staff all contribute to loss of life.

A maternal health programme was started by Médecins Sans Frontières (MSF) in Luwingu in 2010. Teams provide family planning, ante- and postnatal care and assist births at Luwingu district hospital and seven rural health centres. Emergency obstetric referrals are made from clinics to the hospital, where 163 caesarean sections were performed

in 2012. A surgical team also offers fistula repair. Obstetric fistulas are injuries to the birth canal most often resulting from prolonged, obstructed labour. They cause pain and incontinence, which can lead to stigma and social exclusion.

Included in comprehensive sexual and reproductive health services is the prevention of mother-to-child transmission of HIV (PMTCT). The MSF team also conducts awareness and educational activities to reduce stigma regarding HIV – which often prevents people from seeking assistance – and encourages them to come to the centres for testing and treatment.



No. staff end 2012: 76 | Year MSF first worked in the country: 1999 | msf.org/zambia

ZIMBABWE

KEY MEDICAL FIGURES:

- 64,780 patients on first-line antiretroviral treatment
- 4,410 patients began TB treatment
- 1,300 patients treated after incidents of sexual violence

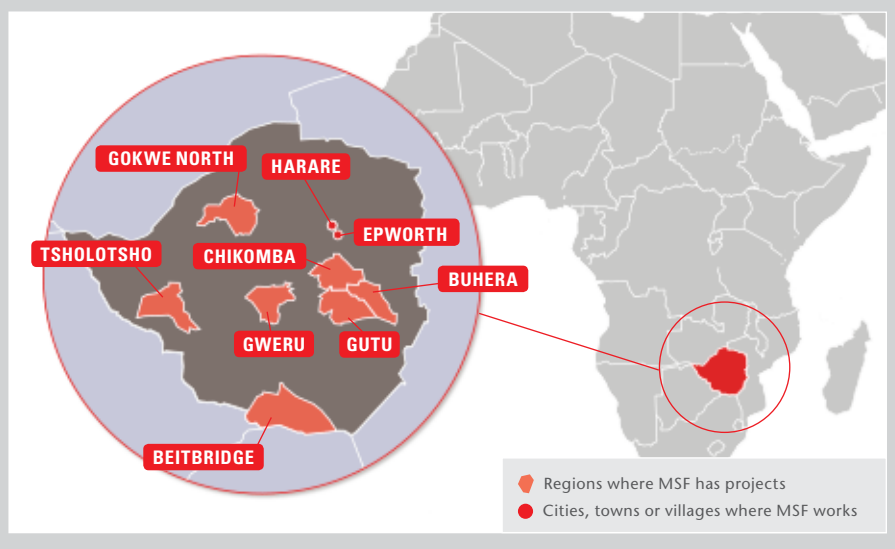
The health system in Zimbabwe continues to struggle with the dual epidemic of HIV and tuberculosis (TB). Babies, children and young adults often do not have access to adequate care.

At several locations, Médecins Sans Frontières (MSF) provides comprehensive HIV and TB care. The package of services includes rapid testing, treatment, counselling, prevention of mother-to-child transmission (PMTCT) and medical and psychological support for victims of sexual violence. In 2012, programmes were further decentralised and integrated into Ministry of Health facilities to improve patients' access to services.

In Tsholotsho, MSF staff work in the hospital and 14 rural health facilities, with a special focus on PMTCT, adolescents and children. As 40 per cent of patients came from neighbouring Umguza district, the team trained nurses in Umguza to initiate antiretroviral (ARV) treatment. A family support clinic was also opened at Tsholotsho district hospital, where MSF provided medical and psychological support to 100 victims of sexual violence.

A new programme was launched in January in the district of Gokwe North. Staff in the district's two rural hospitals and 16 health centres tested 13,900 people for HIV and registered 2,200 patients for care. A total of 325 people began treatment for TB. Here too, the teams provide care and treatment for victims of sexual violence.

In Beitbridge, on the border with South Africa, MSF supported the Ministry of Health to ensure effective HIV and TB prevention, treatment and care. Staff worked in six rural health facilities to increase access to services. MSF also supported the district hospital's outpatient service to integrate the treatment of opportunistic infections. Since the project opened, more than 6,100 patients have started HIV treatment, a third of the number estimated to be in need of it.



Focus on TB

A specific focus in Epworth, a southeastern suburb of Harare, has been TB diagnosis and care. A new testing machine has enabled staff to obtain more reliable results, more quickly: the machine gives results – including for resistance to the drug rifampicin – in less than two hours. A total of 2,798 samples were tested in 2012. Of these samples, traditional microscopy had identified 15 per cent of results as positive, whereas the machine found 22 per cent, thus indicating significantly improved diagnosis. Additionally, nine new patients were enrolled in the multidrug-resistant TB (MDR-TB)

programme. Treatment for MDR-TB takes up to two years and can cause severe side effects. At the end of the year, forty more patients were under MDR-TB treatment in MSF programmes in the country.

Mentorship and handovers

In the district of Buhera, teams mentored Ministry of Health staff in 26 clinics in preparation for the handover of services, as 100 per cent coverage of people in need of ARV treatment had been reached. A new TB testing machine was added to the lab, and approximately 320 tests were carried out per month.



A TB nurse visits to prepare the daily drug regimen for a 44-year-old MDR-TB patient in Buhera district.



© Jule Remy

A group of people living with HIV meet at Gombe clinic, Buhera district, where they sing, dramatise, draw and discuss their illness.

Teams in Gutu and Chikomba districts continued to train and mentor staff in 23 clinics and provide technical support, preparing for a rapid scale-up of HIV treatment. A new TB testing machine was also installed in Gutu Mission hospital. The last remaining patients in the HIV and TB programme in Gweru were successfully transferred to the Ministry of Health at the end of April.

Treating young victims of sexual violence

In Mbare, Harare, a programme for victims of sexual violence offers free medical care, counselling and referrals for psychological, psychosocial and legal support. Working in close collaboration with local partners, MSF teams cared for 900 new and 925 follow-up patients. More than half of them were under 16 years of age.

Psychiatric care in prisons

An assessment at Harare maximum security prison indicated that many inmates

were suffering from undiagnosed and untreated mental illness. MSF opened a new programme in May to fill gaps in psychiatric care, providing patients from Harare and eight other prisons with psychiatric services, psychological consultations and occupational therapy.

Typhoid emergency

Between October 2011 and April 2012 and then from November 2012, MSF assisted Harare city authorities in responding to peaks in a typhoid outbreak. Typhoid fever is a bacterial disease spread through contaminated food and water, with symptoms appearing only one to three weeks after exposure. Patients are treated with antibiotics, although some people remain carriers of the disease even after they have recovered themselves. As well as offering treatment and care, MSF assisted in the provision of safe water, the improvement of sanitation and disease prevention activities.

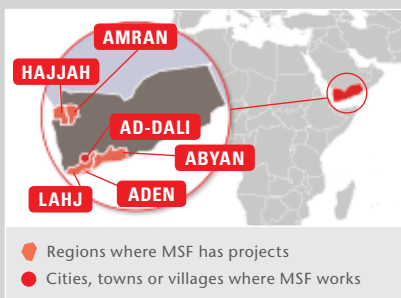
Sikhethkile

received PMTCT treatment in Tsholotsho.

Thanks to the prevention programme, my daughter was born HIV-free. I was so surprised that I called her Surprise! A nurse gave me the medicine I had to take before, during and after giving birth, and she told me what I had to do on the day of delivery. I did everything as the nurse told me, and when I went into labour, I took the two pills that I had been given at the hospital. I remember that day very well!

I am so happy to see her; especially after all the time I suffered while I was sick. At that time I never imagined I could have a baby, but thanks to the prevention programme I managed to have my daughter free of HIV. Soon she will be a year old, and she has already begun to take her first steps.

YEMEN



KEY MEDICAL FIGURES:

- 104,900 outpatient consultations
- 3,400 surgical procedures
- 3,160 births assisted

Violence and political instability are preventing access to healthcare in a number of regions in Yemen.

Security incidents within health facilities further restrict access. In 2012, Médecins Sans Frontières (MSF) was forced to suspend activities on several occasions in some areas. MSF continues to promote the importance of weapon-free health facilities and protecting patients and staff.

Huth health centre closed due to security incident

Huth health centre, in Amran governorate, was closed by the Ministry of Health after armed men entered and threatened MSF staff in September. Emergency, outpatient, maternal, paediatric and inpatient services were halted.

In contrast, the team at Al-Salam hospital in Khamir increased activities, opening a new nursery, a paediatric ward and an intensive care unit, and expanding maternity services. The outpatient feeding programme was handed over to the Ministry of Health so that MSF could focus attention on patients suffering from more complex conditions.

Joint mobile teams of national and MSF staff carried out regular clinics in the remote Osman and Akhrif valleys to screen for and treat malaria and malnutrition. Mosquito nets were distributed and the number of cases of malaria fell to zero in the Osman valley towards the end of the year. More than 300 patients received treatment in total.

Surgical centre opened in Aden

In April, MSF opened a 40-bed emergency surgical centre inside Al-Wahda hospital compound, in the city of Aden. The centre receives patients from within Aden as well as from MSF-supported facilities in Abyan and Ad-Dali. Patients needing specialist reconstructive surgery are referred from here and Sana'a to Amman, Jordan (see page 58).

By the end of the year, most people displaced by the civil unrest had returned home, lessening the demand on health facilities in Aden, and the team withdrew from three clinics in the city.

Supporting emergency services

In Ad-Dali governorate, MSF worked in the emergency department of Al-Naser hospital and managed surgical referrals to Aden. The team also improved sterilisation and waste management, and donated drugs and medical supplies for the operating theatre.

In Abyan governorate, staff provided emergency, surgical and maternity services at the Post Office medical post in Jaar, until public health authorities reopened Al-Razi

hospital in June. The hospital had been closed in September 2011 after an attack on the facility killed seven people. MSF also supports Lawdar hospital and other health facilities in Abyan with donations of drugs and medical supplies.

Measles broke out in Amran and Ad-Dali at the beginning of the year. MSF staff treated 395 patients. In Abyan, 83 people were treated for dengue, a virus transmitted by infected mosquitoes, which causes flu-like symptoms.

Mental health programme opened

An MSF team started to provide mental health assistance to migrants in Haradh, Hajjah governorate, which is on one of the main routes from the Horn of Africa to the Gulf states.

Activities reduced in Hajjah and Lahj

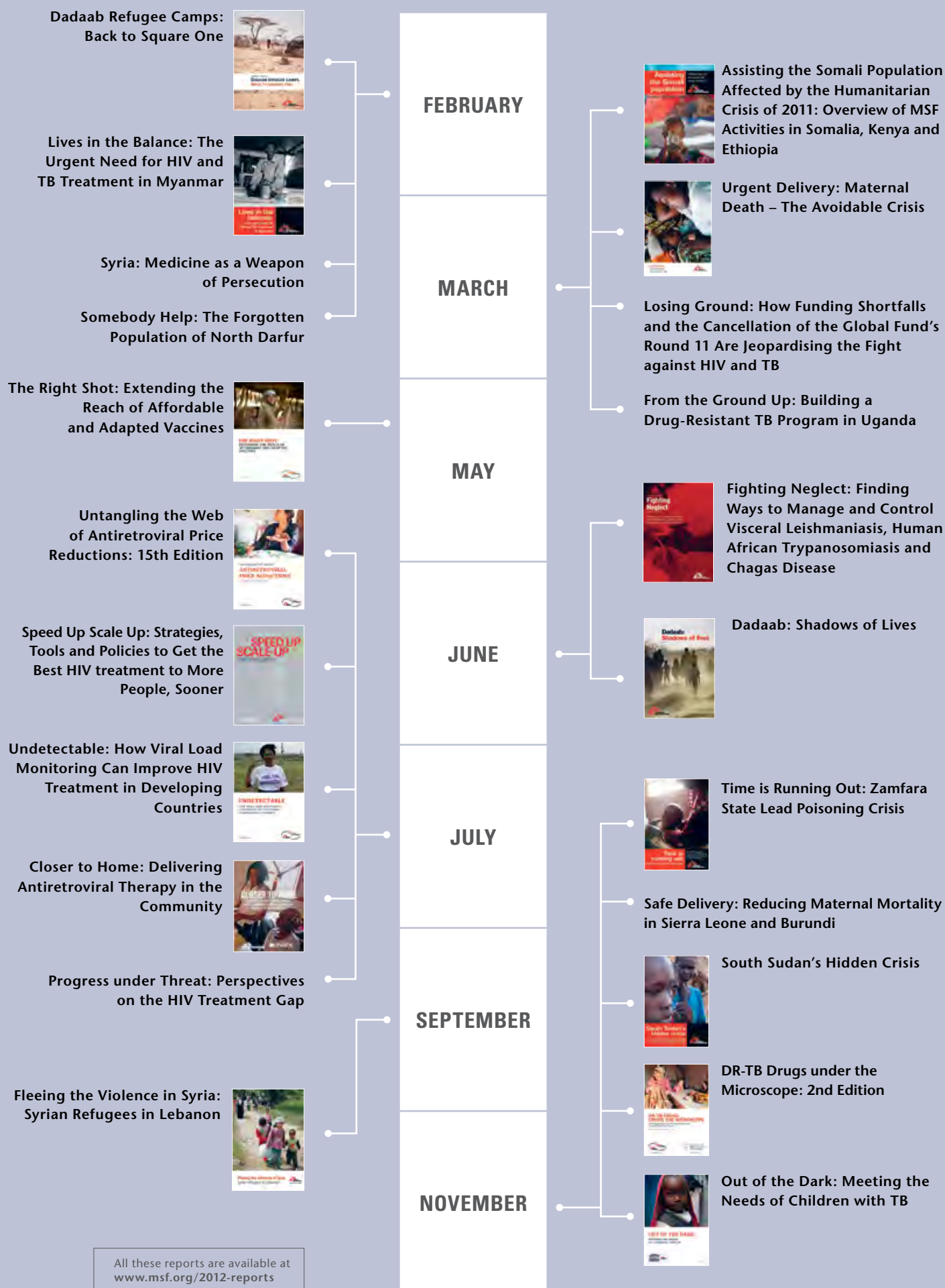
Activities in the hospital near Al-Mazraq, in Hajjah, and in Radfan district hospital, Lahj governorate, were scaled down, as the situation for the displaced stabilised. In December, MSF withdrew from Al-Hosn health centre.

No. staff end 2012: 576 | Year MSF first worked in the country: 1994 | msf.org/yemen



A new paediatric ward was opened at Al-Salam hospital, Khamir, as part of an overall increase in activities.

SPECIAL REPORTS 2012



FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, independent, private and non-profit organisation.

It is made up of 23 associations: Australia, Austria, Belgium, Brazil, Canada, Denmark, East Africa, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Latin America, Luxembourg, Norway, Southern Africa, Spain, Sweden, Switzerland, UK, USA. MSF's day-to-day activities are managed by 19 national offices and nine branch offices (see page 100 for contact details).

The search for efficiency has led MSF to create 10 specialised organisations, called 'satellites', which take charge of specific activities such as humanitarian relief supplies, epidemiological and

medical research, and research on humanitarian and social action. These satellites, considered as related parties to the national offices, include: MSF-Supply, MSF-Logistique, Epicentre, Fondation MSF, Etat d'Urgence Production, MSF Assistance, SCI MSF, SCI Sabin, Ärzte Ohne Grenzen Foundation and MSF Enterprises Limited. As these organisations are controlled by MSF, they are included in the scope of the MSF Financial Report and the figures presented here.

These figures describe MSF's finances on a combined international level. The 2012 combined international figures have been prepared in accordance with MSF international accounting standards, which comply with most of the requirements of the International Financial Reporting Standards (IFRS). The figures have been jointly audited by the accounting firms of

KPMG and Ernst & Young, in accordance with International Auditing Standards. A copy of the full 2012 Financial Report may be obtained at www.msf.org. In addition, each national office of MSF publishes annual, audited Financial Statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

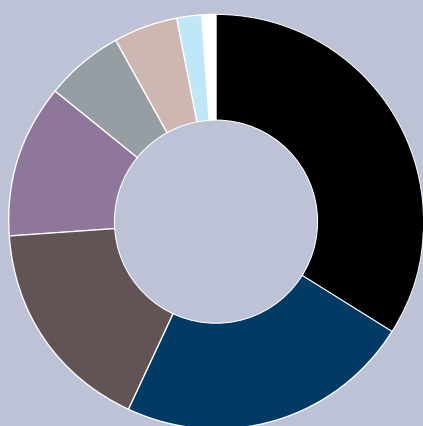
The figures presented here are for the 2012 calendar year. All amounts are presented in millions of euros.

Note: Figures in these tables are rounded, which may result in apparent inconsistencies in totals.

WHERE DID THE MONEY GO?

Programme expenses by nature

Locally hired staff	34 %
International staff	23 %
Medical and nutrition	17 %
Transport, freight and storage	12 %
Logistics and sanitation	6 %
Operational running expenses	5 %
Training and local support	2 %
Consultants and field support	1 %



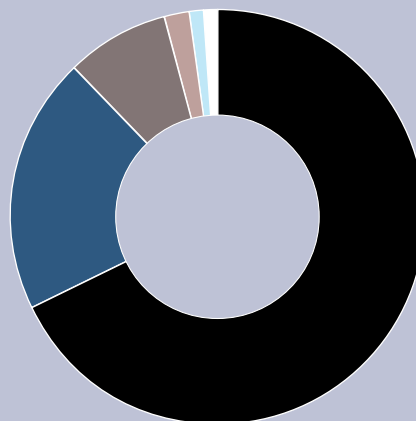
The biggest category of expenses is dedicated to staff working in the field: about 57 per cent of expenditure comprises all costs related to locally hired and international staff (including plane tickets, insurance, accommodation, etc.).

The medical and nutrition category includes drugs and medical equipment, vaccines, hospitalisation fees and therapeutic food. The delivery of these supplies is included in the category of transport, freight and storage.

Logistics and sanitation comprise building materials and equipment for health centres, water and sanitation and logistical supplies.

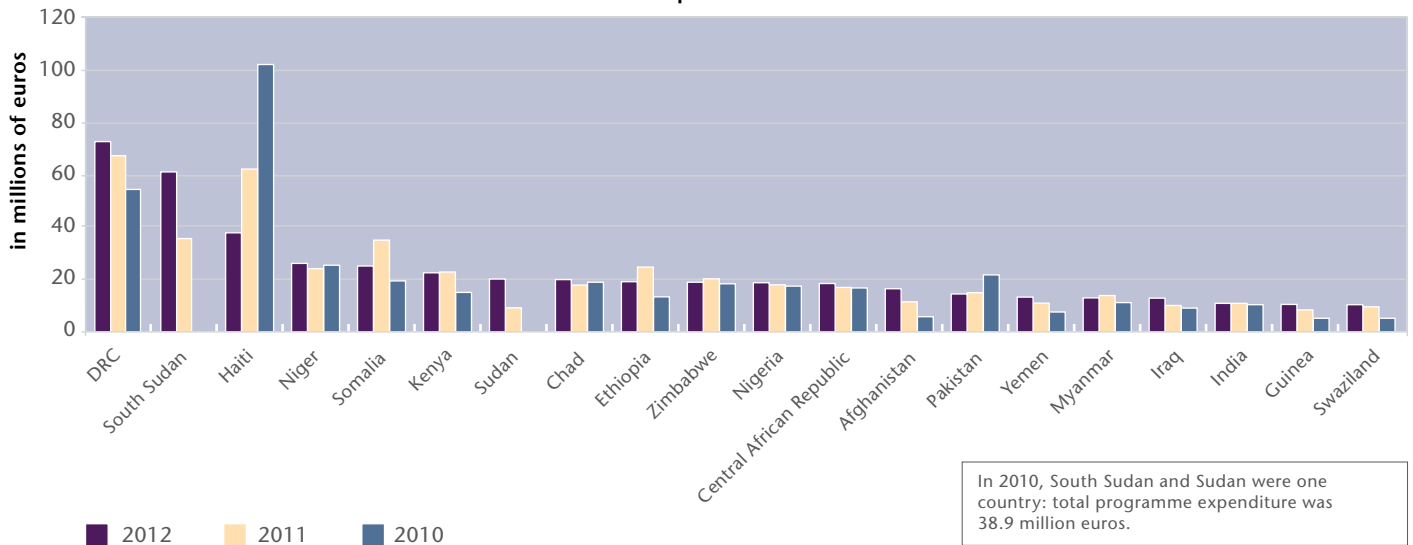
Programme expenses by continent

Africa	68 %
Asia	20 %
Americas	8 %
Europe	2 %
Oceania	1 %
Unallocated	1 %



COUNTRIES WHERE WE SPENT THE MOST

Countries where MSF expenditure is more than 10 million euros



AFRICA

in millions of €

Democratic Republic of Congo	72.8
South Sudan	61.2
Niger	26.2
Somalia	25.2
Kenya	22.6
Sudan	20.2
Chad	20.0
Ethiopia	19.2
Zimbabwe	19.0
Nigeria	18.8
Central African Republic	18.5
Guinea	10.5
Swaziland	10.4
Malawi	9.8
Mali	9.1
South Africa	8.1
Mozambique	7.6
Sierra Leone	7.3
Uganda	6.4
Côte d'Ivoire	4.1
Burundi	4.1
Mauritania	4.0
Cameroon	3.3
Congo	3.1
Burkina Faso	2.4
Zambia	2.0
Egypt	1.5
Madagascar	1.2
Morocco	1.0
Other countries*	2.6

Total 422.2ASIA AND
THE MIDDLE EAST

in millions of €

Afghanistan	16.5
Pakistan	14.5
Yemen	13.3
Myanmar	13.0
Iraq	12.9
India	10.9
Syria	9.6
Uzbekistan	5.9
Lebanon	4.9
Bangladesh	3.7
Occupied Palestinian Territory	3.6
Kyrgyzstan	3.1
Armenia	2.0
Cambodia	1.8
Tajikistan	1.3
Turkey	1.2
Other countries*	4.9

Total 123.1

THE AMERICAS

in millions of €

Haiti	37.9
Colombia	8.7
Bolivia and Paraguay**	2.0
Mexico	1.1
Other countries*	2.0

Total 51.7

EUROPE

in millions of €

Russian Federation	6.3
Ukraine	2.4
France	1.2
Other countries*	1.2

Total 11.1

OCEANIA

in millions of €

Papua New Guinea	5.0
------------------	-----

Total 5.0

UNALLOCATED

in millions of €

Transversal activities	1.2
Other	5.1

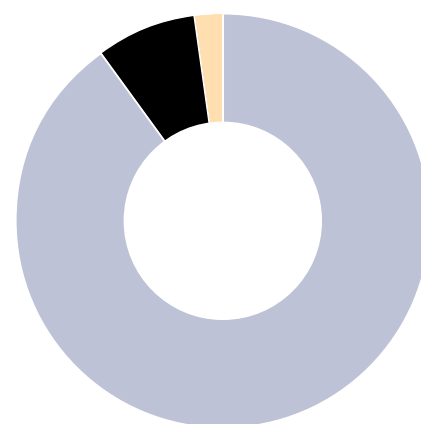
Total 6.3

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

** Bolivia and Paraguay are operated as a joint programme.

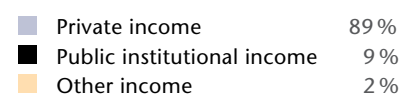
WHERE DID THE MONEY COME FROM?

	2012		2011	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Private	838.9	89%	791.6	89%
Public institutional	82.7	9%	75.2	9%
Other	16.1	2%	18.7	2%
Income	937.7	100%	885.5	100%



HOW WAS THE MONEY SPENT?

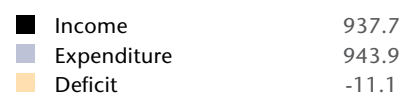
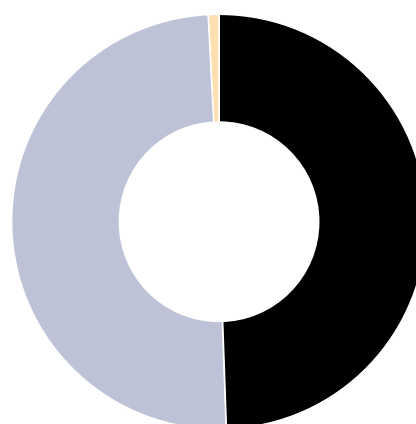
	2012		2011	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Programmes	619.4	66%	609.8	68%
Headquarters programme support	103.9	11%	92.3	10%
Témoignage/awareness-raising	31.7	3%	27.5	3%
Other humanitarian activities	7.4	1%	7.0	1%
Social mission	762.4	81%	736.6	82%
Fundraising	124.8	13%	110.9	12%
Management and general administration	56.6	6%	52.4	6%
Income tax	0.1	–	–	–
Other expenses	181.5	19%	163.3	18%
Expenditure	943.9	100%	899.9	100%
Net exchange gains/losses	-4.8		-1.6	
Surplus/deficit	-11.1		-16.0	



4.6
MILLION
private donors

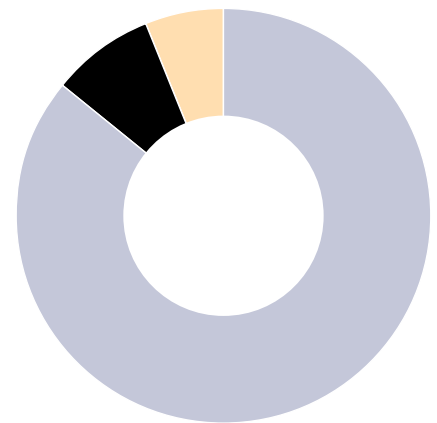
YEAR-END FINANCIAL POSITION

	2012		2011	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Cash and cash equivalents	551.4	79%	572.9	81%
Other current assets	91.1	13%	84.4	12%
Non-current assets	57.4	8%	49.6	7%
Assets	699.9	100%	706.9	100%
Permanently restricted funds	3.4	–	2.5	–
Unrestricted funds	580.2	83%	592.3	84%
Other retained earnings and equities	15.0	2%	16.1	2%
Retained earnings and equities	598.6	85%	610.9	86%
Current liabilities	101.3	15%	96.0	14%
Liabilities and retained earnings	699.9	100%	706.9	100%



HR STATISTICS

	2012		2011	
Medical pool	1,548	26%	1,734	27%
Nurses and other paramedical pool	1,785	30%	1,935	30%
Non-medical pool	2,622	44%	2,707	43%
International departures (full year)	5,955	100%	6,376	100%
	<i>no. staff</i>	<i>percentage</i>	<i>no. staff</i>	<i>percentage</i>
Locally hired staff	29,228	86%	29,302	86%
International staff	2,592	7%	2,580	8%
Field positions	31,820	93%	31,882	94%
Positions at headquarters	2,326	7%	2,062	6%
Staff	34,146	100%	33,944	100%



■ Locally hired staff 86%
■ International staff 7%
■ Headquarters staff 7%

The majority of MSF staff (86 per cent) are hired locally in the countries of intervention. Headquarters staff represent 7 per cent of total staff.

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 2012, 89 per cent of MSF's income came from private sources. More than 4.6 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF included, among others, the European Commission's Humanitarian Aid Department (ECHO) and the governments of Belgium, Canada, Denmark, France, Germany, Italy, Ireland, Luxembourg, Norway, Spain, Sweden, Switzerland and the UK.

Expenditure is allocated according to the main activities performed by MSF. All programme expenditure categories include salaries, direct costs and allocated overheads.

Social mission includes all costs related to operations in the field (direct costs) as well as all the medical and operational support from the headquarters directly allocated to the field (indirect costs). Social mission costs represent 81 per cent of the total costs for 2012.

Permanently restricted funds may be capital funds, where donors require the assets to be invested; funds retained for actual use, rather than expended; or the minimum level of retained earnings that is compulsory for certain sections of MSF.

Unrestricted funds are unspent, non-designated donor funds expendable at the discretion of MSF's trustees in furtherance of our social mission.

Other retained earnings represent foundations' capital as well as technical accounts related to the combination process.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. At the end of 2012, the available portion (excluding permanently restricted funds and capital for foundations) represented 7.6 months of the preceding year's activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, a sudden drop in private and/or public institutional funding, the sustainability of long-term programmes (e.g. antiretroviral treatment programmes), and the pre-financing of operations to be funded by forthcoming public fundraising campaigns and/or public institutional funding.

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

CONTACT MSF

International Médecins Sans Frontières

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 00 | F +41 22 849 84 04
www.msf.org

Humanitarian Advocacy and Representation team

(UN, African Union, ASEAN, EU, Middle East)
T +41 22 849 84 00 | F +41 22 849 84 04

MSF Access Campaign

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 05 | www.msfaccess.org

Australia Médecins Sans Frontières

Level 4 | 1-9 Glebe Point Road | Glebe NSW 2037
PO BOX 847 | Broadway NSW 2007 | Australia
T +61 28 570 2600 | F +61 28 570 2699
office@sydney.msf.org | www.msf.org.au

Austria Médecins Sans Frontières / Ärzte Ohne Grenzen

Taborstraße 10 | 1020 Vienna | Austria
T +43 1 409 7276 | F +43 1 409 7276/40
office@aerzte-ohne-grenzen.at
www.aerzte-ohne-grenzen.at

Belgium Médecins Sans Frontières / Artsen Zonder Grenzen

Rue Dupré 94 | Dupréstraat 94
1090 Brussels | Belgium
T +32 2 474 74 74 | F +32 2 474 75 75
www.msf.be or www.azg.be

Canada Médecins Sans Frontières / Doctors Without Borders

720 Spadina Avenue, Suite 402 | Toronto
Ontario M5S 2T9 | Canada
T +1 416 964 0619 | F +1 416 963 8707
msfcan@msf.ca | www.msf.ca

Denmark Médecins Sans Frontières / Læger uden Grænser

Dronningensgade 68, 3. | 1420 København K
Denmark
T +45 39 77 56 00 | F +45 39 77 56 01
info@msf.dk | www.msf.dk

France Médecins Sans Frontières

8 rue Saint Sabin | 75011 Paris | France
T +33 1 40 21 29 29 | F +33 1 48 06 68 68
office@paris.msf.org | www.msf.fr

Germany Médecins Sans Frontières / Ärzte Ohne Grenzen

Am Köllnischen Park 1 | 10179 Berlin | Germany
T +49 30 700 13 00 | F +49 30 700 13 03 40
office@berlin.msf.org
www.aerzte-ohne-grenzen.de

Greece Médecins Sans Frontières / Γιατρών Χωρίς Σύνορα

15 Xenias St. | 115 27 Athens | Greece
T +30 210 5 200 500 | F +30 210 5 200 503
info@msf.gr | www.msf.gr

Holland Médecins Sans Frontières / Artsen zonder Grenzen

Plantage Middenlaan 14 | 1018 DD Amsterdam
Netherlands
T +31 20 520 8700 | F +31 20 620 5170
office@amsterdam.msf.org
www.artsenzongrenzen.nl

Hong Kong Médecins Sans Frontières

無國界醫生 / 无国界医生
22/F Pacific Plaza | 410-418 Des Voeux
Road West | Sai Wan | Hong Kong
T +852 2959 4229 | F +852 2337 5442
office@msf.org.hk | www.msf.org.hk

Italy Médecins Sans Frontières / Medici Senza Frontiere

Via Magenta 5 | 00185 Rome | Italy
T +39 06 88 80 6000 | F +39 06 88 80 6027
msf@msf.it | www.medicisenzafrentiere.it

Japan Médecins Sans Frontières / 国境なき医師団

3F Waseda SIA Bldg | 1-1 Babashitacho
Shinjuku-ku | Tokyo 162-0045 | Japan
T +81 3 5286 6123 | F +81 3 5286 6124
office@tokyo.msf.org | www.msf.or.jp

Luxembourg Médecins Sans Frontières

68, rue de Gasperich | 1617 Luxembourg
Luxembourg
T +352 33 25 15 | F +352 33 51 33
info@msf.lu | www.msf.lu

Norway Médecins Sans Frontières / Leger Uten Grenser

Hausmannsgate 6 | 0186 Oslo | Norway
T +47 23 31 66 00 | F +47 23 31 66 01
epost@legerutengrenser.no
www.legerutengrenser.no

Spain Médecins Sans Frontières / Médicos Sin Fronteras

Nou de la Rambla 26 | 08001 Barcelona | Spain
T +34 93 304 6100 | F +34 93 304 6102
oficina@barcelona.msf.org | www.msf.es

Sweden Médecins Sans Frontières / Läkare Utan Gränser

Gjörwellsgatan 28, 4 trappor | Box 34048
100 26 Stockholm | Sweden
T +46 10 199 32 00 | F +46 8 55 60 98 01
info.sweden@msf.org
www.lakareutanranser.se

Switzerland Médecins Sans Frontières / Ärzte Ohne Grenzen

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 84 | F +41 22 849 84 88
office-gva@geneva.msf.org | www.msf.ch

UK Médecins Sans Frontières / Doctors Without Borders

67-74 Saffron Hill | London EC1N 8QX | UK
T +44 20 7404 6600 | F +44 20 7404 4466
office-ldn@london.msf.org | www.msf.org.uk

USA Médecins Sans Frontières / Doctors Without Borders

333 7th Avenue | 2nd Floor | New York
NY 10001-5004 | USA
T +1 212 679 6800 | F +1 212 679 7016
info@doctorswithoutborders.org
www.doctorswithoutborders.org

Branch Offices

Argentina

Carlos Pellegrini 587 | 11th floor | C1009ABK
Ciudad de Buenos Aires | Argentina
T +54 11 5290 9991 | www.msf.org.ar

Brazil

Rua do Catete, 84 | Catete | Rio de Janeiro
CEP 22220-000 | Brazil
T +55 21 3527 3636 | www.msf.org.br

Czech Republic

Seifertova 555/47 | 130 00 Praha 3 | Žižkov
Czech Republic
T +420 257 090 150 | www.lekaribezhranic.cz

India

C-106 | Defence Colony
New Delhi-110024 | India
T +91 11 465 80 216 | www.msfindia.in

Ireland

9-11 Upper Baggot Street | Dublin 4 | Ireland
T +353 1 660 3337 | www.msf.ie

Mexico

Champlotón 11 | Col. Roma Sur
CP 06760 | Ciudad de México | Mexico
T +52 55 5256 4139 | www.msf.mx

Republic of Korea

9F Hosoo Bldg. | 68-1 Susong-dong
Jongno-gu | Seoul 110-140 | Republic of Korea
T +82 2 3703 3500 | www.msf.or.kr

South Africa

Orion Building | 3rd floor | 49 Jorissen Street
Braamfontein 2017 | Johannesburg | South Africa
T +27 11 403 44 40 | www.msf.org.za

United Arab Emirates

P.O. Box 47226 | Abu Dhabi | UAE
T +971 2631 7645 | www.msf-me.org

ABOUT THIS REPORT

Contributors

Caroline Abu-Sada, Ali Al-Mawlawi, Halimatou Amadou, Louise Annaud, James Arkinstall, Shaista Aziz, Aurélie Baumel, Niklas Bergstrand, Pierre Borelle, Andrea Bussotti, Jehan Bseiso, Brigitte Breuillac, Talia Bouchouareb, Lali Cambra, Françoise Duroch, Silvia Fernández, Isabelle Ferry, Mathieu Fortoul, Marisol Gajardo, Sarah-Eve Hammond, Carolina Heidenhain, Joanna Keenan, Jo Kuper, Aurélie Lachant, Yann Libessart, Samantha Maurin, Eddy McCall, Robin Meldrum, Isabelle Merny, Agustin Morales, Jessica Neerkorn, Elias Primoff, Yasmin Rabiyan, Catherine Robinson, Javier Sancho, Faith Schwieker-Miyandazi, Victoria Russell, Gregory Vandendaelen, Jonathan Whittall.

Special thanks to

Valérie Babize, François Dumont, Marc Gastellu Etchegorry, Myriam Henkens, Nicolette Jackson, Unni Karunakara, Erwin van 't Land, Caroline Livio, Jérôme Oberreit, Emmanuel Tronc.

We would also like to thank all the field, operations and communications staff who provided and reviewed material for this report.

English Edition

Managing Editor Jane Linekar

Editorial Support Caroline Veldhuis and Yi Ling Hwong

Photo Editor Bruno De Cock

Proof Reader Kristina Blagojevitch

French Edition

Editor Laure Bonnevie, Histoire de mots

Translator Translate 4 U sarl (Alette Chaput, Emmanuel Pons)

Spanish Edition

Coordinator Javier Sancho

Translator Pilar Petit

Editor Mar Padilla

Arabic Edition

Coordinator Jessica Moussan-Zaki

Translator Mouine Imam (Commanine)

Editor Jessica Moussan-Zaki

Designed and produced by

ACW, London, UK

www.acw.uk.com

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation.

MSF is a non-profit organisation. It was founded in Paris, France in 1971. Today, MSF is a worldwide movement of 23 associations. Thousands of health professionals, logistical and administrative staff manage projects in some 70 countries worldwide. MSF International is based in Geneva, Switzerland.

MSF International

78 rue de Lausanne, CP 116, CH-1211, Geneva 21, Switzerland
Tel.: +41 (0)22 849 8400, Fax: +41 (0)22 849 8404

COVER PHOTO

A surgical team carries out an operation to remove a bullet from a patient, northern Syria.
© Nicole Tung

