Médecins Sans Frontières (MSF) was founded in 1971 by a small group of doctors and journalists who believed that all people should have access to emergency relief. MSF was one of the first non-governmental organisations to provide urgently needed medical assistance and to publicly bear witness to the plight of the people it helps.

Today MSF is an international medical humanitarian movement with national sections in 19 countries. In 2008, over 26,000 doctors, nurses, and other medical professionals, logistical experts, water and sanitation engineers and administrators provided medical aid in over 65 countries.
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 that 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 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 assignees for any form of compensation other than that which the association might be able to afford them.

The country texts in this report provide descriptive overviews of MSF work throughout the world between January and December 2008. Staffing figures represent the total of full-time-equivalent positions per country in 2008. Reasons for intervention classify the initial event(s) triggering an MSF medical-humanitarian response as documented in the 2008 International Typology study. Country summaries are representational and, owing to space considerations, may not be entirely comprehensive.
MSF opens and closes a number of individual projects each year, responding to acute crises, handing over projects, and monitoring and remaining flexible to the changing needs of patients at any given location. Several projects may be running simultaneously in a single country as needed.
The year in review

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

2008 was a year of achievement as well as frustration for MSF. While advances in malnutrition treatment allowed more than one million people with severe malnutrition to receive treatment, MSF teams continued to respond to the escalating violence.

Throughout the year, MSF aid workers carried out 8.8 million consultations and 47,500 surgical interventions in over 65 countries. They provided treatment for more than one million people with malaria, and nutritional care for more than 200,000 malnourished children.

When post-election violence broke out in Kenya, a cyclone devastated Myanmar’s Irrawaddy Delta, and a cholera epidemic swept Zimbabwe, MSF medical teams were already in place and ready to offer urgently needed assistance. In Kenya, MSF reinforced its teams on the ground with extra surgeons, emergency physicians, nurses, and logistical specialists in response to the escalating violence.

In Myanmar, they provided medical and psychosocial support, shelter and food to survivors of Cyclone Nargis. For months, MSF was one of the only organisations with access to all cholera-affected areas in Zimbabwe, and by early 2009 had treated 45,000 people.

In the Democratic Republic of Congo (DRC), MSF provided critical medical care to towns affected by fighting in the eastern part of the country. Throughout the region, teams treated war-wounded in surgical programmes, set up cholera treatment facilities, and provided other basic essentials such as clean water and relief items to displaced people and local residents.

After more than two decades working in Afghanistan, MSF was forced to leave in 2004 following the deliberate slaughter of five colleagues. In 2008, teams began exploring the possibility of returning to provide medical assistance again to those affected by escalating insecurity. In neighbouring Pakistan, where 600,000 people fled due to fighting in the North West Frontier Province, MSF teams helped people to access healthcare by offering ambulance services. But ensuring that all parties to the conflict recognise and respect independent humanitarian assistance continued to prove difficult. In early 2009, MSF was forced to suspend its work in Afghanistan due to the escalating violence.

In Sudan, increasing administrative obstacles and insecurity hindered MSF’s response to those most in need in Darfur and other regions. For example, in August, after a series of attacks against staff, teams were forced to leave projects in Tawila, North Darfur, where 35,000 displaced people had gathered, and in Thanyi/Tobuya, where MSF had provided medical care for 28,000 displaced people. Leaving so many people without access to medical care, even if only temporarily, was extremely hard, but without a guarantee of minimum security for humanitarian workers, MSF had no option but to suspend activities for several weeks. Despite this, 7,000 consultations where carried out in these two areas in 2008.

In December, Israel launched the ‘Hard Lead’ offensive in the Gaza Strip. During the fighting, MSF struggled to send in additional medical teams due to Israeli restrictions on the movement of people and aid. However, teams already in Gaza were able to respond immediately by supplying the local hospitals overwhelmed by the influx of wounded. Only once the Israeli forces had declared a ceasefire in January were a surgical team and 21 tons of supplies (including two inflatable hospital tents) able to reach Gaza City.

MSF then concentrated its activities on specialised surgery and on postoperative and physiotherapy treatment. Another key objective in 2008 was to find new ways to fight malnutrition and neglected diseases. Throughout the year, MSF lobbied to improve the standards of care for people on antiretroviral therapy (ART) and the development of new diagnostic and therapeutic tools, estimating that current investment falls at least four times below what is needed to combat the emergence of this deadly, but treatable, disease.

IFV also affects an estimated 1.9 million children worldwide, but only around 200,000 of those who need it receive ART. However, more than 90% of children do not have access to the lifesaving medicines they need. In response to this, MSF called on governments and donors to make existing tests more widely available and to increase considerably the use of a paediatric combination for children with a standard-dose antiretroviral combination drug. A combined effort by governments and aid agencies is needed, and MSF will continue to provide...
comprehensive treatment, including the prevention of mother-to-child transmission of HIV.

MSF also continues to support the search for new treatments for neglected diseases and in 2008 an important step towards improving treatment options for sleeping sickness was taken. The Drugs for Neglected Diseases Initiative (DNDi), together with MSF and Epicentre, pioneered a new, less toxic and easier-to-administer treatment for sleeping sickness, called NECT (Nifurtimox-Eflornithine Combination Therapy). This ten-day treatment is of particular interest to MSF since MSF and the Dutch government. This decision sets a grave precedent for independent humanitarian action. By agreeing to downgrade the consequences of the abduction to a mere commercial dispute, as requested by the Dutch government, the Federal Tribunal’s ruling is contributing to making unpunished crimes against humanitarian workers part of everyday life.

There is no doubt that, in 2009, MSF will continue to challenge barriers to the provision of independent, emergency medical care to those affected by conflict or excluded from healthcare. MSF will seek new, innovative ways to treat malnutrition and infectious diseases, will ensure that medical tools are effective and field-adapted, and will work to increase preparedness to respond to natural disasters. But this vital work can be done only with the continued support of the millions of donors – including 3.7 million individuals worldwide – and the tens of thousands of MSF staff who make it possible every day.

Thank you.

In July 2008, MSF was shocked by a judgement made by Switzerland’s highest judicial body, the Federal Tribunal. The case concerned the repayment of a ransom paid by the Dutch authorities to obtain the release of Arjan Erkel, a Dutch civilian and MSF head of mission, who was held hostage in the North Caucasus region for 20 months having been abducted in August 2002. Following four years of proceedings, and in spite of two previous rulings in favour of MSF, the Federal Tribunal found partly in favour of the Dutch government by ruling that the financial burden should be shared between MSF and the Dutch government. This decision sets a grave precedent for independent humanitarian action. By agreeing to downstage the consequences of the abduction to a mere commercial dispute, as requested by the Dutch government, the Federal Tribunal’s ruling is contributing to making unpunished crimes against humanitarian workers part of everyday life.

There is no doubt that, in 2009, MSF will continue to challenge barriers to the provision of independent, emergency medical care to those affected by conflict or excluded from healthcare. MSF will seek new, innovative ways to treat malnutrition and infectious diseases, will ensure that medical tools are effective and field-adapted, and will work to increase preparedness to respond to natural disasters. But this vital work can be done only with the continued support of the millions of donors – including 3.7 million individuals worldwide – and the tens of thousands of MSF staff who make it possible every day.

Thank you.
1. Somalia’s humanitarian catastrophe worsens
Somalia has some of the worst health indicators in the world, and its people have little or no access to even basic healthcare services. An estimated one in ten women die during child- birth, and more than one in five children die before their fifth birthday.
In 2008, violence in the country escalated to levels not seen in over a decade. Since fighting began in December 2006, a million Somalis have fled their homes. In the first months of 2008, 150,000 families fled Mogadishu now live in appalling conditions on the road out of the capital, and have little prospect of return.
Some Somalis fled for Kenya, where, according to the UN refugee agency UNHCR, some 200,000 live in three camps. Others go north and board boats to try to sail their way to safety. Some 45,500 people – mostly Somalis, but also Ethiopians – attempted the journey in 2008. Gassed into small vessels, many of these would be refuseniks; suffocating, many others drown in the Gulf.
Targeted attacks against aid workers have also increased. Staff have been kidnapped and some, including Kenyan medical doctor and UN worker Gaetan from the World Food Programme are killed. MFH and others have been forced to withdraw teams and curtail medical activities, exacerbating the humanitarian crisis. Such a situation, with a disabled delivery of urgently needed help,

2. Outside the spotlight, Myanmar’s health crisis is still ignored
In May, Cyclone Nargis devastated the Irrawaddy Delta, leaving around 130,000 people missing or dead. As news broke, MFH teams and others brought emergency assistance to the worst-affected areas. Most of MFH’s help was provided by an office in Yangon, who, through dedicated teams, provided health care to patients in remote areas and provided medical assistance throughout the country.
Then, news broke, MFH teams and others brought emergency assistance to the worst-affected areas. Most of MFH’s help was provided by an office in Yangon, who, through dedicated teams, provided health care to patients in remote areas and provided medical assistance throughout the country.

3. Violence and economic collapse exacerbate Zimbabwe’s growing health crisis
In 2008, inflation in Zimbabwe reached 231 million per cent. Political violence escalating and, in the lead up to contested elections in June, additional restrictions continued to stifle the work of humanitarian organisations even further.
There are ten million people living with HIV in the country. The violence and economic meltdown has forced many of those undergoing antiretroviral therapy to interrupt or abandon their treatment, risking grave health consequences. Some can no longer afford to eat and many who try to travel to markets are afraid to leave their homes or have been forced to flee.
The number of Zimbabweans – including much-needed medical staff – have left the country. About three million have fled to neighboring South Africa. Every day, thousands more flee the LSongo river to reach the border of Mozina, risking attacks by bandits. Many of those who reach the other side have to live outside the law to avoid arrest and deportation.
In May, violent xenophobic attacks in South Africa displaced more than 100,000 people.
A cholera epidemic in the Sierra Leone was caused by the mixed pregnancy of the border. The LFAL and the WHO disease outbreaks were detected even before the rainy season – when cholera spreads more easily – had arrived. A national emergency was declared and MFH responded, treating more than 11,000 patients.

4. Civilians trapped as war rages in eastern Democratic Republic of Congo
Renewed fighting among armed groups and the Congolese armed forces (FARDC) have driven hundreds of thousands of people to flee from North Kivu, leaving them with little or no access to food, water, basic shelter or healthcare. The UN peacekeeping force UNIRUC has been largely unable to protect people trapped by the violence. It did lead an armed ‘humanitarian’ relief convoy into Bujumbura after rebel forces took control of the town, but such moves can make the work of independent aid agencies even more difficult by blurring the distinction between military and humanitarian action.
Out of the spotlight, people in Hutu-IDAI district, some 50,000 of whom had already been driven from their homes, fell prey to cross-border raids by the rebel group Lord’s Resistance Army. Here as elsewhere, the fighting renders people near inaccessible to humanitarian organisations while overcrowding, poor sanitation and the lack of clean water in many camps for displaced people leave thousands vulnerable to easily treatable conditions and recurrent epidemics.

5. Ready-to-use food could bring swift recovery to millions of malnourished children
The World Health Organization estimates that there are 175 million undernourished children across the globe. According to UNICEF, the situation is actually getting worse in 16 countries. Up to five million children under five years old die each year, more than 80,000 people are diagnosed each year with tuberculosis (TB), and multi-drug-resistant TB is on the rise. More action by the UN agencies and organisations is urgently needed to protect thousands more vulnerable people from unnecessary suffering and death.

6. Nomadic people isolated and in critical danger in Ethiopia’s Somali region
Drought has already helped to destroy harvests, food stocks, grazing lands and livestock in Ethiopia’s Somali region, making life a continual struggle for the region’s indigenous herders and bush-dwellers. Both before and after the rains, people are now also caught between battling rebel groups and government forces. Some have been directly exposed to the violence; many more are becoming increasingly isolated.

7. Civilians pay dearly as fighting intensifies in northwest Pakistan
In October, more violence sent hundreds of thousands of people into neighboring regions in just a few months. Many found refuge in Pakistan’s border areas, near large urban centers and in areas commonly and large-scale outbreaks of meningitis, measles, cholera, and malaria are relentless.

8. No end in sight to violence and suffering in Sudan
One-third of the people of Darfur have been displaced by the bitter civil war. Although more than 80 humanitarian organisations provided assistance in 2008, it was still difficult to access and assess the needs of thousands of people. Even the help that did get through was in danger of being stopped in the future, as aid lines, shifting alliances and the attacks and increasing government restrictions on aid workers. Eleven were killed in Darfur in 2008 and 149 abducted, according to the UN.

9. Thousands of Iraqis left with nowhere to turn
One of the many challenges facing humanitarian organisations in Iraq is the continued fighting. About 1.6 million Iraqis have been displaced by the war in Iraq, and half of them are trapped within the country, according to the UN refugee agency (UNHCR) and the Norwegian Refugee Council. Bombing and sectarian violence kill and cause injuries that often require immediate and intensive attention, but the long-neglected healthcare system leaves thousands of Iraqis with little or no medical care, even at primary level.

10. Better tools and techniques vital to combat HIV/tuberculosis co-infection
Every year, 3.6 million people (TB) kills about 1.7 million people. It is one of the leading causes of death for people with HIV/AIDS, roughly a third of whom (11 million worldwide) are infected with TB. Yet in 2006 less than one per cent of those living with HIV/AIDS were screened for TB. Diagnosis of TB is difficult: a standard test, involving X-rays of the chest, cannot detect the disease in most people who are HIV-positive. Rapid culture tests achieve better results, but are too complex to perform in the places where most patients live.

10. Treatment for TB is costly, and patients who have HIV/AIDS are more likely to have drug-resistant TB than non-infected patients.
In 2008, in the development of TB medicines, diagnostic tools, and vaccines amounted to an estimated $429 million, according to the Global Fund, of which $100 million was woefully short of the $7 billion annual invest- ment urgently needed to give millions of co- infected people a fighting chance of survival.

UNDER-REPORTED CRISIS OF 2008

8

MEDECINS SANS FRONTIERES
ACTIVITY REPORT 2008

9
Three neglected killers

Ten years ago, when the Nobel Peace Prize was awarded to Médecins Sans Frontières, MSF’s president at the time, James Orbinski, said that more than 90 per cent of all deaths and suffering from infectious diseases occur in the developing world because “life-saving essential medicines are either too expensive, are not available because they are not seen as financially viable, or because there is virtually no new research and development for priority tropical diseases.”

MSF dedicated the award’s prize money to its neglected diseases programmes. In the same year the Access to Essential Medicines campaign was launched, which became a fundamental aspect of MSF’s work, as did its commitment to improving the quality of drugs available, and ensuring that even the poorest communities have access to them.

Over the years, MSF has been able to report that globally research and development has improved for neglected diseases. Yet the needs of victims of the most neglected diseases are still largely unmet. Together three diseases - Kala Azar, Chagas and Sleeping Sickness - endanger the lives of more than 80 million people every year.

Kala Azar, or visceral leishmaniasis, frequently affects poor communities in isolated regions. Spread by the sand fly and fatal if left untreated, the disease is endemic in 88 countries. Ninety per cent of cases occur in Bangladesh, Brazil, India, Nepal and Sudan. Treatment is hampered by drug resistance, high prices, lack of access to existing medicines, and slow progress on research into new cures.

Chagas disease is endemic in many Latin American countries, where it affects an estimated ten to 15 million people and claims up to 40,000 lives every year. The condition damages the heart, nervous and digestive systems in one-third of patients.

Sleeping sickness affects 36 countries in sub-Saharan Africa, where 60 million people are at risk. It was nearly eliminated in the 1960s, but has re-emerged in the 1990s due to war, population movement and the collapse of health systems. Despite a decrease in reported cases due to improved efforts in some areas, sleeping sickness remain undetected and therefore untreated in remote and/or unsafe areas of several countries where it is endemic.

A recent survey produced by the George Institute for International Health revealed that less than five per cent of worldwide research and development for neglected diseases has been directed towards the most neglected diseases, that of, Kala Azar, chagas and sleeping sickness.

In 2008, MSF committed 18 million Euros to the Drugs for Neglected Diseases initiative (DNDi). At the same time MSF will continue to support operational and clinical research through its field programmes, will call for new research into more efficient drugs and demand that governments, companies and agencies take action so that these diseases receive the urgent attention and funding they need.
Many of the worldwide cases of Kala Azar are concentrated in the northeast Indian state of Bihar. The most common treatment is sodium stibogluconate; however, resistance to the drug is a growing problem—especially in India, where as many as 65 per cent of patients become drug resistant. MSF has been working in Bihar’s Vaishali district since 2007, assisting Kala Azar patients with one of the most effective and safest treatments available to fight the disease: liposomal amphotericin B. Medical teams have diagnosed and treated more than 3,000 patients suffering from Kala Azar and achieved a cure rate of 98.4 per cent. The mortality rate is 0.7 per cent and there is a low incidence of adverse reactions.

Armed with this evidence, MSF is calling for liposomal amphotericin B to be included in the Indian treatment protocol as a first-line treatment option or to be used as one of the main drugs in combination therapies in the coming years.

In Bolivia, the country with the highest incidence of the disease worldwide, Chagas is a major public health concern. Yet despite a presidential decree in Bolivia which states that Chagas treatment in children needs to be routine, treatment is rarely available and the people most at risk cannot afford it. MSF is treating Chagas patients up to 50 years of age in rural and suburban Bolivia, an important step forward in the fight against Chagas which even today is often not treated. Often this is due to the need for greater access to proper diagnostic tools, for safer, shorter treatments, for paediatric formulas and for early cure rate predictors to monitor the efficacy of the drugs.

MSF is campaigning for the production and availability of two existing Chagas drugs—nifurtimox and benznidazol—to be secured, and for efforts to find simple, less toxic, more affordable and efficient treatments for all forms of Chagas disease, for children and adults alike, to be stepped up.
Sleeping sickness in Democratic Republic of Congo

CHAGAS DISEASE
First described by the Brazilian doctor Carlos Chagas, this parasitic disease is found almost exclusively in Latin America, though increased global travel has led to cases being reported in the US and Europe. This potentially fatal condition damages the heart, nervous and digestive systems.

The disease is transmitted by blood-sucking insects that live in cracks in the walls and roofs of mud and straw housing, common in rural areas and poor urban slums in Latin America. People can be infected but show no chronic symptoms for years. Debilitating and possibly life-threatening chronic symptoms develop in approximately 30 per cent of people infected. Chagas can cause irreversible damage to the heart, oesophagus and colon, shortening life expectancy by an average of ten years. Heart failure is a common cause of death for adults with Chagas.

Treatment must be given in early acute stages of the infection, and so far drugs have been effective only in the acute and asymptomatic stage of the disease in children. Diagnosis is complicated: doctors need to perform two or three blood tests to determine whether a patient is infected with the parasite. There are few drugs developed to treat the disease and the current line of treatment can be toxic, taking one to two months to complete. Apart from managing symptoms, there has been no effective treatment for chronic Chagas in adults.

MSF Chagas programmes in Bolivia focus primarily on education, preventive measures and screening and treatment for children. MSF is now also attempting to treat adults through a project in Bolivia.

MSF treated over 2,000 people for Chagas in 2008.

CHOLERA
The Greek word for diarrhoea, cholera is a waterborne, acute gastrointestinal infection caused by the Víbrio choleræ bacterium and spread by contaminated water or food. The infection can spread rapidly and cause sudden large outbreaks. Although most people infected with cholera will have only a mild infection, the illness can also be severe, causing profuse watery diarrhoea and vomiting that lead to severe dehydration and, without rapid treatment, death.

Required treatment is the immediate replacement of fluid and salts with a rehydration solution administered orally or intravenously.

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

MSF treated over 68,000 people for cholera in 2008.

HUMAN AFRICAN TRYPANOSOMIASIS (SLEEPING SICKNESS)
Frequently known as sleeping sickness, this parasitic infection is seen in sub-Saharan Africa and is transmitted by tsetse flies. More than 90 per cent of reported cases of sleeping sickness are caused by the parasite Trypanosoma brucei gambiense. The parasite attacks the central nervous system, causing severe neurological disorders and leading to death if untreated.

During the first stage of the illness, people have non-specific symptoms such as fever and weakness. At this stage the disease is difficult to diagnose but relatively easy to treat. The second stage occurs once the parasite invades the central nervous system. The infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, or convulsions and sleep disturbance.

Accurate diagnosis of the second stage of the illness requires taking a sample of spinal fluid and treatment is painful, requiring daily injections. The most common drug used to treat trypanosomiasis, melarsoprol, was developed in 1949 and has many side-effects. A derivative of arsenic, it is highly toxic and fails to cure up to 30 per cent of patients in some areas of Africa. It also kills up to five per cent of people who receive it. Though eflornithine is somewhat difficult to administer because it has to be given intravenously and requires a complicated treatment schedule, it is a safer alternative and is used by MSF in its projects.

In 2009, a new treatment option called NECT (Nifurtimox-Eflornithine Combination Therapy) was added to the World Health Organization’s Essential Medicines List, based on the application submitted by the non-profit

GLOSSARY OF DISEASES

CHAGAS DISEASE
First described by the Brazilian doctor Carlos Chagas, this parasitic disease is found almost exclusively in Latin America, though increased global travel has led to cases being reported in the US and Europe. This potentially fatal condition damages the heart, nervous and digestive systems.

The disease is transmitted by blood-sucking insects that live in cracks in the walls and roofs of mud and straw housing, common in rural areas and poor urban slums in Latin America. People can be infected but show no chronic symptoms for years. Debilitating and possibly life-threatening chronic symptoms develop in approximately 30 per cent of people infected. Chagas can cause irreversible damage to the heart, oesophagus and colon, shortening life expectancy by an average of ten years. Heart failure is a common cause of death for adults with Chagas.

Treatment must be given in early acute stages of the infection, and so far drugs have been effective only in the acute and asymptomatic stage of the disease in children. Diagnosis is complicated: doctors need to perform two or three blood tests to determine whether a patient is infected with the parasite. There are few drugs developed to treat the disease and the current line of treatment can be toxic, taking one to two months to complete. Apart from managing symptoms, there has been no effective treatment for chronic Chagas in adults.

MSF Chagas programmes in Bolivia focus primarily on education, preventive measures and screening and treatment for children. MSF is now also attempting to treat adults through a project in Bolivia.

MSF treated over 2,000 people for Chagas in 2008.

CHOLERA
The Greek word for diarrhoea, cholera is a waterborne, acute gastrointestinal infection caused by the Víbrio choleræ bacterium and spread by contaminated water or food. The infection can spread rapidly and cause sudden large outbreaks. Although most people infected with cholera will have only a mild infection, the illness can also be severe, causing profuse watery diarrhoea and vomiting that lead to severe dehydration and, without rapid treatment, death.

Required treatment is the immediate replacement of fluid and salts with a rehydration solution administered orally or intravenously.

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

MSF treated over 68,000 people for cholera in 2008.

HUMAN AFRICAN TRYPANOSOMIASIS (SLEEPING SICKNESS)
Frequently known as sleeping sickness, this parasitic infection is seen in sub-Saharan Africa and is transmitted by tsetse flies. More than 90 per cent of reported cases of sleeping sickness are caused by the parasite Trypanosoma brucei gambiense. The parasite attacks the central nervous system, causing severe neurological disorders and leading to death if untreated.

During the first stage of the illness, people have non-specific symptoms such as fever and weakness. At this stage the disease is difficult to diagnose but relatively easy to treat. The second stage occurs once the parasite invades the central nervous system. The infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, or convulsions and sleep disturbance.

Accurate diagnosis of the second stage of the illness requires taking a sample of spinal fluid and treatment is painful, requiring daily injections. The most common drug used to treat trypanosomiasis, melarsoprol, was developed in 1949 and has many side-effects. A derivative of arsenic, it is highly toxic and fails to cure up to 30 per cent of patients in some areas of Africa. It also kills up to five per cent of people who receive it. Though eflornithine is somewhat difficult to administer because it has to be given intravenously and requires a complicated treatment schedule, it is a safer alternative and is used by MSF in its projects.

In 2009, a new treatment option called NECT (Nifurtimox-Eflornithine Combination Therapy) was added to the World Health Organization’s Essential Medicines List, based on the application submitted by the non-profit
LEISHMANIASIS (KALA AZAR)
Largely unknown in the developed world, leishmaniasis is a tropical, parasitic disease caused by one of more than 20 varieties of Leishmania and transmitted by bites from certain types of sand flies. The most severe form, visceral leishmaniasis, is also known as kala azar. Hindi for ‘black fever’. Over 90 per cent of cases occur in Bangladesh, Brazil, India, Nepal and Sudan. Without treatment, this form of leishmaniasis is fatal in almost all cases.

Kala azar attacks the immune system, causing fever, weight loss, anaemia and an enlarged spleen. There are considerable problems with existing diagnostic tests, which are either invasive or potentially dangerous and require lab facilities and specialists not readily available in resource-poor settings. Treatment requires painful, daily injections of drugs for 30 days. The drug most widely used to treat kala azar, sodium stibogluconate, was developed in the 1930s, is relatively expensive and causes a toxic reaction in some patients.

Co-infection of leishmaniasis and HIV is emerging as a growing threat, since both diseases attack and weaken the immune system. Infection with one of these diseases makes a person less resistant to the other and treatment becomes less effective.

MSF treated more than 6,400 people for leishmaniasis in 2008.

MALARIA
Caused by four species of the parasite Plasmodium, malaria is transmitted by infected mosquitoes. Symptoms include fever, pain in the joints, headaches, repeated vomiting, convulsions and coma. Malaria caused by Plasmodium falciparum, if untreated, may lead to death.

Malaria is commonly diagnosed on a basis of clinical symptoms alone, such as fever and headaches. Around half the people who present with fever and are treated for malaria in Africa may not actually be infected with the parasite. An accurate diagnosis can be made through a count of parasites by microscope or a rapid dipstick test. Both methods are used by MSF in its projects.

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

MSF treated more than 1.17 million people for malaria in 2008.

MENINGITIS
Meningococcal meningitis is caused by Neisseria meningitidis and is a contagious and potentially fatal bacterial infection of the meninges, the thin lining surrounding the brain and spinal cord. People can be infected and carry the disease without showing symptoms, spreading the bacteria to others through droplets of respiratory or throat secretions, for example when they cough or sneeze. The infection can also cause sudden and intense headaches, fever, nausea, vomiting, sensitivity to light and stiffness of the neck. Death can follow within hours of the onset of symptoms.

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

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

MSF treated more than 7,100 people and vaccinated some 706,000 people against meningitis in 2008.

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

This contagious disease affects the lungs and is spread through the air when infectious people cough or sneeze. Not everyone will become ill, but ten per cent of people will develop active TB at some point in their lifetime. Symptoms include a persistent cough, fever, weight loss, chest pain and breathlessness. TB is also a common opportunistic infection and leading cause of death amongst people with HIV/AIDS.

Drugs used to treat TB are from the 1950s and a course of treatment for uncomplicated TB takes six months. Poor treatment management and adherence has led to new strains of bacilli that are resistant to one or more anti-TB drug. Multi-drug-resistant TB (MDR-TB) is a serious form of this, identified when patients are resistant to the two most powerful first-line antibiotics. MDR-TB is not impossible to treat, but the required regimen causes many side-effects and takes up to two years. A newer strain, extensively drug-resistant TB (XDR-TB), is identified when resistance to second-line drugs develops on top of MDR-TB, making the treatment even more complicated.

MSF treated more than 29,000 people for TB, including 971 for MDR-TB, in 2008.
By September 2008, MSF was treating 4,275 patients, 3,410 of whom, including 126 children, had started antiretroviral therapy. On average there are 100 new cases a month.

Helping street girls and their children
MSF has been providing healthcare to girls living on the streets of Ouagadougou and their young children since 2005. Street girls are particularly vulnerable because most are separated from their families. They are minors with very little education and have no one to protect them. To survive, many of the girls engage in prostitution. They also suffer from social violence and discrimination. Because of sexual exploitation, they are particularly vulnerable because most are separated from their families. They are minors with very little education and have no one to protect them. To survive, many of the girls engage in prostitution. They also suffer from social violence and discrimination.

MSF provided treatment for sexually transmitted infections, and reproductive, obstetric, and antenatal care. MSF also cared for victims of sexual violence. MSF provided treatment for sexually transmitted infections, and reproductive, obstetric, and antenatal care. MSF also cared for victims of sexual violence.

Treat acute malnutrition and malaria in the north
MSF treats children suffering from malnutrition in two districts: Yako and Titao – in the northern region of Burkina Faso where malnutrition is endemic. Children under five years old are deprived of basic nutrients during the annual ‘hunger gap’, when food reserves from the last harvest become depleted.

We are focusing on children under five, as they are the most vulnerable to malnutrition, says Jean-Luc Anglade, MSF programme manager for Burkina Faso. Childhood malnutrition is an underlying cause of death for many children, yet it receives little public attention.

Young children need the right amount of both macro and micro-nutrients in their diet.

Since the programme was launched in September 2007, more than 23,440 children have been admitted. 88 per cent of whom were recovered.

Many children in Burkina Faso also suffer from malaria: between 65 and 70 per cent of the children admitted to MSF malaria programmes also have malaria during the annual malaria peak in the last months of the year.

MSF provided malaria treatment to more than 10,700 children, including those not suffering from malnutrition.

MSF has worked in Burkina Faso since 1995.

Via its mobile ambulance service MSF refers emergency cases 24 hours a day from a dozen health centres to its 35-bed centre in Kabézi.

Via its mobile ambulance service MSF refers emergency cases 24 hours a day from a dozen health centres to its 35-bed centre in Kabézi. MSF intends to use this project to draw attention to the scale of mother and baby mortality in Burundi and emphasise the importance of accessible and free medical care in this domain. A presidential decree adopted in 2006 guarantees free healthcare for pregnant women and children under five in Burundi. Yet this free access remains hypothetical for the population of Bujumbura Rural, due to the poor state of roads and the lack of specialised staff, material and medicine.

Treat sexual violence
Despite the end of years of open conflict, sexual violence has remained a concern in Burundi. In 2008, the MSF’s Seruka centre – seruka means ‘coming out of the dark’ in Kirundi, the national language – provided medical and psychological treatment to victims of sexual violence in Bujumbura Mairie. Since the opening of the centre in 2003, 2,900 cases have been cared for. The Seruka team has seen an increasing number of young patients visiting the centre. In 2008, 60 per cent of the victims had not yet turned 19 years old, half of those were under 12 years old. Statistics clearly show that a large proportion of aggressors are civilians known to the victims.

The Seruka centre remains an exception in Burundi: it is difficult for the victims of sexual violence to find appropriate care, in spite of the fact that rape represents a medical emergency.

In 2008 the Seruka Initiative for Rape Victims was created by local medical staff and is due to take over all activities of the Seruka centre from MSF in 2009.

MSF has worked in Burundi since 1992.

‘Complications arise in 15 to 20 per cent of deliveries,’ explains Dr Pablo Nuozzi, the MSF project coordinator. ‘The mother has to be within reach of an operating theatre and a blood transfusion in order to benefit from emergency healthcare and, as a last resort, a caesarean. The medical care offered by MSF is crucial because obstetric emergencies place the mother’s and baby’s lives in danger and can cause serious after-effects such as sterility or a fatalia between the vagina and bladder.’
CAMEROON

REASON FOR INTERVENTION • Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion
FIELD STAFF 170

MSF continues to be involved in the treatment of Buruli ulcer, one of the most neglected but treatable diseases in the world. Buruli ulcer is a bacterial infection related to tuberculosis and leprosy. The infection destroys skin and bone tissue and, if not treated (for example with physiotherapy), can lead to deformity.

The Buruli ward in Akonolinga hospital in Cameroon’s Centre Province offers free and comprehensive care for patients affected by this disease. More than 700 patients have been treated since the opening of the project. During 2008, on average 54 patients every month were hospitalised. The hospital bed occupancy rate reached 77 per cent.

In 2008 MSF closed the PRETIVI project for the prevention and integrated treatment of HIV/AIDS, which started in 2003 and provided antiretroviral therapy (ART) to people with HIV/AIDS in Douala, the second-largest city in Cameroon. The creation of a national project for HIV/AIDS treatment financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria enabled MSF to take this step.

Reason for Intervention

In 2008, many changes were made to the provision of care: treatment and care were decentralised and a different kind of dressing used so that people living in remote areas could receive treatment without being hospitalised.

Each year MSF gains more experience in treating Buruli ulcer and as a result is able to provide better-quality care adapted to patients’ needs. MSF is also trying to draw the attention of researchers and donors to this disease, which affects not only African countries such as Cameroon and Côte d’Ivoire, but also Australia.

In 2008 MSF gained more experience in treating conflict patients through a network of mobile clinics, hospitals, and health centres across the northwest in Kao, Batangafo, Markounda, Paoua, Bocassanga, Boguila, and in the northeastern areas of Birao and Goridi. More than 383,000 outpatient consultations were conducted and more than 14,800 patients were hospitalised. Patients are being treated for diseases such as malaria, tuberculosis, HIV/AIDS, sleeping sickness, and for malnutrition.

In Memory

On March 10, all MSF vehicle movements came to an abrupt halt after the fatal shooting of Mariam Atim, the mother of an MSF patient. Mariam was struck by a bullet while accompanying one of her children in a well-marked MSF vehicle in the Vakaga region. MSF condemned the murder. Movements and emergency referrals were drastically limited throughout the rest of the year.

MSF has worked in Cameroon since 2000.

CENTRAL AFRICAN REPUBLIC

REASON FOR INTERVENTION • Armed conflict
FIELD STAFF 1,188

Since late 2005, fighting between the government and various rebel groups has caused large-scale displacement of people in the Central African Republic (CAR). Many villages have been looted or burned, forcing their inhabitants to flee. Most people have sought refuge in the bush, or with host families in towns, often far from their destroyed homes.

Despite another increase in international aid in 2008, much of the population continues to live exposed to the elements, in constant fear of new attack and with no access to healthcare, clean water. People struggle to find food and are particularly vulnerable to malaria, respiratory infections, and diarrhoeal diseases.

Treating conflict patients

MSF focused on providing medical assistance to populations affected by the conflict through a network of mobile clinics, hospitals, and health centres across the northwest in Kabo, Batangafo, Markounda, Paoua, Bocassanga, Boguila, and in the northeastern areas of Birao and Goridi. More than 383,000 outpatient consultations were conducted and more than 14,800 patients were hospitalised. Patients are being treated for diseases such as malaria, tuberculosis, HIV/AIDS, sleeping sickness, and for malnutrition.

Helping mothers and children

CAR also has a very high mother and child mortality rate. In response MSF projects provided 30,000 antenatal consultations and assisted at more than 5,000 deliveries during 2008. Mental-health services were also provided to communities living with the threat of displacement and violence. MSF also supported health centres in remote areas through training, the donation of medical supplies, and by setting up referral systems for patients who needed to be hospitalised. However support to peripheral health centres has been restricted by the tense security situation, which often limits the teams’ ability to move.

MSF has worked in the Central African Republic since 1997.

‘We have seen more and more patients whose state of health has been worsened by their flight into the bush. Children come in suffering from malaria, respiratory infections, diarrhoea and conjunctivitis; and adults suffering from a range of other conditions.’

Stéphane Hauser, MSF coordinator, Batangafo
Médecins Sans Frontières Activity Report 2008

CHAD

The various armed conflicts that marked the first half of 2008 left Chad fearing a troubled year ahead. But Chad remained a highly unstable country. Insecurity continued to affect many of the people living there and to hamper humanitarian work.

Violence and displacement

Confrontations between government forces and rebels, looting and banditry meant that for many people conflict is part of everyday life. The conflict between rebel and government forces reached a peak in February, when the capital N’Djamena came under attack. An MSF surgical team supported N’Djamena Ron Samaritain hospital, treating 126 wounded and performing more than 80 surgical procedures. Emergency assistance was also offered to victims of fighting in Adé and Gozbeida in April and June.

In eastern Chad alone, an estimated 185,000 Chadians who have been forced to flee their homes and 250,000 refugees from neighbouring Darfur still live in camps, and there is no short-term prospect of their returning to their home country. Insecurity continued to affect the rest of the year proved less tense, but Chad remained a highly unstable country. Insecurity continued to affect the rest of the year, with sporadic fighting continuing throughout the year until full-scale war resumed at the end of August. Hundreds of thousands of civilians were forced to flee the violence and most aid organisations had organised their activities.

MSF activities in 2008 gradually increased across the provinces of North and South Kivu. In Rutshuru, a town about 43 miles north of Goma, the MSF team continued working in the hospital during the periods of heaviest fighting. More than 3,700 surgeries were carried out in Rutshuru hospital, 19 per cent of which were for gunshot wounds, reflecting the high level of violence.

In 2008, more than 6,700 victims of sexual violence were treated in Kavumu. In Fizi, MSF opened a programme in Kabizo to manage a measles epidemic and provide healthcare to internally displaced people who had recently arrived in the area. The MSF team had to evacuate from Nyanzale several times for security reasons during the last four months of 2008. An MSF team started working in April in a hospital in Mwoe. A team was already working in Kitangan hospital, northwest of Goma. Between them, they conducted more than 350 major surgeries, 120 of which were related to serious injuries in the areas of Kitchanga and Mweso.

In August heavy fighting broke out, leading to disruptions in humanitarian aid. Hygiene conditions deteriorated and access to clean water for displaced people was reduced, which resulted in an increase in the number of people contracting cholera. In response MSF treated more than 2,280 patients in Rutshuru and Bunia.

For the population living in the east and northeast of the Democratic Republic of Congo (DRC), 2008 was a bleak year. In January, a peace agreement signed in Goma between the Congolese army and various armed groups brought a glimmer of hope to the people of North and South Kivu. However, sporadic fighting continued throughout the year until full-scale war resumed at the end of August. Hundreds of thousands of civilians were forced to flee the violence and most aid organisations had organised their activities.

In a highly insecure and rapidly changing situation, running mobile clinics, assessing new areas, and quickly re-locating teams are key to providing an effective response.
In December 2008, Uganda, DRC, and Sudan launched a joint offensive against the rebels of the Lord’s Resistance Army (LRA). In response to military operations against them, LRA fighters started in September to perpetrate acts of extreme violence on the civilian population of Haut-Uélé district. Hundreds of men, women, and children were killed and many young men were enlisted by force into the LRA. By the end of the year, more than 100,000 people were displaced and left largely unprotected from assailants.

MSF teams ran mobile clinics in several locations around the town of Duungu, and in Doruma, Bangadi and Fanafule. However, MSF medical activities were hampered by extreme insecurity in the region. Teams could move only by plane to remote areas, where they were able to stay for a short time. Despite the insecurity and logistical challenges, MSF has been able to screen 21,600 people and treat more than 680 patients for sleeping sickness in Haut-Uélé.

In Opinge, Tshopo district, an MSF team provided some 5,500 consultations for civilians affected by fighting around the town of Dungu, and in the eastern part of the country to be set ablaze.

In 2008, some 500 patients were provided with treatment for schistosomiasis in Shamwana and Dubie, as well as in Petrole and Port Aux Pret in the north.

In Opienge, Tshopo district, an MSF team has been able to screen 21,600 people and treat more than 680 patients for sleeping sickness in Haut-Uélé.

In stable areas of DRC, health needs remain high and MSF teams constantly responded to medical emergencies. In December 2008, central DRC was again hit by an epidemic of the deadly Ebola haemorrhagic fever. An MSF team responded by isolating and caring for those who may have contracted the disease, and controlled the outbreak.

In the first months of the year, MSF teams responded to outbreaks of cholera in the southeastern cities of Lubumbashi, Likasi, and Lubumbashi. Further north in the Tanganyika region, several MSF teams vaccinated half a million children of between six months and 15 years old against measles during the summer of 2008. Although the conflict in Katanga ended in 2006, the medical situation remains precarious. MSF works in three hospitals in Shamwana, Dubie, and Porto. In 2008, 13 health centres. MSF handed over Kivu hospital in June. Among the focuses in these facilities are maternal healthcare, including emergency obstetrics, and mental-health care in Shamwana and Dubie.

MSF continued to treat patients with HIV/AIDS in Kinshasa, the capital city, as well as in Bukavu and Bunia in the east. In December 2008, MSF handed over its Bukavu programme to a partner organisation and local health authorities. Two MSF clinics in the northern city of Kisangani treated an average of 5,000 patients monthly for sexually transmitted infections, and more than 120 patients a month were hospitalised at the MSF hospital in Lubutu, Muanza.

MSF has worked in DRC since 1987.

A website dedicated to telling the stories of those living alongside the fighting in Eastern Congo was launched in 2008. Condition-Critical.org is regularly updated by MSF with new eyewitness accounts, photos and video from the people living through the crisis.

Thousands of people are on the run, fleeing a war raging in the provinces of North and South Kivu, and in the northern Oriental province. MSF believed there was a need to highlight their struggle to survive – using their words to express the dire situation they are in.

A crisis chart in Ethiopia was launched in the Afar region of northeast Ethiopia. In September MSF teams reported a deteriorating humanitarian situation around Wardher in the conflict-affected area of the Somali region. Thousands of people who had fled their homes gathered on the town’s outskirts in search of food and water. With a clinic in Wardher town, MSF was able to provide medical care to the displaced people and the town inhabitants.

Projects continued in Cherrati and Debaghar, also in the Somali region. In Cherrati MSF provided primary healthcare and treatment for tuberculosis (TB). Over the course of the year more than 19,500 outpatient consultations were undertaken and nearly 700 people were started on TB treatment. In December the Cherrati project was handed over to the local health authorities.

In Debaghar medical teams work in a hospital providing inpatient and outpatient care and nutritional assistance. In 2008, more than 7,300 outpatient consultations were provided and the hospital saw 6,000 people received nutritional care.

In July MSF had to close its project in Fiqi, in the Ogaden region due to administrative hurdles and insecurity. This prevented teams from providing medical care to people in and around the town. Despite various agreements signed with the federal authorities, MSF international staff did not receive the necessary work permits and could work for only short periods at a time.

In the north, MSF continued to care for people with kala azar (visceral leishmaniasis) in Humera, Tigray region, and Abdirra. Amhara region; and lobbied for an improved response to this neglected disease. Kala azar, transmitted by sand fly, is almost always fatal if left untreated, but with proper care it is possible to cure over 90 per cent of primary cases. In the health clinic in Abdirra, MSF also cared for people living with HIV/AIDS, including those co-infected with kala azar and TB.

In 2008 some 500 patients were provided with treatment for schistosomiasis and more than 360 children under the age of five were treated for malnutrition. In the clinic’s emergency medical unit, MSF treated more than 670 people throughout the year; including patients with severe cases of malaria and meningitis.

MSF has worked in Ethiopia since 1984.
Guinea-Bissau

Reason for Intervention
- Endemic/Epidemic disease

Field Staff: 7

MSF mounted an emergency response to a cholera epidemic in Guinea-Bissau. An outbreak of the highly contagious bacterial disease was first detected in May, and by July the government had declared an emergency and requested international assistance.

Combating cholera

Cholera remains a problem in Guinea. While it severely hit Conakry in 2007, it stayed more or less contained within the coastal Guinée Maritime region (north of Conakry) in 2008. MSF donated medical material and drugs in Boké, and organised training for some 100 medical staff from different health centres in the capital.

MSF has worked in Guinée Conakry since 1984.

Unacceptable prison conditions

In September 2008, MSF started an emergency intervention in the civilian prison of Guéckédou. On arrival, MSF found malnutrition in one in three adult male prisoners, one in five of whom suffered severe acute malnutrition. Appalling unhygienic conditions had led to dehydration and rampant skin and respiratory infections. Overcrowded cells mixed minors together with adults, and prisoners with tuberculosis with other inmates. Healthcare was only occasionally available. MSF responded to the situation with emergency therapeutic food distribution for about three months. Teams also conducted medical consultations, donated medicines and provided material for water supply, sanitation and personal hygiene, and carried out assessments and vaccinations in three other prisons in the country (in Mamou, Boké and Gaoual). MSF produced a report and spoke out publicly to denounce the situation early in 2009.

More than 3,500 patients were receiving antiretroviral therapy at the end of 2008, including many HIV patients co-infected with tuberculosis.

Mobile teams were deployed to improve water and sanitation provision and make home visits to patients.

Cholera can spread rapidly through contaminated water and is endemic in Guinea-Bissau, where there is no sewage system and access to clean drinking water is severely limited.

By the time MSF started work in August 2008, nearly 4,000 cases had been reported nationwide and 93 people had died. Bissau, the capital, was the area most affected, accounting for 70 per cent of all registered cases. MSF staff helped the Ministry of Health to control the outbreak: teams of coordinators, nurses, logisticians, and epidemiologists took charge of treatment centres, strengthened local capacity and improved early detection and treatment.

Mobile teams were deployed to improve water and sanitation provision and make home visits to patients.

MSF treated more than 8,000 people, and its sanitation and prevention strategies helped to contain the epidemic. By the end of November, MSF handed over the projects to local health authorities and other humanitarian organisations.

MSF worked in Guinée-Bissau from August to November 2008.
In January 2006, MSF and the Ministry of Health and Social Welfare launched a joint programme to provide HIV/AIDS care and treatment, including antiretroviral therapy (ART), at the primary healthcare level in rural Lesotho. The programme was launched in Scott Hospital health service area, which includes a district hospital and 14 primary-care clinics in remote rural communities, and has a catchment of approximately 200,000 people. In addition to general primary care, the clinics provide comprehensive HIV/AIDS services including ART, HIV testing and counselling, prevention of mother-to-child transmission, care and support for children and adults, and management of opportunistic infections and co-infections such as TB.

‘One-stop’ integrated services have been established for patients co-infected with TB and HIV. Among other steps taken to ensure the integration of TB and HIV/AIDS care, all HIV/AIDS patients are systematically screened for TB, and TB patients are routinely offered an HIV test. MSF is also working with local health authorities to strengthen the primary healthcare system by improving laboratory services, drug supply, infrastructure, and programme monitoring and supervision.

By December 2008, 39,500 HIV tests had been carried out since the beginning of the project in 2006, and more than 4,300 patients had been initiated on ART. The clinical outcomes for the first two years are quite encouraging: 86 per cent of adults and 93 per cent of children are still in care after 12 months on ART. In addition, HIV transmission from mother to child has been reduced to less than five per cent for pregnant women who received prevention care. TB recovery has also improved, with treatment success rates reaching 78 per cent in 2008.

Decentralised care
Because the hospital-based ART clinics are so full, there are so few staff and many patients find it hard to reach or afford healthcare, MSF’s goal from the outset was to decentralise all HIV/AIDS care and treatment services to health centre level. The objective has been to bring care and treatment as close as possible to those in need, and to ensure HIV/AIDS care is free. Nurses were trained to assume high levels of clinical responsibility for HIV/AIDS care, including initiating and managing ART for children and adults. Lay counsellors (primarily people living with HIV/AIDS) were recruited and trained to reinforce clinic capacity and provide essential support in the delivery of HIV/AIDS and TB services, particularly treatment adherence. As of December 2008, there were 43 lay counsellors working across the 15 facilities.

Joseph Ramokotsi, a lay counsellor working at one of the mountain clinics, knows what it is like to live with HIV and commit to lifelong ART. ‘The work that I do here is my passion,’ he says. ‘When I tell my patients to take the antiretrovirals to feel better, they trust me because I am a living example. I tell them to be very committed to taking the antiretrovirals, and not to stop in spite of the side-effects.’

MSF lobbied for the elimination of user fees at primary healthcare level, and in the meantime authorised all essential HIV/AIDS-related services in the Scott Hospital catchment area, including drugs and other commodities, lab investigations, equipment, and hospital fees. In January 2008, the Ministry of Health abolished all user fees at primary healthcare level and lowered the fees for other district-level services. However, the costs that remain, including hospital admission for HIV-positive patients not on ART and chest X-rays, are still obstacles to accessing care, including the diagnosis of TB.

The aim of the MSF-supported programme in Scott Hospital was to develop a model that was replicable and sustainable in the long term while meeting ambitious early targets for ART enrolment. The first three-year phase of the programme has now come to a close and the project has entered a handover phase, during which MSF will gradually transfer all responsibilities to the Ministry of Health and other local partners by late 2010.

MSF has worked in Lesotho since 1997.
Liberia

Maternal healthcare

MSF provided free secondary healthcare in Montserrado county in the northwest of the country, home of the capital, Monrovia. In the suburb of Paynesville, MSF worked in Benson, a women’s and children’s hospital, helping to deliver over 3,000 babies and conducting more than 770 emergency gynaecological surgeries. Handover of this project to the Ministry of Health is under way.

MSF also provided free access to healthcare in a paediatric hospital, Island Hospital, in Bushrod Island. This overcrowded area in Monrovia is home to more than 500,000 people. Admissions exceeded 12,600 in 2008. Care was focused particularly on mothers and children of services for mothers and children such as antenatal and postnatal care, vaccinations and prevention of mother-to-child transmission of HIV. Together the centres provided more than 122,300 consultations in 2008.

In 2008, some 80 people with Lassa hemorrhagic fever were admitted to Saclepea’s special hospital unit for treatment. The fever is deadly if not treated quickly with ribavirine, a costly medicine protected by a pharmaceutical monopoly. As part of its planned withdrew from Saclepea, MSF is trying to ensure that ribavirine becomes affordable in Liberia. Teams are also lobbying health officials for continuity of care for HIV-positive patients after the withdrawal. It has now been agreed that HIV-positive patients will be able to receive treatment at Ganta hospital in northern Nimba county, and that screenings for HIV and tuberculosis will continue in Saclepea.

Liberia has significant numbers of HIV-infected people. In 2008, MSF provided antiretroviral therapy to over 12,000 people in Saclepea.

In 2008, MSF teams treated more than 770 people in Bushrod Island, more than 70 per cent of whom were younger than 15 years old. Some 11 per cent were younger than four years old.

Primary care handover

MSF manages a health centre in Saclepea in Nimba county, northeastern Liberia. Plans are under way for handing the project over to the Ministry of Health, but in 2008 the centre conducted more than 3,000 outpatient consultations. More than 100 people took advantage of free anonymous tests for HIV. MSF is also collaborating at the centre with the Ministry of Health, the Centre for Research and Field Epidemiology (Epicentre), and the Drugs for Neglected Diseases Initiative (DNDi) on a study aimed at making artemisinin-based combination therapy available for malaria sufferers throughout Africa.

Treating Lassa hemorrhagic fever

In 2008, an estimated 12 per cent of the adult population is infected. But there is still an acute shortage of nurses and doctors, which means many people are still going untreated.

Tackling the HIV/AIDS problem

MSF has decentralised some services to fixed locations in more rural areas in order to reduce the distance that patients have to travel for routine consultations and medication. Nurses treat opportunistic infections and chronic diseases, and lay counsellors and dedicated volunteers from the community, often HIV-positive themselves, undertake testing and counselling duties. The counsellors and volunteers also provide other essential services such as helping people to adhere to treatment and tracing patients who have stopped coming for treatment. Advances in treatment methods now also allow patients who are in a stable condition, and who have been on treatment for at least a year, to have their medical consultations only every six months as opposed to every two to three months.

Cholera epidemic

In mid-November 2008, a cholera epidemic swept through the country. MSF intervened in three rural districts as well as in the capital Monrovia. MSF provided care for more than 3,700 patients during the epidemic, and logistical support to improve water and sanitation services in nine health centres and one district hospital. MSF also trained local medical and logistic staff, helped a health centre in Blantyre and carried out situation assessments on the border to Mozambique.

In 2008, MSF teams in Chiradzulu carried out an assessment of patients who had abandoned their treatment, finding and interviewing them to discover why they had not finished the course. The main reasons involved the stigma associated with the disease expressed by their family or community, lack of information about the medication or the disease itself, or a perceived overall improvement in their health.

In recent years the Malawi government has made increasing efforts to provide more antiretroviral therapy (ART) in response to the spread of HIV/AIDS. An estimated 12.7 per cent of the adult population is infected. But there is still an acute shortage of nurses and doctors, which means many people are still going untreated.

Tackling the HIV/AIDS problem

MSF has been providing ART in two southern rural districts: Chiradzulu (since 2001) and Thyolo (since 2001). Since these projects began, MSF has started more than 28,000 patients on ART – 12,000 in Chiradzulu and 16,000 in Thyolo. In 2001, MSF achieved its goal of providing universal access to ART in Thyolo, starting 11,520 people on the therapy. In 2008, MSF placed more than 4,300 new patients on ART in Chiradzulu, and more than 4,400 in Thyolo.

MSF is involved in increasing the number and capacity of health centres in the two districts. In 25 health centres, Ministry of Health staff have been trained to prescribe ART and to give follow-up treatment to patients who are in a stable condition.

Prevention of mother-to-child transmission services are available in 20 locations in Thyolo and in ten health centres in Chiradzulu. Since the incidence of HIV/Thyra co-infection is high in Malawi, MSF has been active in identifying potential patients and providing early diagnosis of TB. MSF has also helped provide primary care in two centres run by the Ministry of Health in Clara Town and New Kru Town. Teams supported a range of services for mothers and children such as antenatal and postnatal care, vaccinations and prevention of mother-to-child transmission of HIV. Together the centres provided more than 122,300 consultations in 2008.

Sexual violence

Incidence of sexual violence remains high in Liberia. In Benson, MSF provided healthcare for victims of sexual violence, treating more than 880 rapes survivors. In July the project was handed over to Think, a local NGO, through MSF still provides technical and material support. The partnership carried out more than 2,260 psychological consultations in 2008.

In 2008, the MSF team in Chiradzulu carried out an assessment of patients who had abandoned their treatment, finding and interviewing them to discover why they had not finished the course. The main reasons involved the stigma associated with the disease expressed by their family or community, lack of information about the medication or the disease itself, or a perceived overall improvement in their health.

In recent years the Malawi government has made increasing efforts to provide more antiretroviral therapy (ART) in response to the spread of HIV/AIDS. An estimated 12.7 per cent of the adult population is infected. But there is still an acute shortage of nurses and doctors, which means many people are still going untreated.

Tackling the HIV/AIDS problem

MSF has been providing ART in two southern rural districts: Chiradzulu (since 2001) and Thyolo (since 2001). Since these projects began, MSF has started more than 28,000 patients on ART – 12,000 in Chiradzulu and 16,000 in Thyolo. In 2007, MSF achieved its goal of providing universal access to ART in Thyolo, starting 11,520 people on the therapy. In 2008, MSF placed more than 4,300 new patients on ART in Chiradzulu, and more than 4,400 in Thyolo.

MSF is involved in increasing the number and capacity of health centres in the two districts. In 25 health centres, Ministry of Health staff have been trained to prescribe ART and to give follow-up treatment to patients who are in a stable condition.

Prevention of mother-to-child transmission services are available in 20 locations in Thyolo and in ten health centres in Chiradzulu. Since the incidence of HIV/Thyrion co-infection is high in Malawi, MSF has been active in identifying potential patients and providing early diagnosis of TB.
Mali

Reason for intervention • Armed conflict • Endemic/Epidemic disease

Field staff: 143

Malaria is one of the biggest killers in sub-Saharan Africa. In Mali it is the leading cause of death in children under five years old. MSF works in the Kangaba region in southern Mali where malaria is most prevalent. This is a poor area where few people have access to healthcare, particularly during the rainy season when many villages become isolated, and when malaria spreads the most rapidly.

MSF supports 11 health centres in Kangaba. It has helped ensure that healthcare is free for children under five years old and for pregnant women, and available at low cost for children over five who have a fever. As a result, more cases of malaria are treated early, which helps prevent recurrences that can be fatal. There has been a similar trend in the treatment of other diseases.

MSF has also established mobile teams of community workers. They are trained and equipped by MSF to rapidly detect and treat uncomplicated malaria cases in children under ten years old in remote villages during the rainy season. In 2008, MSF carried out more than 83,500 consultations. The number of people with malaria in 2008 exceeded 35,700 – there were 25,640 in 2007. The percentage of malaria cases that were severe of the total malaria cases that were severe decreased: from 2.13 per cent in 2007 to 1.68 per cent in 2008.

Comprehensive approach to treating fistulas

In Timbuktu, MSF also treats obstetric fistulas. Fistulas occur most often during childbirth if there are complications and little healthcare is available. A fistula is a hole created between the rectum and the vagina, or between the bladder and the vagina. It causes incontinence. Women who suffer from fistulas are often treated as outcasts. In 2008, MSF held three sessions in collaboration with the Timbuktu regional hospital and operated on 160 women without charge. The free care is part of a comprehensive approach including pre- and post-surgery care, health promotion, education, psychosocial support, physiotherapy and a shared place to stay where women can discuss their experience and prepare to return home. MSF also encourages women to overcome the fears many have about undergoing treatment.

Providing care in Kidal

Between May and December, MSF also provided care in the Kidal region, which is affected by a low-intensity conflict between government forces and Touareg rebels. Half of the estimated 52,000 people who were living in Kidal are thought to have left the area due to the tense situation. MSF provided primary healthcare consultations through two mobile teams in the main centres where people gathered, supported Kidal hospital’s paediatric wards, and facilitated surgical referrals to Gao city’s hospital.

MSF has worked in Mali since 1992.

Morocco

Reason for intervention • Social violence/Healthcare exclusion

Field staff: 27

Morocco has become a transit country but also a country where people stay longer, and this causes frustration, uncertainty and violence. In order to reach this population – which does its best to go unnoticed – trust needs to be built, and you can only do this by being where the people are.

Jorge Martin, MSF head of mission.

Many migrants find themselves unexpectedly based in Morocco when they can’t cross into bordering countries. They end up in cities such as Rabat and Casablanca where they often cannot access basic healthcare services.

The MSF teams in Rabat, Casablanca and Oujda run curative and preventative activities; they facilitate access to the health structures and guarantee the quality of the healthcare. In 2008 MSF undertook over 4,000 consultations. In addition MSF is lobbying the authorities and other agencies to ensure they take responsibility for the migrants’ health. In 2008, a report on violence and migration was given to the authorities in both Spain and Morocco outlining the challenges faced.

Because the migrants are trapped in Morocco with no means of generating income, illegal practices have started to emerge such as prostitution and forced labour associated with human-trafficking networks. As a consequence, new health problems linked to sexual and reproductive health are becoming prevalent.

MSF has worked in Morocco since 1997.

S is a 27-year-old man who left Côte d’Ivoire in February 2005. He thought he would arrive in Europe in a month. He is still in Morocco. He lives in the bush between Nador and Berkane. He has tried to cross to Melilla four times by jumping the fence, but the Spanish authorities sent him back and Moroccan military forces beat him before taking him to the border with Algeria. S also tried to swim across, but he was caught by the Spanish authorities and sent back to Morocco.

In 2006, S became really sick. He did not have access to healthcare, so MSF took him to the hospital and has followed his case since then. Begging is the only way he can obtain food. S is stranded in Morocco; he has no money to pay for the journey to Europe and cannot go back to his country since the situation that forced him to leave remains unchanged.
MOZAMBIQUE

Médecins Sans Frontières Activity Report 2008

In Niassa, MSF provides care in the provincial hospital, in health centres in the town of Lichinga, and in three other rural areas. In Maputo in the south, the country’s healthcare system has been left weak and understaffed, its facilities overwhelmed by the HIV/AIDS epidemic. Around 16 per cent of people over 15 years old are HIV-positive, and 68 per cent of tuberculosis (TB) patients are co-infected with HIV. MSF is helping patients with HIV/AIDS care in three districts and encourages the local communities to support patients – by helping them to adhere to treatment, for example. Equipping health facilities in remote locations also reduces the time many patients have to take and the distances they have to travel for medication and routine consultations.

During 2008, MSF carried out more than 229,000 consultations for HIV/AIDS in Mozambique, and initiated more than 6,600 new patients on antiretroviral therapy (ART). MSF has worked in Mozambique since 1984.

NIGER

Médecins Sans Frontières Activity Report 2008

Between May and the October harvest every year, Nigerians face a ‘hunger gap’. Families exhaust their food reserves and their health deteriorates as malnutrition starts to take its toll.

In the districts of Birni N’Konni, Bouza and Madarou (Tahoua region), MSF cooperated with Ministry of Health staff to vaccinate some 437,000 people against meningitis. Starting in September, MSF also supported the treatment of cholera at the Birni N’Konni district hospital following a surge in the number of people contracting the disease. In Agadez, a region affected by the conflict between the government and Touareg rebels, MSF supports maternity services in three health centres.

For further supplies. This approach makes it possible to treat a large number of children with good results. In Zinder for example, the cure rate reached 72 per cent in 2008.

As well as treating malnutrition and associated health problems such as diarrhoea, MSF provides medicines to fight malaria, which is endemic in certain regions, and primary healthcare consultations in outpatient units. More than 100,000 children attended such consultations in the districts of Madarou and Bouza (Tahoua region) and in Dao in 2008.

The health of young children especially deteriorates during the seasonal hunger gap, when the quality of their diet worsens and the quantity of food available diminishes. Each year the number of admissions to feeding centres grows markedly between June and October. To prevent children from becoming severely malnourished, MSF distributed a supplementary nutritive paste to 30,000 children aged from six to 36 months in villages around Maradi and Zinder each month during the lean period. This preventive project initiated in 2007 had promising results, sharply reducing the incidence of severe malnutrition in the targeted areas.

Challenges

In July, the authorities decided to suspend MSF’s activities, although teams had worked in the country for more than eight years on emergency programmes devoted particularly to nutrition. The authorities wanted to re-integrate nutrition into the national programme and avoid independent interventions and publicity about the problem. After two months of discussions however, MSF was able to partially restart its activities.

Responding to emergencies

MSF continues to respond to emergencies and carry out vaccination campaigns. Between April and May, during a seven-week intervention in Zinder and Maradi regions, teams vaccinated about 700,000 children aged from six months to 15 years against measles. MSF also supported national health structures to help care for children affected by the disease. In the districts of Birni N’Konni, Bouza and Madarou (Tahoua region), MSF cooperated with Ministry of Health staff to vaccinate some 437,000 people against meningitis. Starting in September, MSF also supported the treatment of cholera at the Birni N’Konni district hospital following a surge in the number of people contracting the disease. In Agadez, a region affected by the conflict between the government and Touareg rebels, MSF supports maternity services in three health centres.

MSF has worked in Niger since 1985.
In 2008, Nigeria enjoyed a relatively calm political environment after the 2007 presidential elections. However, towards the end of the year there were several days of ethnic clashes in Jos, Plateau state.

In the Niger Delta, despite another wave of violence in Port Harcourt in July, the situation has cooled down. However access to good-quality healthcare remains difficult for people who cannot afford it, and in several places, MSF has worked closely with the Ministry of Health to improve the situation.

Trauma care and primary healthcare in the Niger Delta

In the oil-rich Niger Delta, MSF is running programmes in Rivers state and in Bayelsa state. In Port Harcourt, capital of the Niger Delta where people cannot always afford healthcare, MSF has worked to improve the quality of care provided at its hospital for trauma victims. Teams have enhanced the use of internal fixation, a procedure involving the insertion of a metal component inside a bone to join broken segments. This has significant advantages over external fixations because it reduces the length of hospital stays, allowing patients to return to normal life more quickly.

Port Harcourt is prone to peaks of violence and this year MSF teams have treated more than 9,100 patients in its emergency room and performed more than 3,000 surgeries. MSF has also recently begun offering support to victims of sexual violence. A team of specialists treated 265 people, and will continue focusing on this issue in a city where victims often have nowhere to go for care.

Last October, MSF opened a health centre in Oloibiri, in the south of Bayelsa state, in order to provide primary and mother-and-child healthcare to people there. The ten-bed centre has been fully occupied. In December, more than 400 consultations were carried out, 31 per cent of which concerned children under five. The main pathologies treated include malaria, respiratory infections and diarrhoea. The centre where pregnant women come for antenatal care will also provide assisted deliveries.

Improving maternal healthcare and reacting to epidemics in the north

MSF has also started a maternal health project in northern Sokoto state to help address alarming maternal and infant mortality rates. While Nigeria already has the seventh highest maternal mortality rate in the world, claiming the lives of approximately 59,000 women every year, the rates in Sokoto are estimated to be even higher. MSF is supporting the maternal care programme at the Goronyo hospital in Sokoto state.

MSF opened a new surgical programme focusing on emergency obstetrics and women suffering from fistulas in Jahun, Jigawa state. Fistulas are usually a consequence of poor obstetric care: a woman develops a fistula after being in labour for many hours, or even days. The centre where pregnant women come for antenatal care will also provide assisted deliveries.

MSF supports the Gondoma referral centre in Sierra Leone. It offers inpatient services for women and children and malaria treatment, as well as a therapeutic feeding programme. MSF also runs five outpatient clinics in collaboration with local health authorities and supports 30 smaller rural health posts to make treatment more accessible for people in remote areas. In 2008 MSF performed more than 417,000 consultations.

Malaria: the number one killer

In Sierra Leone the entire population is at risk of developing malaria. As in other countries, those most at risk include children under five and pregnant women. Although artemisinin-based combination therapy (ACT) is supposed to be free in Sierra Leone, people still cannot afford the registration fees, the doctor’s consultation or the cost of other drugs that they might need. During 2008, MSF treated more than 180,000 people with malaria using ACT free of charge.

As the volunteers are based in their own villages, they help overcome the geographical barrier to accessing malaria treatment. Jahaby, a 21-year-old man chosen to be a volunteer by his village, says: ‘I feel very happy to be a volunteer because I am saving lives, especially the lives of children. My village has benefited very much because our people no longer have to walk for miles to the nearest clinic. Through the use of a rapid diagnostic test it is easy for Jahaby to make a diagnosis. If malaria is detected, he will provide ACT to the patient. I have treated people every day, and we have had 44 malaria cases in the last three weeks. They are all very happy because they get treatment quickly and they are all well.’

Maternal health and malnutrition

Sierra Leone has one of the highest maternal mortality rates in the world. The five health clinics and the Gondoma referral centre offer services for women such as antenatal, postnatal and obstetric care, normal and complicated deliveries (including Caesarean section), family planning, treatment for sexually transmitted infections and care for survivors of sexual violence. Malnourished children receive nutritional rehabilitation through a therapeutic feeding centre at the Gondoma hospital. A therapeutic feeding programme in the mobile health clinics also makes it possible to treat more children at home.

Johan Mast, MSF’s head of mission in Sierra Leone, stresses the importance of tackling the country’s health problems appropriately: ‘The huge number of people still lacking basic healthcare due to financial, geographical and human resource barriers is worrying. Increased efforts need to be directed at providing appropriate diagnostic tools and making sure that patients receive adequate treatment. Free access to healthcare is an issue of huge importance.’

MSF has worked in Sierra Leone since 1986.
For many years Somalis have been subjected to violence, forced to flee their homes, had inadequate food and no access to healthcare. A range of factors including the collapse of the local economy, the inability to transport and deliver food aid, drought, inflation, high international food prices and a drastic reduction in humanitarian aid have exacerbated people’s already appalling living conditions.

MSF experienced the impact of this inequality at first hand. In January three colleagues were killed in Somalia and three projects in Kismayo, Mogadishu and Bosasso had to close. In April 2008, intense fighting across the country and specific threats against foreign aid workers forced MSF to evacuate all its international staff from Somalia. However MSF’s projects continue, run by dedicated Somali staff, supported by international staff based in Nairobi who visit whenever security allows.

On the road from Mogadishu to Afgooye, where thousands of people have been forced to flee the violence of the capital, there are thought to be more than 300,000 displaced people living in terrible conditions. MSF has been in the area since 2007 supporting a private clinic and running an outpatient department, paediatric ward and cholera treatment centre, nutrition programme, and managing the distribution of water, blankets and other non-food items.

During 2008 MSF staff saw a huge rise in the number of children needing nutritional care in its intensive and mobile feeding centres in Hawa Abdi and Afgooye. Medical teams treated more than 15,500 malnourished children under the age of five. More than 2,000 of the children were admitted to intensive care, but most were cared for as outpatients.

In Mogadishu, staff in the surgery department of Danilhey hospital treated 3,520 patients in the emergency room, including more than 3,000 people wounded in the conflict. More than half of the patients were women and children under the age of 14. At an outpatient clinic in Mogadishu North, a further 1,400 patients who had been operated on for war-related injuries were provided with dressings. Nutrition was a key concern: early in the year MSF teams started a programme for severely malnourished children and 1,800 patients were admitted and treated. Throughout the country, MSF treated more than 18,400 children for severe malnutrition and more than 16,000 children for moderate malnutrition.

Although most international attention focused on the capital and its surroundings, MSF teams responded to huge needs in nine regions across south and central Somalia. To the north in Galcayo, medical staff treated 470 victims of violence over the course of the year. In Galgudud, more than 600 people were operated on.

Yet it is not just victims of violence who need assistance in Somalia. Curable and preventable diseases spread as a result of the disease and care for patients, rather than being isolated in specialised hospitals. This model of integrated care for HIV/AIDS and TB patients has been replicated in many other settings and is promoted by the World Health Organization as a model for best practice.

The Simelela Centre for survivors of sexual violence in Khayelitsha provides comprehensive services for rape survivors such as emergency medical care, counselling and social and legal support. Links with community activist groups aim to reduce the number of victims of sexual violence by raising awareness and denouncing rape as a crime of violence. The clinic saw nearly 700 patients in 2008.

The projects provide general primary health-care, mental-health support, and referrals to hospitals and specialised medical facilities. MSF treats up to 5,000 Zimbabweans each month in these two projects, mainly for respiratory tract infections, sexually transmitted infections, including HIV, gastrointestinal and diarrhoeal conditions, and stress-related ailments. MSF teams are also treating an increasing number of people who have been subjected to sexual violence, and are seeing a growing number of unaccompanied minors.

MSF has worked in South Africa since 1991.

The projects provide general primary health-care, mental-health support, and referrals to hospitals and specialised medical facilities. MSF treats up to 5,000 Zimbabweans each month in these two projects, mainly for respiratory tract infections, sexually transmitted infections, including HIV, gastrointestinal and diarrhoeal conditions, and stress-related ailments. MSF teams are also treating an increasing number of people who have been subjected to sexual violence, and are seeing a growing number of unaccompanied minors.

Zimbabweans face significant risks, including those of sexual violence, physical and verbal abuse, and police harassment when crossing the border into South Africa, says Sara Hjelmervik, MSF field coordinator in Musina, a town on the Zimbabwean border: ‘And these risks persist in South Africa, where many continue to be harassed by the police and are unable to find sustainable employment.’

Between May and September 2008 there was an upsurge of violence aimed at foreign nationals, which led to 62 deaths and the displacement of more than 100,000 people across the country.

MSF responded to this emergency in more than 15 locations in Johannesburg, Pretoria and Cape Town. Teams treated injuries such as gunshot wounds, head trauma and wounds resulting from beatings, lacerations and burns. They provided primary healthcare to those who had been forced to flee, and distributed hygiene kits, blankets and plastic sheeting.

In Johannesburg, where the violence was most extreme, MSF incorporated mental-health activities into the work of the medical teams. MSF also pressured the South African authorities to improve basic services such as shelter, water and sanitation in temporary camps.

During the crisis, MSF provided 11,000 medical consultations and an additional 8,000 mental-health consultations.

Cholera outbreak

In November, a cholera epidemic spread from Zimbabwe to South Africa. Authorities in the northern province of Limpopo declared Vhembe district, on the Zimbabwean border, a disaster area. MSF reinforced teams in Musina in Vhembe district and in Johannesburg, shifting from providing basic primary healthcare for Zimbabweans to prioritising cholera diagnosis and treatment and hygiene promotion. During the outbreak, the MSF team in Musina referred more than 300 people with cholera via three mobile medical teams working on farms, villages and in other high-risk areas in and around Musina. At the Central Methodist Church in Johannesburg, MSF, together with local health authorities, managed to contain the spread of the disease through intensive health promotion, early case detection, treatment, and water and sanitation improvements.

MSF has worked in South Africa since 1991.

© MSF

© Benedicte Kurzen
Throughout 2008, MSF field staff provided medical services in a country where attacks and outbreaks of violence frequently occur, malnutrition is prevalent, and maternal mortality rates remain among the highest in the world. Tuberculosis and kala azar (visceral leishmaniasis) are common here, as are large-scale outbreaks of meningitis, measles, cholera, and malaria.

Clashes between armed forces and tribal militias along the disputed border of northern and southern Sudan, coupled with political tensions, led to the displacement of several thousand people in Rahel-el-Ghazal state throughout the year. In January MSF opened a new project in the city of Aweil. Because many of the displaced people had to leave behind everything, staff initially focused on distributing kits containing essential items such as soap, jerry cans, mosquito nets, tarpaulins, and cooking sets to the most vulnerable, covering the needs of more than 15,000 people.

MSF also started working in Aweil hospital, providing nutrition and healthcare to mothers and children. Since malnutrition was a key concern, six additional outreach clinics were set up to try to reach as many people as possible. In the course of the year more than 21,000 outpatient consultations were provided and more than 6,000 children were treated for malnutrition.

In February, after an extremely violent attack near the town of Abyei, thousands of people fled to camps in northern Bahr-el-Ghazal state, and an estimated 10,000 people fled into the bush. In May, fighting virtually destroyed Abyei, displacing another 60,000 people. MSF teams have been working in Abyei since 2006 and were able to provide immediate emergency assistance. Owing to the large numbers of war-wounded, surgical and post-operative teams were sent to support the existing MSF team.

In order to reach the people who had fled to the bush, mobile clinics were set up in both Abyei and the nearby town of Agok, and mobile and inpatient nutrition programmes were put in place. By the end of the year 8,950 outpatient consultations had been given and more than 1,200 severely malnourished children had been treated. MSF also organised distribution of non-food items in Muglad, north of Abyei, for around 400 families. Teams remain ready to respond quickly to any further needs that might arise in this unstable area where people are struggling to survive.

Towards the end of 2008, attacks by the Ugandan rebel group, the Lord’s Resistance Army, in the south of Sudan near the Congolese border and in the Democratic Republic of Congo (DRC) caused thousands of Sudanese people to flee their homes. Congolese refugees also crossed the border to seek refuge in Sudan. In response MSF started supporting two primary healthcare clinics in Gambaga and Sakur, in Western Equatoria state, close to the border with DRC. By the end of the year, 7,200 medical consultations had been provided to the residents and refugees in these two areas.

In other parts of southern Sudan MSF continues to provide care to hundreds of thousands of people. In Jonglei, Upper Nile and Unity states, medical staff provide all levels of healthcare, ranging from consultations for respiratory tract infections to life-saving surgery. In 2008 medical teams carried out more than 365,000 outpatient consultations, 19,000 antenatal consultations, 1,000 operations, many of them emergency surgical interventions for gunshot wounds, and admitted more than 8,000 people as inpatients.

Overall, MSF treated 9,000 children for severe acute malnutrition in south Sudan, as well as over 600 people for violent trauma.

Throughout the country MSF teams are prepared to respond to emergencies and epidemics. In July heavy rains and flooding exacerbated a cholera outbreak in Aweil. Working with the Ministry of Health and other agencies, MSF treated more than 6,700 people suffering from cholera. More than 1,200 cholera patients were also cared for in Juba, the capital of southern Sudan, where cases were first detected in May. Because vaccination coverage is low in Sudan, children are vulnerable when there are measles outbreaks. MSF vaccinated more than 19,200 children during two campaigns in July and November 2008 in Jibek county, Jonglei state.

In the north of Sudan, in addition to its programmes in Darfur, MSF runs a project in Port Sudan, in Red Sea state, providing maternal healthcare with a particular focus on pregnant women who have been circumcised. It is estimated that more than 97 per cent of women in Red Sea state are circumcised. This procedure causes serious medical complications for many women for the rest of their lives. During delivery, circumcised women have to be cut open, or ‘defibulated’, to enable the birth of the child. After a birth it is common practice to re-stitch, or ‘re-infuse’, women. However, in Port Sudan the MSF project in Tagogdom hospital MSF does not re-infuse any women following delivery.

In 2008 MSF carried out an average of 1,000 consultations and 64 deliveries each month in this programme. Community teams also provided basic health education and raised awareness of the medical risks of female circumcision.

Where possible MSF has handed over activities. In June 2008, MSF handed over to the local health authorities its activities in Bor hospital, Jonglei state, after two years. At the end of the year, MSF handed over its sleeping sickness programme in Yambio, Western Equatoria state, to the Ministry of Health.

MSF has worked in Sudan since 1979.
rounding villages. Leaving so many people without access to medical care, even if only temporarily, was extremely hard, but without a guarantee of minimum security for humanitarians, MSF had no option but to suspend activities. The team was able to return to Shangil Tobaya in September. In 2008, MSF had to relocate its staff from Kaguro and five other health centres in the Jebel Si, MSF ran a clinic in Kaguro and five health posts in the surrounding area. These provide medical care to around 40,000 people who had been cut off from assistance since 2003, when the area was attacked and most villages were burned down. In the rural town of Kebkabiya, 90 miles west of North Darfur’s capital El Fasher, MSF supports two clinics and five health posts providing basic healthcare including vaccination and the treatment of malnutrition. Teams also support the obstetric department of Kebkabiya hospital and provide comprehensive emergency obstetric care.

In South Darfur MSF ran a 25-bed clinic that provides medical care to around 70,000 people living in and around the town of Muhajariya. Staff offer surgical care and run inpatient and outpatient departments and a laboratory, in addition to providing obstetric health services. Treatment for survivors of sexual violence is also available. In 2008 more than 55,000 people received care from the MSF team in Muhajariya, as did 1,300 inpatients and 440 surgical patients. In April 2008, MSF restarted mobile clinics in Labado and Um Shogeira to enable better access to healthcare. In 2008, 660 malnourished children were assisted through the MSF clinics. In the mountains of the eastern Jebel Mara, a team based in Feina ran a clinic providing outpatient care, antenatal care and a mobile feeding programme. There is also an inpatient department for severely malnourished children and people who need emergency care. Mobile clinics were also run in Golumbi and Derhat.

In 2008, MSF opened a new project in Adila, focusing on an assessment in March that showed that the incidence of acute malnutrition in children had reached 14 per cent. By the end of October, 4,700 children had received treatment.

MSF has worked in Darfur since 2003.

Fatima, who lives in Motorwat camp in the Muhajariya town region with her husband and four children, told MSF that she and her family have had to move eight times so far, from town, to forest, to camp, and back again. ‘Every time we moved, we lost our property’, she says. ‘It is exhausting, but if you don’t move quickly, you could be killed, or you and your children could be killed. Anger is pointless: even if I get angry, there’s nothing I can do.’
HIV/AIDS affects an estimated eight per cent of the population. According to the World Health Organization there are more than one million people living with HIV or AIDS in Uganda, including 312,000 who need antiretroviral therapy (ART). It is estimated that 42 per cent of patients are on ART nationally, but the percentage is much lower in northern Uganda.

In Arua, MSF’s HIV/AIDS clinic includes integrated treatment for tuberculosis/HIV co-infection, nutritional support for malnourished adults and children living with HIV/AIDS, and a programme providing antenatal care and prevention of mother-to-child transmission of HIV/AIDS. More than 4,700 patients are undergoing ART in Arua regional hospital. In parallel, MSF supports three decentralised HIV/AIDS clinics in the West Nile region, in order to ensure that people can access local healthcare.

Only ten per cent of HIV-positive patients have access to care in Madi Opei, Kitgum district. MSF made HIV/AIDS/TB care available, and provided treatment in the outpatient, inpatient and maternity departments. Every month around 2,000 outpatients were seen and 100 patients were admitted to the clinic.

In Gulu district, MSF teams continued their intervention in the health centre in Lalogi, about 21 miles southeast of Gulu town. To build up a system that can be taken on by the Ministry of Health, the teams are making the comprehensive secondary healthcare in Lalogi — which includes maternity, inpatient care, mobile services and HIV/TB care — as sustainable as possible. In 2008, they treated more than 53,000 patients.

Emergency response

In November 2007, hepatitis E appeared in Kitgum as a consequence of the deplorable sanitation in the camps. Hepatitis E is a virus spread through contaminated water or food. Pregnant women and children are at greatest risk so were particularly targeted. By the end of 2008, MSF had treated more than 1,500 patients in Kitgum. MSF also implemented prevention and referral activities to prevent the spread locally and to other districts.

At the height of a cholera outbreak between January and April in Arua district, up to 40 patients were being admitted each day to an MSF cholera treatment centre. Refugees fleeing fighting in the Democratic Republic of Congo at the end of 2008 have been assisted by MSF in Ishasha/Matanda and in Nakivule through a health clinic and the improvement of water and sanitation facilities in the camps.

Malnutrition in Kaabong and Karamoja

In Karamoja, northeastern Uganda, a poor harvest in 2006, little rain in 2007, and late rains in 2008 made food scarce, leading to increased prices and depleted livestock. MSF started a nutritional intervention in June 2007 in Kaabong district. This intervention lasted throughout 2008, ending in a handover to Action Contre la Faim in December.

MSF in Kaabong treated almost 900 cases of severe malnutrition and 2,500 cases of moderate malnutrition in 2008. Malnutrition was treated in the stabilisation centre in Kaabong hospital between January and July. In July 2008, MSF started to expand its project in Kaabong into paediatrics and all areas of reproductive healthcare. The project will grow in 2009 to include victims of violence resulting from government disarmament activities.

Following reports of increased rates of malnutrition in Karamoja, MSF initiated a second nutritional intervention in the districts of Moroto and Nakapiripirit, treating almost 4,000 malnourished children.

MSF has worked in Uganda since 1988.
ZIMBABWE

REASON FOR INTERVENTION • Endemic/Epidemic disease
• Social violence/Healthcare exclusion
FIELD STAFF 579

Political instability has led to economic freefall in Zimbabwe: aggressive inflation, the collapse of basic infrastructure and services, food shortages and a total implosion of the country’s health system. In its regular programmes, MSF focuses on the treatment of HIV/AIDS patients and provides nutritional support to severely malnourished children.

One in five adults in Zimbabwe is infected with HIV/AIDS, and too few of those in urgent need of treatment can access antiretroviral therapy (ART). In its HIV/AIDS programmes in Bulawayo, Epworth, Gweta, Tsholotsho and various locations in Muaniland province, MSF is supporting free care for 40,000 people. In 2008, 26,000 of these people began ART. But increasingly, patients are missing their appointments and risk interrupting their treatment because they cannot get to the few functioning clinics. This is due mostly to the high cost and unreliable nature of the transport system, but sometimes it is because

Dadirai started antiretroviral therapy at the Epworth programme in 2007. Before that, she was so sick she could not walk or eat unaided. Her husband had died, having refused to seek treatment, and both her daughters are HIV-positive. After starting with the programme, Dadirai first worked as a volunteer HIV counsellor, but then went back to school and earned her Nurse Aide certificate. Now she is an MSF staff member working at the Epworth clinic.

patients have had to flee to neighbouring countries. In response to this problem, MSF has started to decentralise treatment, making its services more accessible, especially in rural areas.

Many Zimbabweans who leave the country – an estimated three million to date – flee to South Africa. Since May 2008, MSF has worked in Beitbridge, the exit point most used by these people. The project ensures primary healthcare reaches the most vulnerable, such as refugees, migrants, orphans or commercial sex workers, and deals with victims of violence and abuse. In 2007, MSF started to provide medical assistance to Zimbabwean refugees in the border town of Musina, and in central Johannesburg.

Combating Cholera

By December 31, MSF had helped more than 30,000 people suffering from cholera and more than 1,500 deaths had been recorded. MSF medical teams supported government structures with supplies, staff incentive payments and training, and established separate cholera treatment units in areas that had no other health facilities.

MSF has worked in Zimbabwe since 2000

‘From what we see each day it couldn’t be clearer – this is an enormous medical emergency, spiralling out of control.’

Manuel Lopez, MSF head of mission
Armenia has one of the world’s highest incidences of drug-resistant tuberculosis (DR-TB). In September 2005, in collaboration with the Armenian Ministry of Health, MSF started a pilot programme for diagnosis and treatment of DR-TB in the capital city, Yerevan, where almost half the country’s population lives. Since then, response to the DR-TB epidemic in the country has improved, with support from international agencies and donors helping to strengthen local capacity.

At national level, MSF is advising on the setting up of a ‘directly observed treatment short course’.

MSF’s DR-TB programme in Yerevan covers the city’s population of approximately 1.2 million. Once DR-TB has been diagnosed, patients receive initial treatment at the inpatient unit where MSF has refurbished a 35-bed facility. When patients are no longer contagious, they are discharged and their treatment continues via mobile polyclinics or home-based care until it is complete.

Adhering to the treatment is not easy, since it can take 18 months to two years, involves taking handfuls of drugs daily and there are often side-effects. MSF provides multi-disciplinary services to encourage adherence to treatment: teams of doctors, nurses, psychologists and social workers assist patients in different ways and emphasise the importance of finishing the course.

MSF offers social support to the patients and their families. Food parcels help ensure a balanced diet, a transport allowance covers the costs of getting to the clinic every day and heating allowances help make the coldest months of winter bearable. More than 200 patients have been admitted to the programme since September 2005.

MSF has worked in Armenia since 1988.

Some patients are reluctant to start DR-TB treatment. In some cases patients interrupt treatment because of the side-effects of the second-line drugs. A nurse, a social worker and a psychologist work with each patient individually to try to encourage them to continue treatment.'

Auxiliary TB nurse
The main health problems in Cambodia include HIV/AIDS, diabetes, and tuberculosis (TB). A substantial increase in funding by international donors has helped strengthen efforts by the government of Cambodia and its partners to tackle such prevalent diseases. As a result, MSF has begun reducing its activities in the country.

In the provinces of Siem Reap and Takeo, MSF is running two clinics that use an innovative approach to treat HIV/AIDS as a chronic disease alongside diabetes and hypertension. The approach aims to decriminalize HIV/AIDS by treating it as another chronic disease. Another aim is to increase the focus on diabetes—a disease that is rarely treated in Cambodia and yet affects five to ten per cent of the population.

‘In Cambodia, care for people with HIV/AIDS is expanding and attracts a lot of attention from the international donor community. However, care for people with diabetes, arterial hypertension and other treatable chronic diseases remains limited and the level of government spending on drugs is insufficient,’ says Philippe Berneau, head of mission.

‘Some sufferers even say that they “wish they had AIDS”: since the HIV/AIDS care provision is much better, MSF’s approach of integrating care for HIV/AIDS with care for hypertension and diabetes has resulted in satisfactory outcomes for patients and efficiency gains for the services.’

At the end of the year, the two clinics were treating more than 3,000 HIV patients, more than 1,700 diabetes patients and 390 patients suffering from hypertension. MSF was also treating a small number of patients with TB and multi-drug-resistant tuberculosis (MDR-TB). Preparations have now started for the handover of these activities to local health authorities and partner NGOs.

In Phnom Penh, MSF is treating HIV/AIDS patients in the Khmer-Soviet Friendship Hospital, where 3,650 patients were given antiretroviral therapy (ART). In June, MSF began integrating the treatment into the public health system. The handover was achieved by transferring patients from other provinces to local centres providing ART. Now, the remaining MSF activity in the hospital is the treatment of patients who are co-infected with MDR-TB.

Since 2006 MSF has been providing HIV/AIDS care to prison inmates in Phnom Penh. In June, access to care and treatment in two of the city’s main prisons was increased.

In Kampong Cham, the handover process of HIV/AIDS care to local health authorities was in its final stages by the end of the year. The Cambodian health authorities were then managing the adult caseload, while the paediatric consultations were still carried out by MSF. A project dealing with HIV patients co-infected with TB as well as patients with drug-resistant strains of TB was set up in June.

MSF has long pushed to create a working group on drug-resistant TB, which would involve Cambodia’s health authorities and other interested parties. Such a group was finally created at the end of 2007. Throughout 2008 a series of meetings were held, focusing on establishing national guidelines and long-term plans to tackle MDR-TB.

MSF has worked in Cambodia since 1979.
MSF treats drug-resistant tuberculosis (DR-TB) in Abkhazia, one of the separatist regions of the republic of Georgia, and in Zugdidi, western Georgia. In August 2008, a war erupted over another separatist region of South Ossetia, which caused thousands of people to flee the violence.

TB is the scourge of the Caucasian region; it is estimated that ten per cent of new cases are drug resistant, but that as many as half of the people who have already been treated have developed DR-TB. In 2008, an average of six to seven new patients with DR-TB were admitted every month to the Zugdidi project. Since the seven new patients with DR-TB were admitted in August 2008, five out of the six have been treated and cured. In July 2008, the first Zugdidi programme patient completed his treatment, having taken handfuls of medicine daily for 20 months. Although it is still too early to declare him fully cured, given the risks of relapse, the fact that he finished the course is encouraging. Since then, nine further patients in Zugdidi have finished the treatment programme.

In Abkhazia, MSF treats patients in Gutiplsh, near the capital Sukhumi. MSF has supported the national TB programme in Abkhazia in 1999 and, since 2001, has focused on DR-TB. In 2008, an average of six to seven new patients with DR-TB have been treated, 38 of those in 2008. MSF refurbished the hospital near Sukhumi and supplied it with drugs, materials and laboratory equipment. A third of the MSF patients have few material resources and, without the psychological and social support, firewood, clothes, proper nutrition and other necessities that MSF provides, many of them would be unable to follow their treatment correctly.

MSF introduced life-prolonging antiretroviral therapy (ART) in Abkhazia for HIV/TB co-infected patients. Currently nine patients are on ART. MSF also supports the newly opened national DR-TB programmes in the Georgian cities of Tbilisi and Abastumani, providing training for local nurses and adherence counsellors. The health access programme for vulnerable people in Abkhazia has been downsized. In 2008, 143 vulnerable people, mainly elderly, were registered in the programme.

Assisting those displaced

Tens of thousands of people were displaced as a result of the fighting in August 2008. MSF provided healthcare services and psychological support in Tbilisi and Gori to people who had been forced to flee their homes. Over 30 per cent of the 8,500 medical consultations dealt with chronic conditions. Many people suffered from depression, anxiety, post-traumatic disorder and psychological problems. MSF also strived to keep patients on their DR-TB treatment programmes. Through international MSF staff were evacuated due to the violence, national staff continued the programme. Most of the patients maintained their treatment schedules, which is vital because any interruptions can lead to a relapse or complications.

MSF has worked in Georgia since 1991.

India

MSF provides free care and treatment to groups who can become marginalised from society, such as transgender, commercial sex workers or homosexuals who have not been able to access HIV/AIDS healthcare through the public health system. Working in a clinic in south Mumbai, MSF also offers services preventing mother-to-child transmission of HIV, and has trained NGOs and Ministry of Health staff in HIV testing and counselling. Throughout the year, MSF conducted more than 8,000 consultations in Mumbai and more than 50,000 consultations in Manipur. MSF has so far put 781 HIV-positive patients on ART, about a quarter of whom have now been transferred to the national HIV/AIDS programme.

Primary healthcare in Chhattisgarh and Andhra Pradesh

A low-intensity conflict between Maoist rebels and government forces has displaced tens of thousands of people in government-run camps, or forced them to hide in the jungle where there is little access to healthcare. MSF provides primary healthcare and nutritional support to the people living in camps in Chhattisgarh, settlements around villages in Andhra Pradesh and the Chhattisgarh border area, as well as in local communities in Bijapur district. In 2008, MSF’s mobile clinics treated more than 3,300 people affected with malaria in the Bijapur and Dantewada areas, while 32,600 consultations were conducted in the camps and villages around Andhra Pradesh and the Chhattisgarh border.

Kala azar (visceral leishmaniasis) in Bihar

MSF provides free diagnosis and treatment for people suffering from kala azar in Vaishali district in Bihar state. In 2008, more than 4,600 patients were screened for the disease and 1,574 received treatment with liposomal amphotericin B – a relatively new therapy for the disease. The success rate for treatment is very high: more than 98 per cent of those treated recovered.

Mental health in Kashmir

In Indian-administered Kashmir, MSF offers basic health care and psychosocial counselling to a population traumatised by over 20 years of Violence in the Kashmir valley. In 2008, MSF’s mental-health programme treated 6,324 patients. MSF supported six clinics in Kupwara district with basic healthcare and vaccination services and conducted more than 10,000 consultations in 2008.

Emergency response

MSF has carried out several emergency interventions in response to serious natural disasters in India over the years. In September 2008, teams provided humanitarian assistance to tens of thousands of people in Bihar state who were displaced after the Kosi river burst its banks and wreaked havoc in the area. Many families were already desperately poor, and lost all their possessions. MSF provided medical assistance to the victims of this flood and distributed non-food items such as plastic sheeting and blankets to more than 18,000 families. In 2008 MSF teams conducted more than 22,200 medical consultations.

MSF has worked in India since 1999.

India: ‘Most people have heard little if anything about visceral leishmaniasis. This serious disease is best known as kala azar, and the incidence in India is amongst the highest in the world. Up to 90 per cent occurs in just one state – Bihar. This disease mainly affects the lowest castes, the poorest of the poor. The most frequent treatment for kala azar in Bihar is old, painful and, to cap it all, barely effective. But without treatment the disease is almost always fatal. The MSF team working in Bihar, at Bijapur hospital, are using for the first time on a large scale a drug that shortens treatment to just ten days and has a success rate of over 90 per cent. Our patients are living proof. Seeing how they improve day after day is a marvellous experience.’

Dr Gaurab Mitra, MSF doctor
INDONESIA

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

FIELD STAFF 137

MSF has assisted patients suffering from infectious diseases, violence and natural disasters in Indonesia since 1995. In 2008, however, due to an improved Indonesian capacity to respond to national disasters, MSF decided to end activities here by early 2009. Yet, throughout 2008, MSF continued to monitor and react to emergencies and to provide healthcare in remote areas.

Responding to emergencies

Although the number of emergencies requiring assistance from MSF dropped in 2008, MSF supported survivors of a powerful earthquake in central Sulawesi in November with mental-health activities and mobile clinics. Almost 2,600 people were given psychological training on how to handle stress and what to do in case of another earthquake. More than 1,000 patients also had medical consultations.

When the powerful cyclone Nargis struck nearby Myanmar in May 2008, the MSF emergency team in Indonesia reacted rapidly: within a month, eight chartered flights conducted a mass emergency campaign. More than 8,000 consultations were completed. MSF trained staff at all levels of the health system, put in place safe blood transfusions and set up a radio system so the villagers can call for an ambulance boat in emergencies. Also more than 8,000 consultations were performed through mobile clinics visiting villages in remote districts. Much effort was put into health promotion, since many people in the villages were unfamiliar with modern medicine.

Treatment for a neglected disease

While studying the pros and cons of using rapid diagnostic tests for malaria in Asmat, a swampy and difficult-to-reach district in the Papua province, MSF found disturbing levels of microfilaria, the parasite that causes lymphatic filariasis. Also known as elephantiasis, this disease is endemic in 304 of the 414 districts in Indonesia, but remains a neglected disease in the country.

MSF decided to intervene in two phases: a mass drug administration campaign followed by surgery for people with chronic filariasis. The campaign was conducted in collaboration with the local health authorities, which also guaranteed the necessary follow-up over the next four years. Over three months, 36,644 people were treated in the seven sub-districts of Asmat, and later 36 surgeries were performed.

Focus on mother and child

Malaria, diarrhoea and respiratory infections are the main causes of death and disease among children in the Asmat district, and the harsh living conditions in the thick tropical forest and swamps pose additional health risks for pregnant women. In 2008 MSF continued its programme to improve access to primary and emergency healthcare and services for the vulnerable population. Projects ranging from a comprehensive referral system at village level to a fully operational surgical room in Agats were completed. MSF trained staff at all levels of the health system, put in place safe blood transfusions and set up a radio system so the villagers can call for an ambulance boat in emergencies. Also more than 8,000 consultations were performed through mobile clinics visiting villages in remote districts. Much effort was put into health promotion, since many people in the villages were unfamiliar with modern medicine.

KYRGYZSTAN

REASON FOR INTERVENTION • Social violence/Healthcare exclusion

FIELD STAFF 48

MSF has worked in Kyrgyzstan since 2005. Tuberculosis (TB) is the most common cause of death in the prisons in Kyrgyzstan. Its prevalence is around 35 times higher than it is in the civil sector, and the proportion of resistant forms of TB is particularly high. Bad ventilation, dark overcrowded cells and insufficient nutrition help TB to flourish. Prison hospitals lack medicines, equipment and trained staff.

MSF contributes to the treatment of TB patients in a prison and pre-trial detention centre near the capital Bishkek. In 2008, MSF helped to treat 400 patients for drug-susceptible TB, and 50 people who have strains resistant to first-line anti-TB drugs.

This project is implemented in collaboration with the medical department of the penal administration, the Ministry of Justice of Kyrgyzstan and the International Committee of the Red Cross (ICRC). MSF’s role is to assist with the detection and diagnosis of all suspected TB cases in prisoners and the treatment of people who have TB that is susceptible to first-line anti-TB drugs, while the ICRC focuses on the treatment of patients who have multi-drug-resistant forms of TB.

MSF improved cells and TB facilities in the prisons, equipped TB laboratories and continues to provide medical and lab materials. In 2008, MSF helped set up a system for the faster diagnosis of TB that is resistant to first-line anti-TB drugs in the national TB laboratory. Also, TB patients in the MSF-supported prisons are being screened and vaccinated for Hepatitis B. MSF doctors and psychosocial workers ensure the application of treatment protocols and the patients’ adherence to treatment.

The new set-up will ensure strict separation of TB patients with different forms of the disease in order to avoid cross-infection and further contamination.

MSF has worked in Kyrgyzstan since 2005.

‘The main difficulties faced by released prisoners who need to continue their treatment for TB involve the lack of interaction and information between the prisons and the outside world. TB is a complex, multi-faceted problem in society, and it cannot be handled by medical treatment alone. We can see the political will to resolve these problems, but in reality not much is being done.’ Markus Frits, head of mission.
MYANMAR
Reconnaissance Intervention • Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion • Natural disaster
FIELD STAFF 1,427

In May 2008, Cyclone Nargis wreaked destruction throughout the Irrawaddy delta leaving an estimated 130,000 people missing or dead. The disaster was a devastating blow to a people who have suffered repression, neglect and low-intensity conflict for decades, leaving many living in abject poverty and without basic human rights.

Emergency relief after Cyclone Nargis
MSF began its emergency intervention in the delta within 48 hours of the cyclone. During the critical period when the government restricted external aid, MSF delivered food, shelter, water, healthcare and essential non-food items. As access improved, MSF developed its programmes to include psychosocial support.

Between May and November, around 450 staff assisted a population of more than 520,000 people throughout four townships - Laputta, Ngapudaw, Puyin, Bogale (comprising more than 1,200 villages), until emergency needs had been met. However a number of MSF activities, primarily nutrition and mental health, continued in some of the harder to reach areas which lacked adequate assistance. These programmes now have finished. Meanwhile, ongoing support for reconstruction, especially livelihoods, nutrition, and child education, remains crucial throughout the Delta.

Assisting Myanmar’s vulnerable
For the hundreds of thousands of people suffering from treatable infectious diseases such as malaria, tuberculosis and HIV/AIDS, the chronically under-resourced healthcare system provides little assistance. These programmes have now finished. Meanwhile, ongoing support for reconstruction, especially livelihoods, nutrition, and child education, remains crucial throughout the Delta.

HIV/AIDS: a preventable fate
Of an estimated 240,000 people infected with HIV, 76,000 are in urgent need of antiretroviral therapy (ART), but fewer than 20 per cent receive it. Most of the treatment available in Myanmar is provided by MSF. Working in the former capital of Yangon and the states of Shan, Kachin and Rakhine and in Thanluttari division, MSF provides comprehensive care to 16,000 HIV/AIDS patients, 11,000 of whom received ART. Preventative and educational assistance is also targeted towards high-risk groups including sex workers, intravenous drug users and migrant labourers. Nearing its capacity for ART provision, MSF has continued to lobby for increased assistance, calling for the government of Myanmar and the international community to scale up HIV services urgently and rapidly, especially ART provision.

HIV/TV co-infection
From its clinics throughout Myanmar, MSF also provides care and treatment for people suffering from tuberculosis (TB), one of the most common opportunistic infections for people living with HIV/AIDS. During 2008, MSF admitted more than 2,800 patients for TB treatment, providing additional support such as food supplements and transport fees for the especially vulnerable. In the Thanluttari division, southern Myanmar, MSF provides TB and HIV care in three townships in Dawei district. In Thayetchaung township, MSF also provides primary healthcare. From March 2008, MSF launched a programme for TB in two townships of Dawei, providing health education and free diagnosis to the people, as well as treatment at the clinic.

Malaria
Malaria is one of the leading causes of death in Myanmar. MSF provides malaria testing and treatment in a number of locations where malaria is endemic. In Rakhine state, for example, MSF supports 30 clinics and three mobile health teams dedicated to providing diagnosis and treatment. In 2008, MSF staff in Rakhine treated more than 200,000 people for malaria alone.

NEPAL
Reconnaissance Intervention • Armed conflict • Natural disaster
FIELD STAFF 114

Decades of neglect have hampered the development and improvement of healthcare in Nepal. Local medical authorities are under-equipped and lack dedicated staff. MSF has been in the mountainous Kalikot district since 2005, upgrading the local health centre into a district hospital and providing primary and secondary healthcare.

In the outpatient department, MSF’s team, alongside medical staff from the Ministry of Health, conducted over 22,000 consultations. Free medication was given after consultation. The hospital admitted 1,346 people, 170 surgeries were performed, and 66 women delivered via Caesarean section.

Patients in mobile clinics
MSF started a new project in Central Terai in 2008 in response to internal disturbances prompted by ethnic tension. MSF provided healthcare through mobile clinics, and saw some 12,000 patients during the year. This project has recently been expanded to support the inpatient department of the district hospital, particularly the maternal and child healthcare and obstetric emergency surgeries.

Safe deliveries
Nepalese women have little access to skilled birth attendants. Adherence to traditional practices can lead to high maternal and neonatal mortality rates. Operational manager Katrien Coppens was shocked after she met women in Terai. “Without exception, they had all lost at least one child during pregnancy or just after delivery. One woman even told me how she had lost four of her babies. Especially in this area it is so important for expectant mothers and newborn babies to have regular checkups.”

MSF raises awareness amongst the community about the need for women to seek care at our medical facilities in good time, and provides among others things family planning and antenatal care. November saw the opening of a patient waiting house for pregnant women in high-risk situations such as those expecting twins or with a co-existing medical condition. By staying in the waiting house some time before the expected delivery date, women increase their chances of a safe delivery.

Responding to malnutrition and cholera
Malnutrition has been a particular concern throughout 2008, with a so-called mid-upper-arm circumference screening disclosing a global acute malnutrition incidence of 10.8 per cent. MSF has treated several thousands of children through mobile therapeutic feeding programmes. In one extremely remote location, accessible only via a two-day walk on steep mountain trails, MSF opened a seasonal clinic. MSF teams prepared emergency facilities to combat cholera in a location that has been particularly vulnerable to the disease due to a lack of water, inadequate sanitation and poor hygiene practices. More than 2,200 consultations were carried out, and more than 450 children were admitted to the nutritional programme.

Koshi floods
On August 18, the Koshi river broke its banks. Some two million people were affected in Nepal and India. MSF dispatched a team to the Nepalese side of the border, where about 50,000 people were directly affected. For two months, teams focused on medical emergencies and cholera prevention.

In 2009, MSF will hand over its project in Kalikot to the Nepalese Ministry of Health and Population. MSF will maintain its presence in Terai, and retain a capacity for a quick response to emergencies.

MSF has worked in Nepal since 2002.
PAKISTAN

REASON FOR INTERVENTION
• Armed conflict
• Social violence/Healthcare exclusion

FIELD STAFF 478

Throughout 2008, there were increasing numbers of attacks on civilians leading to the displacement of hundreds of thousands of people. People’s overall health and living conditions have greatly deteriorated in a country that already had high infant and maternal mortality rates. Women and children in the rural areas of North West Frontier Province, the Federally Administered Tribal Areas and Balochistan are particularly vulnerable due to a shortage of medical staff and unaffordable health services. 

While needs have increased dramatically, insecurity and targeted attacks on aid workers have made it extremely difficult to provide assistance.

In Bajaur Agency, Swat and Mohmand regions, hundreds were killed or injured in suicide bombings, or by aerial attacks and fighting. Thousands of people have been repeatedly uprooted from their homes. In October, a peak in violence sent an estimated 600,000 people into neighbouring regions as well as to Islamabad, Lahore and Karachi over the course of a few days. Many found refuge in private homes, mosques, schools, and makeshift camps. MSF provided basic medical materials such as food, hygiene kits, shelter items, blankets and mats. Teams also set up water and sanitation facilities in the camps. Host families took in more than two-thirds of the displaced people. MSF adapted its primary healthcare programmes to respond to sharply increasing numbers of victims of violence. Teams provided medical supplies to treat war wounded, assisted in referrals and, together with local health structures, provided care for the treatment of watery diarrhoea caused by the poor quality of the water.

As local health clinics began to close due to fears of insecurity, MSF opened mobile clinics in partnership with local providers and established a chain of identifiable ambulance service to bring patients safely to hospitals. During the many curfews imposed by the military, the MSF ambulance was one of the only vehicles allowed to travel around, transporting 700 patients over a five-month period – primarily women in labour and victims of violence.

However in Swat this service was suspended after two MSF staff members were caught in cross fire and killed.

Similarly, in Kurrum Agency, providing assistance is increasingly difficult due to violence and insecurity caused by armed groups operating in the area. In addition to mother and child healthcare, including obstetric surgery and neonatal services, MSF teams provided emergency supplies during clashes, and non-food items to displaced families.

Earthquake response

In October, the mountainous region of north-western Balochistan was hit by a magnitude 6.4 earthquake. Most of the mud-brick houses were destroyed. People were forced to sleep-out in the cold due to the damage and fears of aftershocks. The official death toll rose to approximately 300, 35,000 people were injured, and 40,000 left homeless. In addition to emergency medical support and relief supplies, MSF teams also provided mental-health care.

Treating infection

In Mansehra district MSF set up a programme to respond to the parasitic infection cutaneous leishmaniasis. MSF teams estimate that in some villages 60 to 75 per cent of children are infected. Cases are referred to the hospital in Darband in Mansehra district, where an MSF medical team works in the outpatient department and hospital wards and supports the management of emergency cases.

Refuge assistant

Further south, in Balochistan, MSF assists Afghan refugees by supporting mother and child healthcare in Kechla, a town near the capital Quetta. In the border town of Chaman, health agencies are struggling to provide care for city residents, so MSF assists local communities and patients coming from Afghanistan by providing reproductive healthcare, including emergency obstetrics, neonatal services and nutritional support.

In September, MSF was authorised to open new projects in the eastern districts of Jhalpur and Nasirabad following findings of malnutrition. By the end of the year, the feeding programme had admitted 1,300 children, and mother and child healthcare was being incorporated into the programme.

In September 2008, MSF started providing surgical care for patients in the local hospital of Tari town, in the western part of the island, which had been abandoned for the last ten years owing to insecurity. MSF is responsible for emergency care, including surgery for survivors of violence, and obstetric care in the hospital. In just three months, by the end of December 2008, MSF had given more than 1,000 consultations.

MSF has worked in Pakistan since 2000.

IN MEMORY

On February 1, 2009 two MSF staff were killed during fighting in Swat district, north-western Pakistan. Riaz Ahmad, 24, and Nasir Ali, 27, had left Mingora, the main town in Swat valley, in two ambulances to collect people injured during fighting in nearby Charsadda and bring them to the hospital for treatment.

Tragically their ambulances, though clearly identified as medical vehicles, came under fire inside Charsadda and both men were killed.

Both were working on their day off, such was their commitment to MSF and to the people in Swat valley. They will be greatly missed. Their dedication will remain an inspiration to many inside MSF and beyond.

‘Gaining acceptance is a challenge when starting to work in a new area. A mother had brought her two-year-old baby from a long way away by donkey-cart. The baby was severely malnourished as we had to give him special therapeutic food rich in vitamins and minerals. The first time the mother came with just the baby, but when she brought him back for a check-up, her mother and mother-in-law came as well. The baby was doing much better already, and there were tears in all their eyes. The baby had vitamin A deficiency, had probably had it since birth, and was blind. They explained that he used to just lie there limp, but now he was getting a bit more active, showing signs of liveliness. I saw tears of joy and happiness running down the mother’s face. This is the best thing, better than words, and it makes me feel that what we are doing is really worthwhile.’

Aasim Shah, programme officer in Balochistan

In 2008, MSF supported a clinic in the eastern coastal city of Lae, the country’s second-larger metropolitan area. At the Women and Children’s Support Centre, MSF staff offered medical and psychosocial care to survivors of sexual and domestic violence. By December 2008, one year after the clinic opened its doors, the team had treated more than 2,500 patients.

In September 2008, MSF started providing surgical care for patients in the local hospital of Tari town, in the western part of the island, which had been abandoned for the last ten years owing to insecurity. MSF is responsible for emergency care, including surgery for survivors of violence, and obstetric care in the hospital. In just three months, by the end of December 2008, MSF had given more than 1,000 consultations.

MSF has worked in Papua New Guinea since 2007.

PAPUA NEW GUINEA

REASON FOR INTERVENTION • Social Violence/Healthcare exclusion

FIELD STAFF 32

Some 40 per cent of the population live under the national poverty line according to the World Health Organization. Violence at all levels of society presents a significant health burden and the causes are complex. According to the 2008 report by AusAid, Australia’s aid programme, two out of three women experience domestic violence and half the country’s women have experienced rape in connection with tribal fighting.

Ms Naomi is a 30-year-old single mother and HIV/AIDS activist who lives in Lae.

‘I was a victim of a robbery and rape. They took my bag then one chased me and when I fell down he tried to stab me with a knife and he raped me. After it happened I had flashbacks and nightmares and when I came to see the counsellor she talked to me and told me it wasn’t my fault. She helped me – I did what she said and it helped me. I’m happy now. As a patient here, I’ll try to make women and abused children aware of treatment and counselling.’

In September 2008, MSF started providing surgical care for patients in the local hospital in connection with tribal fighting.

In 2008, MSF supported a clinic in the eastern coastal city of Lae, the country’s second-largest metropolitan area. At the Women and Children’s Support Centre, MSF staff offered medical and psychosocial care to survivors of sexual and domestic violence. By December 2008, one year after the clinic opened its doors, the team had treated more than 2,500 patients.

In September 2008, MSF started providing surgical care for patients in the local hospital in connection with tribal fighting.

Ms Naomi is a 30-year-old single mother and HIV/AIDS activist who lives in Lae.

‘I was a victim of a robbery and rape. They took my bag then one chased me and when I fell down he tried to stab me with a knife and he raped me. After it happened I had flashbacks and nightmares and when I came to see the counsellor she talked to me and told me it wasn’t my fault. She helped me – I did what she said and it helped me. I’m happy now. As a patient here, I’ll try to make women and abused children aware of treatment and counselling.’

In 2008, MSF supported a clinic in the eastern coastal city of Lae, the country’s second-largest metropolitan area. At the Women and Children’s Support Centre, MSF staff offered medical and psychosocial care to survivors of sexual and domestic violence. By December 2008, one year after the clinic opened its doors, the team had treated more than 2,500 patients.

MSF has worked in Papua New Guinea since 2007.

MSF has worked in Papua New Guinea since 2007.
PHILIPPINES

REASON FOR INTERVENTION
• Armed conflict
FIELD STAFF 2

The conflict between the Sri Lankan army and the Tamil Tiger rebels (LTTE) escalated in 2008. In January, the government pulled out of the six-year ceasefire between the two parties and stepped up its military attacks against the LTTE, progressively regaining control of key rebel-held territories in the north of the country.

Heavy fighting resumed on the frontlines and added to the plight of civilians who had already been oppressed for years by various militia groups operating with impunity. Subject to abductions, unlawful executions, arbitrary arrests and restrictions of movement, people live in a constant state of fear and intimidation, which seriously limits their access to healthcare.

In 2008, MSF supported local hospitals in the government-controlled areas close to the conflict in Point Pedro, Vavuniya and Mannar. MSF also worked in Kilinochchi (Vanni area), an LTTE-held territory, until the government ordered all NGOs to leave the conflict area in September 2008. The projects offered medical and surgical support as well as obstetric and gynaecological treatment and emergency care. In 2008, MSF conducted 2,550 deliveries and assisted in 1,485 surgical interventions in partnership with the Ministry of Health. MSF has been asking the authorities for access to the area since it was expelled, to provide medical assistance to the thousands of trapped civilians.

MSF has been providing medical treatment, clean water and sanitation services to displaced people in Region XII and ARMM (Autonomous Region of Muslim Mindanao). Since the breakdown of peace negotiations between the Philippine government and the Moro Islamic Liberation Front (MILF) in August 2008, fighting resumed in some parts of Mindanao island. The sudden violence uprooted hundreds of thousands of people. This period of uncertainty lasted five months, and the damage caused meant that some who had fled, had nothing to return to, as their villages had been burned to the ground. Some found refuge with host families, although many of them were already nearing the limit of their own meagre resources. Other displaced people lived in makeshift shelters in nearby forests or by the roadside, and some found shelter in evacuation centres set up by the government.

In addition, MSF provided staff support and medicines for health centres overwhelmed by the influx of new patients. In the town of Datu Pag, for example, the population grew from 42,000 to 82,000 in a few months, overwhelming the local health services.

Since the breakdown of peace negotiations between the Philippine government and the Moro Islamic Liberation Front (MILF) in August 2008, fighting resumed in some parts of Mindanao island. The sudden violence uprooted hundreds of thousands of people. This period of uncertainty lasted five months, and the damage caused meant that some who had fled, had nothing to return to, as their villages had been burned to the ground.

Some found refuge with host families, although many of them were already nearing the limit of their own meagre resources. Other displaced people lived in makeshift shelters in nearby forests or by the roadside, and some found shelter in evacuation centres set up by the government.

MSF has been providing medical treatment, clean water and sanitation services to displaced people in Region XII and ARMM (Autonomous Region of Muslim Mindanao). MSF teams also ran mobile healthcare clinics in ten locations for the displaced population, and carried out some 3,000 medical consultations. Most of the cases were directly related to the harsh living conditions – respiratory tract infections from sleeping outside and diarrhoea from drinking contaminated water.

In addition, MSF provided staff support and medicines for health centres overwhelmed by the influx of new patients. In the town of Datu Pag, for example, the population grew from 42,000 to 82,000 in a few months, overwhelming the local health services.

SRI LANKA

REASON FOR INTERVENTION
• Armed conflict
• Armed conflict • Natural disaster
FIELD STAFF 128

The conflict between the Sri Lankan army and the Tamil Tiger rebels (LTTE) escalated in 2008. In January, the government pulled out of the six-year ceasefire between the two parties and stepped up its military attacks against the LTTE, progressively regaining control of key rebel-held territories in the north of the country.

Heavy fighting resumed on the frontlines and added to the plight of civilians who had already been oppressed for years by various militia groups operating with impunity. Subject to abductions, unlawful executions, arbitrary arrests and restrictions of movement, people live in a constant state of fear and intimidation, which seriously limits their access to healthcare.

In 2008, MSF supported local hospitals in the government-controlled areas close to the conflict in Point Pedro, Vavuniya and Mannar. MSF also worked in Kilinochchi (Vanni area), an LTTE-held territory, until the government ordered all NGOs to leave the conflict area in September 2008. The projects offered medical and surgical support as well as obstetric and gynaecological treatment and emergency care. In 2008, MSF conducted 2,550 deliveries and assisted in 1,485 surgical interventions in partnership with the Ministry of Health. MSF has been asking the authorities for access to the area since it was expelled, to provide medical assistance to the thousands of trapped civilians.

In Point Pedro, at the northern tip of the Jaffna Peninsula, the hospital serves a population of 100,000 people but lacks qualified health specialists, medical equipment and drugs. Security restrictions on movements impede the referral of patients, Jaffna teaching hospital is the only facility for referral. Antenatal and surgical consultations were conducted in two other local hospitals in partnership with Ministry of Health staff. MSF trained the hospital staff to be prepared for mass casualties, in emergency medical and paramedical care, and gave specific nurse training on hygiene, dressings and patients observations.

In Vavuniya district, MSF has been supporting the general hospital since 2006 with medical specialists including at different times surgeons, anaesthetists and lab technicians. A general nutritional assessment was conducted in the district and more than 150 children were treated in MSF’s mobile feeding programme. MSF has also been supporting a local NGO specialising in mental health by training its staff and offering clinical supervision to improve the quality of care available.

Until September 2008, MSF worked in Kilinochchi, in the LTTE-controlled area. Most of the people in the conflict area have had to flee their homes and live in basic conditions. In November, heavy flooding destroyed paddy fields, which led to further deterioration of the living conditions in Vanni. Hoods also displaced thousands of people in Point Pedro. MSF set up an emergency response and distributed relief items such as food, blankets and buckets. MSF’s surgery and emergency obstetric care in Mannar hospital was closed in December 2008.

MSF has worked in Sri Lanka since 2007.
THAILAND

Patchara, aged 43, is serving the last year of a three-and-a-half-year sentence in Minburi prison in Bangkok. ‘I tested HIV-positive in another prison. Stigma was so widespread at the time. These were no HIV/AIDS drugs inside and you could see that women with the disease were just dying one after the other.’

Patchara developed her first opportunistic infection in Minburi, where MSF had been working in partnership with the department of corrections to provide HIV/AIDS treatment and care. ‘In Minburi the atmosphere was very different from what I had known before. The staff encouraged me to take a blood test and provided moral support, and I began antiretroviral therapy in March 2006.’

For Patchara, access to information played a critical role in changing the environment in the prison, along with the availability of treatment. ‘I disclose my status, there’s no discrimination here since we know about transmission and that HIV doesn’t mean death. Groups for people living with HIV/AIDS in the prison are very supportive and I can consult them whenever I need to.

Providing primary healthcare to Lao Hmong refugees

MSF has been providing primary healthcare to the Lao Hmong in Huai Nam Khao village, Petchabun province, northern Thailand, since July 2000. In 2008, MSF conducted 4,620 medical consultations: 319 patients tested positive for TB and 43 began MDR-TB treatment. MSF also offers HIV/AIDS care and ART to HIV-positive and co-infected patients. In 2008, 2,085 HIV consultations were carried out and 52 new HIV/AIDS patients were registered in the programme.

Tuberculosis: Mae Sot

In Mae Sot on the Thai-Burmese border, MSF has been treating undocumentated migrants from Myanmar for tuberculosis (TB) and multi-drug-resistant TB (MDR-TB) since 1999. TB is endemic in Thailand and Myanmar and represents a serious problem for a population with limited access to healthcare. In 2008, MSF conducted 4,620 medical consultations: 319 patients tested positive for TB and 43 began MDR-TB treatment. MSF also offers HIV/AIDS care and ART to HIV-positive and co-infected patients. In 2008, 2,085 HIV consultations were carried out and 52 new HIV/AIDS patients were registered in the programme.

Malaria: Sangklaburi/Mon State

In Sangklaburi, along the border with Myanmar, MSF is running a cross-border malaria project that supports ethnic Mon living in resettlement sites and villages inside Mon State (Myanmar). Malaria is endemic in the area and MSF carried out more than 53,542 consultations in 2008, confirmed 4,360 cases of malaria and distributed 8,381 bed nets, meeting the needs of 16,698 inhabitants. MSF has also provided essential drugs to nine health posts in Mon State, and runs small vaccination campaigns regularly.

For Patchara, access to information played a critical role in changing the environment in the prison, along with the availability of treatment. ‘I disclose my status, there’s no discrimination here since we know about transmission and that HIV doesn’t mean death. Groups for people living with HIV/AIDS in the prison are very supportive and I can consult them whenever I need to.

Providing primary healthcare to Lao Hmong refugees

MSF has been providing primary healthcare to the Lao Hmong in Huai Nam Khao village, Petchabun province, northern Thailand, since July 2000. In 2008, MSF conducted 4,620 medical consultations: 319 patients tested positive for TB and 43 began MDR-TB treatment. MSF also offers HIV/AIDS care and ART to HIV-positive and co-infected patients. In 2008, 2,085 HIV consultations were carried out and 52 new HIV/AIDS patients were registered in the programme.

Tuberculosis: Mae Sot

In Mae Sot on the Thai-Burmese border, MSF has been treating undocumentated migrants from Myanmar for tuberculosis (TB) and multi-drug-resistant TB (MDR-TB) since 1999. TB is endemic in Thailand and Myanmar and represents a serious problem for a population with limited access to healthcare. In 2008, MSF conducted 4,620 medical consultations: 319 patients tested positive for TB and 43 began MDR-TB treatment. MSF also offers HIV/AIDS care and ART to HIV-positive and co-infected patients. In 2008, 2,085 HIV consultations were carried out and 52 new HIV/AIDS patients were registered in the programme.

Malaria: Sangklaburi/Mon State

In Sangklaburi, along the border with Myanmar, MSF is running a cross-border malaria project that supports ethnic Mon living in resettlement sites and villages inside Mon State (Myanmar). Malaria is endemic in the area and MSF carried out more than 53,542 consultations in 2008, confirmed 4,360 cases of malaria and distributed 8,381 bed nets, meeting the needs of 16,698 inhabitants. MSF has also provided essential drugs to nine health posts in Mon State, and runs small vaccination campaigns regularly.

For Patchara, access to information played a critical role in changing the environment in the prison, along with the availability of treatment. ‘I disclose my status, there’s no discrimination here since we know about transmission and that HIV doesn’t mean death. Groups for people living with HIV/AIDS in the prison are very supportive and I can consult them whenever I need to.

Providing primary healthcare to Lao Hmong refugees

MSF has been providing primary healthcare to the Lao Hmong in Huai Nam Khao village, Petchabun province, northern Thailand, since July 2000. In 2008, MSF conducted 4,620 medical consultations: 319 patients tested positive for TB and 43 began MDR-TB treatment. MSF also offers HIV/AIDS care and ART to HIV-positive and co-infected patients. In 2008, 2,085 HIV consultations were carried out and 52 new HIV/AIDS patients were registered in the programme.

Tuberculosis: Mae Sot

In Mae Sot on the Thai-Burmese border, MSF has been treating undocumentated migrants from Myanmar for tuberculosis (TB) and multi-drug-resistant TB (MDR-TB) since 1999. TB is endemic in Thailand and Myanmar and represents a serious problem for a population with limited access to healthcare. In 2008, MSF conducted 4,620 medical consultations: 319 patients tested positive for TB and 43 began MDR-TB treatment. MSF also offers HIV/AIDS care and ART to HIV-positive and co-infected patients. In 2008, 2,085 HIV consultations were carried out and 52 new HIV/AIDS patients were registered in the programme.

Malaria: Sangklaburi/Mon State

In Sangklaburi, along the border with Myanmar, MSF is running a cross-border malaria project that supports ethnic Mon living in resettlement sites and villages inside Mon State (Myanmar). Malaria is endemic in the area and MSF carried out more than 53,542 consultations in 2008, confirmed 4,360 cases of malaria and distributed 8,381 bed nets, meeting the needs of 16,698 inhabitants. MSF has also provided essential drugs to nine health posts in Mon State, and runs small vaccination campaigns regularly.

For Patchara, access to information played a critical role in changing the environment in the prison, along with the availability of treatment. ‘I disclose my status, there’s no discrimination here since we know about transmission and that HIV doesn’t mean death. Groups for people living with HIV/AIDS in the prison are very supportive and I can consult them whenever I need to.
The incidence of MDR-TB in the region is one of the highest in the world – estimated at 13 per cent among new cases of tuberculosis and 40 per cent among people who have been treated previously. Some patients develop strains of TB that are resistant to the second-line drugs designed to treat drug-resistant TB.

In 2008, more than 230 people were admitted to the MSF hospital in Nukus, the regional capital. The number could have been higher but the Ministry of Health had to restrict admission of new patients due to delayed approval to supply second-line TB drugs.

Overall, 830 patients were enrolled in the MSF programme.

On average, MDR-TB patients have to stay in hospital for about two months. Afterwards, they must continue treatment outside the hospital for between 18 months and two years. Many, however, for a number of reasons, do not manage to adhere to the treatment once they have left hospital. The treatment success rate is 59 per cent; MSF aims to increase this to over 70 per cent.

MSF has also equipped and supports a modern laboratory in Nukus, which performs tests for drug sensitivity. The psychosocial component of the MSF programme is critical. Here, patients can discuss with their counsellors how to handle side-effects, and find out about the disease and its treatment as well as the general implications TB has for their personal lives. MSF supports voluntarily testing and counselling for HIV/AIDS and provides regular training for local staff. Training topics range from infection control and outpatient care, to the management of side-effects, new diagnostic methods, improving adherence to treatment, sputum collection, and transport.

MSF has worked in Uzbekistan since 1997.
MSF has worked in Bolivia since 1986.

In Cochabamba, MSF worked in five health centres with the Ministry of Health, aiming to integrate the diagnosis and treatment of Chagas into the health system. Weekly follow-ups allow side-effects to be detected in time to integrate the diagnosis and treatment of Chagas into the health system. Weekly follow-ups allow side-effects to be detected in time to improve access to diagnosis and treatment for under-18s in this semi-urban setting. The project was finally closed in March 2008.

In Tarija, where MSF closed its project in 2006, nearly 1,400 children were treated. In 2008, 969 of these children were seen again to assess the efficacy of treatment and the project’s long-term impact.

The parasitic disease Chagas is endemic in 60 per cent of Bolivia’s territory. Access to diagnosis and treatment is limited and there is almost no treatment for sufferers over 15 years old. MSF is currently treating both adults and children, and is promoting and lobbying for wider access to treatment in the country. To date teams have treated some 3,000 patients with Chagas in Bolivia. Their challenge is to demystify this disease and integrate treatment into the national public health system.

MSF opened a project in Sucre in 2005, and improved access to diagnosis and treatment for under-18s in this semi-urban setting. The project was finally closed in March 2008. In Cochabamba, MSF worked in five health centres with the Ministry of Health, aiming to integrate the diagnosis and treatment of Chagas into the health system. Weekly follow-ups allow side-effects to be detected in time to transfer patients to the hospital if necessary. In 2008, more than 500 patients were treated.

In Tarija, where MSF closed its project in 2006, nearly 1,400 children were treated. In 2008, 969 of these children were seen again to assess the efficacy of treatment and the project’s long-term impact.

Pamela from Cochabamba is the 23-year-old mother of Griselda, one, and Kevin, three.

One day I was in the health centre waiting for the doctor and a woman approached me and started talking about Chagas. I did not pay attention to her until she mentioned that the vinchuca was the insect that transmitted the disease. I realised my house was full of them when I was a girl. She persuaded me to take the test. I was positive, and my children were, too. I cried a lot. I had transmitted the disease while I was pregnant. We were all treated and now we are fine. I am very grateful I could get the medication free, since few health centres give it freely and even fewer give it to people over 15 years old.’

‘My mum died of Chagas when I was a child, now I am 25 years old and I have managed to get the treatment.’

Rosario, patient from the Cerro Verde health centre

Local armed groups have for years controlled slum areas in Rio de Janeiro called favelas, where they recruit young men as soldiers and impose social rules that include harsh punishment for those who do not obey. Clashes between armed groups for territorial control, as well as fighting between police forces and the ruling groups, leave thousands of people trapped by violence. People risk being caught up in fighting and severely injured as they go about their everyday business.

In one of these favelas, Complexo do Alemão, MSF runs a medical structure that provides emergency care and psychosocial support. The complex, a conglomerate of 11 communities on the outskirts of Rio, has a population estimated at 150,000. At the MSF emergency unit, people affected by fighting receive immediate assistance, improving their chances of survival and recovery. Once stabilised, patients are referred to a government hospital outside the community. MSF ambulances can also reach patients inside their homes. Due to checkpoints and blockages set up by the local armed groups, no other ambulance can enter the area. Patients presenting with other medical emergencies, such as the hemorrhagic form of dengue fever, a seasonal disease in Rio, were also seen at the MSF centre. In 2008, MSF provided 11,315 consultations in Complexo do Alemão. In nearly one-third of them, patients were under five years old.

Living permanently surrounded by violence has a serious impact on people’s mental health. MSF provided psychological support to approximately 900 people in 2008. Most of them had been caught up in fighting or had directly witnessed acts of violence. One in ten has had a family member murdered.

To promote the services available at the centre, a team of four community health workers liaises with schools, churches and other local institutions, organises activities in the streets and conducts home visits.

‘One of our goals is to reduce the time between trauma and hospitalisation. We need to treat the patient during the first 60 minutes after the time of the injury.’

Gianfranco de Maio, medical doctor

‘With the emergency unit inside the community, we can get down here and receive medical care much more quickly than if we had to go to another hospital.’

Patient at the MSF emergency unit in Complexo do Alemão

‘My mum died of Chagas when I was a child, now I am 25 years old and I have managed to get the treatment.’

Rosario, patient from the Cerro Verde health centre
Médecins Sans Frontières Activity Report 2008

Colombia

MSF projects around the world | The Americas

Reason for intervention

• Armed conflict • Social violence/Healthcare exclusion

Field Staff 294

Territorial conflicts linked to the narcotics trade caused increasing numbers of people to flee their homes in Colombia in 2008, aggravating the country’s alarming humanitarian crisis. Assistance for those most affected, including the provision of healthcare, is limited. Mental-health care for victims of violence is needed across the country. People living in rural areas and in marginalised urban areas continue to suffer from diseases that could be easily prevented and treated. There are MSF programmes in 17 of Colombia’s 32 departments. The range of services includes primary healthcare, mental-health programmes, mobile clinics in urban and rural areas, reproductive healthcare, emergency obstetric care and assistance to victims of sexual violence, antenatal care, water sanitation, basic refurbishment of health structures, voluntary counselling treatment, pregnancy termination and emergency response.

In the Uraba region, mobile clinics provided medical access to the most isolated communities in the rural areas surrounding Saiza and in Rio Sucio. Here MSF also supported hospital services, offering mental-health and reproductive services and carried out more than 14,700 consultations. In the Norte de Santander department, the teams assisted communities isolated by conflict in El Tarra and La Gabarra. Through mobile clinics, they provided more than 8,400 consultations to rural people who had been forced to flee their homes. In the Sucre and Bolivar departments, MSF gained greater access to the disputed Montes de María region. MSF provided basic healthcare in mobile clinics and carried out more than 10,550 consultations. Services in Sinú and Soledad focused on the basic and reproductive health of people who had been forced to flee their homes, supporting those affected by sexual violence and providing access to HIV testing and counselling.

In the urban area of Buenaventura, MSF set up a fixed health post, mobile clinics in the neighbourhood and a referral system to the state’s healthcare facilities. The programme has offered care for victims of sexual violence, reproductive healthcare, paediatric care and psychological assistance, providing 8,375 medical consultations. A mobile medical team also works on the border between Meta and Guaviare, where the team gave 4,650 medical consultations. In Tolima’s southwest areas, where access to healthcare has improved significantly, MSF gave more than 6,470 medical consultations. There were also 8,670 medical and 180 psychological consultations conducted through mobile clinics in Barbacora, Magüí Payán and Roberto Payán. The medical activities were closed in October 2008. However a reduced team remained in the area attending to displaced people who continued to arrive in Barbacora. MSF provided medical care (including psychological care and health promotion) in the Piamonte municipalities of Caucaso and Puerto Guzman in Putumayo. In 2008, 5,860 medical and 785 psychological consultations were conducted in mobile clinics.

MSF closed its urban project for people who had been forced to flee their homes in the Soacha municipality after ten years and more than 100,000 consultations.

In Chocó, one of the poorest regions in Colombia, MSF provides sexual and reproductive healthcare in urban and rural areas, including assistance to victims of sexual violence. In Quibdó, the main city, MSF runs an urban mobile clinic and supports the maternity ward in the only hospital providing second-level healthcare. In Itimata, a mobile team travels by boat to reach remote villages on the banks of the San Juan river, where 10,470 consultations were provided in 2008.

In the municipality of Tame, MSF teams provided more than 15,300 consultations, giving primary, family planning and antenatal healthcare and psychological support.

During 2008 MSF also responded to the emergency of the Nevado del Huila volcano, Cauca department, and the River San Juan Boods in Chocó.

MSF has worked in Colombia since 1984.

Guatemala

Reason for intervention • Social violence/Healthcare exclusion

Field Staff 21

Civil war, poverty, street gangs, the spread of Mexican drug cartels and the failing judicial system have contributed to a soaring crime rate and ever-increasing violence. On average, more than 17 people were killed every day in 2008: the highest rate of homicides in Guatemala since the end of the civil war.

This situation increases social inequality, unfair distribution of wealth and the disintegration of the family, and there has been an enormous incidence of sexual violence. More than 10,000 cases were officially reported in Guatemala last year.

The violence is concentrated in the capital city and is most prevalent in suburban zones 7 and 18 on the outskirts of Guatemala City. MSF opened programmes in these two zones in 2007. Teams offer medical and psychological support, provide medication, and coach staff from the national Ministry of Health. In 2008 MSF teams gave comprehensive medical and psychological assistance to more than 400 victims. The medical response includes presumptive treatment or prophylaxis, administered to prevent the development of any sexually transmitted infections. Last year the programme was extended to provide further points of access for patients. MSF has installed an open-all-hours service within the Guatemalan Ministerio Publico (office for crime reporting). Women who report a sexual assault are able to receive free medical and mental-health care in the Ministerio Publico.

MSF has established a mobile clinic and plans to set up another open-all-hours medical and mental-health service in Guatemala City’s general hospital, which acts as a central point for referrals from other health facilities.

To raise awareness further, the teams have conducted extensive information campaigns in the communities, but more efforts are required to improve the knowledge of health professionals, authorities, and the broader community.

MSF has worked in Guatemala since 1986.

Honduras

Reason for intervention • Social violence/Healthcare exclusion

Field Staff 46

Homeless young people living on the streets of the capital city, Tegucigalpa, are vulnerable. They barely have access to medical care, live in precarious circumstances and are the first target of violence in an already volatile environment. Last year, more than 500 street people under the age of 24 were murdered in Tegucigalpa.

MSF provides medical and psychological treatment and social care in a therapeutic day-care centre that opened its doors to the homeless in 2005. In 2008, more than 370 street youngsters came to the centre, which is situated in Comayagua, a deprived district in the capital.

MSF provided medical treatment for 310 people in 2008. Most were suffering from respiratory infections; others had skin diseases, dental problems, injuries resulting from violence, and HIV/AIDS.

MSF also coordinated a vaccination service for visitors to the centre. Visitors receive hepatitis B and tetanus vaccinations amongst others.

MSF psychologists help young people cope with street life, fear, and drug abuse. Teams have also set up a medical and psychological referral system for patients who cannot be treated in the daycare centre. Such patients were referred to the psychiatric hospital due to depression, suicide attempts, psychotic episodes or alcohol abstinence syndrome.

MSF has worked in Honduras since 1988.
HAITI

REASON FOR INTERVENTION
• Social violence/Healthcare exclusion • Natural disaster

FIELD ST 813

© Espen Rasmussen
© Siavash Maghsoudi

As the security context continued to stabilise in the capital, MSF teams treated an average of 45 people with gunshot wounds each month at the Trinité trauma centre. This is the only emergency room providing free care in Port-au-Prince.

After emergencies such as the food riots in April 2008 and the collapse of a school in Petionville in December 2008, most of the patients were brought to the Trinité emergency room. This facility offers internal fixation, an orthopaedic technique that allows patients to recover much faster than is usual with traction.

MSF provides surgical care at the centre. In 2008 more than 37,950 patients were treated, and more than 6,100 underwent surgical interventions.

Jude Anne emergency obstetric hospital

Throughout 2008, MSF managed the 65-bed Jude Anne emergency obstetric hospital in Port-au-Prince. In addition to the hospital, MSF runs three mobile clinics in three slum areas offering antenatal, perinatal and postnatal care. The service provides emergency Caesarean sections, voluntary counselling, testing, prevention of mother-to-child transmission of HIV, care for those affected by sexual violence, and the referral of women with uncomplicated deliveries to other hospitals.

By the end of December 2008, more than 14,700 babies had been born at this hospital. The average number of deliveries per month is 1,000, half of which involve complications. The hospital also provides a newborn care unit, where an average of 90 babies a month are admitted to be stabilised before being transferred to the general hospital in Port-au-Prince.

MSF has also distributed hygiene kits for 5,000 families (including plastic sheeting, soap and jerry cans) to help as many people as possible who had been left with nothing after the storms.

MSF mobile medical teams travelled by car, on horseback and on foot around Gonaïves and the surrounding isolated villages to provide assistance to the most vulnerable people staying in temporary shelters. In total MSF teams performed more than 3,500 consultations via this service.

MSF has worked in Haiti since 1991.

Europe and the Middle East
BELGIUM

REASON FOR INTERVENTION • Social violence/Healthcare exclusion
FIELD STAFF 9

Everyone in Belgium is entitled to healthcare. This includes undocumented migrants and asylum seekers, although in practice numerous administrative obstacles restrict their access to health services. Since 1987, MSF has been assisting migrants by providing medical care and lobbying for government services to fulfil their responsibilities.

From January to April 2008, more than 600 consultations were carried out in Brussels. In April, MSF was able to hand over this project.

In Antwerp, MSF continues to provide medical and psychosocial consultations to patients facing healthcare issues. MSF set up a new programme in Paris in 2007. It aims to provide medical and psychological care to these people, as well as social support.

The Paris centre offers psychological care to people in distress who came to France seeking asylum and protection. Most of them have fled from a conflict zone or political violence. Some arrived in France only recently, while others have been living in the country for some time. For MSF patients, as for asylum seekers in general, access to existing psychological care and services is hindered by a combination of several factors including the nature and intensity of their psychological distress, social and administrative insecurity, and the language barrier.

The MSF centre can offer assistance tailored to each patient: therapeutic care is complemented with medical, social and legal referrals and advice. Since the centre opened almost two years ago, it has conducted more than 7,000 consultations. Half of these were related to psychological care, a quarter to medical aspects, the remaining quarter to social assistance. Psychological care has been given to 365 people and 160 are still receiving it.

The precarious conditions in which people without valid immigration papers live, combined with what they went through in their home countries, make them extremely vulnerable. They are likely to suffer from high levels of anxiety. Psychological care is therefore essential to avoid a deterioration of their condition, which can lead to suicide attempts.

Of the patients attending the centre, 41 per cent have reported that they have had suicidal thoughts.

MSF has worked in France since 1987.

BELGIUM

Field Staff 9

• Social violence/Healthcare exclusion

Greece

REASON FOR INTERVENTION • Social violence/Healthcare exclusion
FIELD STAFF 6

Greece is a crossroads between Asia, Africa and Europe. In recent years the number of people arriving from Greece in the Middle East and Asia has rapidly increased, mainly due to armed conflicts and political instability in the migrants’ countries of origin. Most of the people arriving without papers are from Afghanistan, Iraq, Palestine and Somalia, and among them are a significant number of unaccompanied children.

The migrants are using Greece mainly as a passage to Europe – their common intention is to be forwarded to Italy and then to other European countries, but the Greek authorities systematically refuse to grant them refugee status. More than 25,000 applications were submitted in 2007, but only eight asylum seekers received refugee status.

Following an overall review of the situation, MSF decided to conduct an exploratory mission in February. The results highlighted the problems faced by undocumented migrants. These included limited or no access to healthcare services, difficult living conditions, lack of special measures for vulnerable groups such as women and children, absence of mental health services and inadequate provision inside the government detention centres and the make-shift migrant camp in Patra.

Levos island

In June, MSF started work at the detention centre of Lesbos island and at the port landing point, providing medical, psychological and humanitarian assistance. However, MSF decided to end the intervention in September due to limited access to the detention centre, which severely affected efforts to provide medical assistance and improve the undocumented migrants’ living conditions. There were many occasions when the medical team asylum seekers received refugee status.

Following an overall review of the situation, MSF decided to conduct an exploratory mission in February. The results highlighted the problems faced by undocumented migrants. These included limited or no access to healthcare services, difficult living conditions, lack of special measures for vulnerable groups such as women and children, absence of mental health services and inadequate provision inside the government detention centres and the make-shift migrant camp in Patra.

Levos island

In June, MSF started work at the detention centre of Lesbos island and at the port landing point, providing medical, psychological and humanitarian assistance. However, MSF decided to end the intervention in September due to limited access to the detention centre, which severely affected efforts to provide medical assistance and improve the undocumented migrants’ living conditions. There were many occasions when the medical team asylum seekers received refugee status.

Following an overall review of the situation, MSF decided to conduct an exploratory mission in February. The results highlighted the problems faced by undocumented migrants. These included limited or no access to healthcare services, difficult living conditions, lack of special measures for vulnerable groups such as women and children, absence of mental health services and inadequate provision inside the government detention centres and the make-shift migrant camp in Patra.

Levos island

In June, MSF started work at the detention centre of Lesbos island and at the port landing point, providing medical, psychological and humanitarian assistance. However, MSF decided to end the intervention in September due to limited access to the detention centre, which severely affected efforts to provide medical assistance and improve the undocumented migrants’ living conditions. There were many occasions when the medical team asylum seekers received refugee status.

Following an overall review of the situation, MSF decided to conduct an exploratory mission in February. The results highlighted the problems faced by undocumented migrants. These included limited or no access to healthcare services, difficult living conditions, lack of special measures for vulnerable groups such as women and children, absence of mental health services and inadequate provision inside the government detention centres and the make-shift migrant camp in Patra.
Italy has experienced a growing influx of undocumented migrants and asylum seekers since 2002. Looking for refuge, jobs or better living conditions, these people bear the brunt of increasingly strict measures designed to deter migration. As these measures are tightened, so reception conditions deteriorate. As a result, these already vulnerable people face a system unable to meet their basic needs, including protection and healthcare.

Field Staff 23

Every year, the agricultural lands of southern Italy attract thousands of undocumented migrants, a cheap labour force that is subjected to exploitation and intolerable living conditions. Since 2005, MSF has worked in Sicily, Puglia, Calabria and Campania to provide assistance to this population. In 2008, MSF undertook more than 700 consultations and distributed 3,750 hygiene kits, 1,500 sleeping bags and 800 blankets.

To help improve these people’s living conditions, MSF lobbied the authorities for a humanitarian intervention for all migrant workers, regardless of their legal status. As a result, regional authorities in Puglia, Calabria and Campania undertook emergency measures to guarantee basic living conditions – toilets, showers, water tanks – and adequate medical services for the 4,000 migrants working in the area. These measures followed recommendations in the MSF report, A Saison in Höl, which exposes the deplorable health, work and living conditions of migrant workers in southern Italy.

Until October 2008, MSF provided medical care for migrants arriving by boat in Lampedusa, south of Sicily. The harsh journey poses a risk to their health and only through MSF was medical care available to newly arrived migrants. In October 2008, Italian authorities refused to renew the agreement that allowed MSF to work on the island. As a result, MSF was forced to leave and the thousands of migrants who arrive now in Lampedusa have no access to healthcare. Between January and October, MSF provided consultations to 1,420 people. Pathologies such as respiratory infections and skin diseases were mostly associated with the harsh conditions of the sea journey.

MSF is negotiating with authorities a possible return to Lampedusa. In 2008, more than 30,000 undocumented migrants and asylum seekers landed on the island.

Throughout Italy, the work with migrants is carried out with the support of cultural mediators, who help bridge communications and cultural gaps between the team and the patients.

MSF has worked in Italy since 1999.

Malta

Despite stricter border controls at the European Union’s southern frontier, the number of migrants landing in Malta increased in 2008 to 2,740. Once on the island, undocumented migrants and asylum seekers are sent to detention centres. MSF provides them with medical and psychosocial care on their arrival and inside the centres.

Unassecured migrants and asylum seekers set off to Malta on boats leaving the coast of Libya. Nearly 60 per cent originate from countries affected by conflict or widespread violations of human rights, almost half of all newly arrived come from Somalia. Although most of them will eventually be granted refugee status or humanitarian protection by Maltese authorities, they are forced to wait in detention centres for up to 18 months first. These facilities overcrowding, inadequate sanitation and poor general living conditions. The environment has damaging effects on their physical and mental health.

In August 2008, MSF started providing healthcare and psychological support to these people. Activities included medical assessment of new arrivals soon after their transfer to the detention centres and follow-up medical consultations, psychological support, medical triage and health and hygiene promotion inside living areas.

Between August and December 2008, MSF provided more than 1,700 consultations of migrants and asylum seekers in Malta. Among the newly arrived, health complaints often resulted from the harsh conditions endured on the journey. Most people had spent up to seven days on a boat with limited food and water, unable to move, and exposed to the elements. Scabies, respiratory infections and intestinal parasites are common. Musculoskeletal problems, such as joint problems and back pain, are also frequent in a population with limited access to outside space and activity. MSF has continually expressed its concerns to Maltese authorities over the living conditions and inadequate medical care in the centres.

MSF also works in open centres. Once asylum seekers have had their application successfully processed and are granted refugee status, they are transferred to open centres, where they have freedom of movement. They stay there until they are able to rent private accommodation. MSF provides medical consultations to refugees in these centres and facilitates their access to public health services.

Francesca Faraglia, MSF medical coordinator

‘The health problems we find are mainly osteo-muscular, dermatological, respiratory and gastro-intestinal, all related not only to harsh working conditions but also to the unhygienic situation in which the people live. Seasonal migrant workers in southern Italy also have scant access to primary healthcare.’
Transnistria, a politically isolated and predominantly Russian-speaking region, is a strip of land separated from Moldova by the River Dniester. Once the scene of a violent separatist war, Transnistria is not recognised by the international community and little international aid has reached it despite the enormous assistance Moldova receives from international institutions to tackle the HIV/AIDS epidemic.

MSF, working with the Transnistria Ministry of Health, established the region’s first HIV/AIDS programme in early 2007. Owing to the urgency of the situation, the first patients started receiving life-prolonging antiretroviral therapy (ART) four months before the first outpatient department opened in the main hospital of the capital, Tiraspol. MSF also extensively refurbished the hospital’s laboratory and installed a new waste disposal system. The programme’s activities were extended to weekly visits to Bender tuberculosis (TB) hospital for people co-infected with both TB and HIV. In the north of the country to operate a weekly outpatient department opened in the main hospital of the capital, Tiraspol. MSF also started receiving life-prolonging antiretroviral treatment throughout Chechnya, including to patients in the remote mountainous regions who had no access to TB care. Since the beginning of the programme in 2004, 1,800 patients have been treated.

A powerful earthquake hit Chechnya in October 2008, killing 13 people, injuring more than 100 and causing destruction. Shocks continued over several days and people spent cold nights outside, fearful that the remaining buildings would collapse. MSF sent mobile teams to the five most severely affected villages and provided more than 1,000 medical and 3,000 psychosocial consultations.

Thousands of people who lost their homes during the wars are still living as refugees in Ingushetia or Dagestan, or in Grozny itself. MSF ran a medical centre in Nalza, Ingushetia, which provides medical and mental-health consultations for these people. The clinic conducted up to 1,200 consultations a month in 2008. Doctors provided women’s and paediatric healthcare in clinics in Grozny. On average, more than 1,500 gynaecological consultations were provided each month in the Staropromyslovsky area. MSF also supported the Republican Women’s Hospital in Grozny and district hospitals in the mountainous villages of Shatoy, Sharoy and Itum-Kale, supplying drugs and medical materials.

In 2006, MSF opened a surgery project in the republic’s main hospital, Grozny Hospital Number 9, to treat long-standing injuries and chronic disabilities sustained in the war, and is partially deaf as a side-effect of TB medicines. Magomed first contracted TB five years ago when he was in prison. At the time, war was ravaging the land and there was no place and no means to treat people like Magomed effectively. Magomed didn’t complete his treatment and this caused his current relapse. “This disease is treacherous – it comes out of the blue, and takes a long time to get rid of,” he says.

Because MSF does not aim to duplicate the existing or local services, a few MSF programmes in the region were closed down or handed over to local authorities. MSF handed over the two refurbished polyclinics in Grozny in which teams had run free pharmacies and a reproductive and family-planning clinic. Mobile medical teams no longer serve temporary accommodation centres in Grozny. In 2009, MSF will stop its emergency surgery programme in Grozny, since the number of interventions performed there each month is declining.

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

Before the war, there were more than 120 TB doctors for a population of one million. During the two wars the TB service infrastructure was completely destroyed. The MSF programme showed that TB treatment in a post-war setting is possible and yields good results.

Shamsudin Ilkaev, Chechen TB doctor
Iran is in economic crisis, and resentment towards refugees has increased. In November 2007, officially for security reasons, the government declared the regions next to the border ‘no-go areas’. This included areas such as Sistan-Baluchistan, where more than half a million Afghans still remain illegally. Iranian authorities estimate that most Afghans are economic migrants, and therefore are not entitled to legal status or access to free healthcare. In Sistan-Baluchistan, MSF continues to provide primary and secondary healthcare to this population, which has little or no access to the Iranian healthcare system. In 2008, the teams visited an average of 23 newly arrived families a week at Zahedan – an increase from an average of eight families a week in 2007.

Since 2001, MSF has been assisting Afghan refugees in Zahedan, capital of the Iranian province of Sistan-Baluchistan, where they have been crossing the border for the last 30 years. In 2002, despite a deterioration in conditions in conflict-ridden Afghanistan, the Iranian government implemented a policy of forced repatriation. Many people are reluctant to return to their home country and prefer to remain in Iran; some even return after deportation. With Iranian restrictions on work, educational opportunities and health services, living conditions for refugees are difficult. Despite this, people continue to migrate from Afghanistan, essentially for economic reasons, because of drought in the northern provinces or increased insecurity in other areas.

Access to healthcare is problematic, especially after bomb blasts, when it is difficult for the wounded to reach hospitals. Patients with chronic diseases suffer from a general lack of medicines and proper follow-up care.

Large numbers of doctors and medical staff have fled the country since the beginning of the war in 2003. Those who stayed face enormous hardships, even threats to their lives. According to the Ministry of Health, more than 600 medical employees, including 132 doctors, have been killed in the course of the war. Humanitarian organisations have also been targeted.

MSF has struggled for years to gain access to the people. ‘The dilemma we face in Iraq is symptomatic of many conflicts today,’ says Gustavo Fernandez, head of mission for the programmes in Ninewa and Tameen governorates. ‘Reaching civilians caught in midst of conflict and violence has become a huge challenge.’

For the first time since the change of regime in 2003, MSF was able to establish an international team in southern Iraq in 2008. In October a training project was started in Basra general hospital in the south of the country. The project intends to improve pre- and post-operative care.

Cross-border support

Since 2006, medical programmes have been set up in neighbouring countries. MSF has been providing orthopaedic, maxillo-facial and plastic surgery for Iraqi war-wounded in Amman, Jordan, since August 2006. Almost 600 patients who needed treatment too complex to be provided in wartime Iraq were treated in Amman in the programme. The programme was developed in partnership with the Jordanian Red Crescent Hospital and the Iraqi Medical Association.

Reconstructive surgery

In the Kirkish governorates of northern Iraq, MSF provided surgical assistance to the wounded in hospitals in Sulaymaniyah, Erbil and Dohuk. Focusing on prosthetic and orthopaedic reconstructive surgery and care for burn victims.

Reconstructive surgery for war-wounded Iraqis was also provided in Mehran, Iran. MSF had intended to develop a referral system for patients from the war zone to these hospitals, but attempts proved unsuccessful for a number of reasons. MSF decided to stop some of these programmes in the course of 2008 to concentrate reconstructive surgery activities in the hospital in Amman, Jordan, and to give more specific support to hospitals within the conflict zone. The programme for burn victims in Sulaymaniyah continues, and deals with an average of 80 admissions a month. The injuries are caused mostly by accidents or in failed suicide attempts.

Psychological support

In Baghdad, central and south Iraq, MSF supports eight hospitals by providing medical

New humanitarian concerns in Iraq

Humanitarian challenges have evolved over the past few years in Iraq. The Status of Forces Agreement, signed between the United States and Iraq at the end of 2008, has paved the way for the withdrawal of foreign forces from the country – American forces are to withdraw from the main Iraqi cities by the end of June 2009 – and national elections took place in January 2009.

Nevertheless, the situation is still tense, especially in Baghdad and in northern areas: Kirkuk’s future is still undecided, for example, and Mosul is still volatile. The withdrawal of foreign troops is increasing fears of a rise in violence, which will certainly have operational consequences for MSF.

MSF has worked hard to find the most appropriate approach in Iraq: the best way to balance serious security concerns against the medical needs of the people. The organisation has had to adapt quickly to establish networks and build trust with its counterparts in Iraq. For security reasons, MSF’s operations are restricted to urban settings, as it is difficult to make an accurate assessment of the medical and humanitarian needs in rural areas. Teams have had to find ways to reach vulnerable people without endangering the organisation’s reputation and the security of its staff. Many western NGOs, as well as the United Nations, are perceived to be allied with the American forces. This has blurred the important distinction between the armed coalition and humanitarian agencies, creating a challenge for MSF and underlining the critical importance of its neutrality, independence and impartiality in operational matters.

Since the Iraqi Ministry of Health has begun to take over healthcare provision, MSF has reduced the quantity of drugs it supplies and scaled down its support to health structures. MSF is now turning its attention towards more technical medical projects in Iraq, such as complex reconstructive surgery.

Caroline Abu-Sada, interim head of mission

© Kloie Picot

© Siavash Maghsoudi

© Mikael Picot
LEBANON

Reason for intervention • Social violence/Healthcare exclusion
Field Staff

After an evaluation in 2008 that focused on the mental-health needs of Lebanon’s people, MSF began a three-year programme in Burj el-Barajneh. This southern suburb of Beirut is home to many Lebanese, recently arrived Iraqi refugees, and Palestinian refugees who have lived there since 1948.

In Lebanon, 17 per cent of the population have mental-health problems, but only 11 per cent of this group have access to medical treatment. The health system is expensive because it is heavily privatised, and mental-health care is not covered by public health services. The few existing mental-health centres focus only on children, but adults also need this kind of care, including those in the refugee population. The 2006 war highlighted this need among Lebanese people, but the necessary measures have been slow to be implemented.

On 18 December 2008 MSF opened its community mental-health centre on the south side of Beirut. The centre saw around a dozen patients in the last few days of the year, and a rapid increase in patient numbers is expected in 2009. The MSF team comprises international and Lebanese staff. They offer psychological and psychiatric assistance to all those who need it, regardless of age, gender, or national origin. To establish the programme in the area and to overcome the stigma associated with mental-health issues, MSF, with the help of local NGOs, also organises psychosocial activities for the community. Promoting mental health among the area’s residents should facilitate the future handover of the project, and make it easier for people to participate in individual, family, and group therapy sessions at the community centre.

MSF has worked in Lebanon since 2008.

YEMEN

Reason for intervention • Armed conflict
Field Staff

Yemen is considered a haven for thousands of people fleeing from war and poverty in the Horn of Africa, but is affected by its own internal tensions. Since June 2004, a conflict in the governorate of Saada (northwest of Yemen, near the border with Saudi Arabia) is believed to have killed more than 9,000 and injured about 20,000 people. A local group called the Al Houthis, opposes government troops. Five periods of high-intensity fighting have erupted since 2004. The ‘Fifth War’ took place from May to July 2008. Meanwhile the number of refugees coming from Somalia and Ethiopia, risking their lives crossing the Gulf of Aden, continued to increase in 2008.

Healthcare for those affected by the conflict

MSF opened a project in Saada governorate in September 2008. At the end of the year, MSF still supported Al Tahl, Razeh hospitals as well as consultation activities in Dahyan, and operated a referral system to MSF secondary care facilities.

In 2008, around 3,000 consultations were carried out in MSF’s hospitals or outreach projects; about 15,000 patients were seen in emergency rooms; more than 1,500 patients were admitted to hospital; and 900 surgical operations were carried out. Around 1,000 children were admitted for severe malnutrition, nearly 3,000 antenatal consultations were provided as well as 700 deliveries.

Assisting refugees from the Horn of Africa

In the south of the country, in the Abyan and Shabwah governorates, MSF has been providing support to migrants coming from the Horn of Africa across the Gulf of Aden since September 2007. In 2008, according to figures from the United Nations High Commissioner for Refugees, more than 50,000 people fleeing from war, persecution and hunger in Somalia and Ethiopia made the perilous journey in smugglers’ boats, hoping to reach Yemen. Almost 950 died in the attempt.

MSF has worked in Yemen since 2007.
PALESTINIAN TERRITORIES

It is essential that civilians, the health authorities and the humanitarian workers be respected by all parties to the conflict. That has not been the case thus far. Humanitarian law exists to be applied in all conflicts and to be respected by everyone, including governments.’

Dr Marie-Pierre Alix, president of the French section of MSF

REASON FOR INTERVENTION • Armed conflict

FIELD STAFF 127

In the Gaza strip, 2008 was marked by a dramatic deterioration of the economic, security and health situations. Israeli military incursions and offensives continued, reaching a peak of violence at the end of the year. The inter-Palestinian conflict left many wounded, and the strengthening of the blockade aggravated the situation.

In the Gaza Strip

In three clinics MSF offers post-operative and psychotherapy treatment. The many wounded have no other access to this specialised care to help them regain their mobility and independ- 

ence. In 2008, more than 480 patients were followed up via this programme.

A paediatric programme began operating in February 2008 in the northern Gaza Strip. This was MSF’s response to the general lack of care and the overload on the only existing paediat-
ric referral hospital. Outpatient consultations, medical care and follow-up are offered to children under 12 years of age. In 2008, MSF teams treated more than 6,600 children. A psychological-medical-social programme enables people suffering from psychological problems related to violence to continue to cope in this particularly difficult and stressful situation.

Early in 2008, the strengthening of the Israeli blockade drastically restricted supplies. MSF, fearing that access to medication would be restricted, hospital services would become dysfunctional and access to care would be limited, monitored the situation closely.

Between February and March, in response to rocket attacks against Israel, the Israeli army launched an offensive in the northern Gaza Strip. MSF cared for the wounded in its Gaza City clinic, made donations of medical supplies and medication and supported the hospitals, which were overwhelmed by the influx of patients. This offensive resulted in some 120 deaths and 360 people being wounded, including many women and children.

The shortage of fuel seriously hindered MSF’s activities as well as those of the entire health system. In addition, the contradictory policies of the two Palestinian Ministries of Health, the internationally recognised Palestinian author-

ity in Ramallah, and that of the de facto Hamas government in Gaza, led to the general strike of health workers that started on August 30.

In this very fragile health situation, on December 27, Israel launched the ‘Hard Lead’ offensive. MSF responded immediately by supporting the hospitals overwhelmed by the influx of wounded, and by making medical donations. Throughout the war, because of the intensity of the bombardments and the lack of security, MSF clinics could not open. Some of the Palestinian staff had emergency medical kits that enabled them to provide care to those living near them. MSF’s dispensary in Gaza City remained open, but few patients could reach the health facilities.

In the West Bank

In 2008, at Nablus – which did not experience the same degree of violence as Gaza – MSF’s activities remained concentrated on mental health and medical and social support. Cooperation was established with the other local mental-health care providers and contin-ued with mutual referral of patients. In 2008, more than 300 patients received care.

In Hebron, MSF aims to provide psychological, medical and social assistance to people suffer-

ing from the violent consequences of the Israeli-Palestinian conflict, especially those in the Hebron governorate.

To alleviate the psychological suffering, MSF also provided short-term psychotherapy to patients. Teams also refer patients to the MSF doctor and social worker or to the appropriate mental-health structure.

There are about 13,000 Palestinian refugees living in Jenin camp. It is a violent place: there are regular incursions by the Israeli defence forces and frequent clashes between the different Palestinian armed factions. Since the building of the separation wall by the govern-

ment of Israel, Jenin district has been charac-
terised by a deteriorating economic situation, serious socio-cultural problems and social unrest.

The psychological services available to respond to the mental-health needs of the people living in the camp were inadequate. In response, in

June 2008, after months of negotiations, MSF teams arrived to start a project to remedy this. Unfortunately the lack of cooperation and the hostility in the camp forced the closure of the project when it was still in its start-up phase.

MSF has worked in the Palestinian Territories since 1988.

‘Each of us has been affected. Every inhabitant of the Gaza Strip, without exception, has suffered from the war.’ Abu Abed, MSF doctor

Riyad, 19, was born in the City of Beit Lahia in the northern Gaza strip, a zone especially affected by the ‘Hard Lead’ Israeli military offensive. On January 5, he was seriously wounded by shellfire. His left leg had to be amputated. He was given follow-up care in the MSF clinic in Gaza City, where he received post-operative treatment. ‘I was at home. It was a quiet day; we did not hear any planes or tanks. I decided to go out to do some shopping. On my return, I don’t know what happened, but I found myself on the ground. I think I must have been unconscious for a few minutes. My father dragged us, my brother and me, inside the house. He tried to call for help, but in vain. ‘I was unconscious most of the time, but I remember being hit by the shell. I saw my leg fall off. It was attached only by a small piece of flesh. I lost a lot of blood. I was stretched out on the ground and I was thinking “I’m going to die!” My father brought me outside to get help. We waited almost an hour and a half in the street, but no car or ambulance passed. A neighbour finally loaded seven people, including me and my father, on his tractor.

Early in 2008, the strengthening of the Israeli blockade drastically restricted supplies. MSF, fearing that access to medication would be restricted, hospital services would become dysfunctional and access to care would be limited, monitored the situation closely.

Between February and March, in response to rocket attacks against Israel, the Israeli army launched an offensive in the northern Gaza Strip. MSF cared for the wounded in its Gaza City clinic, made donations of medical supplies and medication and supported the hospitals, which were overwhelmed by the influx of patients. This offensive resulted in some 120 deaths and 360 people being wounded, including many women and children.

The shortage of fuel seriously hindered MSF’s activities as well as those of the entire health system. In addition, the contradictory policies of the two Palestinian Ministries of Health, the internationally recognised Palestinian author-

ity in Ramallah, and that of the de facto Hamas government in Gaza, led to the general strike of health workers that started on August 30.

In this very fragile health situation, on December 27, Israel launched the ‘Hard Lead’ offensive. MSF responded immediately by supporting the hospitals overwhelmed by the influx of wounded, and by making medical donations. Throughout the war, because of the intensity of the bombardments and the lack of security, MSF clinics could not open. Some of the Palestinian staff had emergency medical kits that enabled them to provide care to those living near them. MSF’s dispensary in Gaza City remained open, but few patients could reach the health facilities.

In the West Bank

In 2008, at Nablus – which did not experience the same degree of violence as Gaza – MSF’s activities remained concentrated on mental health and medical and social support. Cooperation was established with the other local mental-health care providers and contin-

ued with mutual referral of patients. In 2008, more than 300 patients received care.

In Hebron, MSF aims to provide psychological, medical and social assistance to people suffering from the violent consequences of the Israeli-Palestinian conflict, especially those in the Hebron governorate.

To alleviate the psychological suffering, MSF also provided short-term psychotherapy to patients. Teams also refer patients to the MSF doctor and social worker or to the appropriate mental-health structure.

There are about 13,000 Palestinian refugees living in Jenin camp. It is a violent place: there are regular incursions by the Israeli defence forces and frequent clashes between the different Palestinian armed factions. Since the building of the separation wall by the government of Israel, Jenin district has been characterised by a deteriorating economic situation, serious socio-cultural problems and social unrest.

The psychological services available to respond to the mental-health needs of the people living in the camp were inadequate. In response, in

June 2008, after months of negotiations, MSF teams arrived to start a project to remedy this. Unfortunately the lack of cooperation and the hostility in the camp forced the closure of the project when it was still in its start-up phase.

MSF has worked in the Palestinian Territories since 1988.
MSF COUNTRY PROGRAMME CLOSURES

CÔTE D’IVOIRE

After 18 years, MSF ended all its programmes in Côte d’Ivoire in October 2008. Following the peace agreement signed in 2007, the dismantling of the Zone de Confiance and the gradual return of staff to medical facilities in the north and west, MSF carried out successive withdrawals from Bouaké, Guiglo, Man, Danané and Bangolo, although teams responded to a short-term nutritional crisis in Odienné, in the northwest of the country.

MSF worked in Côte d’Ivoire from 1990 to 2008.

MSF projects around the world

LAOS

Five years ago, MSF was one of the first organisations in Laos to treat HIV/AIDS patients with antiretroviral therapy (ART). At the time, it was necessary to demonstrate that ART could be used effectively in remote, impoverished settings. The strategy included lobbying at national level for the adoption of ART, and the aim from the beginning was to hand the programmes over to Lao health officials. MSF’s programmes were based at Savannakhet provincial hospital and at Setthathirath hospital in Vientiane.

In 2008, nearly 850 patients benefited from the ART provided free of charge by MSF. During the year the teams finalised the handover to local medical staff, who had been trained to work independently.

The international financing institution The Global Fund to fight AIDS, Tuberculosis and Malaria is now overseeing the funding of the country’s HIV/AIDS programmes.

MSF worked in Laos from 1989 to 2008.

CÔTE D’IVOIRE

Five years ago, MSF was one of the first organisations in Côte d’Ivoire to treat HIV/AIDS patients with antiretroviral therapy (ART). At the time, it was necessary to demonstrate that ART could be used effectively in remote, impoverished settings. The strategy included lobbying at national level for the adoption of ART, and the aim from the beginning was to hand the programmes over to Ministry of Health and local partners, such as Pey Sans Frontières and Global Outreach Mission. Although those activities were closed in June, MSF returned to Côte d’Ivoire for a three-month period later in the year to provide treatment for patients with human African trypanosomiasis (also known as sleeping sickness).

MSF worked in Côte d’Ivoire from 1997 to 2008.

MSF COUNTRY PROGRAMME CLOSURES

CONGO-BRAZZAVILLE

A peaceful period continued in Congo-Brazzaville in 2008, completing a fifth year of post-conflict stability. This peace, and the resumption of economic activities, has enabled the country to take over healthcare services in the Pool region where MSF had been working for the last five years.

MSF’s hospital services included outpatient, maternity and emergency surgical care, treatment of infectious diseases such as tuberculosis and HIV/AIDS, and psychosocial counselling. Teams also provided healthcare through mobile clinics to communities near the towns of Mindouli and Kindamba. MSF provided 12,825 consultations in 2008. MSF handed over its programmes at Mindouli and Kindamba hospitals in 2008. Those in Kindamba were handed over to the Ministry of Health and local partners, such as Pey Sans Frontières and Global Outreach Mission.

MSF worked in Congo-Brazzaville from 1997 to 2008.

LAOS

Five years ago, MSF was one of the first organisations in Laos to treat HIV/AIDS patients with antiretroviral therapy (ART). At the time, it was necessary to demonstrate that ART could be used effectively in remote, impoverished settings. The strategy included lobbying at national level for the adoption of ART, and the aim from the beginning was to hand the programmes over to Ministry of Health and local partners, such as Pey Sans Frontières and Global Outreach Mission. Although those activities were closed in June, MSF returned to Côte d’Ivoire for a three-month period later in the year to provide treatment for patients with human African trypanosomiasis (also known as sleeping sickness).

MSF worked in Congo-Brazzaville from 1997 to 2008.

© Renzo Fricke

© Jiro Ose

© Thierry Dricot

© Bruno Stevens

© Other information
Medecins Sans Frontieres Activity Report 06|07

Audited Facts And Figures

Where did the money go?

Programme expenses by country/region

<table>
<thead>
<tr>
<th>Countries/Regions</th>
<th>In M€</th>
<th>In M€</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>47.2</td>
<td>17.6</td>
</tr>
<tr>
<td>Democratic Republic</td>
<td>43.8</td>
<td>12.2</td>
</tr>
<tr>
<td>of Congo</td>
<td>22.7</td>
<td>6.2</td>
</tr>
<tr>
<td>Malaysia</td>
<td>21.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Chad</td>
<td>17.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Zambia</td>
<td>16.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>14.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Nigeria</td>
<td>9.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Kenya</td>
<td>8.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>8.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Mozambique</td>
<td>8.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Liberia</td>
<td>7.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>6.0</td>
<td>1.4</td>
</tr>
<tr>
<td>South Africa</td>
<td>5.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>4.3</td>
<td>4.1</td>
</tr>
<tr>
<td>Cameroon</td>
<td>3.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>3.2</td>
<td>4.1</td>
</tr>
<tr>
<td>Guinea-Conakry</td>
<td>3.2</td>
<td>4.1</td>
</tr>
<tr>
<td>Mali</td>
<td>2.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Burundi</td>
<td>1.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Zambia</td>
<td>1.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Swaziland</td>
<td>1.4</td>
<td>4.1</td>
</tr>
<tr>
<td>Congo-Brazzaville</td>
<td>1.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Other countries*</td>
<td>2.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Total</td>
<td>301.0</td>
<td>4.1</td>
</tr>
</tbody>
</table>

*Other countries* combines all the countries for which programme expenses were below 1 million Euros.

HR Statistics

<table>
<thead>
<tr>
<th>International departures (full year):</th>
<th>In M€</th>
<th>In M€</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical pool</td>
<td>1,052</td>
<td>23%</td>
</tr>
<tr>
<td>Nurses &amp; other paramedical pool</td>
<td>1,452</td>
<td>31%</td>
</tr>
<tr>
<td>Non-medical pool</td>
<td>2,113</td>
<td>46%</td>
</tr>
<tr>
<td>First time departures (full year):</td>
<td>1,142</td>
<td>25%</td>
</tr>
<tr>
<td>* in % of total international departures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field positions:</td>
<td>25,973</td>
<td>100%</td>
</tr>
<tr>
<td>International staff</td>
<td>2,029</td>
<td>8%</td>
</tr>
<tr>
<td>National staff</td>
<td>23,944</td>
<td>92%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HR Statistics</th>
<th>In M€</th>
<th>In M€</th>
</tr>
</thead>
<tbody>
<tr>
<td>International departures (full year):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical pool</td>
<td>1,052</td>
<td>23%</td>
</tr>
<tr>
<td>Nurses &amp; other paramedical pool</td>
<td>1,452</td>
<td>31%</td>
</tr>
<tr>
<td>Non-medical pool</td>
<td>2,113</td>
<td>46%</td>
</tr>
<tr>
<td>First time departures (full year):</td>
<td>1,142</td>
<td>25%</td>
</tr>
<tr>
<td>* in % of total international departures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field positions:</td>
<td>25,973</td>
<td>100%</td>
</tr>
<tr>
<td>International staff</td>
<td>2,029</td>
<td>8%</td>
</tr>
<tr>
<td>National staff</td>
<td>23,944</td>
<td>92%</td>
</tr>
</tbody>
</table>