



ACTIVITY REPORT 2011



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THE MÉDECINS SANS FRONTIÈRES CHARTER

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

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

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

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

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

The country texts in this report provide descriptive overviews of MSF's operational activities throughout the world between January and December 2011. Staffing figures represent the total full-time equivalent positions per country in 2011.

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

The place names and boundaries used in this report do not reflect any position by MSF on their legal status.

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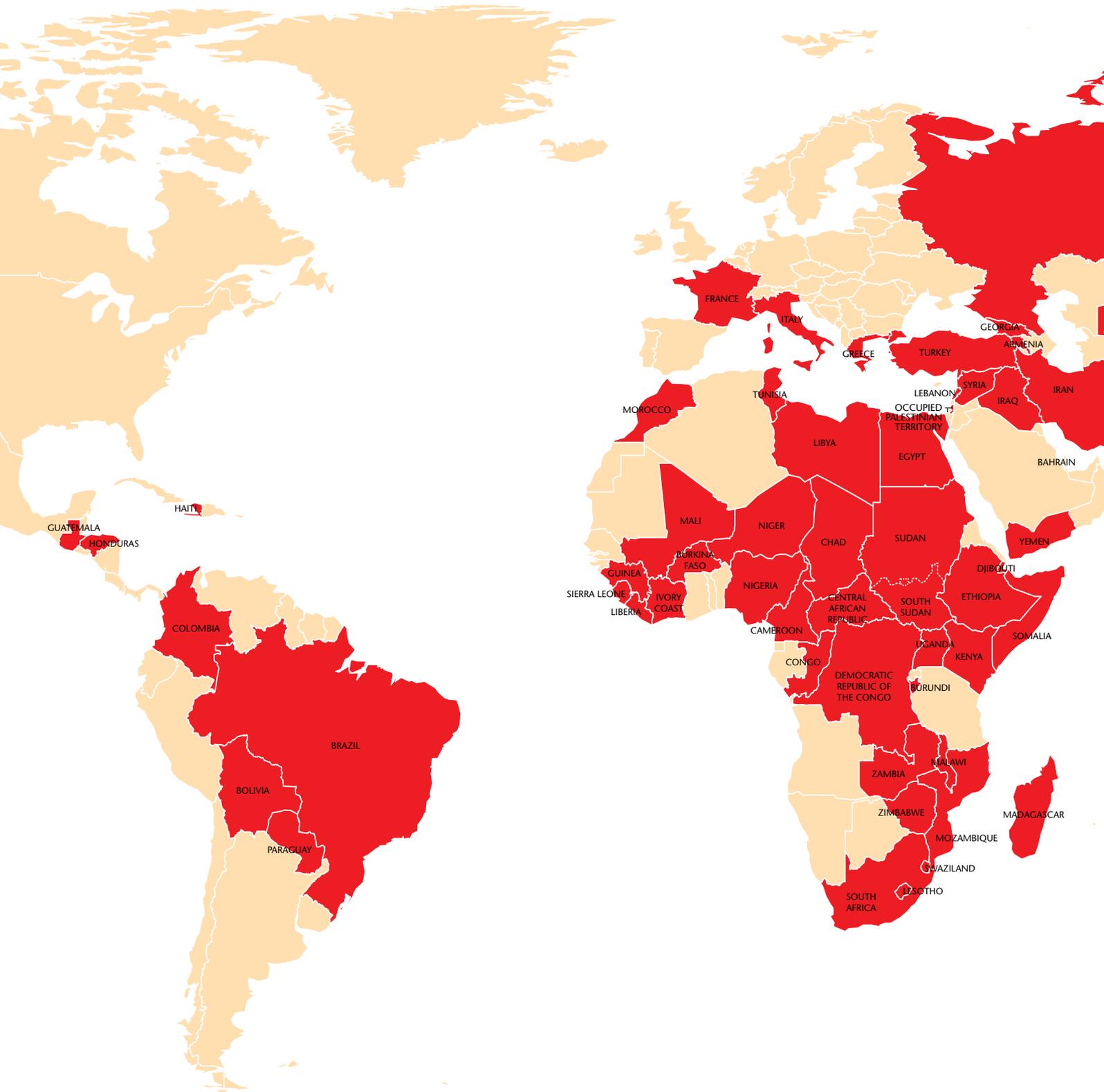


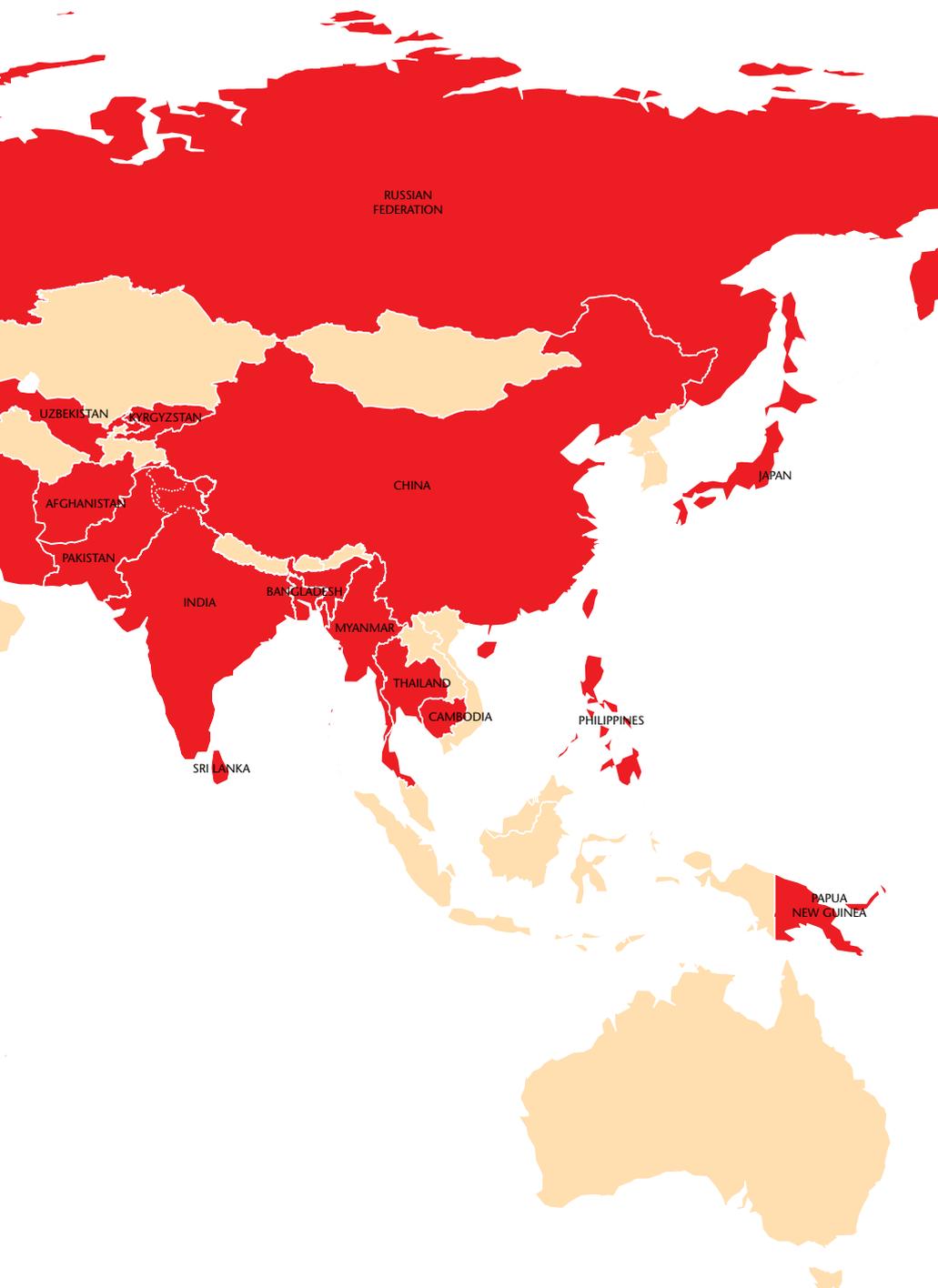
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MSF PROGRAMMES AROUND THE WORLD





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THE YEAR IN REVIEW

Dr Unni Karunakara, International President

Kris Torgeson, Secretary General

2011 was a year of multiple, complex, humanitarian emergencies, and almost all challenged our capacity to respond.

Protracted war, drought and restricted access to medical assistance or relief all contributed to a worsening of the crisis across south-central Somalia. From May to December, Médecins Sans Frontières (MSF) treated more than 95,000 people for malnutrition and over 6,000 for measles in south-central Somalia and in refugee camps in Ethiopia and Kenya. We vaccinated almost 235,000 children against measles and held more than 450,000 consultations.

Yet we still had enormous difficulties reaching the people we suspected to be in the greatest need. For the most part, we were limited to scaling up existing operations. In many places, we were blocked from opening new programmes, while in others, insecurity prevented us from expanding. On 13 October 2011, two of our colleagues, Blanca Thiebaut and Montserrat Serra, were abducted from one of the Somali refugee camps in Dadaab, Kenya. At the very end of the year, our colleagues Philippe Havet and Dr Andrias Karel Keiluhu were both killed while working in Mogadishu. Dedicated humanitarians, Philippe and Andrias had each worked for MSF for more than a decade. (For more on the challenges of working in Somalia, see pages 16–17.)

Conflict and insecurity

When the presidential election led to full-scale military conflict in Ivory Coast, clinics and hospitals were abandoned as people fled violence. “Many of the medical facilities in the western part of the country are not functioning because health staff have not returned to work and because they lack medicine,” said Xavier Simon, MSF’s head of mission, at the time.

MSF teams provided healthcare through hospitals and fixed and mobile clinics across western Ivory Coast and in the city of Abidjan. They also brought medical assistance to Ivorian refugees in Liberia.

In the Democratic Republic of the Congo (DRC), violence and insecurity persisted throughout the year. Our medical staff tended to hundreds of thousands of people who had no other access to healthcare.

The DRC gained a new neighbour in 2011, as South Sudan achieved independence, but it too was afflicted by insecurity and an inadequate health system. MSF teams worked in seven of the country’s 10 states.

When conflict erupted in Libya, MSF supported health facilities in a number of towns with surgery, basic healthcare and psychological support. Teams also assisted some of the thousands of people who fled to Italy and Tunisia. However, it was weeks before we were able to work on both sides of the front line. In Pakistan and Afghanistan, MSF teams

continued to bring medical assistance to people caught up in violence, focusing on emergency medical care and surgery, as well as maternal and paediatric services.

New contexts

In Bahrain, MSF staff brought basic healthcare to the homes of some 200 people, who were unwilling to run the risk of seeking assistance in public health facilities. But our movements were restricted. We spoke out against the arrest of patients and staff in hospitals and clinics, and called on the Bahraini authorities to respect their obligations regarding the provision of healthcare to the sick and injured.

The situation in Bahrain represented a new kind of context for our work: emergencies in middle-income, even wealthy, countries, which have good health systems. We adapted our response accordingly, providing short-term emergency assistance and filling specific gaps. In Egypt, MSF supported national health workers by donating supplies and training staff in emergency preparedness and response.



Displaced Somalis await food distribution in Mogadishu.

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A patient receives treatment for a gunshot wound at Dungu hospital, Democratic Republic of the Congo.

Responding to natural disasters

An earthquake and tsunami wreaked havoc in northeastern Japan in March. Again, MSF adapted its response to a new context. "The set-up with these very flexible mobile teams is responding to the needs", said Eric Ouannes, general director of MSF Japan. "Most urgent needs are covered... there are some gaps, and we are here to try to fill those gaps". Our teams targeted their support, helping to build a temporary clinic, conducting medical consultations and providing counselling.

In Latin America, MSF brought assistance to people displaced by flooding in Brazil, Guatemala and Honduras, donating relief supplies and operating mobile clinics. We also supplied aid in southeast Asia, after a typhoon in the Philippines and floods in Thailand. When Van province in Turkey was hit by earthquakes, we offered relief and mental healthcare.

Neglected needs, protracted crises

MSF responded to many emergencies, but also continued to work in places where people endure situations of chronic crisis.

In both Haiti and South Sudan, MSF is responding to a pressing need for specialist

healthcare by investing in hospitals, in order to improve access to surgical care and other lifesaving secondary health services.

Basic healthcare still remains a priority. In the Central African Republic, we are supporting nine hospitals as well as 36 health centres. But both government and donor funding for health in the country is declining, although studies in 2011 revealed excess mortality rates in the town of Carnot – which has not suffered any particular crisis – to be three times the emergency threshold.

The high rates of mortality in the Central African Republic are caused by a high prevalence of diseases that can be prevented, and treated. Indeed, globally, outbreaks of some of the more common, treatable, infectious diseases, like measles and cholera, are increasing. However, our approaches to prevention and treatment have changed little in decades. MSF vaccinated over five million people against measles in 2011, and treated nearly 139,000 for cholera. But our response is inadequate: three million measles vaccinations in the Democratic Republic of the Congo could not prevent 129,000 people falling ill, and 1,500 dying.

We are advocating for a system that effectively anticipates and prevents outbreaks, and for improved treatment options, in order to be able to provide effective, good-quality care.

Assuring quality

Our standards of care reflect the respect in which we hold our patients, but assuring these standards can be a challenge.

In Paraguay, our team temporarily had to stop screening for Chagas disease, as production of the drug used to treat it was halted. Chagas disease affects some 14 million people and kills 50,000 every year. Yet only one company, based in Brazil, produces benznidazole, the most commonly used medicine for Chagas. An international outcry prompted the Brazilian Ministry of Health to ensure production restarted. However, at the end of the year, there were still interruptions in supply.

As governments raise more regulatory barriers to imports, and ministries of health or other organisations frequently have their own sources of supply, quality assurance is becoming more of an issue in relation to the medicines we use. The increased risk was brought home to us



Surgical consultation at Ben Ashour clinic, Tripoli, Libya.

when falsified antiretroviral (ARV) drugs, which had been purchased from one of the most reputable distributors in Kenya, one of the most highly regulated countries in East Africa, were found at an MSF clinic. MSF introduced a drug quality assurance system in 2002, but cooperation at a global level, with governments and other medical organisations, is required if we are to ensure that patients receive the quality medicines they need.

Progress in jeopardy

We also need the unprecedented international solidarity, which has resulted in improved treatment for millions of HIV, malaria and tuberculosis (TB) patients, to continue. With adequate funding, we can halt the spread of these diseases. But funding is declining. Just as we are poised to win the battle against some of the biggest problems in global health, obstacles are being thrown in our way. Safeguards in India's patent law, which permit the production of affordable generic medicines, which in turn have enabled India to become the supplier of 80 per cent of ARV drugs, are being challenged in the courts. In addition,

the EU is trying to negotiate a free trade agreement that protects intellectual property at the expense of public health.

An alternative means of producing adapted, affordable medicines – voluntary licensing – is not proving to be the breakthrough we had hoped for. The first pharmaceutical company has joined the Medicines Patent Pool for ARV drugs, but so far every licence granting the right to produce generic medicines includes restrictions that prevent prices from being pushed as low as they could be. (For more on HIV care in 2011, see pages 22–24.)

Forty years of medical assistance

2011 saw the closure of our longest-running mission: MSF left Thailand after 35 years in the country, as our team was unable to provide medical assistance to the undocumented migrants who needed it most. Since 1976, our programmes in Thailand have been the scene of innovations and developments that have improved our emergency response worldwide (see pages 18–21).

2011 was also MSF's 40th anniversary. Over the past four decades, MSF has

grown to include some 30,000 people working in more than 60 countries. At our International General Assembly in December, we welcomed four new associations to our Movement: MSF Brazil, MSF East Africa, MSF Latin America and MSF South Africa. MSF now numbers 23 associations worldwide. Expansion has made us change the way we work. We have reformed our governance structure in order to improve our decision-making.

Our intention is to make sure that MSF remains both true to its founding principles and fit to respond to the humanitarian emergencies of the 21st century. The core values of humanitarianism, independence, neutrality and impartiality, first affirmed in 1971, continue to drive and inspire us to work for what ultimately matters: being there in the field, reaching that one person in crisis, and assisting their survival.

Thank you.

© Niklas Bergstrand



Consultation at the inpatient feeding centre in Dera Murad Jamali district headquarter hospital, eastern Balochistan, Pakistan.

OVERVIEW OF OPERATIONS

Largest country programmes based on project expenditure

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

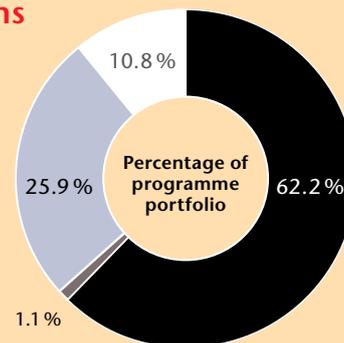
The total budget for our programmes in these 10 countries is 329 million euros, **54 per cent** of MSF's operational budget.

Programme locations

Number of Programmes

| | |
|------------|-----|
| ■ Africa | 271 |
| ■ Europe | 5 |
| ■ Asia* | 113 |
| ■ Americas | 47 |

*Asia includes the Middle East and the Caucasus



Staff numbers

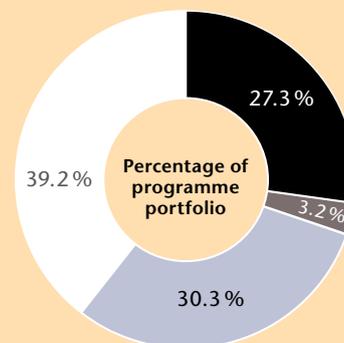
Largest country programmes based on the number of MSF staff in the field. Staff numbers measured in full-time equivalent units.

| | |
|-------------------------------------|-------|
| 1. Haiti | 3,872 |
| 2. Democratic Republic of the Congo | 2,919 |
| 3. South Sudan | 2,169 |
| 4. Somalia | 1,729 |
| 5. Niger | 1,705 |

Context of interventions

Number of programmes

| | |
|------------------------|-----|
| ■ Armed conflict | 119 |
| ■ Post-conflict | 14 |
| ■ Internal instability | 132 |
| ■ Stable | 171 |



Outpatient consultations

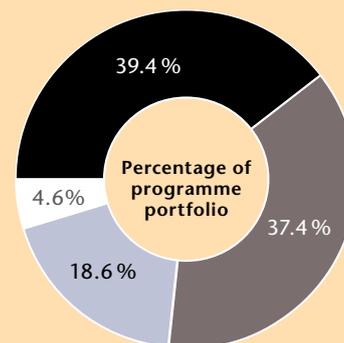
Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.

| | |
|-------------------------------------|-----------|
| 1. Democratic Republic of the Congo | 1,346,245 |
| 2. Myanmar | 669,948 |
| 3. Central African Republic | 557,947 |
| 4. Somalia | 551,321 |
| 5. Ivory Coast | 531,298 |

Event triggering intervention

Number of programmes

| | |
|--------------------|-----|
| ■ Armed conflict | 172 |
| ■ Epidemic | 163 |
| ■ Health exclusion | 81 |
| ■ Natural disaster | 20 |



2011 activity highlights

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

| Activity | Definition | Total |
|---|---|-----------|
| Outpatient | Number of outpatient consultations | 8,300,000 |
| Inpatient | Number of admitted patients | 445,000 |
| Malaria | Malaria: total number of cases treated | 1,422,800 |
| Therapeutic feeding centres | Number of severely malnourished children admitted to inpatient or outpatient feeding programmes | 348,000 |
| Supplementary feeding centres | Number of moderately malnourished children admitted to supplementary feeding centres | 60,000 |
| HIV | Number of HIV patients registered under care at end 2011 | 228,700 |
| Antiretroviral treatment (first-line) | Number of patients on first-line antiretroviral treatment at end 2011 | 201,600 |
| Antiretroviral treatment (second-line) | Number of patients on second-line antiretroviral treatment at end 2011 (first-line treatment failure) | 3,200 |
| PMTCT – mother | Number of HIV-positive pregnant women who received prevention of mother-to-child transmission (PMTCT) treatment | 10,500 |
| PMTCT – baby | Number of eligible babies born in 2011 who received post-exposure treatment | 10,100 |
| Deliveries | Number of women who delivered babies, including by caesarean section | 192,000 |
| Surgical procedures | Number of major surgical procedures, including obstetric surgery, under general or spinal anaesthesia | 73,100 |
| Violent trauma | Number of medical and surgical interventions in response to direct violence | 54,300 |
| Sexual violence | Number of patients medically treated for sexual violence | 14,900 |
| Tuberculosis (first-line) | Number of new admissions to tuberculosis first-line treatment | 30,700 |
| Tuberculosis (second-line) | Number of new admissions to tuberculosis treatment, second-line drugs | 1,060 |
| Mental health (individual) | Number of individual mental health consultations | 169,700 |
| Mental health (group) | Number of group counselling or mental health sessions | 19,200 |
| Cholera | Number of people admitted to cholera treatment centres or treated with oral rehydration solution | 130,800 |
| Measles vaccinations | Number of people vaccinated against measles in response to an outbreak | 5,034,000 |
| Measles treatment | Number of people treated for measles | 126,500 |
| Meningitis vaccinations | Number of people vaccinated against meningitis in response to an outbreak | 952,600 |
| Meningitis treatment | Number of people treated for meningitis | 5,900 |

GLOSSARY OF DISEASES AND ACTIVITIES

Chagas disease

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

Diagnosis is complicated, requiring laboratory analysis of blood samples. There are currently only two medicines available to treat the disease: benznidazole and nifurtimox, which were both developed over 35 years ago. The cure rate is almost 100 per cent in newborns and infants, but as the gap between the date of infection and the beginning of treatment lengthens, the cure rate declines.

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

MSF admitted 2,500 new patients to Chagas treatment programmes in 2011.

Cholera

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

water or food, or direct contact with contaminated faeces. Large outbreaks can occur suddenly and the infection can spread rapidly. Most people will suffer only a mild infection, but the illness can be very severe, causing profuse watery diarrhoea and vomiting that can lead to severe dehydration and death. Treatment consists of a rehydration solution – administered orally or intravenously – which replaces fluids and salts.

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

MSF treated 130,800 people for cholera in 2011.

Health promotion

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

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

HIV/AIDS

The human immunodeficiency virus (HIV) is transmitted through blood and body fluids and gradually breaks down the immune system

– usually over a three- to ten-year period – leading to acquired immunodeficiency syndrome, or AIDS. As the virus progresses, people begin to suffer from opportunistic infections. The most common opportunistic infection that leads to death is tuberculosis.

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

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

MSF provided care for 228,700 people living with HIV/AIDS, and antiretroviral treatment for 205,000 people in 2011.

Kala azar (visceral leishmaniasis)

Largely unknown in wealthy countries, kala azar – Hindi for 'black fever' – is a tropical, parasitic disease transmitted through bites from certain types of sand fly. It is endemic in 76 countries, and of the estimated 250,000–300,000 annual cases, 90 per cent occur in Bangladesh, India, Nepal, South Sudan, Sudan and Brazil. Kala azar is characterised by fever, weight loss, enlargement of the liver and spleen, anaemia and immune-system deficiencies. Without treatment, kala azar is almost always fatal.



A lab technician carries out blood tests at MSF's programme in Abdurafi, Ethiopia.

© Michael Tsegaye

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

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

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

MSF registered 7,600 new patients for kala azar treatment in 2011.

Malaria

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

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

MSF treated 1,422,800 people for malaria in 2011.

Malnutrition

A lack of essential nutrients causes malnutrition: growth will falter and a child's susceptibility to common diseases increases.

The critical age for malnutrition is from six months – when mothers generally start supplementing breast milk – to 24 months. However, children under five, adolescents, pregnant or breastfeeding women, the elderly and the chronically ill are also vulnerable.

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

MSF uses ready-to-use food (RUF) to treat malnutrition. RUF contains fortified milk powder and delivers all the nutrients that a malnourished child needs to reverse deficiencies and gain weight. With a long shelf-life and requiring no preparation, these nutritional products can be used in all kinds of settings and allow patients to be treated at home, unless they are suffering severe complications. In situations where malnutrition is likely to become severe, MSF takes a preventive approach, distributing nutritional supplements to at-risk children to prevent their condition from further deteriorating.

MSF admitted 348,000 malnourished patients to nutrition programmes in 2011.

Measles

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

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

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

MSF treated 126,500 people for measles and vaccinated more than 5,000,000 people in 2011.

Meningococcal meningitis

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

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

Meningitis occurs throughout the world, but the majority of infections and deaths are in Africa, particularly across the 'meningitis belt', an east-west geographical strip from Ethiopia to Senegal, where epidemics are most likely to be caused by meningitis A. A new vaccine against this strain provides protection for 10 years and even prevents healthy carriers from transmitting the infection. Preventive vaccination campaigns

have now been implemented in Burkina Faso, Mali and Niger and are planned to cover the entire meningitis belt.

MSF treated 5,900 patients for meningitis and vaccinated 952,600 people against the disease in 2011.

Mental healthcare

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

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

MSF staff held 189,000 individual and group counselling sessions in 2011.

Relief items distribution

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

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

MSF distributed 225,500 relief kits in 2011.

Reproductive healthcare

Comprehensive emergency obstetric and neonatal care form part of MSF's response to any emergency. Medical staff assist births and

perform caesarean sections where necessary, and sick newborns and babies with a low birth weight receive medical care.

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

Good antenatal and obstetric care can prevent obstetric fistulas. Obstetric fistulas are injuries to the birth canal, and are most often a result of prolonged, obstructed labour. They cause incontinence, which can lead to social stigma. Around two million women are estimated to have obstetric fistulas, and a number of MSF programmes carry out specialist obstetric fistula repair surgery.

MSF held more than 821,800 antenatal consultations in 2011.

Sexual violence

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

MSF treated more than 14,900 patients for sexual violence-related injuries in 2011.

Sleeping sickness (human African trypanosomiasis)

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

The other 10 per cent of cases are caused by *Trypanosoma brucei rhodesiense*, which is found in eastern and southern Africa.

During the first stage, the disease is relatively easy to treat but difficult to diagnose, as symptoms such as fever and weakness are non-specific. The second stage begins when the parasite invades the central nervous

system and the infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, convulsions and sleep disturbance. At this stage, accurate diagnosis of the illness requires a sample of spinal fluid.

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

MSF admitted 1,400 new patients for sleeping sickness treatment in 2011.

Tuberculosis

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

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

Diagnosis of TB depends on a phlegm sample, which can be difficult to obtain from children. There is a new molecular test that can give results after just two hours, and detect a certain level of drug resistance, but it is costly, depends on a reliable power supply, and still requires a phlegm sample.

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

MSF treated 30,700 people for tuberculosis, and 1,060 for MDR-TB, in 2011.

Vaccinations

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

In countries where vaccination coverage is generally low, MSF strives to offer routine vaccinations for all children under five as part of its basic healthcare programme. Vaccination also forms a key part of MSF's response to outbreaks of measles, yellow fever or meningitis. Large-scale vaccination campaigns involve awareness-raising activities regarding the benefits of immunisation and the set-up of vaccination posts in places

where a community is likely to gather. A typical campaign lasts between two and three weeks and can reach hundreds of thousands of people.

Water and sanitation

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

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

In 2011, MSF distributed more than 96,000,000 litres of safe water.



A health worker prepares medication to treat drug-resistant tuberculosis.

HUMANITARIAN ACTION: AT ANY PRICE?

Between 2004 and 2011, thirteen Médecins Sans Frontières (MSF) staff members were killed in the course of their work in Afghanistan, the Central African Republic, Pakistan and Somalia.

In 2008 and 2009, several sections of MSF had to leave Niger and the north of Sudan because the authorities had either suspended their activities or issued them with a deportation order. In 2009, under threat of expulsion from Sri Lanka, MSF signed a Memorandum of Understanding obliging it to remain silent in an – ultimately unsuccessful – attempt to gain access to combat zones. In 2010 in Yemen, MSF withdrew public statements that the government deemed inaccurate and insulting in order to keep its activities running.

Since the 1990s, the revival of western military interventionism, the development of international criminal justice and the integration of aid and politics in the United Nations have all contributed to a blurring of distinctions between what is military and political, and what is humanitarian. Over recent years, MSF has been vehemently denouncing the harm caused by this blurring of lines.

Yet there are no legitimate perimeters to humanitarian action. There is no clearly defined legal and moral ‘humanitarian space’ that, if proclaimed, will automatically be acknowledged and respected, allowing humanitarian organisations to go about their work of assistance and relief. What there is, however, is a space for negotiation.

Making humanitarian space

MSF seeks to provide impartial assistance to victims of conflict or natural disasters, to respond to neglected public health problems, and to care for people excluded from healthcare. In many cases, MSF is seeking to alleviate suffering that has been decreed – or is at the very least tolerated – by the established order.

MSF’s ambitions therefore come up against a range of interests: perhaps an armed group using humanitarian aid as a means of legitimacy, or states seeking to isolate a regime, or forces

who do not make any distinction between combatants and non-combatants. Authorities may be more concerned about the political consequences of an epidemic than its effects on health, or they may want health workers to help them manage a discriminatory health system.

The space for humanitarian action must be carved by negotiation with these other interests, by repeated transactions with local and international political and military forces. The scope of the space will depend largely on the organisation’s objectives, the diplomatic and political support it can garner, and the interest taken in its activities by those in power.

An acceptable compromise?

Acknowledging that humanitarian aid is only possible when it coincides with the interests of political powers does not mean that MSF has to give way to political forces. But how can it avoid doing so? How can MSF ensure that its negotiations will result in an agreement it can live with? How do we judge whether a compromise is acceptable?

From past experience, we know that everything is open to negotiation – the safety of staff, the



In Myanmar, MSF is treating some 23,000 patients for HIV.



Negotiations in Angola, 1999.

activities undertaken, the quality of assistance, control over resources – and we can draw on this experience to work out how to negotiate an acceptable outcome.

Judging for ourselves

A key objective for MSF is to keep a distance from “that blurry, but very real, line beyond which assistance for victims imperceptibly turns into support for their tormentors”.¹

That line is never clear. In Sri Lanka, when desperately trying to gain access to people caught up in fighting in Northern province, it was very difficult for MSF to be confident about its decisions. MSF had been a powerless witness to the brutal all-out offensive launched by the government against the Tamil rebellion, which killed tens of thousands of people who had been used by the insurgents as human shields. When MSF was finally authorised to set up a hospital outside the camps where the government had placed survivors of the offensive, it had legitimate doubts about the proposal. Staff had only an approximate idea of the health situation of the displaced, since the government was not allowing non-governmental organisations to conduct independent epidemiological surveys. How could MSF be sure that it was treating the people most in need of medical attention, if it had no control over who came from the camps? MSF asked many such questions as it became the regime’s de facto public health auxiliary.

In Myanmar, MSF also accepted restrictions: on where it could work, on its international

staff’s access to patients and on its freedom of expression. But it achieved results. MSF’s HIV programme has saved the lives of more than 23,000 people in Myanmar.

It is important for MSF to be able to judge for itself, and to justify the compromises it makes according to its own principles. Its justification must be based in an ethics of action founded on a principle of medical effectiveness, and its refusal to collude with policies of domination. If, by its actions in a given context, MSF cannot hope “to reduce the number of deaths, the suffering, and the frequency of incapacitating handicaps within groups of people who are usually poorly served by public health systems”,² then the compromises it agrees to are neither justifiable nor acceptable.

Seizing the moment

The crux of the matter is not so much achieving total freedom of action – only in exceptional and temporary circumstances does MSF ever have total freedom – but rather being able to choose alliances in accordance with its own objectives, with no concern for allegiances or loyalty to any particular party or faction. In this respect, MSF is an unreliable and unfaithful partner. It justifies this by the need to identify auspicious openings in the political space and seize opportunities.

MSF left Afghanistan in 2004, when five members of staff were assassinated, cruelly driving home the fact that, despite having worked in the country for 20 years, MSF could no longer secure respect for a

humanitarian exception in the country. The context had changed, and MSF was increasingly at odds with the agendas of the main political parties, military factions and aid organisations on the scene.

Five years later, however, MSF returned. The situation was no less polarised, and it was without doubt far more violent. The key change for MSF was that medical activities in conflict areas were being seen by the competing warring parties as contributing, in varying degrees, to their claims to legitimacy. MSF was able to return to Afghanistan by playing along with these changing perceptions, demonstrating that its medical assistance could appeal to each side.

Ultimately, rather than trying to gauge the extent of an imagined humanitarian space, it may be more pertinent – and more useful – for humanitarian workers to maintain negotiations with all parties, while evaluating the constantly evolving opportunities and risks, so they can then seize the humanitarian moment.

¹ Rony Brauman, *President’s Report*, 1987, MSF France.

² See Jean-Hervé Bradol, “Caring for Health”, *Humanitarian Negotiations Revealed*, p. 216.



This is an edited extract from Marie-Pierre Allié’s introduction to C. Magone, M. Neuman and F. Weissman (eds), *Humanitarian Negotiations Revealed: The MSF Experience*, 2011, Hurst & Co.

SOMALIA: EXTREME NEEDS, EXTREME CHOICES

Among the terms used to describe the situation in Somalia – hopeless, chaotic, miserable, disastrous – many talk of ‘donor fatigue’, another way of saying that people are tired of hearing and caring about this part of the world. However, Somalia requires that the world overcomes its short attention span; because this is a place where so many people are stripped of their humanity.



Insecurity in Somalia is such that MSF employs armed guards.

In south-central Somalia, civilians and combatants fall to wounds from bullets and bombs, and conflict has displaced hundreds of thousands of people from their homes. Malnutrition is rampant due to drought and displacement, and simple, curable diseases such as measles go untreated in the absence of any healthcare system.

How Somalia finds itself in such a situation is complex and contentious. Environmental conditions have frequently been cited as a factor, especially in the past year, when poor rainfall caused a drought, and thousands of lives were lost. While weather

patterns played a role, they were not the root cause of the 2011 emergency. Had they been, malnutrition and mortality rates would have been similar in the population of the wider region, where rains had been similarly poor. They were not.

Twenty years of conflict

The main difference in south-central Somalia is 20 years of factionalised, fragmented civil war, in which not only Somalis, but also external parties, have sought to influence the situation.

In Somalia, simple vaccination campaigns for measles, tetanus or diphtheria take

place only exceptionally, prevented by insecurity or because local authorities are hostile to such interventions, on cultural or ideological grounds. Many of the children who died in MSF's nutrition centres in Mogadishu were infected with measles.

A persistent state of war has contributed to the development of a culture of impunity and lawlessness. Kidnapping and piracy have become industries, and humanitarians are not exempt. At the time of writing, two MSF colleagues are still held captive, having been abducted from the Dadaab refugee camp in Kenya, close to the border with Somalia, in October 2011. In December, a long-time employee of MSF shot and killed two MSF colleagues in a pre-meditated act inside the MSF compound in Mogadishu.

Between a rock and a hard place

Despite these obstacles, MSF remains one of the few organisations that have been able to work across Somalia continuously over the past 20 years, and believes it has brought valuable assistance to the population. But at what cost?

Operational security in Somalia, and especially in Mogadishu, is first and foremost a balancing act, which requires juggling the allocation of the benefits and resources that a relief operation brings – such as salaries, car rental fees and procurement of local supplies – among all the clans and political, military and business interests. On top of this fragile management of local power structures, Mogadishu is also the centre of a broader conflict in Somalia, involving other powers. This, too, requires clear lines of communication with all warring parties to ensure that their military strategies do not target medical facilities.

Negotiation, communication and juggling the distribution of resources, then, are key to security. They are just as important as armed protection – the iconic image of security in Somalia.

Dangerous oversimplifications

Of course, the medical crisis in Somalia and the emergency response it requires do not occur in a political vacuum. But the current portrayal of the situation carries two dangerous oversimplifications: the first is that Al-Shabaab is solely to blame for the conflict and underlying humanitarian crisis; the second is that the response to the crisis can only occur in areas under the control of the African Union Mission in Somalia (AMISOM), the Ethiopian army, the Kenyan army or the Transitional Federal Government (TFG) and pro-TFG forces.

In such a complex and highly volatile environment, the last thing humanitarian organisations need is for politicians to suggest that aid personnel are working on their behalf. As soon as humanitarian assistance is perceived to be part of the political agenda of any side, the painstaking efforts made to reach an agreement on security risk being brought to naught. Indeed, many aid efforts in Somalia are restricted today precisely because states involved in the conflict have successfully portrayed humanitarian assistance as a part of their military policy.

To be perceived as an 'implementing partner' of one of the many parties involved in military action, or of their sponsors, because of warring parties' rhetoric, risks the closure of aid programmes. And it is the Somali people who will pay the price, as they will not get the assistance they desperately need.

Complex choices

It was only after a visit to Mogadishu in July that MSF decided to expand emergency assistance programmes in 2011. From a distance, expanding operations, and taking the risk of being seen as an agency supporting AMISOM and the TFG in creating a 'safe haven' for displaced Somalis was considered a significant political risk, and the large number of relief organisations present seemed to be able to cover people's needs. Once in the city, however, the team saw that the medical and living conditions of the new arrivals were so bad that the enormous needs outweighed the political risk.

Since that brief period of world attention in the middle of 2011, the need for humanitarian assistance has not vanished.

The people in Mogadishu, and much of the rest of Somalia, are experiencing one of the worst humanitarian crises in the world.

Complex choices remain before us. We have said a sad, final farewell to two of our workers, and our thoughts are with two others that are held against their will (at the time of writing). Somalia is still a place where we must make extreme choices if we are to provide aid for people in extreme need.

In 2011, MSF was working in 11 regions of Somalia. In many places, MSF hospital programmes represented the only specialist healthcare available. MSF provided treatment for malnutrition, measles and cholera. In total, MSF treated 864,000 patients in Somalia, nearly double the assistance provided in the previous year. For more information on activities in Somalia in 2011, see pages 92–93.



People line up for vaccinations in Mogadishu.

THAILAND

MÉDECINS SANS FRONTIÈRES CLOSES ITS LONGEST MISSION



Medical staff provide emergency care to Cambodian refugees in Sakeo camp, November 1979.

1976: Still in its infancy, Médecins Sans Frontières (MSF) brings aid to Cambodian refugees.

In October 1976, an MSF medical team arrived at the border with Cambodia, where camps had been set up to shelter Cambodians who had sought refuge when the communist Khmer Rouge forces swept into power in mid-1975. Three years later, tens of thousands of Cambodians fleeing starvation and the advancing Vietnamese army crossed into Thailand, in need of assistance.

Thailand became the setting for the development of new techniques and ideas in emergency assistance. It was in the refugee camps in the northeast of the country that MSF designed its first emergency kits and mobile hospitals.



More than 35,000 refugees are still living in Mae La camp, near the border town of Mae Sot.

MSF collaborates in the development of a new treatment for malaria.

In 1984, fighting between the Burmese military and the Karen Liberation Army drove an estimated 10,000 Karen from their villages across the border to Thailand. MSF began what was to become 20 years of assistance in the camps along the border. In Mae Sot, MSF's collaboration with the Shoklo Malaria Research Unit, of the Mahidol University of Bangkok, led to a critical medical breakthrough in the battle against malaria: the development of artemisinin-based combination therapy, which almost completely eradicated malaria from the camps.



© Stefan Plegier

A doctor examines an HIV patient receiving ARV treatment, Surin province, 2004.

In 2000, MSF offers antiretroviral (ARV) treatment to HIV patients for the very first time.

At the end of 2000, MSF offered ARV treatment in Thailand, at a time when it was rarely available in government hospitals. The following year, working closely with the Ministry of Health, MSF launched several HIV programmes across the country, and introduced ARVs in Mae La refugee camp. MSF also collaborated with Thai civil society in major disputes with pharmaceutical companies over patents, and in campaigns for the local production of generic ARVs. The consequent reduction in the cost of generic medicines enabled the national ARV programme to be extended to thousands more patients, and MSF could therefore focus on high-risk groups of people who were still excluded from treatment, such as drug users and sex workers. MSF also developed a successful model of care for prisons in Bangkok.

Tuberculosis (TB) treatment programmes for migrants and refugees show that a more inclusive policy can work.

A team in Mae La camp began treating refugees for TB in 1985. MSF later set up a TB programme for migrant workers, opening a chest clinic in Mae Sot in 1999 and then a pilot cross-border treatment programme. These projects contributed to changes in international policy towards TB.



© Espen Rasmussen

A consultation with a TB patient in Mae La refugee camp, 2007.



© Michael Heine

More than half of migrants from Myanmar have no official status in Thailand. Many work as fishermen.

MSF extends health services to migrant workers.

Thousands of migrant workers came to Thailand to seek employment in reconstruction and other sectors after the 2004 tsunami. Without documentation, migrants have very limited access to healthcare in Thailand, and they are often too scared and too poor to seek assistance. MSF's programme in the southern province of Phang Nga delivered basic health services, as well as HIV and TB treatment. At the same time, MSF lobbied the Ministry of Public Health on the need to provide all workers with access to healthcare.



© Greg Constantine

Children at the MSF clinic in Huay Nam Khao refugee camp, Phetchabun province, 2007.

Hmong refugees are excluded from healthcare and at risk of forced repatriation.

From 2005 to May 2009, MSF was the only non-governmental organisation providing medical care, water supplies and sanitation in the camp in Phetchabun, northern Thailand, where Hmong refugees from Laos were living. During this time, MSF repeatedly denounced the Thai and Lao policy of forced repatriation, calling on the UN refugee agency, UNHCR, to oversee a process to ensure the refugees' safety upon their return to Laos. In May 2009, MSF ended its activities in Phetchabun in protest at the increased restrictions imposed by the Thai military on the programme and on access to patients.



© Veronique Terrasse

A health worker carries out a consultation in Mon state, Myanmar, 2008.

Medical teams are given training and supplies so that they can work across the border in Myanmar.

Many people living in semi-autonomous Mon state in Myanmar have very limited access to medical services. Based across the border in Sangkhla Buri in Thailand, MSF provided malaria training and essential drugs to Mon medical workers, who then travelled to remote villages in Myanmar to deliver basic healthcare and diagnose and treat malaria. Drawing from this experience, an MSF team in Mae Hong Son also began training 'backpackers' to carry out similar activities in the border area.

2011: After offering emergency assistance to flood victims, MSF leaves Thailand

December 2011 marked the end of MSF's 35 years of medical assistance in Thailand. After failing to get official authorisation from the Thai government to work, MSF was forced to close its projects providing healthcare to undocumented migrants in Three Pagodas Pass and Samut Sakhon and suspend its activities with backpackers working in the border area between Myanmar and Thailand. However, a medical team responded to the floods that hit the country in October and November, distributing emergency relief and carrying out medical consultations.



© Veronique Terrasse / MSF

MSF assists people affected by flooding in central Thailand in 2011.

SCALING UP HIV TREATMENT: GETTING AHEAD OF THE WAVE OF NEW INFECTIONS

In 2000, Médecins Sans Frontières (MSF) began to provide HIV treatment to a small number of people in Thailand, South Africa and Cameroon, at a time when very few had access to treatment in developing countries. Sceptics said it couldn't be done, claiming that antiretroviral medicines were too expensive, and fragile health systems would not be able to cope.



Charles Sako, from Nairobi, Kenya, shows an image of himself in 2005, when he began antiretroviral treatment.

© Sven Torfinn

Today, MSF provides treatment to 220,000 people in 23 countries. In total, eight million people in developing countries are on treatment. While that is still less than half the number of people who need treatment, it is a testament to the huge progress made in the past decade.

In that time, MSF has learned how to reach more people with better care. Ensuring people have access to treatment early on, and before they get ill, helps people stay healthy in the long run. Providing medicines with fewer side effects makes adhering to treatment easier. Entrusting treatment to nurses working in clinics not only brings care closer to where people live, but also helps overcome medical staff shortages. Making sure people can receive HIV and tuberculosis (TB) care in one clinic, from the same health worker, at the same time, is one way to rein in the dual epidemic.

Two further ingredients have been vital to getting treatment to more people: lowering the price of drugs, and raising the funding needed to pay for them. But both are under threat.

Progress under threat

The price of HIV treatment has come down dramatically since 2000 – by close to 99 per cent. This has been possible because of competition among manufacturers of generic medicines, primarily in India, where there were no patents to block the production of more affordable versions of proprietary drugs.

But with international trade rules now forcing India to grant patents, the production of affordable versions of the newer generation of HIV medicines – which many people will need as their illness progresses – looks increasingly bleak.

MSF will continue to support efforts to keep the door open for the production of generic medicines, particularly in India, which are so crucial to keeping down the cost of treatment.

On the funding side, HIV treatment has also hit major roadblocks. Even before the global economic downturn, donors had begun to turn their back on financing global health. In late 2011, because of insufficient funds, the Global Fund to Fight AIDS, Tuberculosis and Malaria—created in 2002 as a ‘war chest’ to fight the pandemics—had to cancel a funding round for the first time ever. While the Global Fund has since announced that it is back open for business, this crisis is just part of a wider trend of cuts to health financing. Much more sustained funding will be required to begin turning the epidemic around.

Opportunity amid the challenge

Yet, while the challenges grow, the opportunities at this moment could not be more promising.

In 2011, news from the scientific community confirmed what people living with HIV had long assumed: getting people on treatment early reduces the likelihood of transmitting the virus by 96 per cent. This breakthrough has forever changed the discourse surrounding HIV/AIDS, putting an end to old debates of whether tackling

the epidemic through treatment or through prevention is the best approach. Treatment itself is a form of prevention.

In several of our programmes, MSF has been looking at ways to make use of the latest scientific findings. In South Africa, our team is piloting an innovative approach, not only scaling up treatment dramatically in order to save lives, but also using treatment as a way to reduce new HIV infections in the community. The pilot project in Uthungulu district, in KwaZulu-Natal, the province hardest hit by HIV, seeks to demonstrate the feasibility of scaling up testing, providing treatment to people in an earlier stage of the disease’s progression, and increasing uptake of prevention methods. The aim is to reduce HIV and TB-related illness, as well as to cut the number of new HIV infections.

Policy-makers seem to be recognising the opportunity to get ahead of the wave of new infections. At the United Nations in June 2011, all governments committed to ensuring 15 million people are reached with treatment by 2015 – this means nearly doubling the number who have access today. But these same governments have failed to come through with their financial commitments to turn these targets into reality.

MSF continues to focus on working in countries most affected by HIV, and in those countries that struggle the most to offer appropriate care, like the Democratic Republic of the Congo and Myanmar, where the proportion of people on treatment is abysmally low.

By documenting both the progress and the threats we see on the ground, we are pushing for renewed political commitment to HIV treatment, backed up by predictable financing of global health, and for access to the affordable medicines needed to keep people alive in the

long run. MSF is still grappling with the HIV/AIDS epidemic, and is committed to ensuring more people can get better treatment, sooner.

MSF’s Access Campaign works to help our medical teams give quality care to our patients through promoting the development of new vaccines, medicines and tests, and challenging existing barriers to treatment – such as cost – for patients in poorer countries. To learn more, visit www.msfastcess.org or follow @MSF_access on Twitter.

Grace’s story

Homa Bay, Kenya

Grace works as a peer educator at the Homa Bay clinic in Kenya: she gives health talks and assists patients before they attend consultations. Her story demonstrates the impact that scale-up of ARV treatment can have.

In 2003, after falling pregnant, Grace decided to take an HIV test. She tested positive:

“I was given PMTCT [prevention of mother-to-child transmission of HIV], and I was very happy to give birth to a healthy child. She is now seven-and-a-half, and healthy and active. She is in class two at school and doing very well.

“I have six children. Three of them are HIV positive and are receiving care. And I have six grandchildren. I encouraged their mothers to use the PMTCT services and only one is HIV-positive.

“Even though they are on treatment, you wouldn’t suspect that my children were sick. They are healthy and active and can do their work. I too live a normal life. I am happy that I can see my grandchildren.”

KEEPING HIV MEDICINES AFFORDABLE

More than 80 per cent of the medicines used by MSF to treat HIV are Indian generics, and MSF relies on producers in India for drugs to treat other diseases and conditions as well. India is the ‘pharmacy of the developing world’: millions of people rely on affordable, quality generics produced in India to stay alive.

But the source of affordable medicines is under threat of drying up. Patent protection in India already means that generic versions of newer HIV medicines will be blocked from production, and we cannot expect to see any dramatic price drops unless urgent action is taken

to overcome barriers. India’s patent law has pro-health flexibilities to limit some of the negative impact, but even this is under attack. As we write, the European Union is pursuing a free trade agreement with India that could further harm generic production, and large pharmaceutical companies like Novartis are attacking the pro-health measures in India’s patent laws through the courts.

The struggle for lifelong access to affordable medicines will continue, and MSF will be at the forefront of this effort to ensure people in our projects and beyond have the medicines they need to stay alive.

CARE IN THE COMMUNITY

“I was here in 2001, when we were first starting patients on ARVs, and the ones that were coming were very sick, most were in wheelchairs. But today most of our patients look well, and most walk to the clinic.”



© Sven Torfinn

Charles Sako, an HIV patient in Kenya, takes a dose of ARV treatment.

Nicholas Oucho is a clinical officer with MSF at Homa Bay district hospital, in Kenya. Between appointments, he talks about the positive impact MSF’s HIV programme has had on the lives of people living here, on the shores of Lake Victoria, in western Kenya.

More than 10,000 patients now regularly make their way up the hill to MSF’s HIV clinic. As Oucho says, “The programme has done a lot to help the lives of patients. But we need to build capacity and improve the quality of care in local sites. By building capacity, we will encourage patients to go to the facility nearest them.”

It is estimated that anywhere between 13,000 and 29,000 people living in Homa Bay and neighbouring Ndhwa district are not accessing the care they need. From the hills above Homa Bay, one of the obstacles to access becomes clear – houses sprawl across the countryside, and it is hard to see where one village ends and another begins. This is a rural, but densely populated region, and the distance to the nearest HIV clinic can be prohibitive. Many do not get to a clinic until they are already very ill, prejudicing their chances of survival.

BRINGING TREATMENT CLOSER TO PEOPLE

The Kenyan government has set a national objective for 80 per cent of HIV patients to be able to access treatment at their nearest medical facility. An MSF team supports HIV services in eight health centres in the area with regular visits.



© Julie Diamond / MSF

MSF clinicians who work at Homa Bay hospital also support local health centres.

The team provides mentoring to the permanent staff, offers counselling to patients and traces patients who have missed appointments.

MSF has decided to focus more on building the capacity of these local sites. “We want to try and make each centre independent of the main hospital,” says Catherine Moody, MSF head of mission in Kenya.

By investing in staff, laboratory services and counselling, MSF hopes to support the provision of quality care, get more people onto treatment, and improve patients’ adherence to treatment throughout the two districts. These kinds of strategies, and others, such as community drug distribution programmes, offer the possibility of meeting the medical need and allowing us to expand treatment, not only saving the lives of those individuals already infected with HIV, but also, as we now know, preventing the virus from spreading – effectively offering protection from HIV to the whole community.



© P.K. Lee

Consultation at a mobile clinic in a displaced persons' camp in Sindh province, Pakistan.

ACTIVITIES BY COUNTRY

| | | | | | | | | | |
|----|-----------------------------|----|--|----|------------|----|--------------------------------------|-----|------------|
| 26 | AFGHANISTAN | 44 | DEMOCRATIC REPUBLIC OF THE CONGO | 64 | ITALY | 85 | OCCUPIED PALESTINIAN TERRITORY | 100 | SYRIA |
| 28 | ARMENIA | 46 | DJIBOUTI | 65 | JAPAN | 86 | PAKISTAN | 101 | THAILAND |
| 29 | BAHRAIN | 47 | EGYPT | 66 | KENYA | 87 | PAPUA NEW GUINEA | 102 | TUNISIA |
| 30 | BANGLADESH | 48 | ETHIOPIA | 68 | KYRGYZSTAN | 88 | PARAGUAY | 103 | TURKEY |
| 31 | BOLIVIA | 50 | FRANCE | 69 | LEBANON | 89 | PHILIPPINES | 104 | UGANDA |
| 32 | BRAZIL | 51 | GEORGIA | 70 | LESOTHO | 90 | RUSSIAN FEDERATION | 105 | UZBEKISTAN |
| 33 | BURKINA FASO | 52 | GREECE | 71 | LIBERIA | 91 | SIERRA LEONE | 106 | YEMEN |
| 34 | BURUNDI | 53 | GUATEMALA | 72 | LIBYA | 92 | SOMALIA | 108 | ZIMBABWE |
| 35 | CAMBODIA | 54 | GUINEA | 74 | MADAGASCAR | 94 | SOUTH AFRICA | 110 | ZAMBIA |
| 36 | CAMEROON | 55 | HONDURAS | 75 | MALAWI | 95 | SRI LANKA | | |
| 37 | CENTRAL AFRICAN REPUBLIC | 56 | HAITI | 76 | MALI | 96 | SOUTH SUDAN | | |
| 38 | CHAD | 58 | INDIA | 77 | MOROCCO | 98 | SUDAN | | |
| 40 | CHINA | 60 | IRAN | 78 | MOZAMBIQUE | 99 | SWAZILAND | | |
| 41 | CONGO | 61 | IRAQ | 80 | MYANMAR | | | | |
| 42 | COLOMBIA | 62 | IVORY COAST | 82 | NIGERIA | | | | |
| | | | | 84 | NIGER | | | | |

AFGHANISTAN

Decades of conflict in Afghanistan have taken a huge toll on the quality of medical services available, and Afghans' ability to access them.

Many people face long and dangerous journeys to reach hospitals. Private clinics are often the only option, but they are expensive, unaffordable for much of the population, and the quality of care is not guaranteed.

In 2011, Médecins Sans Frontières (MSF) significantly expanded its activities. A new hospital opened in Kunduz, providing lifesaving surgical care to the people of northern Afghanistan, and a new maternity hospital in Khost is due to open in early 2012.

Ahmad Shah Baba, Kabul

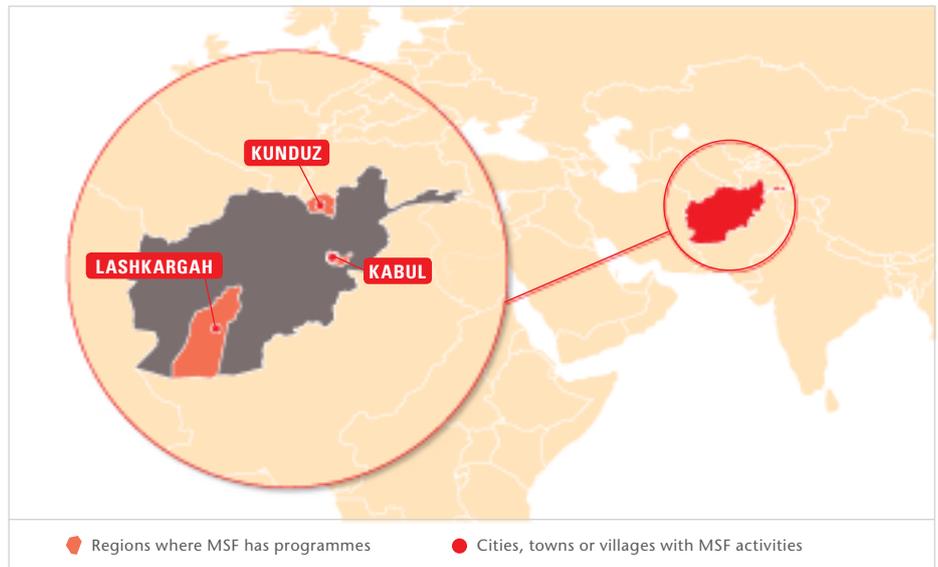
The number of people living in Kabul has tripled over the past decade, with tens of thousands of displaced people fleeing more insecure areas of the country, and refugees returning from Pakistan. This has put a severe strain on health services. Ahmad Shah Baba, in eastern Kabul, has a growing population of between 200,000 and 300,000 inhabitants. MSF started working in Ahmad Shah Baba district hospital in 2009.

MSF staff work in all departments of the hospital. Their focus has been to improve the quality of, and access to, free medical care, with a particular emphasis on maternity and emergency services. MSF donates medicines and equipment to the hospital. In 2011, new women's and paediatric outpatient departments were built. Some 550 babies are now born at the hospital every month, compared with 330 in 2010, while the outpatient department sees an average of 9,000 patients per month.

Helmand

Helmand continues to be one of Afghanistan's most volatile provinces, and its one million inhabitants are among those most affected by conflict. MSF started working in Boost hospital, in Helmand's capital Lashkargah, in 2009. It is one of only two functioning referral hospitals in southern Afghanistan.

The team at Boost has improved the provision of medical care across the various departments, including maternity, paediatrics, internal medicine, surgery and emergencies. By the end of 2011, the hospital was equipped with 180 beds and



admitted an average of 1,500 patients per month – ten times the monthly figure of 120–160 in 2009.

In 2011, MSF opened a new outpatient service, which now sees over 6,000 patients every month, many of whom have travelled from areas far outside Lashkargah. An extension to the hospital, allowing for more beds in the paediatric department, was also completed during the year. Malnutrition continues to be a chronic problem in Helmand, in particular among children, and MSF has set up a therapeutic feeding centre to provide specialised care.

Kunduz

In August, MSF opened a new surgical hospital in the northern province of Kunduz. This is the only hospital of its kind in northern Afghanistan. The staff provide surgical care for victims of conflict as well as patients with injuries from other causes. Before the hospital opened, the main option for treatment was a long, expensive journey across the border.

The hospital has 58 beds, which will be increased to 70 during 2012. It is equipped with an emergency department, two operating theatres and an intensive care unit, as well as X-ray and laboratory facilities.



A doctor tends to a malnourished child in Boost hospital, Lashkargah, Helmand province.

© MSF



© Peter Casner

Women collect prescriptions from the dispensary of the outpatient service at Boost hospital, Lashkargah, Helmand province.

There are separate surgical wards for male and female patients. A full-time physiotherapist follows up patients and helps with their rehabilitation after surgery. Staff at the hospital are trained and equipped to respond quickly to serious incidents involving several severely injured patients.

Since it opened, an average of 350 patients have come to Kunduz hospital every month. Most are from Kunduz, but as word has spread, MSF has also seen patients from neighbouring provinces, even from close to the Iranian border.

Khost

The conflict's impact on the country's healthcare services has given rise to some of the highest maternal and child mortality rates in the world. The availability of decent and free maternal healthcare is very limited, and most women still give birth without assistance in unhealthy and dangerous conditions. In March 2012, MSF will open a maternity hospital in Khost province, eastern Afghanistan. The 56-bed hospital will provide quality ante- and postnatal care to women in the region, and will be equipped with an operating theatre for surgery during complicated births.

Afghan family Boost hospital, Lashkargah

Reda*:

"I live with my sons, their wives and children. We all live together in the same house. All morning we could hear bullets flying past really close to the house. Suddenly the shooting stopped and there was complete silence. The women stayed inside, and the men and children started to move outside."

Abdul*:

"I was sitting on the window sill outside, and my father was lying down. My little nephew, Zabiullah, was sitting next to me. I only saw an aeroplane flying over and then suddenly, this thing – they call it hawan here – exploded in our garden in front of us. I remember seeing a piece of shell fly into Zabi's head. He died instantly."

Reda:

"Three of my grandchildren were killed: two boys, five and six years old, and one girl, Haifa, who was 11. The mothers were safe because they stayed inside. Nine other members of the family were wounded."

Abdul:

"We heard that our house wasn't totally destroyed, but we haven't been back yet. Every day people tell us there's shooting, more trouble in our village. We can't go back but we can't stay here in Boost hospital for ever either."

Ali*:

"Landmines and fighting control our lives. My brother wasn't able to take his son to the doctor that day because of landmines; they had to come back home. Then they were both killed at home."

**All the patients' names have been changed.*

At the end of 2011, MSF had 496 staff in Afghanistan. MSF first worked in the country in 1980.

ARMENIA



In Armenia, Médecins Sans Frontières (MSF) is supporting the treatment of patients suffering from drug-resistant tuberculosis (DR-TB).

DR-TB can be caught from someone already suffering from the disease, or it can develop when a patient with drug-sensitive TB becomes resistant to medication, which can happen if their treatment regime is disrupted.

MSF began working with Armenian authorities to improve the detection, diagnosis and treatment of DR-TB in 2005. Supporting people who have fallen through gaps in the national programme – often those with social or psychological difficulties that may put them

at risk of stopping treatment – is a key part of MSF's activities.

In 2011, MSF expanded its programme for children with DR-TB, and helped improve facilities at several medical laboratories. At the end of the year, 290 patients were undergoing treatment for DR-TB in Armenia.

Treatment challenges

A patient with drug-sensitive TB has to take medication daily for between six and nine months, while a complete course of treatment for drug-resistant TB can take up to two years, is much more costly, and is not always readily available.

Patients are usually admitted to hospital at first, where they are closely monitored, and even when they return home they must continue a gruelling treatment regime. Many of the drugs are toxic and side effects can include headaches, vomiting and dizziness. For some patients, the treatment is unbearable.

MSF uses a range of methods to help patients cope with side effects and to encourage adherence to treatment. In addition to regular check-ups with medical staff, counsellors offer support in individual or group sessions. Staff also make home visits to patients and provide food if necessary.

Shortages affecting care

Regular staff shortages in the national TB programme, in particular a lack of nurses, prompted MSF to allocate more staff to patient care and counselling in 2011.

Then, in July, a global shortage of one of the key DR-TB drugs, capreomycin, resulted in an increase in the number of people put on waiting lists for treatment. MSF introduced specific counselling sessions for patients who had been on waiting lists for more than one month to explain why they couldn't get treatment, offer advice on infection control measures and provide basic TB education.

Widening scope

In 2010, MSF began collaborating with the national tuberculosis programme in the northern provinces of Armenia, and this initiative was expanded in 2011. The aim is to enable geographically isolated patients in the rural areas of Kotayk, Ararat and Lori to complete their treatment at home, with the support of local clinics. MSF increased cooperation with national partners during 2011, including the further handover of home-based care activities to the Armenian Red Cross.

At the end of 2011, MSF had 85 staff in Armenia. MSF has been working in the country since 1988.



A patient with drug-resistant tuberculosis receives a home visit.

BAHRAIN



Staff at Salmaniya hospital wait for the arrival of people injured during riots.



Protests began on 14 February 2011 in Bahrain. Within two days, a Médecins Sans Frontières (MSF) team was in the country to conduct an assessment of medical needs.

In March, MSF was invited to give training to about 40 health professionals from both the public and private sectors on managing care for large numbers of injured people.

Good-quality healthcare is available in Bahrain, but MSF noted at that time that access to services was hampered. Health facilities and personnel had been drawn

into the centre of the conflict. In its report, *Health Services Paralysed by Bahrain's Military Crackdown on Patients*, published in April, MSF raised concerns about the loss of neutrality of Bahrain's medical facilities, and the related deprivation of care for numerous sick and wounded people.

While engaging with the government and awaiting a response to its proposal to assist, MSF continued to provide basic first aid to the sick and injured. Between March and July, staff brought assistance to almost 200 patients who did not seek care in public health facilities because they feared being arrested for involvement in the protests or affiliation with protesters. In July, MSF's premises in Bahrain were raided, and a local staff member was arrested and detained. He was released in early August.

Since then, MSF has been pursuing negotiations with the authorities to register formally in the country. MSF has proposed the set-up of mental health activities for health workers and people in distress, and offered to support emergency preparedness at hospitals and to help restore trust in the health system.

At the end of 2011, MSF had 3 staff in Bahrain. MSF started working in the country in 2011.

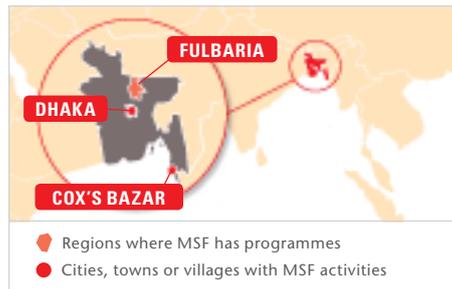
Abdul*
29 years old

"I stayed in Salmaniya for five days after I was wounded in the protests. The police used to come into the ward regularly to prevent us from sleeping. They would come in with masks and sticks. It was scary. They would come at 1am and hit us. I begged the doctor to discharge me. I wanted to leave. It was not safe for me in the hospital. When I tried to run away, I was arrested by the police. I was taken to a police station where I was blindfolded and beaten. They finally let me go at 3am. I found a nurse to treat me at home. If I go back to the hospital now to get more treatment they will ask me how I got these wounds and then beat me more."

When the MSF team examined Abdul during a medical assessment, he was suffering from pain in his chest and had difficulty using his right hand, which had been bound.

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

BANGLADESH



There are acute medical needs in Bangladesh, and Médecins Sans Frontières (MSF) is working in a range of contexts, treating people who would not otherwise have access to medical services.



A mother attends MSF's day centre in Kamrangirchar, near Dhaka, with her baby.

In Fulbaria, north of the capital Dhaka, MSF runs a kala azar treatment centre with the Ministry of Health.

Kala azar (visceral leishmaniasis) is transmitted by a sandfly that lives in the cracks of mud houses. After malaria, it is the second-biggest parasitic killer worldwide. Women and children are particularly vulnerable to the disease, which, if left untreated, is fatal.

In 2011, MSF treated more than 1,700 patients for kala azar and related illnesses in Fulbaria using liposomal amphotericin B, the treatment it introduced in 2010. This drug is safer and more effective than earlier drugs, which were highly toxic and needed to be taken for longer. Treatment time has been reduced to just three days over a five-day period, and patients no longer have to be hospitalised. In 2011, over 99 per cent of patients treated for kala azar by MSF were cured.

Despite a high prevalence of the disease in the area, not many people are aware of kala azar. An outreach team works in the community to identify patients with the disease and refer them for treatment. The team teaches people about the symptoms of the disease and how it is transmitted, informs them about treatment options and carries out health education activities. MSF also provides an extra level of quality control and supervision within the Ministry of Health vector control programme, reporting findings to the head of the kala azar elimination programme.

Healthcare in the capital

Dhaka, Bangladesh's capital, is one of the most densely populated cities in the world. Thousands of informal settlements have sprung up as socioeconomic and environmental pressures bring people from rural areas to the city.

Most residents of these settlements lack access to good-quality health services. In Kamrangirchar, home to nearly 400,000 people, MSF runs two basic health centres offering free maternal and paediatric care, and focusing particularly on treating severe malnutrition. Staff conducted approximately 28,000 consultations and admitted more than 900 children and 580 pregnant or breastfeeding women to the nutrition programme. Many patients were suffering from diarrhoea and skin infections, often a direct result of poor water quality and unhygienic living conditions. MSF also responded to a measles outbreak in Kamrangirchar.

Improving access to healthcare

In Cox's Bazar, one of the poorest districts of Bangladesh, thousands of Rohingya who have fled Myanmar remain unregistered and are considered illegal immigrants. Many are living in and around the makeshift camp of Kutupalong.

In Kutupalong clinic, MSF treated over 55,000 patients in 2011, both Rohingya from the camp and local Bangladeshis. Staff provided basic outpatient and inpatient care, maternity services, family planning, vaccinations and mental healthcare.

The team carried out a nutritional survey and found high rates of malnutrition among the Rohingya. From January to September, staff admitted 440 malnourished children suffering from medical complications to the clinic. In addition to medical activities, MSF lobbied for improved living conditions for the stateless Rohingya people.

At the end of 2011, MSF had 323 staff in Bangladesh. MSF has been working in the country since 1985.

Salma

"My name is Salma. I live in Kamrangirchar together with my mother and my two small daughters. I have to work to support them all, because my husband left me for another woman. I work on a building site, where I carry bricks, bags of cement, climb stairs. The men there swear and threaten to hit me if I don't work hard. It is very difficult for me, but I have to do it – where else will the money come from?"

"Every few days, I suffer from pains, feel feverish, catch colds, and I also get sores and ulcers on my limbs. I was unable to produce breastmilk, and therefore my youngest baby became very thin and sick. Now MSF is looking after her in many ways, and makes sure she is properly nourished. They come and check up on the baby and also give me advice on how to cook good food. I am very happy for this."

© Stanley Greene/NOOR

BOLIVIA



A Chagas disease patient receives a medical examination, Aiquile, Cochabamba.



Chagas disease is widespread in Bolivia, and it can be deadly. People living in poor housing are most at risk, but they are also less likely to be able to access care.

Chagas is a parasitic disease, transmitted mainly by the vinchuca beetle, which lives in cracks in the walls and roofs of mud and straw housing. Consequently, people living in this type of building are more vulnerable to the disease.

Although Chagas can cause serious, even fatal, heart and intestinal problems, people infected with the disease can live without symptoms for many years. Screening is therefore a particularly important component in tackling Chagas. But health services often have to be paid for directly in Bolivia, and many people likely to have the disease are unable to access care.

Cochabamba

In April 2011, Médecins Sans Frontières (MSF) handed over its Chagas programme

in Cochabamba City to the Bolivian Ministry of Health. Staff had been working in some of the most deprived parts of the city for three years. During this time, of more than 20,000 people screened for the disease, some 3,000 tested positive and more than 1,900 people received treatment.

A team continued to work in the department of Cochabamba, running a programme in the rural province of Narciso Campero. Prevalence of Chagas in this province is among the highest in the country. MSF was the first to offer diagnostic and treatment services, bringing healthcare to patients who had not yet developed cardiac or intestinal complications.

MSF staff work directly with patients, but also with the staff from local clinics and health centres. MSF offers training, and collaborates with the authorities to improve Chagas drug supply chains and treatment. The aim is for Chagas prevention, diagnosis and treatment services to be integrated into local health facilities. The teams also engage with the community to raise awareness of the disease and how vector control – controlling the vinchuca beetle – can help reduce transmission. They hold educational workshops with teachers, students, community leaders and patient groups, and take part in a regular radio show.

In 2011, 3,270 people were screened for Chagas in Narciso Campero: 1,270 tested positive and 716 started treatment. In the rural health centres supported by MSF, an additional 1,833 people were screened, and of these 399 started treatment.

Eliseo

55 years old

Fifteen years ago, Eliseo was tested for Chagas, and the results came back positive. But at the time, there was no treatment available. In 2010 Eliseo started working with MSF. At first he didn't dare to tell his colleagues of his diagnosis, but then he decided to take part in an MSF screening, and again he tested positive for Chagas. He started treatment in April 2011. Side effects, such as abdominal pain, almost made Eliseo quit, but with the support of his family and co-workers, he completed treatment in July.

"I am happy that I had the screening and medication," says Eliseo. "I feel my quality of life has improved. Now I always help other people so that they can be treated for Chagas too."

There is currently no reliable test of cure for Chagas. MSF is involved in a study with the Drugs for Neglected Diseases initiative (DNDi), which could lead to just such a test. Researchers are testing patients in Bolivia to see whether polymerase chain reaction, a technique that amplifies pieces of DNA, can help to measure accurately patients' response to treatment.

Shortage of medication

Benznidazole is the most commonly used treatment for Chagas. But in October, shortages of the drug affected treatment programmes in several Latin American countries. MSF was forced to suspend new projects it had planned in Bolivia.

Among other factors, the shortages were caused by a lack of planning by Brazil's state-owned laboratory, where the drug is manufactured. MSF urged the Brazilian Ministry of Health to commit to speed up benznidazole production, but at the end of 2011 there were still supply shortages.

Emergency in La Paz

A landslide in Callapa, a neighbourhood in the city of La Paz, left 5,000 people homeless in February. MSF contributed to the emergency response by helping to provide water and sanitation in seven of the temporary shelters to which the homeless were relocated.

At the end of 2011, MSF had 32 staff in Bolivia. MSF has been working in the country since 1986.

BRAZIL



Haitians first began arriving in Tabatinga, a small town located at the border between Brazil, Colombia and Peru, in March 2010.

More than 1,200 Haitians, who had fled the devastation of the earthquake of January 2010 and sought asylum in Brazil, were stranded. They were not allowed to work or leave Tabatinga until they received authorisation, and this was taking months.

Many were living in extremely poor conditions, having spent all their savings on the journey to Brazil. In some cases, one latrine was being shared by up to 40 people. In one residence, as many as five people were living in each tiny room without proper light or ventilation.

Living in such conditions can have a serious impact on health. Stomach infections and psychological disorders were common. In mid-November, Médecins Sans Frontières (MSF) began offering psychological support and distributed washing kits. Staff acted as mediators and interpreters for Haitians attending Brazilian health centres, and lobbied local and provincial authorities to improve access to healthcare.

On 11 January 2012, the Brazilian Ministry of Justice announced that some 4,000 Haitians who had arrived in the country since the earthquake would be granted residence and work visas. The federal government also adopted a clear policy aimed at regularising the situation of the Haitians in Brazil, and opened up legal migration opportunities

from Haiti. As a result, the number of Haitians arriving in Tabatinga dramatically decreased. With the improvement in the situation, the programme was closed in February 2012.

Many Haitians left Tabatinga for the city of Manaus. MSF lobbying of the city authorities helped ensure that they took responsibility for the people's health needs. An MSF team also supported the response by giving training in mental healthcare and health promotion to health staff and social workers in Manaus.

Flooding

In January, heavy floods and landslides affected an area north of Rio de Janeiro, leaving thousands homeless. After carrying out an assessment and identifying gaps in mental healthcare, MSF provided training to more than 150 psychologists in four towns on how to support survivors of natural disasters. MSF also lobbied for mental healthcare to be included in the overall disaster response.

At the end of 2011, MSF had 4 field staff in Brazil. MSF first worked in the country in 1991.



More than 1,200 Haitians were stranded in the Brazilian border town of Tabatinga.

BURKINA FASO



© Yann Libesart/MSF

An inpatient at the feeding centre for severely malnourished children in Yako.



A hostile climate and fluctuating prices both limit the availability of food for many people in Burkina Faso. Médecins Sans Frontières (MSF) works in the north of the country, operating free nutrition programmes for children under five.

Teams in Loroum province treat children for malnutrition and also provide basic healthcare at 11 outpatient programmes and one inpatient centre at the hospital in the provincial capital Titao. Activities in five health centres in Yako were gradually handed over to the United Nations Children's Fund as it became more involved in child health in the town.

MSF cared for children with a range of conditions, the most common being diarrhoea, malaria and respiratory infections. Patients were also offered routine vaccination.

Malaria is the main cause of sickness and death in Burkina Faso, especially among under-fives, and between July and December the number of cases spikes. In collaboration with the Ministry of Health, MSF treated malaria patients in Titao hospital year-round, and extended

treatment activities to outlying health centres during the malaria season. Staff tended to some 820 patients.

In total, almost 4,500 children received treatment in 2011. Since 2007, when the programme began, staff have tended to more than 55,400 children.

MSF has begun exploring possibilities for new programmes in the country: the malaria epidemic in the south of the country, increasing political unrest, growing insecurity close to the border due to fighting in neighbouring Mali and fears of a particularly acute malnutrition crisis were all cause for concern as 2012 began.

At the end of 2011, MSF had 215 staff in Burkina Faso. MSF has been working in the country since 1995.

BURUNDI



In Burundi, Médecins Sans Frontières (MSF) focuses on maternal health, providing emergency obstetric care and obstetric fistula repair.

Kabezi

Skilled medical assistance during labour can prevent obstetric fistulas. In the town of Kabezi, in Bujumbura Rural province, MSF is managing an emergency centre for gynaecological and obstetric care (CURGO). The CURGO also offers neonatal services. An ambulance service transports women in need of emergency attention from 24 different health centres in the surrounding area to the CURGO in Kabezi. Almost 2,200 babies were born at the centre in 2011, and 446 of them were admitted for intensive neonatal care.

Responding to emergencies

Through regular contact with an extended network of medical authorities and organisations across the country, MSF's emergency response unit makes sure it has the latest information regarding the risk of emergencies in Burundi.

When measles broke out, the unit participated in an immunisation campaign, vaccinating more than 291,000 people.

The team also assisted health authorities during an outbreak of cholera, providing treatment and follow-up for 1,072 patients, and treated over 6,100 people for malaria.

At the end of 2011, MSF had 239 staff in Burundi. MSF has been working in the country since 1992.

Women are particularly affected by the limited access to healthcare in Burundi. According to the World Health Organization, 4,000 women die in childbirth and 1,200 develop an obstetric fistula every year.

Obstetric fistulas are injuries to the birth canal, and are most often caused by prolonged or obstructed labour. These fistulas cause incontinence, and women have to live not only with the debilitating physical consequences, but also, in many cases, with shame and social exclusion.

However, most fistulas can be repaired, and women who have successful fistula repair surgery are usually able to return to their normal lives and integrate back into society.

The Urumuri health centre

At the Urumuri health centre, in the city of Gitega, central Burundi, MSF offers free, around-the-clock treatment to women suffering from obstetric fistulas. Surgeons performed more than 370 fistula repair operations in 2011 and began training two Burundian doctors in the technique. MSF is planning to increase the capacity of the centre and expects the number of operations to rise to 450 in 2012.

If women are treated for fistula early, surgery can be avoided, and in 2011, MSF piloted a programme to do just that. For women who have developed fistulas within the previous six weeks, doctors in Gitega insert a catheter to drain the bladder of urine. This decompresses the bladder walls and allows the wounded edges to meet and join together, so that the fistula heals naturally.

Many women do not know that it is possible to treat or repair obstetric fistulas. To promote awareness of the options available, MSF has set up an information line, which people can call with any questions about the condition.

291,000 MEASLES vaccinations



Patients wait for treatment at a mobile clinic.

© Gwennola Francois / MSF

CAMBODIA



Overcrowding, lack of ventilation and generally poor living conditions all contribute to the high risk of contracting tuberculosis (TB) in Cambodian prisons.

Cambodia is on the World Health Organization's list of 22 countries with a high burden of TB. TB is spread through the air by an infected person coughing. It is an opportunistic infection that takes advantage of weakened immune systems, which are all too common among people living in poverty in Cambodia. Malnutrition, poor hygiene and living conditions and HIV infection are all key contributing factors to the spread of the disease.

Healthcare in the capital's prisons

Médecins Sans Frontières (MSF) has been working in three prisons in Phnom Penh, where 25 per cent of all Cambodia's prisoners are held, since February 2010. Teams provide care and treatment for HIV and TB, and have introduced measures to improve infection control, such as a quarantine area in one of the prisons.

Staff carried out a comprehensive HIV and TB screening programme for all prison inmates. Mobile teams then conducted daily visits, carrying out an average of 100 consultations per month. At the end of the year, 94 HIV patients were on antiretroviral treatment. More than 3,600 people had been screened for TB and 32 were receiving treatment for the disease, bringing the number treated since 2010 to approximately 200.

Being able to keep up with treatment is crucial if patients are to avoid developing drug resistance. So, when they are transferred or released, MSF staff provide follow-up. They help make sure patients have access to the drugs they need, as well as to medical services.



Villagers in Kampong Cham province meet to learn more about tuberculosis.

Inside the prisons, the teams are extending their activities to provide basic healthcare, including the treatment of skin diseases and sexually transmitted infections. Staff also engage in health promotion activities, such as improvements to sanitation.

Kampong Cham TB programme

In Kampong Cham hospital, MSF offers treatment for TB and drug-resistant TB (DR-TB). In the paediatric ward, staff work with the hospital's doctors to identify children who may have TB.

Follow-up is key to the strategy. If patients are unable to come to the hospital, staff make home visits. A telephone hotline has been set up for patients to call in case of emergencies. Over the year, MSF conducted over 6,000 consultations at the hospital and registered more than 600 new TB patients.

The team is working to get more people tested for TB earlier. Counsellors have begun asking new patients whom they have been in contact with, so that people at risk can be invited to take a free TB test. Testing and detection have improved with the introduction of a new testing machine that reduces the time it takes for diagnosis.

Twice a month, an MSF doctor and counsellor participate in a radio programme about TB. Awareness-raising events are regularly held at pagodas, universities, high schools and mosques. The aim of

such outreach activities is to increase understanding of the disease and reduce stigma. MSF also advocates at a national level for improvements to Cambodia's national TB response.

At the end of 2011, MSF had 136 staff in Cambodia. MSF has been working in the country since 1979.

Srey*

"In the beginning of my DR-TB treatment I suffered bad side effects like fever, dizziness, headaches and abdominal pain – it was very hard. I wanted to stop the treatment but, when I saw the other patients trying, I wanted to continue, even though it was so difficult. MSF people come to my house often to talk with me and check how my four children are. They also bring me food sometimes – if I don't have enough food to eat, I get really unwell and the side effects are worse. The village nurse comes every day to give me drugs and see how I am doing."

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

CAMEROON



In Cameroon, there are significant obstacles to providing high-quality treatment for patients with HIV, particularly those who are developing resistance to medication.

Tens of thousands of people living with HIV in Cameroon are on antiretroviral (ARV) drugs thanks to the government's commitment to promote universal access to ARV treatment and the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

However, close to 10 per cent of patients develop resistance to first-line drugs, usually after several years of treatment, sometimes because of problems with adhering to the medication. Drug-resistant strains of the virus can also be transmitted from person to person. Patients with drug-resistant

forms of HIV need to move on to second-line treatment, which is far more expensive for both the government and patients.

Addressing HIV drug resistance

In Nylon district hospital, in the economic capital Douala, Médecins Sans Frontières (MSF) medical teams have introduced an improved first-line treatment, which includes the medicine tenofovir (TDF), for more than 1,500 HIV patients. TDF has fewer side effects, and staff are hoping that the new medication, together with better patient follow-up, will encourage adherence and reduce the risk of developing resistance.

MSF successfully lobbied the Ministry of Health and international donors to follow suit and change the national standard first-line medical protocol from a combination of drugs including stavudine (d4T) – which often causes side effects – to TDF-based combinations. The TDF-based regime has been validated for first-line treatment and the drugs are available in pharmacies.

Fifty-four HIV patients in Douala were switched to second-line treatment.

Buruli ulcer

In the town of Akonolinga, central Cameroon, MSF treated 160 patients with Buruli ulcer. Although not normally life-threatening, Buruli ulcer is extremely incapacitating and painful. Related to leprosy, it can cause irreversible deformities, which can restrict

movement and lead to secondary infections and long-term disability. Skin lesions can also result in social stigma and exclusion.

Early treatment is crucial – the later someone seeks medical attention, the longer treatment and recovery take – but it is not easy to implement. The disease is prevalent mainly among poor, rural communities, in places where health services are not able to provide the complex and expensive treatment Buruli ulcer requires. Investment in research is necessary so that prevention, diagnosis and treatment can be improved. The mode of transmission of the disease is still not known.

Cholera

An MSF team helped the Ministry of Health tackle two cholera epidemics. The main symptom of cholera is profuse, watery diarrhoea, which can quickly lead to severe dehydration. An outbreak was declared in Yaoundé, the capital city, on 20 March. MSF set up a 300-bed cholera treatment centre (CTC), where some 1,350 patients received treatment.

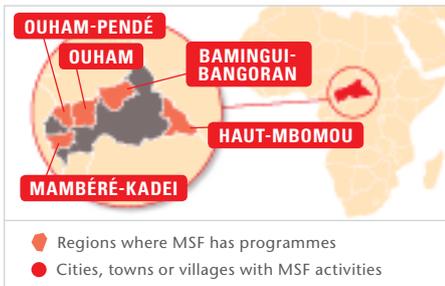
Douala was hit by cholera in November. MSF staff set up and operated a 130-bed CTC next to the central hospital of Laquintinie for nine weeks. On the first day alone, 56 patients were admitted. In total, more than 1,000 patients were treated for the disease.

At the end of 2011, MSF had 83 staff in Cameroon. MSF has been working in the country since 1984.



A doctor conducts a medical examination at the 'Buruli pavilion' in Akonolinga.

CENTRAL AFRICAN REPUBLIC



In the Central African Republic, mortality rates are consistently above the emergency threshold countrywide, indicating an urgent need for large-scale medical assistance.

Recorded death rates were particularly high in 2011, caused by a high prevalence of preventable, and treatable, diseases, a failed health system and years of conflict. Despite this, funding for health is declining. In the report *State of Silent Crisis*, published in 2011, Médecins Sans Frontières (MSF) called for greater medical assistance in the Central African Republic.

MSF works in five of the country's 17 prefectures, supporting nine hospitals and 36 health centres, mainly in the more unstable border areas, where it can be very difficult for people to access healthcare.

Emergency programmes

In 2010, MSF's team in Mambéré-Kadeï opened a new programme in the district of Carnot, providing paediatric healthcare and integrated tuberculosis (TB) and HIV treatment in the district hospital and four health posts. In 2011, MSF registered almost 520 new HIV patients and conducted 5,500 consultations.

Although Carnot is neither affected by conflict nor host to large numbers of displaced people, mortality surveys carried out in 2011 revealed death rates to be at least three times above the emergency threshold.

The emergency assistance programme in the town of Gadzi was handed over to authorities in October.

In Zémio, on the border with the Democratic Republic of the Congo (DRC), MSF continued to assist people fleeing violence in the DRC, carrying out close to 31,000 medical

consultations. Towards the end of the year, MSF started offering antiretroviral (ARV) treatment to people with HIV.

Supporting basic and specialist health services

In the town of Paoua, in Ouham-Pendé, an area recovering from conflict, an MSF team provides paediatric, surgical, maternal, emergency and outpatient services. As well as conducting 18,900 outpatient consultations and admitting more than 2,700 patients to the hospital, staff carried out consultations at seven health centres in the surrounding area.

Teams provide similar services in places still beset by insecurity and violence. In the neighbouring prefecture of Ouham, at Batangafo, Boguila and Kabo hospitals, staff carried out some 16,700 consultations, admitted 940 inpatients and assisted more than 180 births every month. At Boguila, MSF regularly organises 'surgical camps', in which a team visits for a limited period to perform specialist surgery that would not otherwise be available in the area. Staff also work in 14 health posts around the hospitals.

MSF confirmed that sleeping sickness (human African trypanosomiasis) has been brought under control in the Maitikoulou area. Sleeping sickness is a parasitic infection transmitted by the tsetse fly, and it is usually fatal without treatment. MSF showed that prevalence had fallen to below 0.5 per cent. The team carried out more than 56,000 general medical consultations and 35,000 antenatal

consultations, before closing some health posts and handing management of Maitikoulou hospital over to the Ministry of Health.

In Ndele, the capital of Bamingui-Bangoran prefecture, an MSF team is providing medical assistance to both displaced people and local residents. Surgeons performed an average of 14 operations per month at the hospital. Teams also ran mobile clinics and worked in five health centres.

Combating three killers: malaria, HIV and TB

Malaria remains a major threat to public health and the principal cause of death and illness among children in the Central African Republic. In total, MSF treated more than 212,000 patients for the disease in 2011.

By July 2011, 998 HIV patients were receiving ARV treatment at MSF clinics, a large increase over the previous year. However, the National Centre for the Struggle against AIDS has estimated that 45,000 people, including 14,000 children, currently need ARV treatment. At present, only one-third, or some 15,000 people, have started treatment.

The prevalence of TB has increased significantly among both HIV-positive and HIV-negative people, and is estimated to have at least doubled between 1990 and 2009. MSF provides TB diagnosis and care at its hospitals in Batangafo, Kabo and Ndele.

At the end of 2011, MSF had 1,341 staff in the Central African Republic. MSF has worked in the country since 1996.



A pregnant woman is referred to Paoua hospital, Ouham-Pendé.

CHAD

Chad bears the grim distinction of having the highest under-five mortality rate in the world. Médecins Sans Frontières (MSF) teams in the country focus on maternal and paediatric services, and respond to emergencies.

In Am Timan, MSF supports a Ministry of Health district hospital and seven health centres. Staff cared for more than 3,700 children on the paediatric ward, held some 7,300 antenatal consultations and assisted 1,795 births. More than 5,300 children under five were treated for malnutrition.

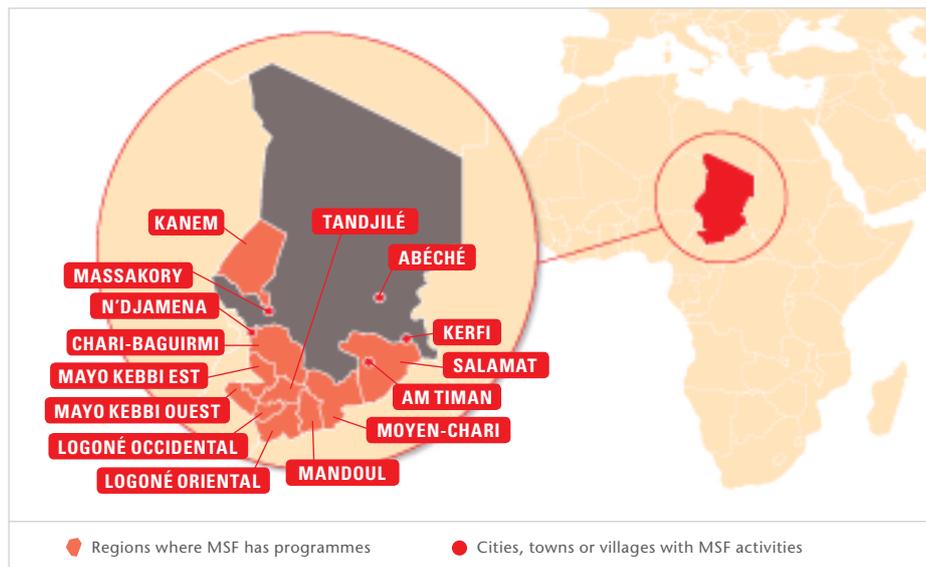
In the southeast, in Kerfi health centre, MSF provided comprehensive healthcare including nutritional support, blood transfusions and hospital referral both to Chadians displaced by conflict and the local community. Staff also offered reproductive healthcare and assistance for victims of sexual violence. The team treated more than 27,800 patients. Maternity staff held 3,500 antenatal consultations and assisted 188 births. As the displaced left the area, reducing pressure on health services, MSF withdrew from the health centre.

In Massakory, western Chad, MSF is mainly involved in treating malnutrition in under-fives and delivering emergency medical care to under-15s. During the time of year known as the 'hunger gap', when food scarcity is an acute problem, more than 170 beds in Massakory hospital are reserved for children in need of nutritional support or other vital medical care. In total, about 1,200 children were admitted for malnutrition in 2011. Another 750 children were admitted with malaria, meningitis, diarrhoea or respiratory infections. Around 3,200 severely malnourished children were treated in MSF's outpatient feeding programme, and more than 6,400 children under three received supplementary food to prevent malnutrition.

Further north, in Nokou district, in Kanem, MSF extended its response to the nutrition crisis, treating 3,600 children.

Obstetric fistula

An estimated two million women live with obstetric fistulas worldwide, most of them in Africa, in poor and remote areas with limited or no access to maternal healthcare. Obstetric fistulas are injuries to the birth canal that are mostly caused by prolonged



or obstructed labour and they generally result in incontinence, which in turn can lead to women being rejected by their families and communities. In Abéché's regional hospital, where MSF supports gynaecological and obstetric services, specially trained medical staff performed fistula repair surgery on 222 women, and assisted more than 2,980 births. Skilled obstetric care can prevent fistulas.

Malaria

The malaria programme in Moissala, Mandoul region, includes treatment and prevention activities, and focuses on

children under five and pregnant women, for whom malaria is particularly dangerous. In a region where every child may have an average of two bouts of malaria per year, and where some villages are a three-hour walk from the nearest health centre, bringing healthcare to the communities can make a crucial difference. MSF trains workers to go to villages to perform rapid diagnostic tests for malaria and provide treatment for simple cases. Children suffering complications are sent to the nearest health centre or transferred to a ward built by MSF at Moissala district hospital. More than 2,100 people were



A child receives an identity label before a consultation at a mobile clinic in Molobou, Kanem region.

© Alfons Rodriguez



Meningitis vaccination in Kelo district, Tandjilé.

treated at Moissala hospital in 2011, and 17,000 mosquito nets were given to young children and pregnant women.

Cholera

Despite efforts to contain the cholera outbreak that began in 2009, it continued through much of 2011. Inadequate sanitation was the main reason for the persistence of the disease: cholera is an infection spread by contaminated water or food. It causes profuse watery diarrhoea and vomiting that can lead to severe dehydration and death if not treated early. Treatment consists of administering rehydration solutions to replace fluids and salts. Some 325 MSF staff worked in 23 health centres throughout the country, caring for more than 12,700 patients.

Measles

MSF vaccinated approximately 575,000 people against measles, the majority of them children, in districts in the southern and southeastern regions of Logoné Occidental, Logoné Oriental, Moyen-Chari and Salamat. More than 2,800 people were treated for the disease, and the team donated drugs to the Ministry of Health to treat an additional 3,500. Measles is a contributing cause of malnutrition, and MSF staff treated almost 3,000 children in nutrition programmes in Logoné Occidental.

Meningitis

Southern Chad falls within the so-called meningitis belt, a huge strip across sub-Saharan Africa where the disease is particularly prevalent. Meningitis causes inflammation of the membranes surrounding the brain. In 2011, MSF staff vaccinated more than 900,000 people in campaigns that covered five regions. They treated close to 3,500 people for the disease and provided drugs to treat an additional 3,000. In Mandélie, Chari-Baguirmi region, the team introduced a new vaccine, used for the first time in Chad, which offers protection for 10 years – four times the protection of the old vaccine.

Regional instability

War in neighbouring Libya aggravated instability in Chad. In the eastern provinces, road ambushes, car jackings, robberies and the risk of kidnapping persisted. As a consequence of the heightened security risk, some MSF teams had to reduce their activities. Despite these constraints, staff provided medical assistance to 1,850 Chadians fleeing political violence in Libya and vaccinated 3,000 against measles.

At the end of 2011, MSF had 977 staff in Chad. MSF has been working in the country since 1981.

Moussa*

12 years old

"When I got to school I didn't feel well. I had a backache. I had to take an exam that morning, but I lay on the bench. The teacher told me to get up, but I couldn't."

At home, Moussa's pain worsened: his joints ached, especially his ankles, wrists and neck. He had a fever. His mother took him to the hospital, where he was diagnosed with meningitis.

Meningitis is treated with antibiotics. When treated early, the chances of cure are high. Without treatment, however, only 50 per cent of people survive the disease, often with serious after effects such as deafness or a physical disability.

Moussa said the injections were quite painful but that the doctors were nice and careful. He stayed in hospital for the injections and treatment for dehydration, and to have his temperature monitored. A few days later, he returned home with his family.

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

CHINA



An MSF doctor consults with an HIV patient in Guangxi province.



Floods caused damage and displaced thousands of people in various regions of China, and Médecins Sans Frontières (MSF) teams assisted the emergency response.

In China, emergencies caused by extreme weather events are frequent. The country is hit several times a year by severe flooding, landslides, typhoons or earthquakes. Over the past 10 years, China has improved its responses to natural disasters; however, significant gaps remain, particularly in terms of providing adequate food and relief to those most in need.

In 2011, MSF sent teams to assist after major floods struck central and southern parts of the country. They supplied relief items such as tents, plastic sheeting and cooking kits to 3,860 families in Xincheng county and Gaosui in Guangxi province, Wangmo county in Guizhou, and Baiyi in Sichuan province.

Unequal access to healthcare

With the transition to a market economy, the healthcare system has been undergoing significant changes. Market incentives and decreased government funding have affected the quality of care. Fewer people are using public services, and this has resulted in further decreases in funding. The overall effect of these changes has been to increase out-of-pocket expenditure for healthcare to the extent that, for many, it is no longer affordable – particularly in impoverished rural areas where annual household income is less than US\$ 475.

People from poor rural areas are therefore flocking to wealthy cities to find work, but here they also have problems accessing health services, due to a complex resident registration system and social discrimination.

Even when access is available, the quality of care varies dramatically, depending on the socioeconomic status of the patient.

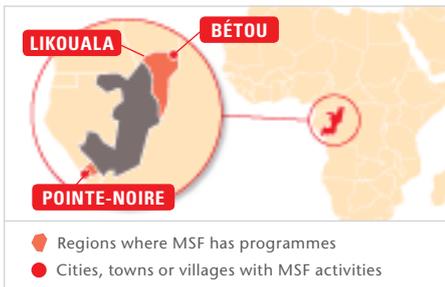
Medical challenges

Migrants comprise 43 per cent of the population of Guangzhou city, Guangdong province. Guangzhou has also drawn hundreds of thousands of immigrants from across Africa in the last decade. Migrants from rural areas are not granted social security in cities and their access to vital public services such as education and medical care is restricted.

Many migrant women make a living as commercial sex workers, and the lack of healthcare combined with the rapidly growing commercial sex trade has led to a huge increase in sexually transmitted infections (STIs) in the city. In 2010, the Guangzhou Center for Disease Control and Prevention found that one in five female sex workers had an STI. In 2012, MSF plans to set up a programme offering basic healthcare in Guangzhou, focusing particularly on STIs.

At the end of 2011, MSF had 15 field staff in China. MSF has been working in the country since 1988.

CONGO



Thousands of refugees who fled violence in the Democratic Republic of the Congo in 2009 remain across the border in Congo-Brazzaville, afraid to return home.

Médecins Sans Frontières (MSF) is assisting with the provision of medical care in Bétou district, in the department of Likouala. An average of 400 people were admitted to

the 89-bed Bétou hospital every month: around half of these were women requiring maternity care and one-third were children. Staff assisted more than 2,600 births. MSF also worked with the staff of the Congolese HIV and tuberculosis (TB) programmes. Since January 2010, MSF has treated 80 people for TB, and 60 people with HIV have started antiretroviral treatment. More than 2,600 outpatient consultations were held at the hospital per month, mostly with children, and mainly for respiratory infections and malaria.

In order to ensure access to healthcare for people living along the Ubangi River, MSF supported two health centres in Ipenkbele, to the north, and Boyele, to the south, and operated mobile clinics in more remote areas. Staff offered basic medical and antenatal care, and treated people for severe malnutrition, carrying out more than 8,900 consultations per month. People in need of urgent, more specialised medical attention were transferred by boat to Bétou.

Polio outbreak in Pointe-Noire

At the beginning of December 2010, polio broke out in southwest Congo, and the Ministry of Health asked MSF to assist in responding to the epidemic. A team started work in the intensive care unit in Adolphe Cissé hospital, in the city of Pointe-Noire.

Polio is an incurable viral disease that attacks the nervous system and can cause paralysis. Staff treated patients for symptoms and offered physiotherapy sessions, crucial to limiting long-term damage from the disease. More than 140 patients received care. In March, as the number of cases declined, MSF withdrew, handing physiotherapy services and mobility assistance over to Handicap International.

At the end of 2011, MSF had 280 staff in the Congo. MSF has been working in the country since 1997.



Mobile clinics are conducted by boat in order to reach people living in remote areas along the Ubangi River.

COLOMBIA

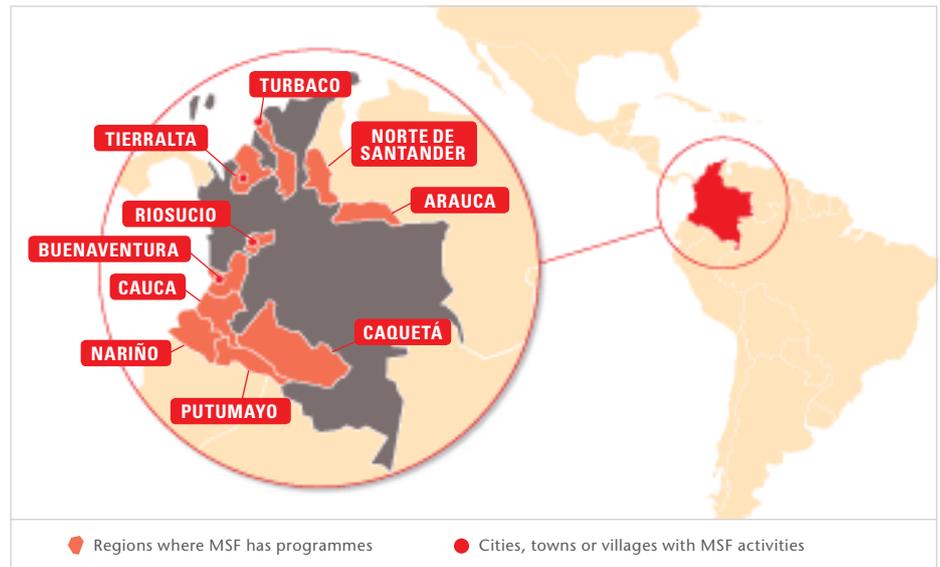
Conflict in Colombia has taken a severe toll on the population, and medical assistance is often scarce for people living in zones affected by fighting.

Guerrilla groups continue to fight government forces, while paramilitary groups have re-emerged in many areas. The strife has displaced an estimated three million people, many of whom live in poverty on the outskirts of the bigger cities, while large parts of the countryside remain unsafe.

Assisting rural communities

In the southern departments of Caquetá, Nariño, Putumayo and Cauca, Médecins Sans Frontières (MSF) set up additional permanent or semi-permanent clinics in order to improve the quality of care available to people living in conflict areas. Teams provided basic health services, reproductive healthcare, check-ups and vaccinations for children, an emergency referral system and dentistry. Dentists perform essential work – such as extractions – which has a considerable impact on patients' health and wellbeing.

As part of its antenatal programme, MSF began offering counselling and testing for HIV. There is still significant stigma attached to HIV, but the testing service has been well received by pregnant women. Those women who test positive for the virus



are offered prevention of mother-to-child transmission services.

More than 54,200 patients attended consultations at rural clinics in 53 locations across the four departments. Over 1,600 people traumatised by conflict also received mental healthcare at MSF programmes in municipal hospitals in Cauca and Caquetá.

Over the course of the year, MSF provided medical and psychological assistance, as well as water and sanitation services, to 4,800 people during 19 emergency interventions. Most of them were suffering from conditions caused by conflict and forced displacement. When widespread

flooding hit Cauca, MSF delivered washing kits, blankets and mosquito nets to 4,430 people. However, MSF teams were still unable to reach 16 locations because of security problems.

In Turbaco, Bolívar, and Tierralta, Córdoba, MSF offered basic healthcare and psychological assistance to people also suffering the direct consequences of conflict. Teams conducted more than 780 individual mental health consultations and 53 group counselling sessions. Mobile teams conducted another 9,000 medical consultations. In November, the programme was closed due to a relatively low number of patients.

Through its report *Access to Health is Access to Life: 977 Voices*, MSF gave medical evidence of the barriers that Colombians have to overcome in order to access decent healthcare. People living in rural zones have greater difficulty obtaining medical assistance than people living elsewhere in the country. The report exposed the necessity of extending health services, both qualitatively and quantitatively, making them free of charge for more people, and increasing the availability of essential medicines in health facilities. It also highlighted the intrinsic relationship between conflict and the lack of access to medical care.

MSF was invited to present this report and its 2010 report *Three Times Victims: Victims of Violence, Silence and Neglect, Armed Conflict and Mental Health in the Department of Caquetá* to the Colombian parliament.



A child receives treatment at a clinic in Buenaventura.



© Caroline Fernandez

A young child is tested for Chagas disease at an MSF clinic.

Assistance to victims of sexual violence

At its clinic in the town of Riosucio, in Chocó department, MSF provides mental and reproductive healthcare, and assists victims of sexual violence. Staff carried out more than 3,900 consultations over the year, as well as training and outreach activities with teachers, health staff and primary school students to raise awareness about sexual abuse and sexual violence.

Healthcare in Buenaventura

A great many people displaced by violence in the Pacific coast area seek shelter in the city of Buenaventura. But the ratio of health workers in Buenaventura is three times below the national average. In 2011, MSF opened a second clinic in the city and conducted more than 33,200 consultations. Staff provided a range of services, including emergency assistance, medical and psychological care for victims of sexual violence, basic healthcare, ante- and postnatal care, family planning, vaccination and treatment for acute malnutrition. Some 360 tuberculosis (TB) patients, including 42 with multidrug-resistant TB, began treatment.

Teams also carried out health promotion activities and vaccinations in around 15 neighbourhoods. In several areas, MSF helped residents to set up safe water supplies.

Offering treatment for Chagas disease

Chagas disease is an endemic parasitic disease that causes chronic health problems over many years, and if untreated, usually leads to fatal heart disease. It goes largely untreated in Colombia. In collaboration with the Ministry of Health, MSF has developed treatment protocols for Chagas. Mobile teams in Norte de Santander and in the Tame municipality of Arauca provided screening and treatment, reaching more than 2,000 children aged between nine months and 18 years in 2011: 41 patients in Tame began treatment and the two children in Norte de Santander who tested positive will start treatment in 2012. The programme was closed in November, given the relatively low number of patients found to have Chagas.

At the end of 2011, MSF had 361 staff in Colombia. MSF has been working in the country since 1985.

Cristóbal*

9 years old

Cristóbal arrived in Florencia two years ago and is still trying to adapt. He misses the river that ran near his old house. He misses riding his horse through the woods. He misses the milk, cheese and good food. He misses his teacher and his friends and the games he used to play with them in the afternoon. He weeps when he talks about the armed group that killed his father two years ago a few steps from his house, after accusing him of supporting another armed group.*

Cristóbal is receiving care in an MSF psychological programme, but, like many other boys and girls from Caquetá and other parts of Colombia, he is in unfamiliar surroundings and traumatised, trying to recover from unspeakable tragedy.

**The patient's name, and place names, have been changed.*

DEMOCRATIC REPUBLIC OF THE CONGO

Accessing even basic healthcare in the Democratic Republic of the Congo (DRC) is difficult.

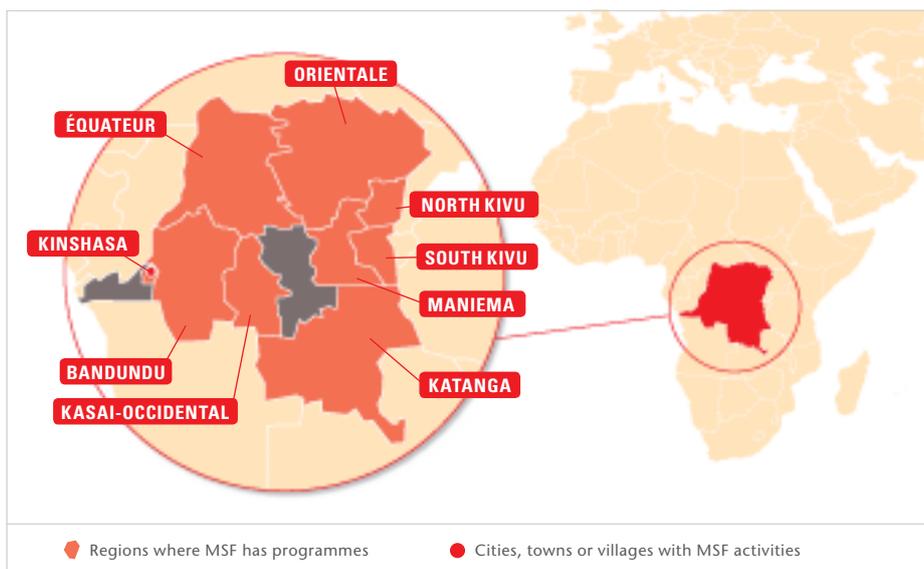
In the eastern part of the country, violent incidents occur daily, as a result of shifting alliances between armed groups, and banditry.

Medical needs are great in eastern DRC and the infant mortality rate is one of the highest in the world, but general insecurity and crime in the region have at times forced Médecins Sans Frontières (MSF) to suspend medical activities.

Responding to epidemics

MSF has a network of emergency teams ready to respond to outbreaks of disease across the country. In 2011, in response to a measles epidemic, MSF staff vaccinated over three million children, and treated more than 13,700 for the disease.

Malaria accounts for approximately 40 per cent of child deaths in DRC. MSF saw a 250 per cent



increase in the number of patients with malaria in its hospitals in the east of the country compared with 2009, and treated more than 158,000 people in North Kivu, South Kivu, Katanga, Équateur, Orientale and Maniema provinces.

Teams also responded to outbreaks of cholera in the provinces of North Kivu, South Kivu, Orientale, Bandundu, Équateur, and the capital Kinshasa, setting up treatment centres and treating thousands of patients.



A surgeon operates on a woman injured in a motorcycle accident, Dungu hospital.

HIV care

More than one million people are estimated to be living with HIV in DRC, yet antiretroviral (ARV) treatment coverage is among the lowest in the world: some 350,000 are in need of treatment, but do not receive it. Donors are withdrawing funding from HIV programmes, and MSF is seeing the number of people in urgent need of treatment grow.

An MSF team in Kinshasa runs a hospital dedicated to HIV treatment, and MSF programmes at hospitals and health centres across the country also offer HIV care: in total, more than 5,000 patients are registered for HIV treatment with MSF.

Sleeping sickness programme

The prevalence of sleeping sickness (human African trypanosomiasis) in the districts of Haut-Uélé and Bas-Uélé, Orientale province, is considered to be one of the highest in the world. A parasitic disease transmitted by the tsetse fly, sleeping sickness is deadly if not treated. In 2011,

© Ben Milipas



A nurse examines a 16-month-old child at the malnutrition clinic in Niangara hospital.

MSF staff screened tens of thousands of people through a mobile clinic and in programmes in Dingila, Haut-Uélé, and Doruma, Bas-Uélé, and treated around 1,500 patients for the disease.

Providing healthcare to victims of conflict

At the end of 2011, more than 500,000 people in North Kivu were registered as displaced, while another 630,000 in South Kivu had fled their homes.

MSF runs a number of programmes, working from hospitals and health centres across the provinces, to provide healthcare to people trapped by conflict. In North Kivu, teams in Masisi, Mweso, Pinga, Birambizo, Rutshuru, Nyanzale, and in and around Goma and Butembo towns provide basic and specialist healthcare. Last year, some services at Rutshuru hospital were handed over to the Ministry of Health. In total, staff carried out more than 404,000 consultations in the province. In South Kivu, similar services are offered in Kalonge – where the programme was extended to three more health centres – Lulingu, Hauts Plateaux and Shabunda, and in a second hospital in Matili. In addition, staff operate mobile clinics for people living in more remote areas – some locations can be reached only by long journeys on foot – and in camps. There is also an MSF team in South Kivu dedicated to emergency response.

At five camps on the border between South Kivu and Katanga, MSF provided

basic healthcare, including vaccinations, and nutritional support. The team also ensured access to safe water. In September, staff began assisting people in two camps in the north of Kalemie town, in Katanga, providing basic healthcare and food aid.

In Katanga and North Kivu, teams of surgeons spent several weeks performing fistula repair operations in MSF programmes in Manono, Shamwana and Masisi. Obstetric fistulas are injuries to the birth canal that usually occur as a result of prolonged or obstructed labour. They cause incontinence, which often leads to social exclusion. In 2011, more than 110 women underwent fistula repair surgery.

In Orientale province, MSF handed over some of its activities in Bunia to a local organisation, Sofepadi, which offers treatment for sexually transmitted diseases, family planning services and assistance to victims of sexual violence. MSF provides medical, technical and financial support to Sofepadi, and now focuses its work on emergency response and HIV treatment for children under 15. In Gety, a team provides basic and emergency health services and runs a 24-hour therapeutic feeding centre.

In South Kivu in April, armed and uniformed men opened fire on an MSF car travelling to Marungu, near Hauts Plateaux, robbed the driver and stole everything.

Later, gunmen attacked another MSF car on the road between Bukavu and Uvira: two staff members were wounded. In November, a number of armed men forced their way into the MSF residence in Masisi, North Kivu, and opened fire. One member of the team received a gunshot wound to the shoulder. MSF suspended mobile medical activities in the area, but continued to provide a minimum level of emergency support at Masisi general referral hospital. There were 108 attacks involving humanitarian workers in North Kivu in 2011.

Hospital care in Maniema

MSF took over Lubutu hospital in 2006. By the end of 2011, the capacity of the hospital – which serves 100,000 people – had grown to 160 beds, and mortality in the area had dropped fivefold since 2005. In 2012, MSF plans to hand over activities to another non-governmental organisation.

Sexual violence

As well as assisting victims of sexual violence in many of its regular healthcare programmes, MSF responded to around ten incidents of mass rape around Fizi, South Kivu, and Pinga, North Kivu. Altogether, more than 2,300 people received medical and psychological assistance.

At the end of 2011, MSF had 2,919 staff in the Democratic Republic of the Congo. MSF has been working in the country since 1981.

DJIBOUTI



In Djibouti, screening by Médecins Sans Frontières (MSF) teams in the first half of 2011 revealed a rise in the number of children suffering from moderate levels of malnutrition.

Staff continued to see a large number of children in the programme who were also suffering from tuberculosis (TB): 81 tested positive, and after completing treatment in the feeding centre, were referred to the national TB programme. The inpatient feeding programme will be handed over to national authorities in April 2012.

Lobbying for change

A hot, dry climate means there is little capacity for crop cultivation in Djibouti, and this has recently been further diminished by a regional drought. In Djibouti City, where some 60 per cent of the country's population live, food supplies are under strain. A 'floating population' of migrants passing through the country adds to the pressure.

MSF petitioned the UN and the government to take steps towards preventing further deterioration of the situation, and advocated the use of nutritious ready-to-use food.

This ready-to-use food has an animal protein base and contains all the nutrients that are vital for a growing child, unlike the corn-soy blend of fortified flour that is more commonly used to supplement children's diets.

The Ministry of Health is in the process of revising the national protocol for the treatment of malnourished children under five to include nutritious ready-to-use foods.

Responding to cholera

Cholera – a water-borne bacterial disease that causes profuse, watery diarrhoea – broke out in July and August, and MSF supported the health authorities' response by treating 190 patients. When a smaller outbreak occurred in October, MSF again provided assistance.

At the end of 2011, MSF had 134 staff in Djibouti. MSF has been working in the country since 2008.

Over the course of the year, staff saw a 60 per cent increase in the number of children admitted to the inpatient therapeutic feeding centre: from 1,029 in 2010 to 1,735 in 2011. Teams also treated more than 2,200 children for malnutrition in six health centres on the outskirts of Djibouti City.

A situation of chronic malnutrition

The nutritional situation in Djibouti is critical, but it is unchanging. In order to focus on emergency activities, MSF is handing over its services in Djibouti. In August, the outpatient programme was transferred to the Ministry of Health and other longer-term, non-governmental organisations.



Paediatric consultation at a clinic in Djibouti City.

EGYPT



Children are seen by a nurse before the consultation with the doctor.



Egypt has a competent medical sector and numerous qualified doctors and health professionals, but medical needs during the political crisis of January and February 2011 exceeded what even a strong health system could prepare for.

MSF teams delivered medical supplies to three hospitals in Cairo. They also helped provide care in an improvised clinic in a mosque close to Tahrir Square, the focal point of unrest. MSF staff with experience of working in conflict settings gave training

During Egypt's revolution, Médecins Sans Frontières (MSF) gave assistance and supplies to support local medical staff treating the wounded.

in responding to the medical needs of large numbers of people in a short period of time, and set up additional emergency preparedness systems.

When new clashes between protesters and security forces broke out in November, MSF donated essential drugs and medical and surgical supplies to four hospitals in Cairo and one in Suez.

As a result of MSF's collaboration with Egyptian volunteer doctors during the revolution, there is now a group of medical staff ready to respond to any future emergency in the country. MSF plans to offer training in the future.

Emergency response in Libya

In February, MSF staff in Egypt supported the medical response to the conflict in

eastern Libya by procuring and shipping medical supplies, and supporting medical and logistical teams.

Future health programmes

In 2011, MSF was officially registered in Egypt, allowing the development of new programmes. Teams are considering assisting residents of some of the most deprived districts in Cairo, and supporting treatment for multidrug-resistant tuberculosis and hepatitis C.

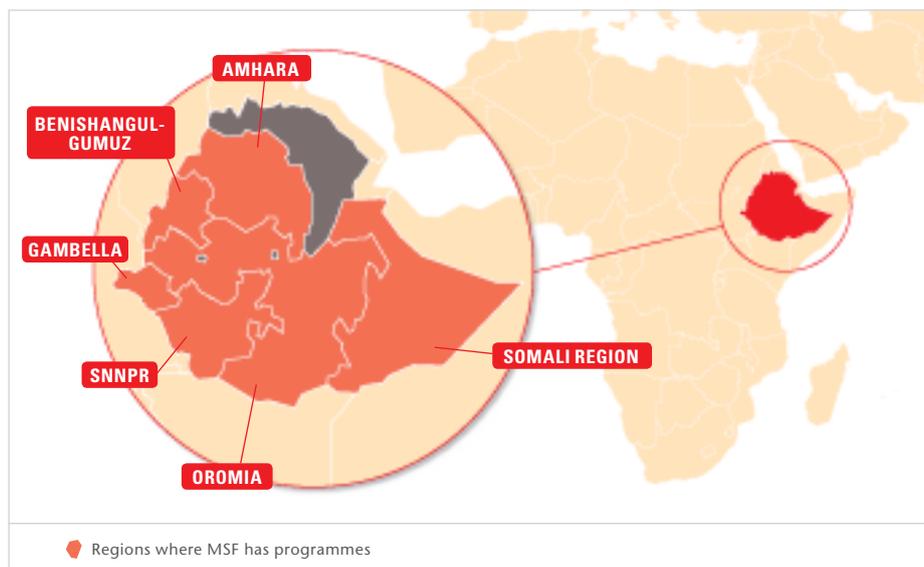
At the end of 2011, MSF had 7 staff in Egypt. MSF has been working in the country since 2010.

ETHIOPIA

In 2011, responding to the nutritional crisis in the Horn of Africa, and providing people living in remote areas with access to healthcare, were the focus of Médecins Sans Frontières (MSF) activities in Ethiopia.

In the border areas close to Somalia, MSF massively scaled up its activities in response to the dire nutritional situation. Drought, a collapsed health system and violent conflict in Somalia saw more than 120,000 refugees arrive in camps in Ethiopia's Liben zone. Services in two existing camps were expanded and three new camps were established to meet the huge needs. At the peak of the crisis in July, 3,000 refugees were crossing the border at Dolo Ado every day. MSF set up a medical screening unit at the refugee reception point. When refugees reached the camps, the team provided basic healthcare and nutritional support. For those who could not make it on their own, staff used all means, including donkey carts, to get people to medical facilities. Over the course of the year, tens of thousands of children were enrolled in nutrition programmes, which were run in partnership with the government of Ethiopia, the UN refugee agency UNHCR and other organisations.

Overall, MSF admitted more than 31,600 children to nutrition programmes in the camps, vaccinated over 53,000 people against measles



and held more than 61,000 consultations. By the end of the year, the mortality rate had returned to normal levels, although tens of thousands of refugees remained in camps, requiring humanitarian assistance.

Assisting marginalised populations

In Somali region, MSF continued working with people affected by the Ogaden conflict, in places where even the most basic services are lacking.

In Degehabur, where fighting between government forces and insurgents has hindered access to healthcare, MSF has been supporting the regional hospital for four years, providing a host of services, including outpatient and inpatient care, nutrition

programmes, sexual and reproductive healthcare, as well as treatment for malaria and tuberculosis (TB) and assistance for victims of violence. MSF conducted nearly 4,000 antenatal consultations and delivered 519 babies in Degehabur. Our staff also attended to over 230 wounded and carried out 270 surgical interventions.

In the town of Wardher, MSF expanded its services, creating new 'satellite' sites and mobile clinics, and conducting 136 field trips to ten different locations. The team carried out more than 67,000 consultations with people living in remote communities. Over 1,250 people were admitted to the regional referral hospital, where MSF provides maternal healthcare as well as treatment for malaria and TB.

Further southwest, in East and West Imey districts, MSF conducted an average of 3,000 medical consultations per month, offering maternal healthcare, nutritional support and vaccination. More than 300 patients also received treatment for TB. In total, staff tended to more than 35,000 patients in East and West Imey.

Nutritional support in Oromia and SNNPR

In Oromia region, 300 kilometres east of the capital, where bad harvests can put a severe strain on local people, MSF supported 54 mobile feeding clinics operated by the Health Bureau – 30 in Arsi and 24 in Anchar – ensuring the appropriate medical treatment for malnourished children and women and the supply of drugs and therapeutic food. In total, more than 4,000 patients were enrolled in MSF's therapeutic and supplementary nutrition programmes in Oromia. As levels of malnutrition decreased,



A Somali refugee is vaccinated against polio at a reception centre in Liben zone.



© Michael Tsegaye

Somali refugees arriving at the reception centre in Liben zone are offered health screening.

MSF started handing over its programmes to the Health Bureau. This process was formally completed in February 2012.

In September, MSF started nutritional activities in Bensa and Aroessa districts, in the Sidama zone of the Southern Nations, Nationalities and People's Region (SNNPR). As in Oromia, the teams supported mobile feeding clinics and treated severely malnourished children in intensive feeding centres.

Focus on neglected diseases

In the northern town of Abdurafi, in Amhara region, MSF focuses on treating kala azar (visceral leishmaniasis), a chronic and potentially fatal parasitic disease. Many patients in this project are co-infected with HIV. With around 600 people on antiretroviral treatment, some 1,100 in other HIV-related programmes and an average of 600 on medication for kala azar per year, MSF continued to show how treatment can effectively be implemented in resource-poor settings.

More than 11,000 people attended MSF photo exhibitions about kala azar in Gondar, Bahir Dar and Addis Ababa, which highlighted in particular migrant workers' vulnerability to the disease. In 2012, MSF plans to continue treating kala azar patients in northwest Amhara region, while also investigating better treatment options.

An outbreak of measles, potentially deadly to people who have not been vaccinated, occurred in central Amhara region in the middle of 2011. Between September and October, MSF treated more than 5,000 patients and conducted a vaccination campaign that covered some 34,400 children aged between nine months and five years of age.

Caught between two worlds

The Nuer population of Gambella region, in the far west of Ethiopia, grew as people fled local and regional fighting across the border in South Sudan. Intercommunal feuds, which generate regular, violent cross-border cattle raids, have been increasing in intensity for the past few years. In 2011, MSF staff conducted over 35,000 consultations in the Mattar health centre and a further 17,000 through mobile clinics. Around 1,200 patients were admitted to hospital, and maternity staff assisted an average of 17 deliveries per month.

In November 2011, fighting that broke out between the Sudanese army and the SPLM-North militias in the Blue Nile state of Sudan forced a large number of people to escape to the Benishangul-Gumuz region of Ethiopia. Approximately 25,000 registered Sudanese refugees live in three camps: Sherkole, Tongo and Adamazin. Thousands more are hosted within local communities. MSF teams ran health centres and managed outreach activities as well as hospital referral

at two sites. However, direct access to the camps in Benishangul remains difficult to obtain from the Administration for Refugee and Returnee Affairs. MSF developed medical programmes outside of the camps in order to assist the refugees.

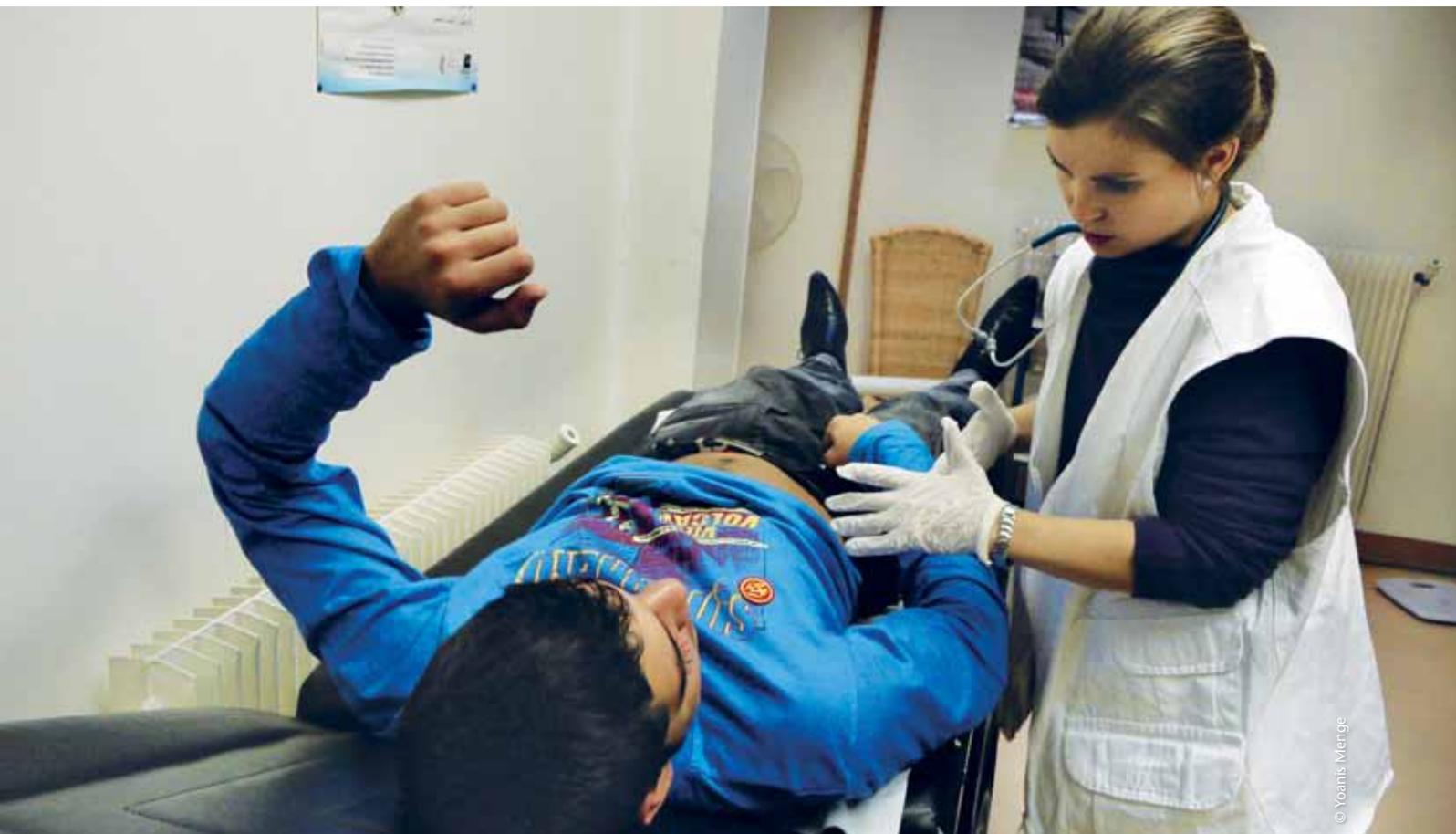
At the end of 2011, MSF had 1,396 staff in Ethiopia. MSF has been working in the country since 1984.

Aden Abdi

28 years old, father of four children, Boqolmayo refugee camp.

"I came from Wajid, Somalia, a few days ago. It took us 10 days to reach Ethiopia on foot. We didn't have any money to get transport. I am in the health centre because my daughter is sick and she is in a very bad condition. She is getting treatment now from MSF. I left Somalia because of drought and conflict. I was a farmer but, because of the lack of rain for the last two years, I couldn't feed my family and I was forced to flee. My camels, goats and sheep died because of the drought. I hope to go back to my country when it rains again. But I don't think this will change in the near future."

FRANCE



The centre in Paris offers medical and psychological support for people who have difficulty accessing healthcare.



At their medical and psychological centre in Paris, a Médecins Sans Frontières (MSF) team takes care of people who have sought refuge in France. Most have fled war zones in Afghanistan, Chechnya or Sri Lanka and are suffering from a range of health problems. Many of the people who come to the centre have had extremely difficult lives and have suffered numerous traumatic experiences, including that of exile.

The main aim of the staff is to help the most marginalised people – those who do not speak French and who do not have documentation permitting them to stay in France. Psychologists, social workers, doctors and nurses all work at the centre, so patients have access to a range of support. In total, staff carried out 6,300 consultations, and mental health staff saw 200 new patients.

The vast majority of the 1,000 patients who received medical assistance in 2011 from MSF doctors and nurses sleep on the streets or in temporary accommodation, and have no health insurance.

During the course of the year, in order to further improve access to healthcare, MSF nurses started holding weekly clinics at three emergency hostels run by the non-governmental organisation Emmaüs.

At the end of 2011, MSF had 30 field staff in France. MSF has been providing medical assistance in the country since 1987.

The economic problems in France are making access to healthcare more difficult for migrants. The rights of migrants, asylum seekers, and foreigners in ill health are increasingly being called into question.

GEORGIA



Kala azar is a parasitic disease transmitted to humans and animals through the bite of a certain kind of sandfly. It is not known for certain why the incidence in Georgia has risen, but deforestation and large-scale migration from rural to urban areas have been suggested as possible explanations. Symptoms of kala azar include fever, weight loss, anaemia and enlargement of the spleen and liver. If left untreated, the disease is fatal.

In Tbilisi, Médecins Sans Frontières (MSF) has launched a kala azar programme in collaboration with the city's Parasitological Hospital. MSF staff provide initial training in diagnosis and care, and hospital staff

The incidence of kala azar (visceral leishmaniasis) is increasing in Georgia, and most cases are being reported in urban areas, such as the capital Tbilisi.

then take on programme management and patient treatment. More than 130 people were admitted to the programme in 2011, some 70 to 80 per cent of whom were children.

MSF has introduced rapid testing, which is less expensive and far less complex and invasive than previous screening methods, which required bone marrow samples. A new treatment regime has also been implemented, using the drug liposomal amphotericin B. Treatment now takes just 10 days, rather than 30.

Tuberculosis

Mortality rates for people with tuberculosis (TB) have declined in Georgia, but the number of deaths remains high. Multidrug-resistant tuberculosis (MDR-TB) is one of the main reasons for this. MSF is treating patients with drug-resistant forms of TB in the autonomous republic of Abkhazia.

MDR-TB is contagious, and can be transmitted through the air when an infected person sneezes or coughs, or it can develop when a patient becomes resistant to at least two of the standard TB drugs, either through mismanagement or misuse of medication. Treatment is difficult: it can take up to two years and causes severe side effects.

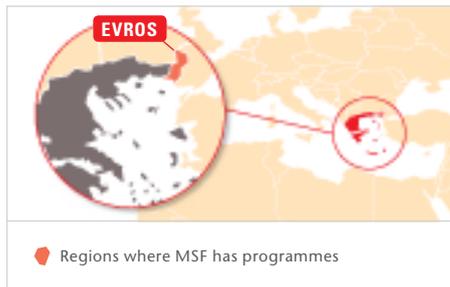
In June 2010, after 11 years of treating patients for TB, MSF decided to hand over the programme to local medical authorities. In 2011, the team worked to support the restructuring and strengthening of the Abkhazian TB programme, in preparation for the handover. MSF also continued to offer health education and counselling to help patients adhere to treatment. Since January 2010, 208 patients have started treatment for TB.

At the end of 2011, MSF had 72 staff in Georgia. MSF has been working in the country since 1993.



Laboratory testing at the tuberculosis programme in Georgia.

GREECE



During the first nine months of 2011, some 1,000 migrants were arriving at the Greek border every day, many in need of medical attention.

The Evros River, on the Greek–Turkish border, is the main entry point in Europe for undocumented migrants. In 2011, border controls were tightened: a fence was built along the northern border, and a team from Frontex, the EU border security agency, was deployed in the northeast. Consequently, the number of people arriving in north Evros fell by almost one half compared with 2010. However, there was a threefold increase in arrivals in south Evros.

On entering the country, migrants are arrested by the police. They are registered and given an expulsion order. Many voluntarily give themselves up to the police, because without an expulsion order they cannot buy a bus or train ticket to continue their journey.

Critical conditions in detention

Médecins Sans Frontières (MSF) began providing relief items and healthcare at the border police stations of Feres, Soufli and Tycherio in 2010, and reported on the critical situation for migrants and asylum seekers in detention.

In 2011, hygiene and sanitation remained poor. Throughout the year, the number of people having to share a latrine exceeded the emergency standard by almost four times. Detainees were not provided with any basic necessities, such as cooking utensils, soap or blankets, nor with any legal information or counselling. The Ministry of Health irregularly provided only basic health services. There was no medical surveillance or follow-up in the detention centres. MSF systematically reported these problems.



A migrant receives medical treatment at a police station in Evros.

In March, the Ministry of Health began to address direct medical needs, and MSF handed over its activities. However, in August, the ministry suspended its work due to lack of funds, and MSF again provided medical assistance and water and sanitation services in five detention centres. In October, the Ministry of Health resumed its operations, and a second MSF handover was finalised.

Between January and April, and August and September, MSF teams held nearly 2,700 medical consultations, as well as more than 170 mental health sessions. At Filakio, MSF distributed basic essentials, such as sleeping bags, washing kits, towels, toothbrushes and clothing. The teams also repaired blocked toilets and broken windows, disinfected cells and distributed materials so that detainees could keep their living quarters clean.

Vulnerable people left without shelter

In an effort to ease overcrowding, the Greek authorities made a decision not to detain people for longer than one or two days. However, without the means to move on or find shelter, many people, including pregnant women and young children, ended up sleeping outside the detention centres and police stations in harsh weather conditions. MSF teams regularly distributed sleeping bags, warm clothes and soap.

At the end of 2011, MSF had 3 field staff in Greece. MSF has been providing medical assistance in the country since 2008.

Charles*

27 years old

"I come from Ivory Coast. My father arranged for me and my two brothers to leave the country. If we did not leave, we were in danger of being killed. I lost my brothers in Turkey. I don't know where they are now.

"I crossed the river in a small boat. My friend was rowing when a tree branch hit him. He fell in the water and drowned. We took his dead body out of the water, we left him there at the river bank and left.

"Then they arrested us and brought us to this border police station. I have been here for 45 days. I heard that they have registered me as Nigerian. I don't know why they did that. I have talked with the policemen many times, also with the police commander, but nobody explains to me why. I don't know where my brothers are. I tried to call my father twice, but he did not answer. He might be dead. I cannot stay here any more. Please help me."

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

GUATEMALA



The health centre in Zone 7 of Guatemala City offers treatment and support for victims of sexual violence.



Working alongside the Ministry of Health in Guatemala City, Médecins Sans Frontières (MSF) offers 24-hour emergency care to victims of sexual violence.

Between January and November 2011, close to 4,000 cases of sexual violence were recorded in Guatemala, although the real number is likely to be far higher, as so many incidents go unreported.

MSF has been working in Guatemala City since 2007, improving access to medical and mental health services for victims of sexual violence. Teams work in the emergency department of the general hospital and in clinics in neighbourhoods where violence is particularly common. A team also offers medical assistance at the Ministry of Justice, where incidents of sexual violence are reported.

In 2011, nearly 780 new patients received medical and psychosocial support, and MSF staff carried out more than 1,270 medical consultations. Some 1,500 follow-up psychological consultations were conducted with patients suffering acute post-traumatic stress, anxiety and other symptoms arising from their experiences.

As part of its care, MSF offers medication that, if taken within 72 hours of an assault, significantly reduces the likelihood of contracting HIV or other sexually transmitted infections. In 2011, around 61 per cent of patients sought assistance early enough for this treatment to be effective.

But many people in Guatemala are unaware that the physical and mental effects of sexual violence can be treated. Victims generally receive little support. As well as providing medical services, MSF teams organise events and carry out activities to raise awareness and demonstrate to the authorities, the medical community and the public that sexual violence is a medical emergency, and that medical attention must be sought as a matter of urgency after an attack.

Advocating policy change

There have been some positive developments in national policy and practice regarding the treatment of victims of sexual violence recently. In September 2010, the Ministry of Health adopted a national protocol that facilitates access to healthcare for victims

Daniela* 17 years old, and **Maria***, her mother

Daniela: "It's been very difficult for me to get over the rape. I got pregnant so young and had to leave my studies and many other things behind. Each psychotherapy session helps me find relief and consolation. I try to see life differently and to move forward... People don't understand or see the magnitude of sexual violence in Guatemala, or when they do see it, they judge us, the victims."

Maria: "Psychotherapy has greatly helped Daniela. I was also able to participate in a group therapy session. Before, I didn't even know how to react. It has helped our whole family, as Daniela's rape has affected every one of us."

*The names of the patient and her mother have been changed.

of sexual violence. In June 2011, MSF was asked to participate in the promotion of the protocol in various health facilities.

MSF began handing over services in two city clinics to the Ministry of Health in early 2011, while continuing to monitor the care that is given to victims of sexual violence. In 2012, MSF will pursue the handover of activities and follow up implementation of the protocol on the provision of care to victims of sexual violence.

Torrential rains and flooding

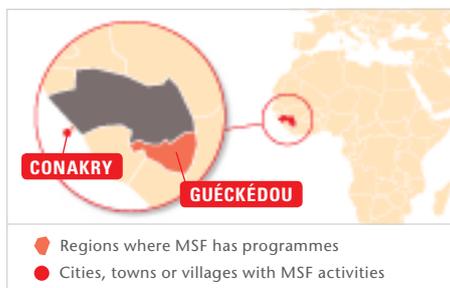
The risk of natural disaster in Guatemala is high, and aggravated by climate change. In mid-October, a tropical depression caused flooding and damage in departments on the Pacific coast. MSF distributed blankets, mattresses and washing kits to 1,000 families living in the department of Escuintla.

At the end of 2011, MSF had 40 staff in Guatemala. MSF has been working in the country since 1984.

GUINEA



The Guéckédou youth basketball club passes on messages about malaria transmission and prevention.



An inefficient drug supply system, unevenly distributed facilities and a shortage of medicines and equipment are major challenges currently facing Guinea's national health service.

Guéckédou, in the south. MSF supports HIV care in five health centres in the Matam district of Conakry, with an emphasis on paediatric HIV and prevention of mother-to-child transmission.

Mother and child health

Since 2009, MSF has been operating a mother and child programme in Matam, in collaboration with the national health authorities. The district is home to 242,000 people, including an estimated 43,600 children under five. The objective is to improve the quality of healthcare and to make it more accessible, particularly for those most vulnerable to illness.

Sixty-five health workers raise awareness about health issues within the community, encouraging pregnant women to visit a health centre for antenatal care and to make sure their youngest children get the medical assistance they need. In 2011, MSF carried out more than 47,000 paediatric and maternal health consultations in three health centres.

Malaria

Malaria is hyperendemic in Guinea, meaning that incidence is high and continuous throughout the year. It is the main reason for hospital admissions in the country, and transmission peaks during the rainy season, between April and November.

In June 2010, MSF launched a malaria programme with the aim of decreasing transmission and improving treatment for people in Guéckédou. An MSF team offers expertise to 16 public health facilities (one hospital, six health centres and nine clinics), and in addition, trains Ministry of Health medical staff. The team has also trained some 45 community health workers from the region to diagnose and treat simple cases of malaria in their villages. In 2011, MSF treated more than 55,000 patients for the disease.

At the end of 2011, MSF had 283 staff in Guinea. MSF has been working in the country since 1984.

Guinea's national HIV programme is unable to secure sufficient funding and is barely functional. The government's decision in 2007 to supply free antiretroviral (ARV) treatment has not been implemented. Patients are still asked to pay for drugs, laboratory tests and medical follow-up. As many patients cannot afford to pay, they cannot get the care they need.

Although the prevalence of HIV is low in comparison with many other countries in sub-Saharan Africa, the lack of investment in care and the stigmatisation and discrimination that patients with the disease encounter mean that HIV is a significant problem in Guinea.

At the end of 2011, Médecins Sans Frontières (MSF) was providing ARV treatment to 7,440 people in Conakry, the capital, and

HONDURAS



In Honduras's capital Tegucigalpa, Médecins Sans Frontières (MSF) is developing a programme to improve medical assistance for people affected by violence.

Drug trafficking, clashes between gangs and legal access to guns have made violence commonplace in Honduras.

An MSF survey carried out at the end of 2010 found that nearly 59 per cent of under-18s living on the streets of Tegucigalpa had experienced physical violence within the past year, while 45 per cent reported that they had been victims of sexual violence.

Working on the streets of Tegucigalpa

MSF has set up mobile teams, made up of a social worker, psychologist, doctor and nurse, who visit 20 sites around the city each week – perhaps a public square or street corner – providing on-the-spot healthcare where they can, or referring people in need of more advanced or complex treatment to Ministry of Health facilities.

The team conducted 1,860 consultations in 2011. As the year progressed, there were signs that the programme was beginning to influence behaviour and encouraging more people to seek medical treatment. In March, 19 per cent of street-based patients referred to a health centre by

MSF actually went. By December, the number had risen to nearly 26 per cent.

Introducing treatment for victims of sexual violence

MSF also assists victims of sexual violence in four health centres in some of the most violent areas of Tegucigalpa. A team of one nurse and one psychologist provides psychological and medical care to patients and trains Ministry of Health staff.

Since February, MSF has been actively participating in the elaboration of a national protocol for the treatment of victims of sexual violence, helping to draw up the medical content. MSF is also advocating that sexual violence be considered a public health emergency.

At the end of 2011, MSF had 22 staff in Honduras. MSF has been working in the country since 1974.



Staff working on the streets of Tegucigalpa provide on-the-spot medical care as well as referrals.

HAITI

At the end of 2011, almost two years after the earthquake, nearly half a million Haitians were still homeless and living in unhealthy conditions. The health system requires a huge amount of investment in reconstruction.

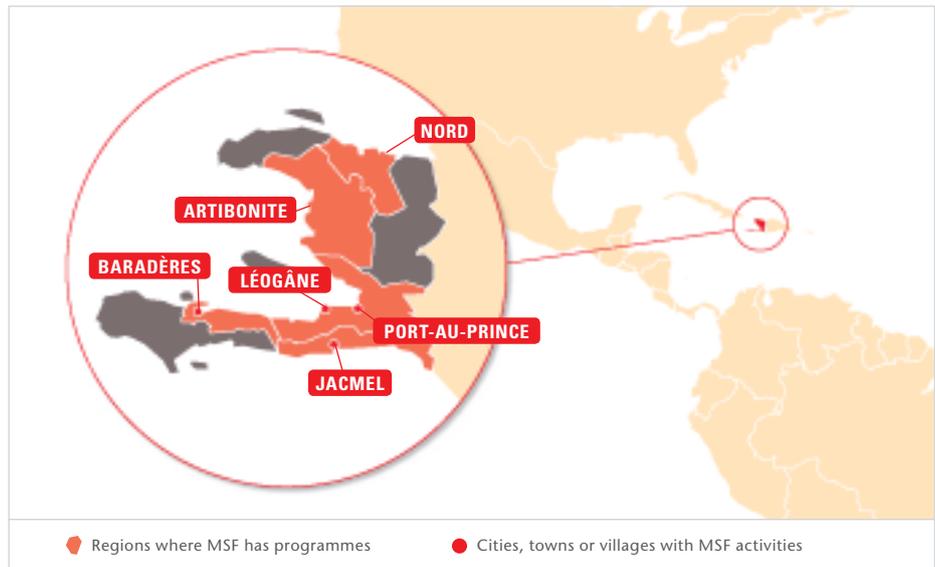
Médecins Sans Frontières (MSF) continued to respond to the cholera epidemic and provide specialist medical care in Port-au-Prince and nearby Léogâne.

Cholera epidemic

The cholera epidemic, which broke out in October 2010, had infected 520,000 people by the end of 2011, killing more than 7,000. MSF treated around 170,000 patients for cholera symptoms during this time, working in 50 facilities across the country.

In Nord department, MSF opened 19 treatment centres and 90 oral rehydration points. Staff treated more than 31,700 patients in Nord department alone. In the first months of the year, when the number of new patients started to stabilise, MSF began to hand over activities. Staff provided six months of training and logistical support to Ministry of Health workers in Nord department before withdrawing in October.

MSF continued to provide treatment for cholera elsewhere in Haiti, particularly



for people suffering complications due to pregnancy or existing chronic diseases. In May, the rainy season began and the rate of infection rose again. Staff reopened emergency treatment centres in Port-au-Prince, bringing capacity up to 1,000 beds in eight sites.

At the end of the year, cholera was still not under control, and unexpected rises in infection continued to occur. As long as people are obliged to live in conditions that exacerbate the spread of infectious diseases – half the population of Haiti does not have access to safe drinking water – the resurgence of cholera will be a risk. MSF spoke out about the need to strengthen the national surveillance and response systems.

Maternal healthcare

Before the earthquake, MSF's work in Haiti concentrated on maternal healthcare. A large proportion of maternal deaths are due to pregnancy-related hypertension disorders, such as pre-eclampsia, which are treatable, but many women do not have access to emergency obstetric care.

The earthquake destroyed MSF's emergency obstetric hospital in Port-au-Prince. In March 2011, a new referral centre for obstetric emergencies (CRUO) was opened in the neighbourhood of Delmas 33. This 80-bed hospital offers free 24-hour care to women experiencing serious complications in their pregnancies. Staff at the centre also provide postnatal and neonatal care, family planning, mental healthcare and a programme to prevent mother-to-child transmission of HIV. In 2011, MSF assisted over 4,000 births at the centre, most of which were emergency deliveries.

Hospital care in the capital

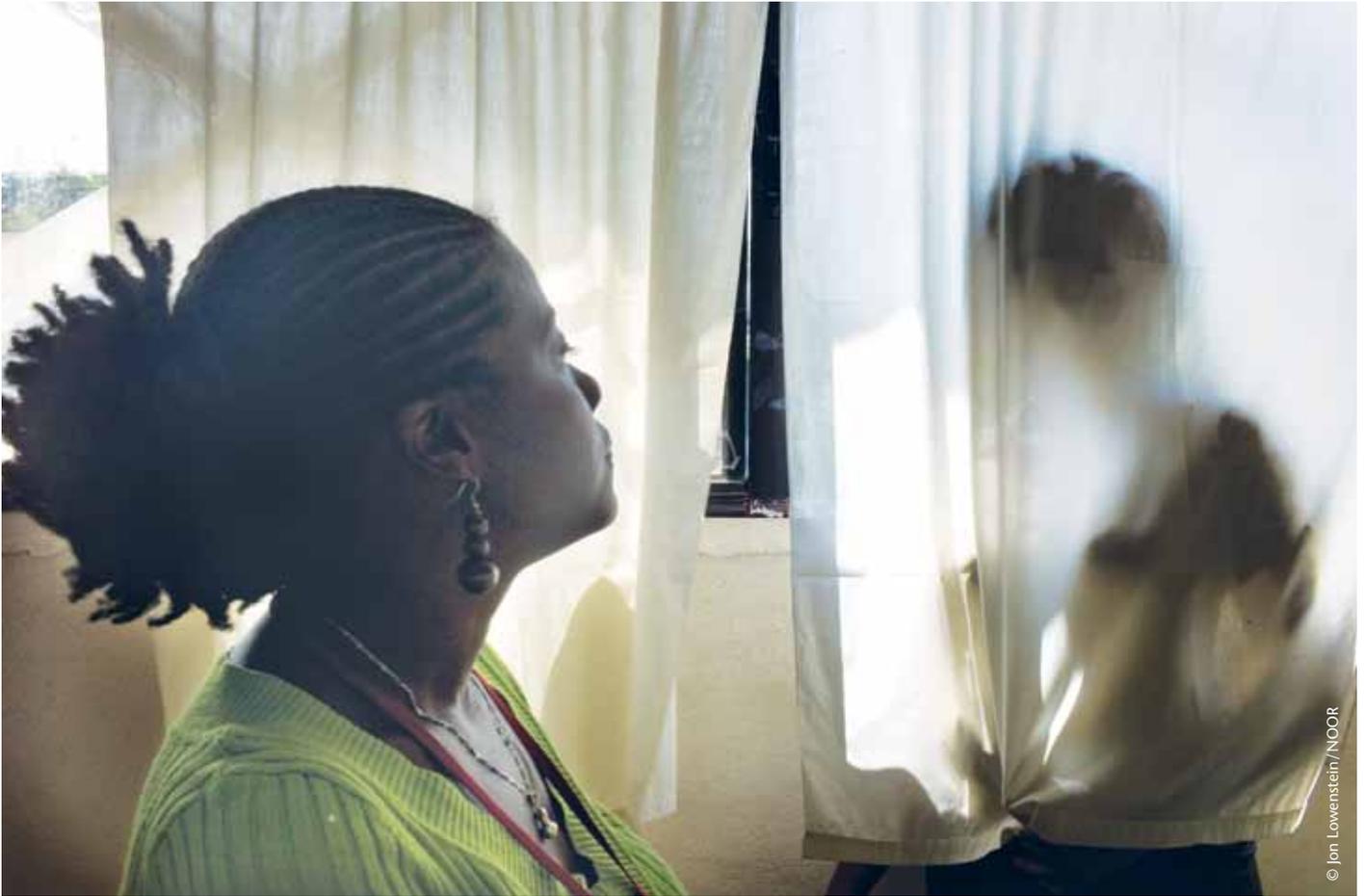
At hospitals across the capital, MSF has switched its focus from emergency response to more routine specialist medical services. Bicentenaire hospital, which had been set up in a former dental clinic just after the quake, was closed in July. It offered emergency care and surgery, paediatric care and mental health services, as well as ambulance referral. In the hospital and two mobile clinics, Bicentenaire staff saw around 4,000 patients a month in 2011.

In the impoverished neighbourhood of Cité Soleil, MSF staff at the Ministry of Health's Choscal hospital worked in the two operating theatres, the emergency



Emergency treatment at MSF's hospital in Tabarre, Port-au-Prince.

© Yann Libessart



A patient receives treatment following an incident of sexual violence, Port-au-Prince.

© Jon Lowenstein/NOOR

department and the paediatric and maternity wards. They also provided medical and psychosocial care to victims of sexual violence.

MSF's 40-bed emergency and stabilisation centre in Martissant withstood the earthquake. In addition to emergency assistance, the hospital continues to offer maternity care, internal medicine and mental health services. In Sarthe, MSF runs a centre offering wound care and orthopaedic and reconstructive surgery. Handicap International physiotherapists work with MSF to rehabilitate patients and help them adapt to mobility aids.

In May, MSF's inflatable hospital, set up on school playing fields in the days after the earthquake, was replaced by a new 200-bed hospital in Drouillard district. Drouillard hospital offers a wide range of services and has a specialised burns unit. Surgeons performed around 20 operations a day, and 29,000 patients were admitted for emergency treatment over the course of the year.

Access to care outside the capital

Léogâne, a city just west of Port-au-Prince, was almost completely destroyed by the earthquake. In October 2010, MSF replaced the tent hospital it had set up in the

city immediately after the earthquake with a semi-permanent container hospital. Chatuley hospital has 160 beds and mainly focuses on trauma and obstetric emergencies. The outpatient department offers basic healthcare to women and children under the age of five.

In Jacmel, in the southeast of the country, MSF began supporting Ministry of Health staff at the Saint Michel hospital directly after the earthquake. Staff provided emergency care, surgery, paediatric and maternal care, as well as mental health services. In February 2011, as emergency needs had abated, MSF withdrew.

At the end of 2011, MSF had 3,872 staff in Haiti. MSF has been working in the country since 1991.

170,000
PATIENTS
treated for cholera
since October 2010

Moïse

33 years old

"I'm from Bogbanique. The illness began when I was in my garden. I was working. It began all of a sudden. I didn't know what was happening to me. I lost consciousness. Some people took me to the clinic. They put me on a drip. I remember that, because that was when I came to. But the medical centre there didn't have the right treatment for me, so they put me on a motorbike and we came to Thomassique. I fainted again. I don't remember arriving here. But now I am conscious again, and I feel better.

"I've seen others with cholera. I don't think I'm any worse off than them, but I'm no luckier either. When this disease gets you, it's life or death."

INDIA

Quality healthcare remains out of reach for millions of people living in India.

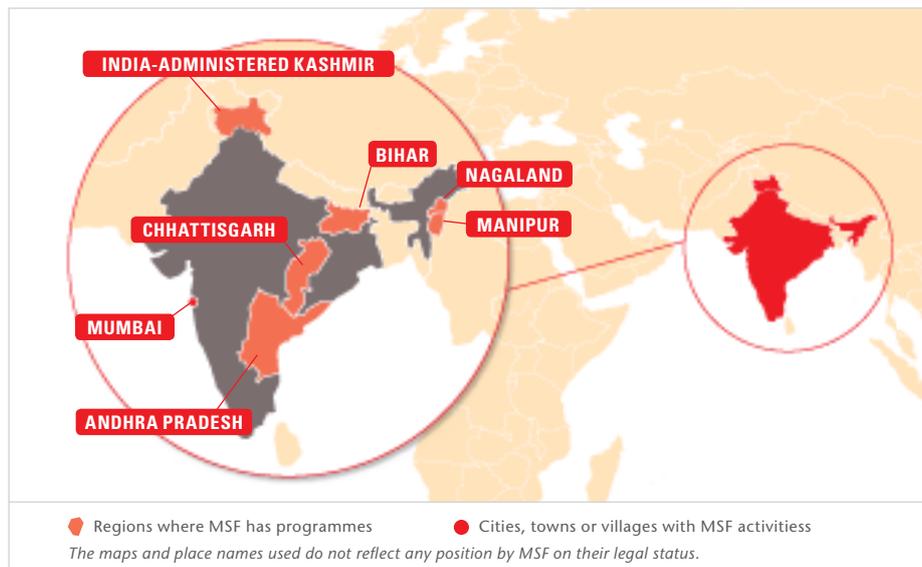
Médecins Sans Frontières (MSF) provides free health services to people living in the states of Bihar and Chhattisgarh, the disputed region of Kashmir, remote villages on the border with Myanmar, as well as the enormous city of Mumbai.

Chhattisgarh: caught up in conflict

Villagers living in the forests of Chhattisgarh state are caught up in the long-running conflict between government forces and the Naxalites (a Maoist group). Medical facilities are scarce. MSF runs mobile clinics in 16 locations, providing healthcare and hospital referrals to rural communities in southern Chhattisgarh and to displaced people in camps in the neighbouring state of Andhra Pradesh.

In 2011, MSF expanded its activities in the area, conducting almost 68,000 consultations, covering antenatal care, nutritional support to children and pregnant women, treatment for malaria and tuberculosis (TB) and health promotion activities.

MSF carried out nearly 20,000 consultations in the mother and child centre it runs in the town of Bijapur. The team administered more than 11,000 vaccinations and treated approximately 5,000 people for malaria. In the district hospital, staff screened for TB and performed emergency obstetric surgery. MSF also supports a community



health centre in Konta with TB counselling and health promotion activities.

Health needs in the disputed region of Kashmir

In Kashmir, more than 20 years of instability and violence have taken a toll on people's health and on the availability of medical services, particularly in the areas along the militarised Line of Control. At clinics near the Line of Control, MSF delivers ante- and postnatal care, vaccinations and TB screening services. Female doctors are available for reproductive health consultations.

Mental health needs are great in Kashmir, due to the history of conflict, and MSF provides

psychosocial services and counselling to traumatised people. In 2011, mental health staff saw almost 4,000 patients.

Countering neglect in the northeast

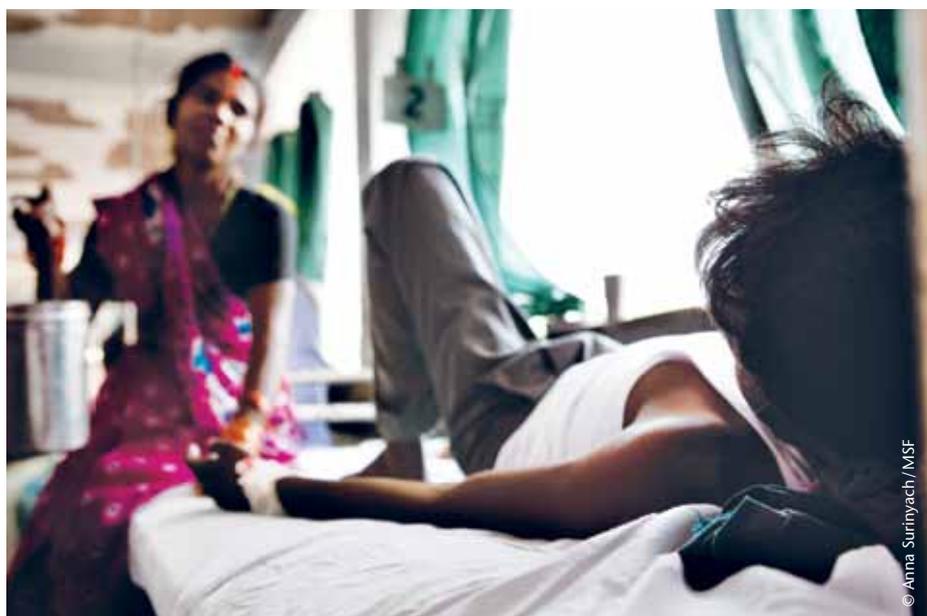
Nagaland, in northeastern India, near the border with Myanmar, is an isolated and neglected state, partly due to its geographical location, but also as a result of cultural differences and a long-running, low-level conflict between separatists and state security forces. The health infrastructure and supply system are poor, and there are few specialist medical staff.

During 2011, MSF rehabilitated the buildings of Mon district hospital, constructed a zone for waste management, improved basic healthcare services and trained hospital staff. The team held more than 30,000 outpatient consultations, and 3,044 people were admitted as inpatients.

The neighbouring state of Manipur has also suffered from years of internal conflict. MSF continues to offer medical assistance at its clinics in rural areas, including reproductive health services and measles vaccinations. The team runs an HIV programme, providing both first-line antiretroviral (ARV) treatment and second-line, for patients who develop resistance to first-line drugs. In addition, staff test, treat and counsel people with TB and multidrug-resistant TB (MDR-TB), and have introduced an innovative home-based model of care. Approximately 30,000 consultations were carried out in 2011.

Mumbai: HIV care for marginalised groups

HIV care in India is improving, but some people remain unable to access treatment



© Anna Surinyach/MSF

In Vaishali district, more than 1,900 patients received treatment for kala azar.



Members of the kala azar team in Vaishali district, Bihar.

© Anna Surinych /MSF

in the public health system. These include individuals co-infected with HIV-2, a less common strain of HIV, hepatitis B, hepatitis C and MDR-TB, as well as those requiring alternative first-line drug regimes, and those whose second-line treatment fails.

Since 2006, MSF's ARV treatment centre in the Khar area of Mumbai has been providing medical and psychosocial care to these marginalised groups. The team also conducts outreach activities in the community and carries out operational research in an effort to improve HIV care countrywide.

India has the second-highest number of MDR-TB patients in the world, and in 2011 MSF increased the number of patients it treated for the disease at its Mumbai clinic. At the end of the year, 295 patients were on ARV treatment, 29 of whom were co-infected with MDR-TB. In addition, MSF initiated third-line HIV treatment for seven patients.

Kala azar and malnutrition in Bihar

Kala azar (visceral leishmaniasis) is endemic in Bihar state in eastern India. People living in poor conditions are most susceptible to the disease, which frequently goes undiagnosed and is fatal if left untreated. MSF has been diagnosing and treating kala azar in five local health centres in Vaishali district since 2007. Most people are treated as outpatients; only

those suffering complications are admitted to Sadar hospital. More than 1,900 people received treatment with liposomal amphotericin B in 2011. MSF is investigating potential alternative treatments, including single-dose and combined therapies.

Bihar is one of the poorest states in India and there are high levels of malnutrition in children aged between six months and five years. In Darbhanga district, MSF operates a 20-bed inpatient therapeutic feeding centre for children in a critical condition, and five outpatient centres, where those with severe malnutrition come for weekly medical check-ups and receive therapeutic food. More than 2,900 children were admitted to the programme in 2011.

Local communities were also educated about the causes, symptoms and treatment of malnutrition, while an art exhibition helped raise public awareness of this neglected issue.

At the end of 2011, MSF had 736 staff in India. MSF has been working in the country since 1999.

Rama Chhattisgarh

Rama lives in a village in the forests of Chhattisgarh. She has TB, but defaulted from treatment last year, due to social pressure in her village, but also because she found it difficult to travel the long distance to the clinic in a conflict zone.

Rama's husband has now been trained by MSF teams to administer her injections and make sure that she takes her medication every day.

"I'm more committed and motivated to stick to the treatment. This time I will not fail. I'm very happy that I can work again, because the whole family needs this income. If MSF were not here I would not have any other place to receive treatment for the disease. There are more people in my village with the same disease, but they are still afraid to come so far to get treatment. If they see my improvement, they may get motivated to come."

IRAN



Since 2001, Médecins Sans Frontières (MSF) has provided basic and specialised healthcare to both Afghans and Iranians who would otherwise have difficulty accessing medical services in three health clinics and one specialised mother and child clinic in the city of Zahedan, in Sistan-Baluchestan.

Between January and September 2011, MSF carried out more than 26,500 consultations, 38 per cent of which were for children under five. Staff referred patients requiring emergency medical attention to a Ministry of Health hospital, and then provided medical follow-up. A team of 20 home visitors distributed relief items, such as food, blankets and cleaning materials, to 820 families.

In 2011, Afghan and Iraqi refugees registered in Iran received some good news: they were at last eligible for medical insurance. However, undocumented Afghans and Pakistanis in the country face increasingly restrictive rules and policies, and they continue to be deported.

Sistan-Baluchestan has been closed to international humanitarian workers since 2007. In mid-2011, security concerns led to the closure of two of the clinics and the end of home visits. The team focused its activities on medical emergencies and women's health instead. However, after three years of tension between the Iranian Bureau for Aliens and Foreign Immigrants' Affairs and MSF, a decision was finally made in September to stop medical activities, and MSF closed the Zahedan programme.

Health services for women and children in south Tehran

In the south of the capital Tehran, the neighbourhoods of Darvazeh Ghar, Khazaneh Molavi and Shush are home to vulnerable people such as sex workers and drug users.

The Iranian authorities have recently started to talk about some social issues more openly.

This year, for the first time since the 1979 revolution, authorities acknowledged that prostitution, child labour and child homelessness were national concerns. The Ministry of Health and some municipalities are setting up medical and social centres in several areas of Tehran, offering services such as social protection, methadone maintenance therapy and health education to sex workers and drug users. Nevertheless, many people still have no access to medical or social support.

MSF is collaborating with a network of associations working mainly in child protection or harm reduction, and in early 2012 plans to open a new programme, providing healthcare to children under five and women living in the Darvazeh Ghar area.

At the end of 2011, MSF had 62 staff in Iran. MSF has been working in the country since 1996.



Staff worked in four clinics in Zahedan and also made home visits to patients.

IRAQ



Years of economic sanctions, neglect, war and violence have resulted in an overall deterioration in national health facilities and services in Iraq. There are gaps in emergency services and obstetric care, and a striking absence of mental healthcare.

In parts of the country, violence persists. Health workers have to carry out their work in insecure conditions, and with fewer resources. Despite insecurity, Médecins Sans Frontières (MSF) was able to scale up its activities.

Obstetric and neonatal support in Najaf

Al-Zahra district hospital is the main referral centre for obstetric, gynaecological and paediatric care in Najaf governorate. Some 24,000 babies are born in the hospital every year. MSF works in close collaboration with hospital staff, helping to build capacity in specialised units such as intensive care and the maternal and neonatal departments. MSF specialists in obstetrics and emergency paediatrics held a conference with hospital staff, advocating improved obstetric practices in an effort to reduce neonatal deaths. The team also provides training and works with the hospital to improve sterilisation and infection control. Facilities in the maternity ward were renovated.

Emergency care and surgery

Every month, as many as 20,000 people seek emergency medical care at Basra general hospital in the far south of the country. In 2011, an MSF team trained staff in the management of emergency arrivals and situations involving large numbers of injured people. MSF also offered training in post-operative and neonatal care, and renovated the operating theatre in the emergency department, improving conditions for the 300 or so operations that



Surgery at Hawijah general hospital.

are performed each month. The programme was handed over to the Ministry of Health in June 2011.

Another team continues to offer surgery and obstetric care in Hawijah hospital. Between January and June, surgeons carried out 212 operations.

Treating kidney failure

In Kirkuk general hospital, some 200 kilometres north of Baghdad, MSF offers treatment to people with non-communicable diseases. The team mainly cares for patients with severe kidney failure. The capacity of the dialysis unit was improved and the number of patients tripled: 88 were receiving dialysis at the end of 2011.

Psychosocial care

MSF staff conducted more than 10,700 counselling sessions with some 3,800 patients in three hospitals in Baghdad and Fallujah. Since 2009, staff have been working to reduce the stigmatisation around mental health issues in Iraq by organising awareness-raising activities in the community. In conjunction with the Ministry of Health, MSF produced a film exposing the types of mental health problems that are common in the country and explaining that help is available.

Reconstructive surgery in Jordan

Since August 2006, MSF has been running a reconstructive surgery programme for

wounded Iraqis in Amman, Jordan. Over the years, the programme has expanded to admit patients from elsewhere in the region, including Gaza, Yemen, Libya and Syria. MSF provides specialists in plastic, orthopaedic and maxillofacial surgery. In 2011, they performed a total of 913 operations. The team also offers psychosocial support and physiotherapy.

Around 50 new patients are admitted to the programme each month. They may stay in the centre for several weeks or as long as two years, depending on their injuries.

By the end of 2011, more than 1,700 patients had received advanced surgical care since the programme began.

At the end of 2011, MSF had 264 staff in Iraq. MSF first worked in the country in 2003.

IVORY COAST

The dispute over Ivory Coast's presidential election in November 2010 provoked violence that had escalated to full-scale war by February 2011.

According to the UN, more than 1,000 people were killed. Hundreds of thousands of people fled their homes, as villages were burned. While some gathered in camps or crossed the border into Liberia, others hid in the bush, afraid to seek assistance.

Many of the country's health facilities closed due to the conflict. Médecins Sans Frontières (MSF) set up mobile clinics and supported hospitals and health centres in Abidjan and western Ivory Coast, where the heaviest fighting took place.

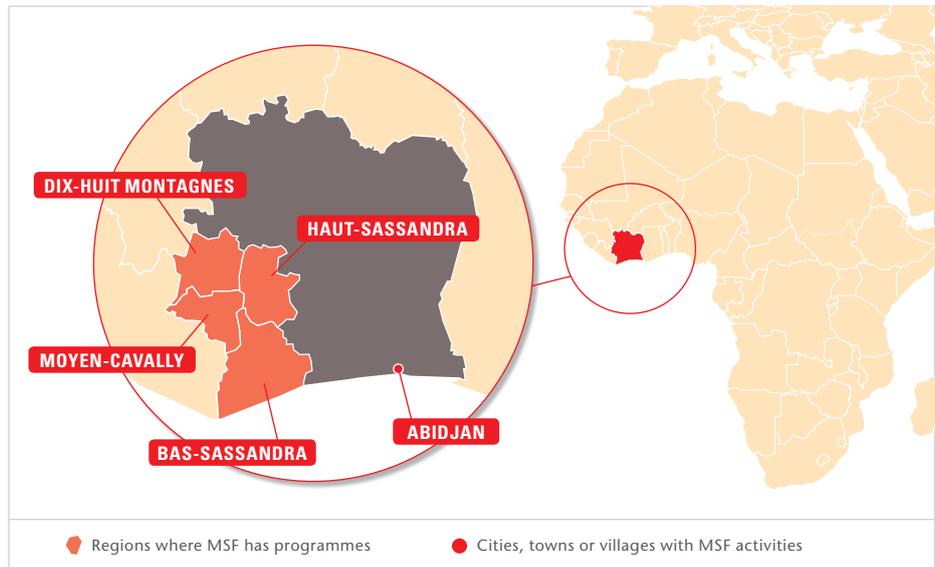
Western regions

In the western regions of Moyen-Cavally and Dix-huit Montagnes, medical facilities that had not been destroyed were short of supplies and staff. Many people who had been displaced by violence had no access to medical services. MSF began to offer emergency medical assistance in the town of Duékoué in early January. Staff provided emergency treatment for some 4,600 patients and assisted more than 1,480 births. Close to 100,000 consultations were held at mobile clinics and a health centre in the area.

From March, teams began to support the hospital and operate mobile clinics in the department of Guiglo, carrying out more than 77,000 consultations. New programmes were opened in Boléquin, to the west, and Taï, further south, in September and December, respectively. In total, almost 1,000 patients were admitted to hospital.

MSF also set up mobile clinics and carried out more than 33,000 consultations in and around the towns of Man, Zouan-Hounien and Toulépleu. Over 300 malnourished children were admitted to a nutrition programme in Man between July and September. The 15-bed health centre in Bin Houye, just north of Toulépleu, was reopened, and staff provided emergency care for 175 patients.

In March alone, a surgical team in Bangolo performed 147 operations, more than 70 per cent of which were for gunshot wounds. Some 470 patients received



psychological support. Staff also ran mobile clinics in the surrounding area, seeing over 5,000 patients.

In May, medical programmes were opened further east, in the towns of Tabou and Daloa, and staff carried out more than 80,000 consultations in total.

Abidjan

On 28 February, MSF opened Abobo Sud hospital, on the front line of the conflict in Abidjan. Surgical teams worked around the clock. Between mid-April and the end of August, they performed more than 2,200 operations. Some 3,890 patients were admitted to the emergency department,

and in other departments, MSF staff assisted over 4,100 births and conducted around 20,250 consultations. As the violence calmed, more people came to the hospital, and queues started to form from 4am. To reduce the pressure on Abobo Sud, MSF began working in eight health centres and in two other hospitals in the north of the city – Anyama and Houphouët-Boigny.

In the south, Koumassi hospital was the first health facility to resume activities and offer free healthcare to a population of 600,000. MSF health workers provided support to hospital staff, holding more than 19,800 consultations between April and May. In June, MSF set up a cholera treatment unit



A patient with bullet wounds has his dressing changed, Bangolo hospital, Dix-huit Montagnes.

© Peter DiCampo



© Peter DiCampo

At Nanan Yamouso clinic, Abidjan, staff carried out wound dressing and surgery.

in the hospital to respond to an increase in the number of people with the disease. The team also set up a unit in the camp where the majority of cholera patients came from, and organised the decontamination of areas where cholera was found.

In Treichville, MSF donated essential drugs and medical supplies to the hospital and opened a trauma centre in Nanan Yamouso clinic. Gynaecological and obstetric services started shortly afterwards, and staff treated more than 750 emergency patients, performing over 470 operations. In June, as the number of patients grew, the teams transferred activities to the larger Port-Bouët general hospital, just east of Treichville.

At Port-Bouët, MSF renovated two operating theatres and the inpatient department, increasing the number of beds to 120. Staff carried out more than 4,000 emergency consultations and 1,300 surgical procedures, and assisted 1,250 births. Handicap International worked with MSF, rehabilitating patients after surgery. In addition, MSF supported six health centres located around the hospital between May and July, carrying out over 17,700 consultations. The team set up a cholera treatment unit and treated 84 patients.

In the west of the city, in Yopougan, MSF began handling emergency admissions at Attié general hospital in April, when fighting in the immediate surroundings had severely restricted access to the hospital. Some 22,270 consultations were held in just over a month. Close to 950 patients were admitted for surgery, including 169 who had been wounded by bullets or shrapnel. A team also set up a mobile clinic at a nearby church, where more than 1,000 people had taken refuge.

As the violence subsided and people returned to their homes, access to healthcare slowly improved across Ivory Coast, and MSF began handing activities back to the Ministry of Health and non-governmental organisations.

At the end of 2011, MSF had 646 staff in Ivory Coast. MSF first worked in the country in 1990.

Charles*

72 years old

"On Monday 28 March I was at home, because I am old and retired. Armed people came and took me to the big road. They laid me down on it, doused me with gasoline and set me on fire. My foot and my clothes were burnt. Somebody took me to the hospital on his moped the next day.

"Then the rest of my family followed me here. Our home was destroyed, burned down. We don't have anything left. The harvest has gone. Everything has been ransacked.

"I need to heal my foot. But when I get out of hospital where am I going to go and where am I going to put my family? I'm panicking just thinking about going back to my village. I don't really care who the president is, whether it is Paul or Joe, I just want to be in peace."

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

ITALY



Tens of thousands of people undertook dangerous journeys across the sea to seek refuge in Italy in 2011.

Most people were fleeing violence and conflict in Libya or Tunisia. Many were sub-Saharan Africans who had come to Tunisia or Libya in search of a better life.

When conflict then broke out in these countries, thousands of people risked their lives to reach Italy, crossing the Mediterranean Sea in overcrowded, unseaworthy boats. Most headed for the small island of Lampedusa, which is less than 150 kilometres from Tunisia. More than 2,000 men, women and children never arrived, drowning at sea when their boats sank.

Many of those who survived arrived in a state of extreme fatigue and shock. Médecins Sans Frontières (MSF) offered assistance to people as they arrived on shore, giving out blankets and determining who needed priority medical treatment. More than 200 people were referred to hospital by ambulance, while over 1,900 people received medical attention upon landing.

At the peak of new arrivals in March, 3,000 people spent several days and nights on the docks, sharing 16 latrines and surviving on 1.5 litres of water each per day. MSF teams provided medical assistance to nearly 2,000 people, and distributed thousands of relief items such as blankets and washing kits.

When migrants, asylum seekers and refugees had been transferred to detention centres, MSF medical staff provided follow-up. The most common complaints were gastrointestinal, pulmonary and respiratory infections. The team also treated patients who had suffered violence, and in centres in Mineo, on the island of Sicily, they gave mental health support to 400 asylum seekers.

Assisting detained migrants

The most vulnerable migrants and asylum seekers – pregnant women, and victims of

torture and sexual violence, among others – were systematically detained in closed centres while the authorities assessed their status. In late June, MSF staff witnessed that some refugees and asylum seekers had already been kept in transit and reception centres for as long as 40 days. In several of these centres, services were practically non-existent – with limited access to basic healthcare, no information, no interpreters, no legal advice and no telephones. Detainees, including pregnant women and people with medical problems, were sleeping on mattresses on the floor, and there was rarely separate accommodation for single women or families.

In the absence of appropriate facilities, unaccompanied minors were also detained, in blatant violation of European and international standards. In June, MSF found that more than 300 under-18s had been locked in transit centres on Lampedusa for weeks, 80 of them for more than 30 days. MSF also counted 450 unaccompanied minors in transit and reception centres in Sicily (Pozzallo, Porto Empedocle, Mineo, Caltanissetta).

Closure of Lampedusa holding centre

In September, the overcrowded holding centre in Lampedusa was set on fire in protest at Italy's policy of forced repatriation. Then riot police clashed with hundreds of migrants and asylum seekers during a protest about living conditions. The Lampedusa centre was closed and, at the end of the month, the port was declared

unsafe for rescue-at-sea operations, putting even more lives at risk.

Calling for protection

MSF repeatedly drew attention to the appalling living conditions in the reception centres and their impact on detainees' physical and mental health.

In May, MSF sent an open letter to the member states of the European Union, calling especially on those directly involved in the conflict in Libya to protect victims of war there and in Europe. MSF asked for decent reception conditions for all those escaping violence, access to asylum procedures for those who requested it, and recalled the right of refugees to protection against forcible return. MSF reminded the EU and its member states of their responsibility for the fate of these victims of war and their obligation to ensure that refugees' rights are respected.

Migrant workers in need of assistance

Hundreds of sub-Saharan migrants head for Rosarno, in the south of mainland Italy, in search of seasonal work. Housing and living conditions for seasonal workers in Rosarno are very poor, and bad weather in 2011 made them worse. In November, MSF distributed washing kits and blankets to hundreds of people in need of assistance.

At the end of 2011, MSF had 8 field staff in Italy. MSF first provided medical assistance in the country in 1999.



A team carries out medical triage and delivers relief to migrants arriving in Lampedusa.

© Natalia Insolera

JAPAN



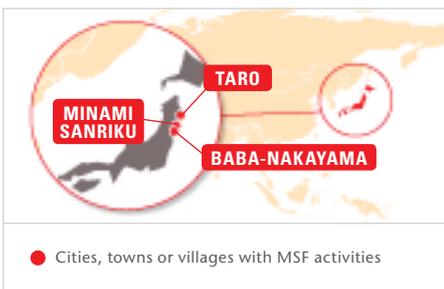
A consultation at an evacuation centre for earthquake survivors in Minami Sanriku.

Ha Young Lee

Coordinator of the MSF psychological team

“Although some people have their own coping mechanisms and can deal with the situation in which they find themselves, others find it very difficult. People can have intrusive memories of the event, flashbacks, nightmares. They can withdraw and not want to communicate. Some will not be able to sleep or eat. And all of these things can make them very different than they used to be and can cause significant suffering.

“Children are particularly vulnerable – it can be difficult for them to understand what is going on. They have limited space where they can freely express their emotions. They have lost the space to learn and play.”



Ensuring access to medical care

MSF worked principally in the northern coastal towns of Minami Sanriku and Taro, where the main healthcare facilities were totally destroyed. From March to June, medical teams conducted some 4,840 consultations. Patients' main complaints were hypertension and upper respiratory tract infections.

MSF delivered two 30-seater buses to authorities in Minami Sanriku to help transport patients from evacuation centres and temporary housing to medical facilities.

At the request of people staying in a centre in Baba-Nakayama, MSF designed and helped construct a semi-permanent shelter close by. The team supervised 25 evacuees, who built a private space for approximately 30 women and children, which reduced overcrowding in the existing centre.

In Taro, MSF designed and built a temporary clinic, for use until a more permanent structure is completed. This was handed over to local health authorities in December.

MSF also delivered a vehicle specifically designed to transport disabled patients living in and around Taro.

Invisible scars

After the initial emergency response, the team shifted focus to the mental health needs of survivors, offering psychological support, especially for people living in evacuation centres.

MSF psychologists carried out activities to raise awareness of mental health issues and the support that was available.

Staff conducted interviews with the media, including a local radio station set up by survivors of the disaster. They discussed how to identify potential problems and manage stress, how parents can help their children, and where to seek support. MSF staff accompanied nurses on visits to temporary shelters and provided direct training in mental health during consultations with patients. They also visited schools to advise teachers on supporting children post-trauma.

In April, a café was set up near the Bayside Arena of Minami Sanriku. Here, people could talk in an informal setting, with a team of MSF psychologists on hand to provide counselling. For those in need of extra support, staff offered one-to-one sessions.

The main problems reported by people at the café related to stress management, difficulties with memory and concentration, and sleeping disorders due to crowded conditions in temporary housing. Older people were often concerned about dementia.

At the end of June, MSF handed over its activities at the café to a local association. More than 4,100 people had used the space, and 646 people had received psychological assistance. Over 970 individual support sessions and 295 group sessions were held in Minami Sanriku and Taro.

During 2011, MSF had 4 field staff in Japan. This was the first time MSF had provided medical assistance in the country.

The earthquake and tsunami that struck Japan on 11 March devastated the northeastern coast of Honshu Island.

Approximately 15,000 people were killed and 6,000 were injured. At the end of the year, some 5,000 people were still missing.

Japanese emergency teams were largely able to respond to the needs of survivors, and Médecins Sans Frontières (MSF) offered specialist assistance. The day after the quake and tsunami, staff made their way to affected areas by helicopter and began providing survivors with medical care and distributing relief items.

In the weeks that followed, MSF distributed 4,030 blankets, 6,500 litres of water, a generator for a temporary shelter in Baba-Nakayama village and 10,000 hygiene kits containing soap, toothbrushes, toothpaste and towels. MSF also provided kits containing batteries, candles and matches to some 4,000 people and donated 110,000 euros' worth of medicines, medical equipment and supplies.

KENYA

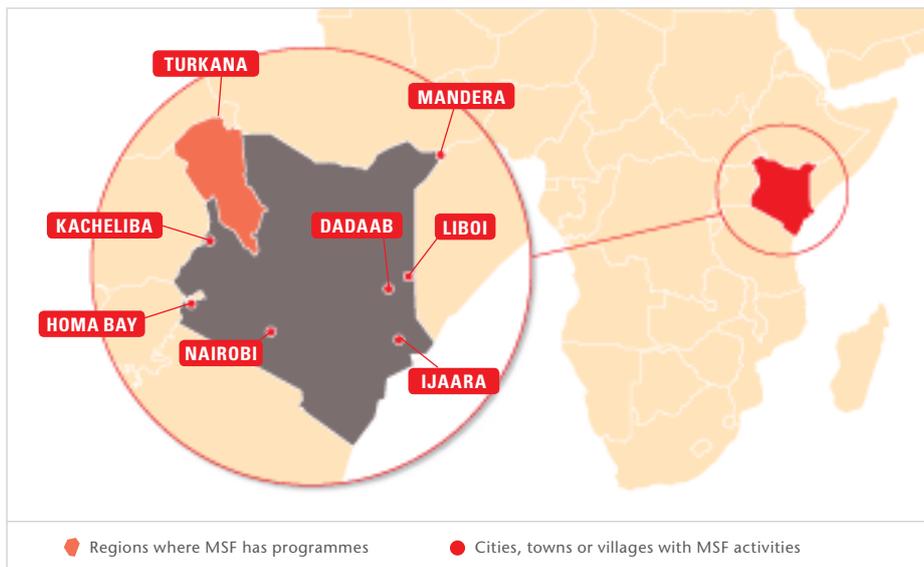
For more than two decades, Médecins Sans Frontières (MSF) has been providing medical care in Kenya. In 2011, MSF assisted both local people and the large Somali refugee population.

Drought in the Horn of Africa aggravated the already dire situation for refugees in the overcrowded camps around Dadaab, in eastern Kenya. A surge of people fleeing Somalia in search of safety, food, healthcare and shelter in the three camps of Ifo, Dagahaley and Hagadera resulted in a humanitarian emergency. The camps, which had been built for 90,000, swelled to a total population of nearly half a million, making the Dadaab area the third-largest city in Kenya. At the height of the crisis in July, malnutrition levels were well above the emergency threshold. Aid agencies struggled to cope.

Two new camps were opened – Ifo 2 and Kambioos. However, at the end of the year, some 5,000 refugees were living outside Dagahaley, unable to find a place to stay in any of the camps. Inside Dagahaley, MSF was the main provider of healthcare for nearly 125,000 registered refugees, and also catered for the needs of refugees referred to its hospital from other camps. The team tripled capacity, setting up an emergency nutrition centre with more than 200 beds, while maintaining a 100-bed hospital for maternal care, paediatrics, emergencies and general medical assistance.

MSF conducted more than 170,000 consultations in its hospital and health posts in Dagahaley camp, over 4,000 more per month than planned. Admissions for nutritional support averaged at 350 per month. Over 11,500 patients were admitted to the outpatient nutrition programme during the year. As most of the refugees from Somalia had had little or no access to healthcare for two decades, outbreak of disease was a major concern, and MSF launched a measles vaccination campaign.

After protracted negotiations with the government of Kenya and local communities, MSF began working in Ifo 2 camp in July. However, just three months later, in October, two staff members were abducted by a group of armed men, forcing MSF to reduce health activities in the camp.



As insecurity grew, refugee registration was closed. Refugees were no longer being transported to Dadaab or relocated elsewhere. There was a general reduction in non-lifesaving activities, which threatened to reverse the gains achieved during the year.

Liboi, 80 kilometres from Dadaab, is one of the primary crossing points between Somalia and Kenya. When the flow of new arrivals was at its peak, MSF worked in a health centre there, providing care for both Kenyans and Somalis. Further south, in Ijaara district, MSF assisted Ministry of Health staff in the provision of maternal and child healthcare. In March, fighting in the Somali town of Bula Hawa drove

approximately 15,000 refugees and 5,000 displaced people to the Kenyan border town of Mandera. MSF supported the district hospital and conducted over 1,500 outpatient consultations.

The drought in the Horn of Africa also affected other parts of Kenya. In April, MSF organised mobile clinics and ensured access to water for nomadic pastoralists in Ijaara district. In addition, the team offered reproductive healthcare and saw an increase in the number of women seeking medical assistance during childbirth. In June, MSF launched an emergency nutrition programme in the Lapur and Kibish subdistricts of Turkana, in northwestern Kenya.



Children attend an MSF nutrition programme in Mayan, Turkana.



© Brendan Bannon

A severely malnourished child is examined at Dagahaley camp, Dadaab.

Breaking ground in addressing neglected diseases

In 2011, the Kenyan government, with the help of MSF, launched the first ever national strategic plan to control neglected tropical diseases, including kala azar (visceral leishmaniasis). Kala azar, which is transmitted by the bite of a sandfly, is almost always fatal if not treated.

MSF has worked with kala azar patients in Kacheliba, western Kenya since 2006, and in 2011 concluded a validation study of rapid diagnostic tests (RDTs) for the disease. The results of this study contributed to the government's decision to approve the tests as a first-line diagnostic tool. An RDT is ideal for use in resource-poor settings, and allows a greater number of people to be screened for the disease, thereby improving access to treatment.

A new combination treatment for kala azar, which takes just 17 instead of 30 days, was introduced, and MSF also gave training to local medical staff working in districts where kala azar is endemic.

HIV and tuberculosis (TB) care

Around 1.3 million people are living with HIV in Kenya, but only an estimated 550,000 are receiving antiretroviral (ARV) treatment. MSF has been providing HIV

and tuberculosis (TB) treatment for over a decade, and is currently treating more than 17,000 people living with HIV/AIDS and TB in urban areas and rural communities in Nairobi and Nyanza provinces.

In September, MSF detected quality problems with one ARV medicine, Zidolam-N. The drugs were confirmed to be falsified versions of World Health Organization quality-assured medicines that were purchased via a distributor certified by the Kenya Pharmacy and Poisons Board. MSF took immediate measures to trace and inform patients, replace the affected drugs and provide medical follow-up.

In 2011, MSF completed the switch from d4T-based first-line treatment to a TDF/AZT-regime, which has fewer side effects. All new patients are put on TDF/AZT.

New TB diagnostic machines have been introduced in Nairobi, which are faster and more sensitive. MSF also expanded its TB programme in Mathare, Nairobi, to the predominantly Somali neighbourhood of Eastleigh, where only limited TB treatment services were available. Some 900 patients with chronic diseases other than HIV also received treatment at MSF health centres in Nairobi. Due to be completed in 2012, MSF is building a new health centre on the

outskirts of Kibera slum. It will at first be run jointly by MSF and the Ministry of Health, then gradually handed over to the ministry.

Addressing sexual violence

In the slums of Kibera and Mathare, MSF continues to focus on treating victims of sexual violence. In both areas, the number of child victims is very high – 65 per cent of patients in Mathare are under 18. MSF provided medical assistance to over 1,000 new patients, offering post-exposure prophylaxis – treatment to reduce the risk of infection with HIV and other sexually transmitted diseases – as well as counselling and social support.

At the end of 2011, MSF had 798 staff in Kenya. MSF has been working in the country since 1987.

KYRGYZSTAN



capital Bishkek, and treated 370 patients in 2011. They also worked to improve infection control standards and living conditions, and renovated the TB wards.

Multidrug-resistant TB (MDR-TB)

In one detention facility, MSF installed a new machine that tests for TB, which facilitates better and more rapid detection of drug-resistant TB, and enables patients to start treatment earlier.

MDR-TB is either transmitted directly from another person with the disease, or develops when a patient with drug-sensitive TB, either through mismanagement or misuse of medication, becomes resistant to at least two of the standard TB drugs. Treatment for MDR-TB is much harsher than for TB: it takes up to two years and causes severe side effects.

Kyrgyzstan is one of 27 countries listed by the WHO as having a high level of MDR-TB. MDR-TB is even more prevalent in prisons because close proximity makes it difficult to implement infection control measures, and because high-risk behaviour such as drug or alcohol addiction is more common among prisoners, making adherence to medical treatment more difficult. As a result, around two-thirds of TB patients in Kyrgyzstan's prisons have drug-resistant forms of the disease.

MSF has set up a support system for patients who are released before finishing their treatment for TB or MDR-TB, to help them keep taking their medication. Volunteers living close to the patients visit them regularly and offer support until the treatment programme is successfully completed. A hotline is also available, so that patients can call if they need help. Between January and October, a network of 20 volunteers helped 192 TB and MDR-TB patients to complete their treatment.

After the 2010 riots

Political unrest and interethnic violence in 2010 aggravated conditions of poverty for many people in Kyrgyzstan. During the unrest, MSF donated drugs and medical supplies, and facilitated access to health services for those who were afraid to travel to health centres. Between December 2010 and April 2011, teams continued to offer assistance to people in Osh, the second largest city in the country. Staff held more than 1,000 medical consultations, some 1,800 mental health consultations, and distributed 5,900 washing kits, 11,900 blankets and 800 cooking kits. In July, the team started to develop a new TB programme in Kara Suu district, Osh province.

At the end of 2011, MSF had 94 staff in Kyrgyzstan. MSF has been working in the country since 2005.

The underfunding of prisons in Kyrgyzstan is affecting medical services: many prisoners with tuberculosis (TB) are not receiving the care they need.

The incidence of TB among prisoners in Kyrgyzstan is estimated to be 20 to 30 times higher than among the general population, and mortality rates can be 60 times higher. Poor conditions make inmates more susceptible to the disease and encourage its spread.

Working in collaboration with the Ministry of Health and prison authorities, Médecins Sans Frontières (MSF) began providing TB care in detention centres in 2006. Teams work in two centres (Sizo 1 and Colony 31) near the



Staff work in two detention centres near Bishkek, treating patients for tuberculosis.

LEBANON



© Dina Debbas

A social worker meets a recently bereaved family in Burj el-Barajneh refugee camp, Beirut.



Following the arrival of thousands of Syrians fleeing violence in their country, Médecins Sans Frontières (MSF) extended its activities in Lebanon.

MSF began by donating emergency supplies to health centres near the border with Syria. In November, a team set up a mental health programme in Wadi Khaled, a region in northeastern Lebanon, serving a local population of more than 20,000

people as well as Syrians seeking refuge in Lebanon. Staff carried out psychological and psychiatric consultations.

Mental healthcare in Palestinian refugee camps

Life in the overcrowded Palestinian refugee camps is arduous, and this has a significant impact on mental wellbeing, particularly for those who have already suffered traumatic experiences. MSF offers community-based mental health services – counselling, treatment and social support – in two refugee camps and the area surrounding them.

Staff make home visits and work to raise awareness of mental health services in an effort to reduce the stigmatisation of mental illness. On World Mental Health Day, 10 October, the MSF-produced documentary film *Where Do I Begin?* directed by Lebanese-Palestinian filmmaker Carol Mansour, had its premiere screening in Beirut.

Both Palestinian refugees and local people who would otherwise be unable to afford mental healthcare can go to the MSF community mental health centre outside Burj el-Barajneh

camp in Beirut, as well as to MSF services at the United Nations Relief and Works Agency (UNRWA) clinic and the Palestinian Red Crescent hospital inside the camp.

In April, MSF extended its services to Ein el-Hilweh refugee camp, in the city of Sidon (Saïda), south of Beirut, where some 75,000 people live within just one square kilometre. There are regular security incidents and clashes between political factions. MSF's team works in the two UNRWA clinics and in Al-Nidaa Al-Insani hospital. Close to 380 patients in Sidon, mostly aged between 18 and 40, received psychological or psychiatric care in 2011.

In total, staff saw more than 1,000 new patients and carried out more than 7,500 mental health consultations in Lebanon. Patients were mainly suffering from depression, anxiety, psychosis and personality disorders.

At the end of 2011, MSF had 34 staff in Lebanon. MSF first worked in the country in 1976.

LESOTHO



Life expectancy for women in Lesotho is less than 47 years, and one in 32 women die from pregnancy- and childbirth-related conditions.

HIV and tuberculosis (TB) epidemics have contributed to this situation, and nearly 60 per cent of maternal deaths are HIV-related. In May 2011, Médecins Sans Frontières (MSF) opened a new programme that aims to help reduce the number of maternal and infant deaths.

Roma and Semonkong are small towns in remote parts of the country. About 170,000 people live in the area, and some 23,500 have HIV/AIDS.

MSF supports St Joseph's district hospital in Roma, six basic healthcare clinics in the surrounding lowlands and three clinics in Semonkong. All these facilities provide comprehensive, integrated HIV and TB care, so patients with both HIV and TB only need to go to one place for treatment. As part of

their maternal health services, the clinics and hospital also work with patients to prevent mother-to-child transmission of HIV. Between July and December 2011, staff assisted more than 550 births.

Six health centres now have a CD4 testing platform. By measuring a patient's CD4 count, medical staff are able to determine more accurately how far HIV has progressed, and what treatment each patient requires. Antiretroviral (ARV) treatment can be started earlier, reducing the patient's risk of developing a number of HIV-related illnesses. In 2011, MSF enrolled 8,025 people in HIV care, and more than 5,300 patients started ARV treatment. Between July and December, more than 8,220 people were tested for HIV.

Introducing a new automated test for TB to the laboratory at St Joseph's hospital has significantly speeded up diagnosis, in particular for some forms of drug-resistant TB, meaning people can start treatment earlier.

Encouraging more people to seek care

By bringing services closer to the patient, MSF teams are hoping to encourage more people to actively seek medical attention.

But if HIV and TB services are to be available in more places, additional staff are needed to deliver them. MSF wants to introduce task-shifting in the health centres, which will mean that nurses as well as doctors will be able to initiate and follow up treatment for HIV and TB, and non-medical staff will be able to offer health education and counselling for patients on ARV treatment.

Mobile MSF medical and counselling teams have already begun mentoring and providing training to health staff.

It is hoped that the community will also get involved, with village health workers supporting HIV and TB patients. MSF provides guidance to enable members of the community to refer their neighbours to health facilities, carry out health education activities and conduct workshops. These workshops provide training for lay counsellors and help develop an awareness and understanding of issues related to HIV. Village health workers also help patients stick to treatment by enquiring after and offering support to people who miss appointments at the clinic, or who do not pick up their drug refills.

Limited access to healthcare

Accessing healthcare facilities is not easy for anyone living in this mountainous country, and it is especially problematic for people living in remote areas. Many have to walk for up to 12 hours to reach a health centre.

In 2012, MSF will buy an ambulance for the emergency transport of patients from Semonkong to St Joseph's hospital. The team is also assessing new technological tools that could help improve communications between patients and hospital staff, including SMS reminders for patient appointments and equipment to enable community health workers to collect data electronically.

At the end of 2011, MSF had 27 staff in Lesotho. MSF has been working in the country since 2006.



People living in remote areas of Lesotho have great difficulty accessing health services.

8,025
PATIENTS
enrolled in
HIV CARE

LIBERIA



More than 150,000 people fled Ivory Coast and sought shelter in Liberia, where Médecins Sans Frontières (MSF) provided emergency assistance throughout the year.

The vast majority of Ivorian refugees were hosted in local people's homes, mainly in the counties of Grand Gedeh and Nimba. Others found shelter in refugee camps.

In January, MSF launched an emergency programme in Nimba, delivering free healthcare to both refugees and local residents. The teams primarily treated respiratory and skin infections, watery diarrhoea and malaria in mobile clinics and in a health post at the Bahn refugee camp. MSF also vaccinated children under 15 years old against measles and provided local health centres with free drugs and technical support. Staff conducted more than 45,800 consultations; over 2,700 of these were antenatal, and some 14,500 were for malaria.

In March, MSF started operating mobile clinics in villages hosting refugees in Grand Gedeh, to the south of Nimba. The team conducted more than 38,300 consultations, admitted 226 children to a nutrition programme, and carried out more than 1,900 mental health sessions. Water and sanitation staff constructed wells and latrines and ensured the supply of safe water. Later, MSF extended its services to camps in the area, where some refugees had settled.

Despite the political resolution of the conflict in Ivory Coast in April, the situation initially remained insecure. Many refugees did not return home, afraid of rape, torture and intimidation. Many had no source of income as they had lost the land they had been working on, or had missed the planting season. Nonetheless, the situation had stabilised sufficiently by the end of the year for MSF to hand over activities in



People living at the transit camp in Saclepea, Nimba county, receive medical screening.

Grand Gedeh to the Liberian Ministry of Health and non-governmental organisations. Teams continued to work in Nimba into early 2012.

Sexual violence in Monrovia

In Liberia's capital Monrovia, MSF offers comprehensive medical and psychosocial care to victims of sexual violence. Teams work with specialist Ministry of Health staff in two hospitals to provide a walk-in service seven days a week, with medical staff or a social worker on call 24 hours a day.

The teams conduct medical examinations and treat patients for injury and sexually transmitted infections (STIs). Patients arriving within 72 hours of an assault receive post-exposure prophylaxis to reduce the risk of HIV and STIs. Trained mental health workers offer counselling and emotional support to victims and their families.

Staff can provide medico-legal certificates and put patients who fear for their safety in touch with a network of safe houses. MSF also works with a local non-governmental organisation, Mer-League, which is raising awareness in the community about sexual violence and the medical care that is available. In 2011, 993 new patients received care after a sexual assault, 92 per cent of whom were under 18 years old, and 1,115 follow-up consultations were also arranged for patients requiring further support.

At the end of 2011, MSF had 101 staff in Liberia. MSF has been working in the country since 1990.

Fred*

from Toulépleu, Ivory Coast

"When they attacked Toulépleu, we all ran away together to a 'campement' [a small shelter next to a plantation] near my mother's house. We were not there long when fighters came and started shooting at us. We ran and hid again.

"We stayed for two months in the bush, moving from place to place whenever we heard fighters moving. We were attacked many times. In one attack, several children were shot. They took my wife away with them.

"In the bush there was no medicine so we had to treat the children with traditional medicine for their gunshot wounds. Only weeks later did we make it to Liberia, where MSF took them to the hospital.

"My wife was gone for almost two months and we found each other again here in Liberia. While she was kidnapped the fighters raped her. She is still very anxious and disturbed and doesn't eat well. At night she jumps up, remembering what happened to her."

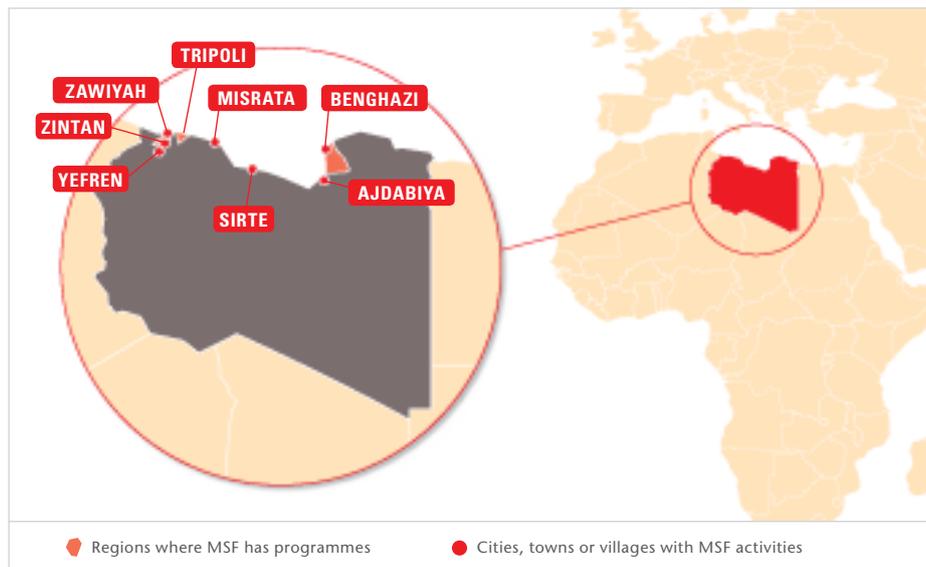
**The patient's name has been changed.*

LIBYA

A few days after violent clashes broke out on 17 February 2011, a Médecins Sans Frontières (MSF) medical team crossed the border from Egypt into eastern Libya to provide medical assistance to health facilities trying to tend to large numbers of injured people.

In the country's second city, Benghazi, MSF donated much-needed medicines and supplies, such as anaesthetics, antibiotics and external fixators to help mend fractures. But in several conflict zones, such as Zawiyah and Misrata, thousands of people were cut off from any external assistance, and critical medical needs and shortages of medicines and materials were reported. Some MSF staff were able to provide logistical support for the delivery of medical supplies to areas under siege, but other teams were blocked from entering the country. MSF repeatedly called for urgent, unhindered access to medical assistance for people caught up in the conflict.

In Benghazi and Ajdabiya, MSF provided psychological support to health personnel and patients, and trained medical staff in psychological first aid for victims of violence.



Assisting people trapped in Misrata

Part of Misrata's main hospital had been bombarded, while the remaining functioning clinics were overflowing with severely injured patients. On 21 March, MSF managed to get a first shipment of surgical kits to the hospital. An additional six tons of medical supplies reached the hospital in April.

Also in April, MSF organised two medical evacuations by boat of a total of 135 patients from Misrata. Medical teams provided urgent assistance while the boat was heading

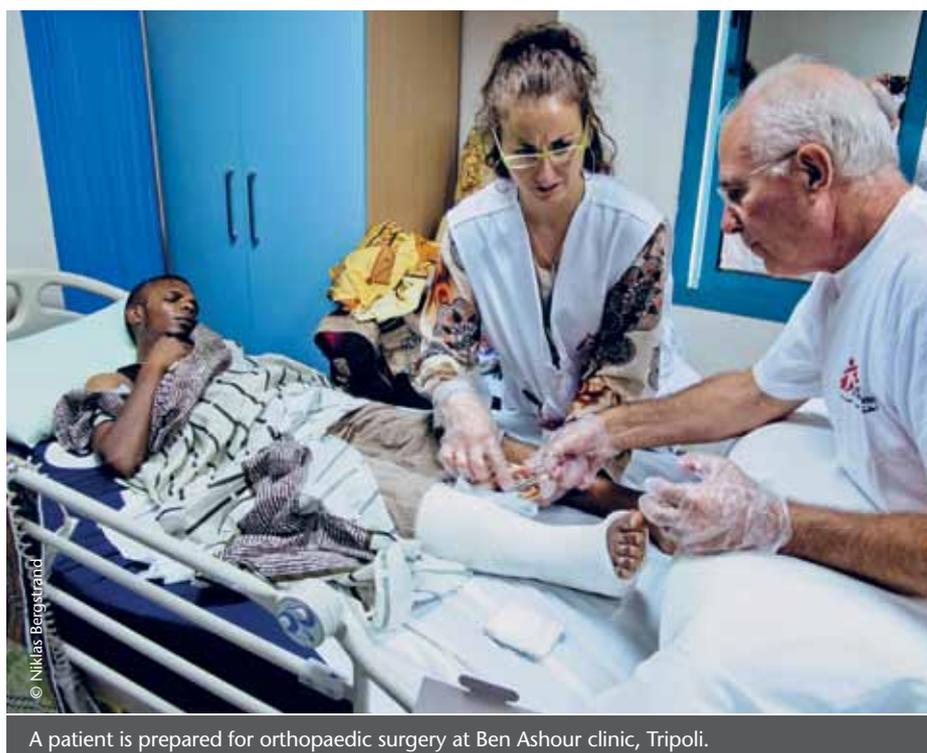
to Tunisia. Upon arrival, patients were transferred to medical facilities for treatment.

In the same month, an MSF team from Benghazi succeeded in reaching Misrata by boat and started supporting four medical facilities, working alongside Libyan health workers in surgical wards and obstetrics departments, and providing training on war surgery, hygiene, sterilisation and waste management. Teams carried out 137 surgical operations in Qasr Ahmed and Abbad hospitals. In Qasr Ahmed hospital, MSF also carried out 780 physiotherapy sessions with patients who had undergone surgery. Twelve patients in need of reconstructive surgery were transferred to the MSF programme in Amman, Jordan. In Ras Tubah medical centre, staff supported the paediatric and emergency obstetric surgery department, assisting 1,914 births, 312 of which were by caesarean section.

MSF donated several tons of drugs and medical supplies to health facilities and provided training, materials and ambulance equipment to the health posts near the main front line.

In May, MSF launched a mental health programme in Misrata, and by the end of the year, more than 3,000 patients had received psychological support through 200 group and 455 individual consultations. In addition, staff gave training to 20 Libyan psychologists.

MSF also provided medical assistance in four detention centres, carrying out a total of 2,600 consultations, including 311 for violent trauma. Doctors working in the centres repeatedly came across patients with injuries caused by torture during interrogation – they treated



A patient is prepared for orthopaedic surgery at Ben Ashour clinic, Tripoli.



A physiotherapy session at a detention centre in Misrata.

115 people with such wounds. MSF reported all cases to the relevant authorities in Misrata, but medical staff continued to receive new victims of torture, and some detainees were denied any medical care. In January 2012, MSF publicly denounced the situation and suspended its activities in detention centres.

Following the line of battle

MSF teams supported health facilities in the towns of Zintan and Yefren, in western Libya, by performing surgery, donating medical equipment and supplies and training medical staff in responding to large numbers of casualties. Between April and October, MSF treated more than 2,200 war-wounded patients and conducted over 270 surgical interventions in the two towns. The mental health team carried out 470 individual consultations and over 1,000 group sessions between July and October.

As heavy fighting moved towards the capital Tripoli, an MSF surgical team went to Zawiyah, to the west of the city. On the first day alone, they treated over 70 casualties in the general hospital. In Tripoli, MSF worked in medical facilities, donating lifesaving medication and supplies, and transferring patients in need of urgent medical assistance.

When fighting reached Colonel Gaddafi's home town of Sirte, MSF provided surgical supplies and 150,000 litres of water, and organised the resumption of surgery in Ibn Sina hospital. After the hospital came under fire and armed fighters started checking patients inside the hospital, MSF called on the warring parties to immediately halt all attacks on and intrusions into medical facilities.

Assisting displaced minorities and undocumented migrants

From August, MSF provided medical care in four camps in and around Tripoli, where some 4,000 migrants and internally displaced people belonging to the Tawargha minority had settled. Residents in these camps had been subjected to intimidation, theft and assaults. Teams carried out more than 5,100 medical consultations and offered psychological support in over 200 individual and 33 group sessions.

Many people fled Libya during the fighting. MSF teams in neighbouring countries, such as Italy and Tunisia, provided them with medical assistance and reminded governments, particularly members of the European Union, of their responsibility under international law to keep their borders open to people fleeing Libya, and to ensure proper reception conditions.

At the end of 2011, MSF had 64 staff in Libya. This is the first time that MSF has worked in the country.

Abdul 13 years old

Abdul suffered second-degree burns after a bottle of benzene caught fire when bombs hit the house next to his. Three days after receiving care in a Misrata clinic, he was evacuated to a Tunisian hospital. Ten days later, he could open his eyes again.

Ali 45 years old

Ali had been diabetic for many years. During the fighting, he was unable to receive his treatment as Misrata hospital was overwhelmed with so many seriously injured patients that it could no longer care for the chronically ill. The interruption to Ali's treatment caused skin lesions to appear on his feet. After his evacuation from Misrata, Ali had two toes and the front of one foot amputated.

MADAGASCAR



and half of all medical personnel now working will retire within the next ten years.

Strengthening medical care in an isolated area

In April, MSF started to work in the hospital in the small town of Bekily, in Androy district. The hospital has 20 beds and offers general medical, maternal and paediatric services. There is no operating theatre, so surgical and obstetric emergencies are transferred in four-wheel-drive vehicles to Ejeda or Isoanala hospitals, which are four and two hours' drive away, respectively.

MSF staff work in all three departments of Bekily hospital. They assist around 25 births a month. More than 450 patients were admitted to the hospital between April and the end of the year.

The teams also assisted three health centres and mobile clinics in the surrounding area. Paying particular attention to maternal care, they renovated clinics, donated supplies, offered training and conducted joint consultations with local health staff.

Work was suspended at the end of December, however, following disagreements between

MSF and Ministry of Health staff over ethical issues concerning the management of patient care, such as deciding when patients could be discharged from hospital. Since then, conditions have been agreed and activities have resumed in the hospital.

Towards the end of the year, MSF started working with the Centre for Tuberculosis Testing and Treatment. Staff in Bekily carry out TB awareness-raising activities and screen and treat patients for the disease.

Risk of natural disaster

Madagascar is affected by on average one natural disaster a year, and the risk of emergencies is therefore high. Cyclones and floods are a particular threat and tend to hit the island between November and March. MSF is in close contact with the National Office for Disaster and Risk Management – sharing information and carrying out evaluations – in order to be able to react quickly to such emergencies.

At the end of 2011, MSF had 33 staff in Madagascar. MSF first worked in the country in 1987.

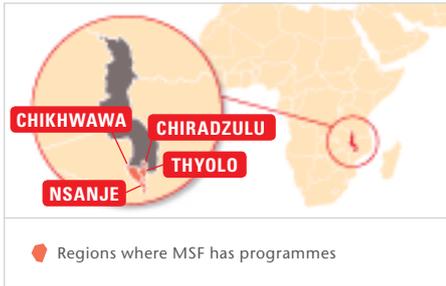
In 2011, Médecins Sans Frontières (MSF) opened a programme in a remote area in the south of Madagascar, where many people have difficulty accessing healthcare because of the long distances to regional hospitals.

Madagascar's health system is facing a number of serious problems, which are compounded by the current financial crisis. The health budget was recently cut by 50 per cent,



Children are vaccinated at a mobile clinic in Bekily.

MALAWI



The HIV epidemic in Malawi has reduced life expectancy to just 43 years.

More than 10 per cent of Malawians aged between 15 and 49 are living with HIV. In the southern district of Chiradzulu, home to around 310,000 people, the prevalence of HIV is even higher, at over 17 per cent.

Médecins Sans Frontières (MSF) began providing antiretroviral (ARV) treatment and follow-up at Chiradzulu district hospital in 2001. The programme was designed to demonstrate that ARV treatment was effective in resource-poor rural contexts. Ten years later, more than 55 per cent of the patients who started treatment in 2001 are still alive and healthy. At the end of 2011, 22,000 patients were on ARV treatment in Chiradzulu, including 2,700 children.

New approaches to treatment

The scale of health needs in Malawi, and the shortage of medical staff – there are just two doctors in Chiradzulu district – have prompted MSF, in collaboration with the Ministry of Health, to adopt new approaches that enable more people to access care. For example, certain medical tasks have been delegated from doctors to nurses – an approach known as task-shifting. Thanks to this, MSF has been able to extend HIV treatment activities from the hospital to 10 health centres across Chiradzulu.

As the programme has developed, the 'six month appointment system' has been introduced. Stable patients, who have no special health issues other than their HIV infection, need see medical staff only every six months. This system reduces the workload of health staff and saves patients both time and money as they make fewer trips to health facilities. Some 3,500 people were on the six-month programme at the end of the year, representing 7,000 fewer consultations.



Antenatal consultation at Namitembo health centre, Chiradzulu district.

Scaling up treatment elsewhere

MSF began offering ARV treatment in Thyolo district in 2003, implementing the same models as in Chiradzulu, and is now able to provide treatment to everyone who needs it. At the end of 2011, more than 24,420 patients were receiving care. As the national treatment programme has grown and strengthened, MSF has started handing over responsibility for HIV services to the Ministry of Health.

Staff will now share lessons learned from the successful programme in Thyolo with medical personnel in the neighbouring districts of Nsanje and Chikhwawa. In an effort to boost HIV services, MSF will mentor staff, support the scaling-up of treatment and work to improve both the accessibility and quality of care.

Preventing mother-to-child transmission (PMTCT)

Without appropriate treatment, the rate of mother-to-child transmission of HIV is close to 40 per cent. For those who have access to prevention services, this figure falls to just three per cent.

There are two recommended treatment options for pregnant women. 'Option B' involves administering ARV medication during pregnancy and breastfeeding, stopping only when the baby has been weaned. Under 'option B+', pregnant and breastfeeding women start ARV treatment and continue taking it for life. In both cases, the baby receives ARV medication until it is

six weeks old. Option B+ was introduced in Malawi in October 2011 and is now part of the national treatment programme. MSF fully supports this decision.

By December, more than 1,650 pregnant women in Chiradzulu and 1,500 in Thyolo had enrolled in the PMTCT B+ programme. Overall, in 2011, MSF assisted the births of nearly 3,400 babies.

Circumcision of adult men

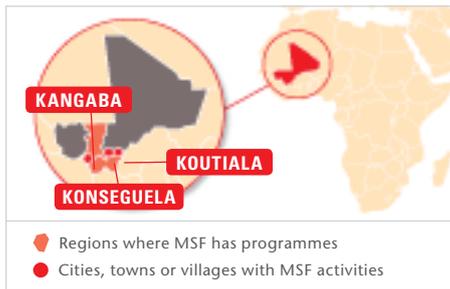
Evidence from several recent studies has shown that male circumcision reduces the risk of HIV being sexually transmitted from women to men by approximately 60 per cent. MSF has developed a programme to offer circumcision to adult male patients in Chiradzulu. The service will be available from April 2012.

Tuberculosis

More than 80 per cent of tuberculosis (TB) patients who register for treatment at Chiradzulu district hospital are HIV positive. TB and HIV care have therefore been integrated, and patients need only go to one appointment to receive all the treatment they need for both diseases.

At the end of 2011, MSF had 819 staff in Malawi. MSF has been working in the country since 1986.

MALI



Although significant progress has been made in reducing child mortality in Mali, 178 of every thousand children born in the country still die before they reach the age of five.

Malnutrition and malaria are the cause of at least half of all these deaths, and malaria is the leading cause of illness and death throughout the country. In southern Mali, Médecins Sans Frontières (MSF) runs two paediatric programmes, focusing in particular on these two deadly conditions.

Malaria treatment in Kangaba

The number of people who die from malaria is especially high in Kangaba, Koulikoro region, and MSF has been providing treatment for the disease since 2005. In 2011, MSF supported 11 health centres in the province, delivering free basic healthcare to 6,500 people, about half of whom were children under five.

To improve access to care, a team of 66 malaria experts, elected by local communities, has been trained and equipped to screen and treat people living in villages more than five kilometres away from a health centre. In five years, the mortality rate among children

under five has dropped by 50 per cent. Eight times as many people are attending health facilities. In April, MSF handed the project over to a Malian association, the Medical Alliance against Malaria, which is continuing some of the activities in partnership with an international non-governmental organisation, Alliance for International Medical Action (ALIMA).

Basic healthcare in Koutiala

In Koutiala district, Sikasso region, MSF has worked in five health centres and the paediatric ward of the district hospital since 2009. In four of the centres, MSF assists Ministry of Health and community health centre (CSCOM) health workers, providing additional staff, supervision, donations of drugs and logistical support in carrying out outpatient consultations and vaccinations, as well as screening and treatment for malnutrition. Staff treated 53,000 children – 30,000 of them for malaria.

In the fifth, Konseguela, MSF offers comprehensive health services for children. Healthy children aged between six months and two years receive supplementary milk-based food, routine vaccinations and mosquito nets, and are seen every three

to six months. In 19 villages in the health area, community health workers test for and treat malaria. They also refer people with other conditions, such as malnutrition, to the centre. The community health workers treated 7,500 people for malaria in 2011. MSF carried out 20,000 paediatric consultations at Konseguela health centre, and provided 1,700 children with supplementary food.

In Koutiala hospital's paediatric ward, MSF has also set up a therapeutic feeding centre and a paediatric intensive care unit. During the annual malaria peak, between August and November, the hospital is able to receive up to five times the normal number of admissions, as total capacity is increased to 350 beds. In 2011, more than 6,600 children were admitted to the paediatric ward, and another 4,800 were admitted to the therapeutic feeding centre.

In 2012, MSF plans to start offering antimalarial drugs to all under-fives as a preventive measure during the annual malaria season, since this age group is most at risk of developing severe malaria.

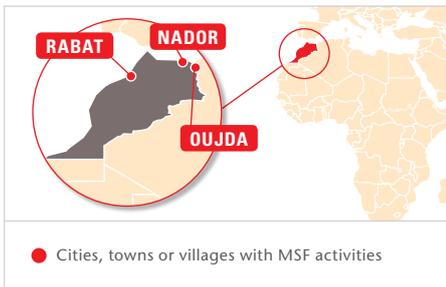
At the end of 2011, MSF had 360 staff in Mali. MSF has been working in the country since 1992.



Villagers from Konseguela, where MSF has a clinic, take part in research into health-seeking behaviour.

© Marianne 107/MSF

MOROCCO



Sub-Saharan migrants trying to enter Europe often get stuck in Morocco, in precarious conditions. Médecins Sans Frontières (MSF) helps migrants to access health services.

Restrictive EU migration and asylum policies, including increased and more rigorous controls at the EU's external borders, are having serious consequences on the physical and mental health of migrants and asylum seekers.

According to the Ministry of the Interior, there are between 10,000 and 20,000 irregular migrants in Morocco. Police raids in areas where migrants live are frequent, as are deportations to the desert border area between Algeria and Morocco, where temperatures are extreme and living conditions are particularly hard.

Women, children and unaccompanied minors are direct victims of smuggling networks, and most are victims of human trafficking: they are particularly vulnerable to kidnapping, rape, sexual exploitation and violence.

MSF works in the northern towns of Oujda and Nador, which are close to the border, and in the Moroccan capital Rabat, where many migrants tend to gather. In 2011, nearly half of those who sought medical care from MSF had symptoms relating to poor living and hygiene conditions, such as skin and respiratory infections and digestive problems.

Medical and mental health services in Oujda and Nador

Although local health authorities have officially set up support systems for women and children who have been victims of violence, the systems lack funding and staff. In Nador, close to the Spanish enclave of Melilla, many people in need of medical care are afraid even to visit health facilities for fear of being deported.



Growing numbers of migrants are living in extremely poor conditions in Morocco.

In January, MSF opened a centre in Oujda, providing emergency medical assistance, and medical and mental healthcare to migrant women. Staff carried out 1,110 outpatient medical consultations and responded to 135 medical emergencies. More than 40 victims of sexual violence received specialised medical and mental health support.

Unaccompanied minors do not receive special attention from the authorities. MSF staff have developed a register of young, unaccompanied migrants, and offer them mental healthcare and social support. A Moroccan association, Fondation Orient Occident, has begun conducting psychosocial activities with women and under-18s.

In total, MSF staff provided psychosocial support to more than 1,000 migrants, holding a total of 290 individual mental health consultations and 115 group sessions in Oujda and Nador.

As well as carrying out medical activities, MSF distributed approximately 3,900 washing kits, 3,750 blankets, 2,250 plastic sheets, 1,130 winter kits and 1,120 coats to migrants in need. Teams also ensured access to safe water for people living in forests on the outskirts of Oujda and Nador.

Caring for victims of sexual violence in Rabat

MSF opened a new programme in Rabat for migrant women who have been subjected to sexual violence. The team worked in close collaboration with the Ministry of Health and non-governmental organisations to coordinate a response to the needs of victims of sexual

violence, offering medical and mental health services and facilitating patients' referral to social and legal services. The programme moved to a new shared centre, in partnership with Moroccan organisation Oum El Banine, where staff assisted 175 victims of sexual violence and provided antenatal care to 188 women who fell pregnant after being raped. A total of 106 mental health consultations were held, including the provision of psychosocial support to 70 victims of sexual violence.

MSF staff also work as intermediaries between patients and health staff in Moroccan health centres and hospitals, and helped 1,400 migrants in this way.

At the end of 2011, MSF had 32 staff in Morocco. MSF has been working in the country since 1997.

Claudine* from Cameroon

"When we arrived in Morocco we all went to the university campus in Oujda, where many migrants live. I was feeling very sick and I was afraid I was going to die, so I asked the chief to seek medical help for me. Two days later he called the MSF medical team – they came the same day and transferred me to the hospital.

"I have been here now for almost a week. I am still hoping that I will manage to get better and continue my life in Europe. I dream that one day I will be healthy and I will be together with my daughter again."

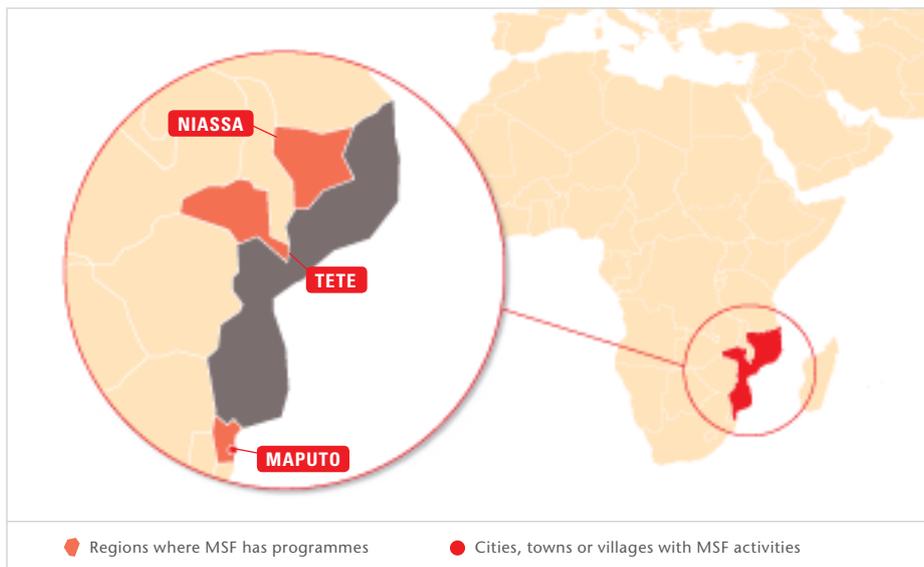
**The patient's name has been changed.*

MOZAMBIQUE

In Mavalane, the biggest and most populated district of Mozambique's capital Maputo, more than 80 per cent of HIV-positive people now have access to the antiretroviral (ARV) treatment they need.

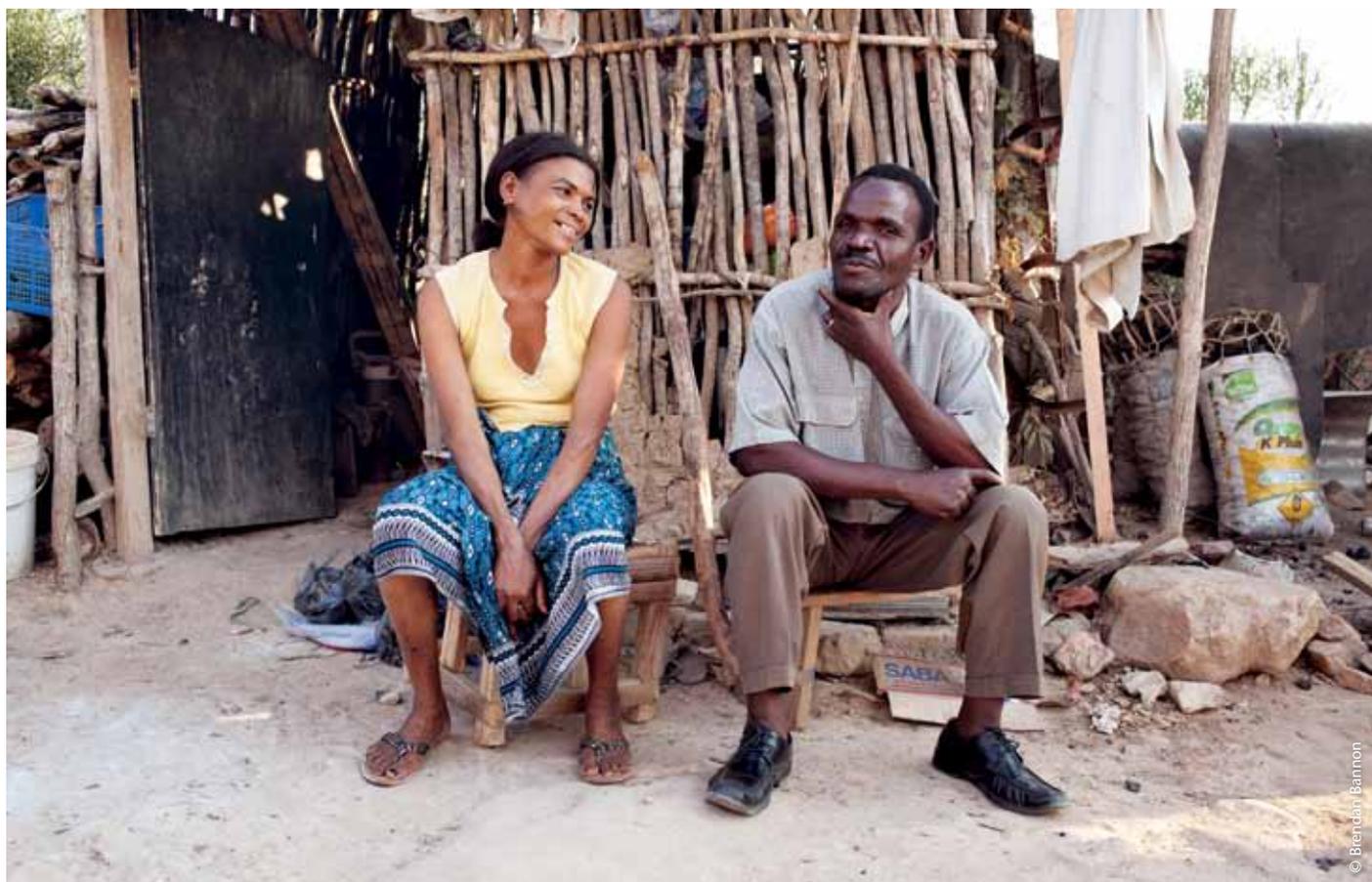
Médecins Sans Frontières (MSF) has been continuously pushing the HIV treatment agenda in Mozambique for the past 10 years, supporting the Ministry of Health in scaling up ARV treatment across the national health system. MSF supports five of the 11 health facilities that provide HIV care in Mavalane, as well as five of the seven health centres in a second district, Chamanculo. In November, the team completed the handover of the HIV programmes in Angonia, in Tete province, and in Lichinga, Niassa province, to the Ministry of Health.

By exploring innovative methods of HIV care, MSF has demonstrated that providing and scaling up ARV treatment in low-resource settings is feasible. Staff training, task-shifting (where nurses are able to provide treatment that was once the sole responsibility of doctors,



and non-medical staff are trained to do jobs once carried out exclusively by nurses), and the decentralisation of services from large hospitals to local clinics have been key to bringing HIV and tuberculosis (TB) care to more people in Maputo, Angonia and Lichinga. The integration of HIV and TB care also means that patients with both diseases have access to all the treatment they need in one place.

Overall, in 2011, MSF teams provided treatment and care to 28,320 HIV patients, of whom more than 1,600 were children. They also supported a referral centre for patients who need special attention. Staff assist in caring for patients with complicated conditions, such as HIV patients who are on second-line treatment, who have the cancer Kaposi's sarcoma, who are co-infected with TB, or who are suffering



Carmen, who is on antiretroviral treatment, lives in Tete province with her husband and two children (see box).



Patients at Lifidzi, one of the health centres supported by MSF in Angonia, Tete province.

severe side effects of medication, and people with other chronic diseases.

Community ARV groups

Piloted by MSF in 2008, community ARV groups are made up of about six HIV patients who come together to support each other in taking treatment, and who take turns to visit the health centre. Each month, one member goes to the health centre to get a check-up and pick up drugs for the whole group. The system is a practical solution to the difficulties of getting to the clinic – such as transport costs and the time the visit takes – while it also reduces the pressures on medical staff and the number of patients having to queue for treatment. Moreover, the mutual support provided by group members helps them to adhere to treatment and overcome the stigma associated with HIV.

This approach has been so successful that the national authorities have adopted the concept and, with the support of MSF, will work on rolling it out across the country in 2012.

Besides assisting this national roll-out, MSF will also focus on developing a strategy for building up community ARV groups in seven districts of Tete province and on adapting the model for Maputo, to make it suitable for urban slums where HIV prevalence is high. The teams will pilot specific community groups for patients

co-infected with HIV and TB, patients not yet on ARV treatment, children, adolescents and sex workers, with the goal of actively involving patients in managing their own treatment. Staff will also start developing community-based counselling and testing services. A mobile team will travel to clinics with a CD4 machine, so that patients' CD4 counts can be measured closer to their homes. By monitoring a patient's CD4 count, medical staff can determine more accurately how far HIV has progressed, and what treatment each patient requires. In 2011, MSF enrolled 10,720 people in HIV care, and some 5,420 patients started ARV treatment. Between July and December, 8,220 people were tested for HIV.

Reduced funding for healthcare

Despite significant advances in HIV care, many challenges remain. About 500,000, or roughly two-thirds, of all Mozambicans in need of ARVs do not have access to this lifesaving treatment.

Low government spending on healthcare and a reduction in international support have slowed the response considerably. In 2001, the government pledged to raise health spending to 15 per cent of the budget. But it still falls far short of this level, at only seven per cent, and the country is heavily reliant on donor funding. MSF will continue pushing for the scaling-up of

quality treatment, despite funding constraints and administrative challenges.

At the end of 2011, MSF had 444 staff in Mozambique. MSF has been working in the country since 1984.

Carmen

32 years old, Tete

"I cried when I came back from the hospital on the day I found out I was HIV positive, and I had no idea what to do. It was my sister who encouraged me to follow what the doctor said. And I am glad I did because without the medication, I expect I would be dead by now. Now I take my pills two times a day. And right from the start, I began to feel better. Before, my husband would come back from work and find me bedridden. But now the medicines have really changed my life – now I cook every day, and I am running a small business right here at my place. We also want to build a house on a piece of land that we have, down by the river, where we can have a garden. There is so much to live for."

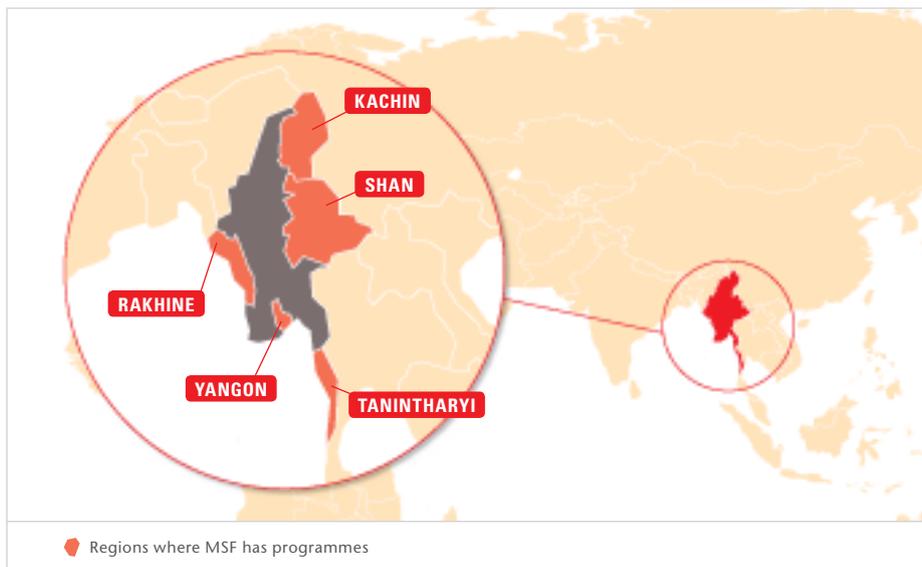
MYANMAR

More than two-thirds of the 120,000 people living with HIV in Myanmar do not have access to the lifesaving antiretroviral (ARV) medication they need.

While there have been encouraging efforts to increase the health budget, the state health system remains underfunded. Furthermore, although Myanmar is one of the least developed countries in Southeast Asia, with a high incidence of HIV and tuberculosis (TB), it receives very low levels of aid.

HIV care: needs not being met

Médecins Sans Frontières (MSF) is working in close collaboration with the Ministry of Health and other agencies to build up the technical capacities and resources of the various HIV care programmes in the country. Overwhelming numbers of people are in need of treatment, but there are only a few sources supplying medicines. MSF has had to make tough choices about whom to treat,



and in some areas staff have been forced to restrict ARV treatment to the sickest patients.

At the end of 2011, MSF was the largest ARV treatment provider in the country, with just over 23,000 HIV patients enrolled at its clinics in Kachin, Rakhine and Shan states, and

Tanintharyi and Yangon regions. Staff also offered health education to high-risk groups such as intravenous drug users, sex workers and men who have sex with men, and provided testing and counselling, and prevention of mother-to-child transmission services.



© Greg Constantine

This 34-year-old man tested positive for HIV in November 2011, and started antiretroviral treatment one month later.



A patient collects medication from the pharmacy at the clinic in Insein, Yangon.

In Insein prison, Yangon, MSF started 150 prisoners on ARV medication and treated 66 patients for TB.

TB and multidrug-resistant TB

TB can remain in an inactive state for decades without causing symptoms or spreading to other people. The body's immune system can fight off the infection and stop the bacteria from spreading by forming scar tissue around the bacteria and isolating it from the rest of the body. However, when the immune system of a patient with dormant TB is weakened, the TB can become active, and without treatment, be fatal.

Because HIV attacks the immune system, the body becomes more susceptible to infections, including TB. In many developing countries, TB is one of the first opportunistic infections to take hold in people with HIV, and is the main cause of death.

TB prevalence in Myanmar is nearly three times the global average. MSF provides TB treatment, diagnosis and counselling as part of its HIV programmes. Staff also conduct outreach activities in the districts surrounding the clinics, offering testing and following up on patients. In 2011, MSF enrolled approximately 3,000 TB patients across its programmes in Myanmar.

The World Health Organization estimates that 9,300 people develop multidrug-resistant TB (MDR-TB) in Myanmar each year. MDR-TB can be transmitted in the same way as drug-sensitive TB, through sneezing or coughing, but can also develop when a patient, either through mismanagement or misuse of medication, develops resistance to two or more of the standard TB drugs. Treatment for MDR-TB takes up to two years and has numerous side effects.

In a pilot project set up by MSF with the Ministry of Health in Yangon, 72 patients have begun MDR-TB treatment, and there are plans to add MDR-TB treatment to HIV and TB services already being offered in Dawei, in the southern region of Tanintharyi.

MSF will continue to scale up treatment for HIV/AIDS and MDR-TB while urging donors to keep their pledges.

Exclusion from healthcare in Rakhine

MSF continued to provide medical care to a stateless Muslim minority in Rakhine, who are marginalised in many ways and often excluded from accessing the most basic medical services. Activities focus on basic healthcare, with a specific emphasis on reproductive health and malaria.

Treatment for malaria

Malaria is one of the leading causes of death in Myanmar. MSF clinics provide diagnosis, treatment and prevention measures in areas where the disease is particularly common. Staff treated some 93,900 people in total.

At the end of 2011, MSF had 1,290 staff in Myanmar. MSF has been working in the country since 1992.

93,900 PEOPLE treated for MALARIA

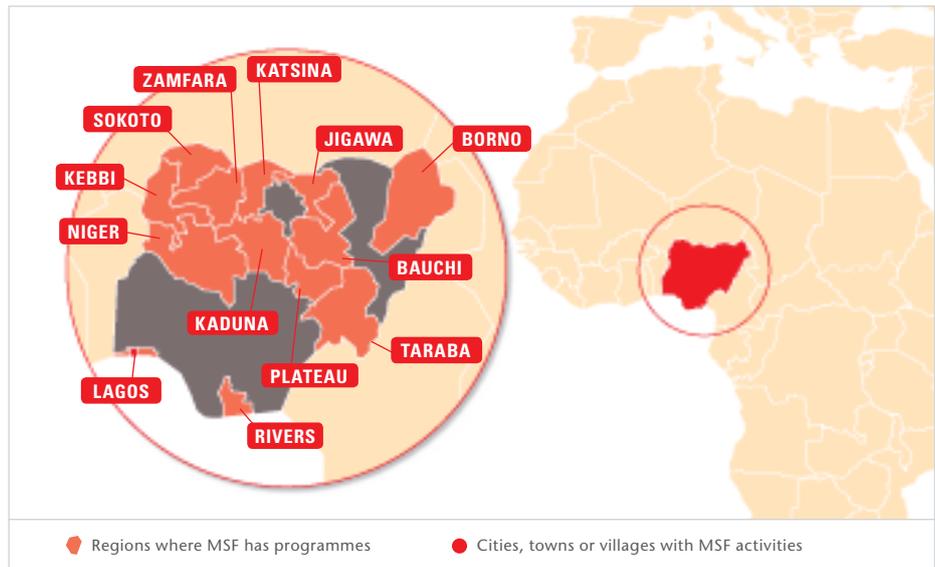
NIGERIA

Growing insecurity, combined with frequent outbreaks of disease and a weak health system, especially in the north, make access to healthcare difficult for many Nigerians.

Lack of access to basic medical services is a serious problem in much of northern Nigeria. The armed group Boko Haram carried out several deadly attacks in 2011, as inter-religious tensions increased. Growing insecurity poses a potential threat to the future of Médecins Sans Frontières (MSF) programmes in this part of the country, which would restrict access to healthcare even further.

In Sokoto state, MSF supports health centres in Goronyo town and the surrounding area. Staff conducted just over 70,300 consultations with children under five, and more than 28,700 antenatal consultations.

At Jahun hospital, in Jigawa state, a surgical team carried out 390 operations to repair obstetric fistulas, which are injuries to



the birth canal, mainly caused by a long, obstructed labour. They result in incontinence and infertility, and can lead to stigma and social exclusion. With good obstetric care, fistulas can be prevented. MSF responded to obstetric emergencies, and assisted more than 5,800 births at Jahun hospital in 2011.

Malnutrition is endemic in Kazaure, a densely populated region at the edge of the Sahel, near the border with Niger. In 2011, MSF carried out nutritional surveillance and treated more than 16,000 children for severe malnutrition. More than 4,000 children had to be admitted to hospital.



Staff and patients at Jahun hospital in Jigawa state, which offers obstetric care and fistula surgery.

© Penny Bradfield

Lead poisoning in Zamfara state

MSF was first alerted to a high number of fatalities in villages in Zamfara in March 2010 and has since treated more than 2,500 children for lead poisoning. Local, small-scale gold-mining practices using lead have contaminated the environment of several villages in Zamfara. MSF has been working with Nigerian agencies and international organisations to encourage villagers to adopt safe mining practices and clean up the environment. In 2012, MSF will host a conference, bringing together a range of experts to find sustainable solutions to the problem.

Trauma hospital in the Niger Delta

In Port Harcourt, capital of Rivers state, MSF runs an emergency trauma facility to bolster local capacity. With 75 beds, the hospital provides free emergency surgery and healthcare. Staff held more than 12,000 emergency consultations in 2011. Three-quarters were related to violence or road traffic accidents. Surgeons carried out an average of 340 operations a month. The hospital also assisted more than 750 victims of sexual violence.

Emergency response

Outbreaks of diseases are frequent, particularly in northern Nigeria, and MSF retains a dedicated emergency response team in the country. When measles broke out in northwestern Nigeria, MSF treated more than 7,900 patients. Staff also treated almost 4,800 people when cholera hit the region. After receiving reports of high numbers of children dying from malaria in two villages, staff gave antimalarial treatment to 277 people and distributed more than 1,400 mosquito nets.

MSF also treated 15,700 people in measles outbreaks in Bauchi and Katsina states between January and March. Staff assisted the Ministry of Health in a vaccination campaign, immunising almost 190,000 children against measles in the south of the country, and more than 300,000 against polio in Plateau and Kaduna states. In addition, MSF treated more than 3,200 people during a cholera outbreak in Taraba and Jigawa states and vaccinated 260 people against diphtheria in Borno.

Concerned about potential politically motivated violence, MSF medical staff also worked in two health centres in the volatile area of Jos North during the presidential elections.



A young patient at the trauma facility in Port Harcourt.

Accessing healthcare in a megacity

Providing adequate healthcare for a city the size of Lagos is challenging. The population is around 18 million, and growing. MSF has been striving to ensure that some of the most deprived inhabitants have access to medical services. The Aiyetoro health centre was set up to serve people living in the slum area of Makoko, but its location on a main road has attracted people in need of healthcare from much further afield. To cope with the extra patients, staff have introduced an appointment system and begun referring people to other facilities.

As in Makoko, the homes in Riverine have been mainly built on stilts on Lagos lagoon, by newcomers to the city who cannot afford to live elsewhere. Building has extended so far into the water that some residents have never set foot on dry land, and are unable to access health facilities on shore. MSF opened a floating health clinic in Makoko in January, and a health post in Badia, near the railway line. MSF provides the only free medical services available in the area.

In October, MSF handed over the basic health services it was running in the Otto area of Lagos to the Ministry of Health, to focus activities on sexual and reproductive healthcare.

In total, more than 18,100 patients came to MSF clinics in Lagos for consultations. Staff administered more than 18,000 vaccinations, assisted some 1,200 births and admitted 900 patients for 24-hour care.

Amina

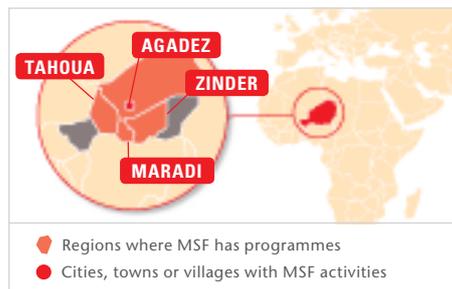
At the age of 16, Amina went into labour. She was at home, and she was alone. In accordance with her culture, she made no noise and had no assistance. But when the baby had still not come after four days, she was taken to a hospital by her neighbour, where she delivered a stillborn baby.

The baby could not pass through Amina's underdeveloped pelvis. Without skilled medical assistance, the soft tissues of Amina's pelvis were compressed for days during the labour. The tissue died and she was left with an obstetric fistula.

For four years, Amina was incontinent. Her husband divorced her. Her stepmother thought she was unclean. At last, she found her way to Jahun hospital, where she received surgery to repair her fistula, and aftercare to help regain continence and get her life back.

At the end of 2011, MSF had 1,051 staff in Nigeria. MSF has been working in the country since 1996.

NIGER



Despite major improvements in its response to malnutrition, Niger struggles with chronic nutrition crises and high rates of child mortality.

Every year, Niger is affected by a nutrition crisis that peaks during the 'hunger gap', which normally falls between May and September. Although there were good harvests in 2010, the acute malnutrition rate among children in Niger was constantly around the 10 per cent alert threshold.

Most of the emergency nutrition programmes launched to respond to the 2010 crisis continued in 2011. The Ministry of Health collaborated with national and international organisations to treat some 300,000 children for severe acute malnutrition, and enrolled more than 650,000 at-risk children on supplementary feeding programmes.

Insecurity and the risk of kidnapping affected relief organisations' ability to reach some communities. However, Médecins Sans Frontières (MSF) improved accessibility

to treatment by decentralising care and delivering it at more sites. Working with local partners, MSF treated a total of 104,000 acutely malnourished children.

Maradi region

Since 2008, MSF and FORSANI (Forum Santé Niger), a medical association in Niger, have run a joint nutrition and paediatric programme in Madarounfa, in the southern Maradi region. In 2011, the programme provided outpatient treatment for severe malnutrition in five health centres. Severely malnourished children who were suffering medical complications, such as severe anaemia or pneumonia, were admitted to a therapeutic feeding centre.

MSF and FORSANI also began offering supplementary rations of milk-based food at all five centres to prevent severe malnutrition. A 2010 study by Epicentre, MSF's epidemiological research unit, indicates that appropriate supplementary feeding could lower child mortality by 50 per cent. From May, MSF and FORSANI supported the paediatric unit of Madarounfa district hospital, and staff had tended to more than 900 children by the end of the year. During the annual malaria season, MSF and FORSANI treated 750 children for the disease at a 20-bed centre in Dan Issa, south of Madarounfa. When measles broke out early in the year, 14,000 children in the area were vaccinated.

In the departments of Dakoro and Guidan Roundji, MSF carried out similar work, supporting the departmental hospitals. In Dakoro, staff worked in the maternity and paediatric departments, delivered sterilisation and laboratory services and managed an

emergency ambulance referral system. In Guidan Roundji, MSF provided medical supplies and drugs, as well as water and sanitation support. Staff worked in the paediatric ward and operated an intensive therapeutic feeding centre. Teams also ran nutrition programmes at five health centres in Dakoro.

In all, 76,500 consultations were conducted in Maradi, more than 44,000 of which were for malaria.

Zinder

In the neighbouring region of Zinder, MSF focused on children under five living in Zinder city – Niger's second-largest city – and the surrounding areas. The teams have decentralised treatment, making medical care available via community health workers. They also carry out preventive and outreach activities, such as vaccinations and health screening, and provide information on health issues.

Staff worked in nutrition programmes in 18 community health centres. Following a measles outbreak, 26,700 people were vaccinated against the disease. Staff also ran nutrition programmes and carried out paediatric consultations in the city of Magaria, on the border with Nigeria. Outside the city, MSF worked to strengthen services in health posts in Dan Tchao and Dungass. Altogether, MSF treated about 13,000 children for malaria, 11,000 for diarrhoea and 9,000 for respiratory infections.

Tahoua and Agadez regions

In Tahoua, there were very high rates of malaria compared with previous years, and MSF treated more than 43,000 people for the disease. At the height of the epidemic, over 300 people suffering from both malnutrition and malaria were being registered each week. MSF ran two nutrition programmes in the Madoua and Bouza districts of south-central Tahoua.

Agadez is located on a primary migration route for people trying to reach Europe. Vulnerable individuals in need of medical assistance regularly pass through the region. MSF focused on reproductive and paediatric healthcare for temporary residents and conducted nearly 4,500 consultations.

Cholera

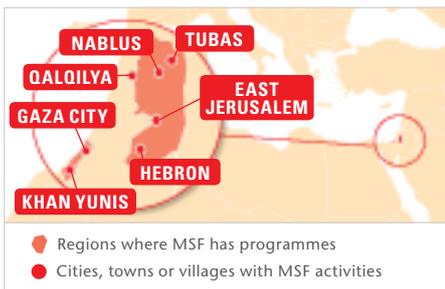
Between June and September, MSF helped to respond to a cholera outbreak in the capital Niamey. The team set up treatment centres, rehydration points and waste treatment systems. They also donated medicines and other supplies and trained Ministry of Health staff.

At the end of 2011, MSF had 1,705 staff in Niger. MSF has been working in the country since 1985.



A child is examined at the intensive therapeutic feeding centre in Guidan Roundji, Maradi region.

OCCUPIED PALESTINIAN TERRITORY



Residents of Occupied Palestinian Territory continued to suffer the consequences of violence and conflict in 2011.

In 2011, the number of attacks, shootings, detentions, demolitions, evictions, raids, night incursions and violent incidents increased alarmingly. In the West Bank, more than 700 Palestinian civilians were displaced by force. Conflict between Palestinian factions also caused injury and trauma.

Care for patients traumatised by violence

Médecins Sans Frontières (MSF) teams provide medical care, short-term psychotherapy and social assistance and referral to people affected by violence and conflict in the West Bank districts of Hebron, Qalqilya, Nablus and Tubas. The teams focus on people who show signs of acute stress, anxiety, post-traumatic syndromes or depression. In total, staff carried out more than 1,600 medical consultations and over 4,000 mental health consultations.

The programme is being extended to people in East Jerusalem who are suffering from psychological distress and have no access to such healthcare: in 2011, staff held 223 consultations with residents of Shu'fat refugee camp and the neighbourhood of Silwan.

Similar programmes are operating in the Gaza Strip, but a decision by health authorities forced their suspension in



A family from Iraq Burin, near Nablus, is given psychological support.

August. Between January and August, staff carried out 870 medical consultations and more than 2,000 mental health consultations. Most patients were children.

Shortages of medical supplies

The continuing Israeli embargo of the Gaza Strip, years of financial crisis within the Palestinian National Authority in Ramallah and the chronic lack of cooperation between the Palestinian National Authority and Gaza authorities have all contributed to a deterioration in the capacity of the public health sector. Since mid-2011, health facilities have been facing a serious shortage of medicines and other supplies. MSF donated essential medicines to the cardiology department of Al-Shifa hospital, and made other periodic donations as needs arose.

Assisting burns victims

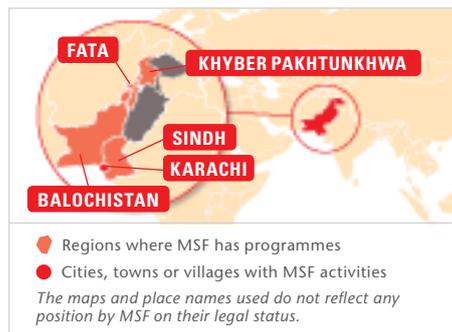
Since 2007, MSF has been running a rehabilitation programme for burns victims in the Gaza Strip. The team provides physiotherapy and wound dressing to

patients referred from the burns units of Al-Shifa and Nasser hospitals.

MSF also operates a specialised surgery programme in Nasser hospital, which is in Khan Yunis, in the south of the Gaza Strip. Several times a year, teams of surgeons, operating theatre nurses and anaesthetists carry out complex surgical operations that are not otherwise available. Most of those who undergo surgery are children, and most suffer from burns.

At the end of 2011, MSF had 136 staff in Occupied Palestinian Territory. MSF has been working there since 1989.

PAKISTAN



Insecurity and natural disasters have reduced access to essential healthcare in Pakistan.

At the beginning of 2011, some six months after the floods first hit Pakistan, many people started returning to their homes. Médecins Sans Frontières (MSF) teams providing medical care and safe water scaled down their activities. In Sindh and Balochistan provinces, where the water was slowest to retreat, the road to recovery remained daunting, and people still lacked food and shelter. For this reason, teams in Dera Murad Jamali, Balochistan province, and Johi and Karachi, Sindh province, continued their activities, running nutrition programmes and providing relief and temporary shelters. With the onset of winter in Johi and Jamshoro districts, around 2,000 temporary shelters made of bamboo and plastic sheeting were distributed.

On the outskirts of the city of Karachi, more than 20,000 people were living in camps in unhealthy conditions. To prevent the spread of disease, MSF started running mobile clinics and distributing safe water and emergency relief. After conducting around 21,000 medical consultations, the team handed over medical

and water and sanitation services to the Karachi health authorities at the end of May.

In August, weeks of rain once again led to severe flooding, and Sindh was particularly badly hit. In the subdistrict of Tando Bago, land on both sides of the elevated main roads was still under water two months later. From September until November, MSF provided medical care through mobile clinics to displaced families living in camps or on the roadside in Badin and Tharparkar districts. Staff extended the same support to people affected by floods in Moro district.

During the monsoon season, to cope with the increasing number of patients with acute watery diarrhoea, MSF opened temporary diarrhoea treatment centres in several areas of Khyber Pakhtunkhwa province, and in Kurram Agency in the Federally Administered Tribal Areas (FATA). A total of 9,774 patients were treated.

Emergency care

Although there were periods of respite, the situation in the northern regions of Khyber Pakhtunkhwa and FATA remained tense due to longstanding sectarian violence and fighting between government forces and armed opposition groups.

In this context, emergency medical assistance continued to be a key component of MSF's work. In Khyber Pakhtunkhwa, staff treated thousands of patients in the emergency departments and operating theatres of hospitals in Dargai and Timergara. More than 18,800 patients were treated in the resuscitation room in Timergara, and surgeons performed over 2,000 operations. Around 70 kilometres from the Afghan border, in Hangu, teams provided lifesaving care in the emergency

department of the Tehsil headquarter hospital, where they saw an average of 1,500 patients each month.

In the towns of Alizai and Sadda in Kurram Agency, MSF supported local hospitals, providing paediatric care and managing incidents involving large numbers of casualties. MSF also operated an ambulance service, which transferred patients from Kurram and Hangu to Peshawar for further treatment.

In October, after working in the casualty department of the main hospital in Mingora, Swat district, for 18 months, MSF boosted its capacity and handed activities over to the Ministry of Health.

MSF also provided emergency care in the district hospital of Chaman, Balochistan province. Chaman lies on the border with Afghanistan, and Afghans often come in search of medical assistance. MSF treated nearly 9,300 patients in 2011.

In all the hospitals where MSF works, a no-weapons policy is implemented, for the safety of both patients and medical staff. Each hospital is set up to cope with the arrival of a large number of wounded, for example after a traffic accident or bomb blast.

Maternal and child health

Limited access to good-quality emergency obstetric care means women in Pakistan face significant risks during childbirth. In insecure areas, travel restrictions make access even more difficult.

In Khyber Pakhtunkhwa province, MSF staff delivered more than 7,000 babies in Dargai and Timergara hospitals. In May, MSF opened a women's hospital in Peshawar district. The 30-bed hospital focuses on providing care during complicated pregnancies and births. MSF also supports ante- and postnatal care at clinics run by the local authorities.

In Balochistan, staff deliver comprehensive obstetric care in the district hospitals of Dera Murad Jamali and Chaman. MSF has opened a paediatric hospital in Quetta, the provincial capital. The 50-bed hospital provides free neonatal and paediatric care, and has an inpatient therapeutic feeding centre.

In the town of Kuchlak, home to many Afghan migrants and refugees, as well as nomads and a local settled population, MSF runs a mother and child clinic that also contains a birthing unit. Women who require caesarean sections or other specialist medical care are transferred to Quetta hospital.

At the end of 2011, MSF had 1,295 staff in Pakistan. MSF has been working in the country since 1986.



A mobile clinic is set up in an abandoned public building, where hundreds of families have taken refuge from flooding.

PAPUA NEW GUINEA



Victims of domestic and sexual violence face problems accessing health services in Papua New Guinea.

Rates of domestic and sexual violence in Papua New Guinea are high. Most victims are women and children. Poverty, unemployment and drug and alcohol abuse are contributing factors to the violence, which is often not reported. Although the problem is widespread, care remains inadequate and, in many places, there is none available.

In the city of Lae, Médecins Sans Frontières (MSF) runs the family support centre at Angau Memorial general hospital. This is a confidential and safe space that provides medical and psychosocial care to victims of family and sexual violence. In 2011, staff at the centre offered comprehensive, free care to approximately 2,200 people. A team also runs a family support centre in Tari, in Southern Highlands province, and assisted approximately 900 people. MSF offered guidance to health staff in facilities around the country, to help them establish their own family support centres.

At Tari hospital, MSF provides emergency surgical services in addition to managing the family support centre. The surgical team performed more than 800 operations and carried out over 10,000 outpatient consultations. More than one-third of cases were violence-related.

Healthcare in southern Bougainville

The Autonomous Region of Bougainville has been the scene of recurrent conflict, especially in the 1980s and 1990s, and the healthcare system has been neglected for some years. Low-level conflict persists, and access to healthcare is poor.



Members of the team working at the Family Support Centre in Angau Memorial general hospital, Lae.

MSF first supported Buin health centre, in the south of Bougainville Island, after the ceasefire of 1998. In April 2011, MSF returned to Buin to improve access to care. Staff carried out some 6,820 outpatient consultations and cared for more than 570 inpatients.

Many women in Bougainville have to travel enormous distances if they wish to give birth in a health facility. MSF and Papua New Guinea's Division of Health have opened a maternity waiting home in Buin, where women can stay in the last weeks of pregnancy, so that they are not far from medical services when they go into labour. More than 210 women gave birth in the health centre and 28 complicated cases were referred to Buka hospital.

The health centre is also being renovated. Laboratory services are being updated, and this will improve MSF's support in the treatment and follow-up of tuberculosis (TB) patients. In 2011, staff cared for 44 TB patients.

When Bougainville experienced its first recorded cholera outbreak, in Buka, in April and May, MSF treated 521 patients.

At the end of 2011, MSF had 164 staff in Papua New Guinea. MSF first worked in the country in 1992.

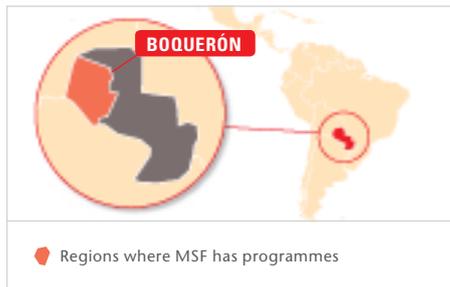
Mona

23 years old, Buin health centre

"I am eight months pregnant and I am here because I lost the babies of my first two pregnancies, when I tried to give birth at home. I want this baby so much. I will wait here until I am due, and I know that I can deliver my baby safely here at the health centre."

1,540 BIRTHS assisted

PARAGUAY



A shortage of medication in October forced Médecins Sans Frontières (MSF) to reduce screening activities for Chagas disease in Paraguay's Boquerón district.

At first, a person with Chagas may not have any symptoms, but up to one-third will develop serious health problems later in life, such as heart and intestinal complications, which can be fatal. The disease is primarily transmitted by the bite of the vinchuca beetle, which often lives in the cracks in mud and straw buildings. People living in poor housing are therefore most at risk of infection.

Drug supplies interrupted

In recent years, the response to Chagas disease has improved. Medical evidence has shown the benefits of using benznidazole more widely, including with adults in the chronic – non-symptomatic – stage of the disease, and this has resulted in an increase in demand.

But problems with planning at Brazil's state-owned laboratory – the only laboratory manufacturing benznidazole – brought production to a halt in 2011. MSF urged the Brazilian Ministry of Health to take immediate measures to make the drug available. Despite the ministry's commitment to speed up manufacturing and regulatory approval, supplies were still interrupted at the end of the year.

Gran Chaco

Paraguay's approach to Chagas has been to focus on prevention through vector control, targeting the vinchuca beetle. In some regions, this has led to the successful eradication of Chagas transmission.

MSF is focusing on treatment and raising awareness among health staff – especially staff working in local facilities – about the options for treatment.



People from the village of Campo Loa are screened for Chagas disease.

The Gran Chaco is an extensive but isolated area in northwestern Paraguay. The climate is harsh, towns are small and remote from one another, and public transport is limited. Health centres are few and far between.

In Boquerón department, MSF supports the regional hospital in Mariscal Estigarribia. Having furnished it with new laboratory equipment, teams began screening people for Chagas in 2010. In May 2011, the first group of patients completed their treatment.

MSF and national authorities worked together to train staff in 10 health facilities in Boquerón. MSF staff also supported rural health centres in the towns of Doctor Pedro P. Peña and Pirizal, and mobile teams visited more remote communities, informing them about Chagas and offering screening and treatment. They encouraged people to report the presence of vinchuca beetles to the authorities, so that fumigation could be carried out.

In 2011, more than 3,100 people were screened for Chagas, and of these, 416 were diagnosed with the disease. More than half – 218 people – started treatment. Of the rest, some chose not to start treatment, while others were unable to because of their age, or because they were pregnant or breastfeeding.

Chagas bus

An MSF team continued to travel around the country in the 'Chagas bus'. This bus takes MSF staff to schools and hospitals

around Paraguay, where they stop and offer information about Chagas, how it is spread and how to seek testing and treatment. In 2011, the bus visited the capital Asunción, and the departments of Paraguari, Cordillera and Central.

With the support of the Ministry of Health and the Pan American Health Organization, MSF organised a scientific symposium on Chagas at the University of Asunción. More than 200 people, most of them medical professionals, attended the event.

At the end of 2011, MSF had 35 staff in Paraguay. MSF has been working in the country since 2010.

3,100 PEOPLE screened for CHAGAS DISEASE

PHILIPPINES



In late September, typhoons Nesat and Nelgae hit the northern part of the Philippines, causing severe flooding and damage on the country's main island of Luzon.

A Médecins Sans Frontières (MSF) emergency team of doctors, nurses and logisticians found that six low-lying areas in the hard-hit central province of Bulacan were in need of healthcare. The team set up mobile clinics and conducted more than 2,600 consultations with people affected by the floods in Bulusan, Meyto, Panducot, San Jose, Santa Lucia and Sapang Bayan.

Travelling by boat and car to reach those in greatest need of assistance, staff treated

people suffering from acute respiratory infections and children with malnutrition. They were also able to monitor for outbreaks of acute watery diarrhoea and leptospirosis, a severe bacterial infection that is transmitted through contaminated water.

In addition, the team tended to patients suffering from chronic diseases, such as diabetes and hypertension, whose treatment had been interrupted. Patients requiring lifesaving medical attention were transferred to the provincial hospital in Ministry of Health ambulances.

In the town of Calumpit, in the southwest of the province, the district hospital had been

damaged by the flooding. MSF helped the local health authorities to rehabilitate the hospital and donated drugs and equipment.

The team also distributed 20,000 litres of drinking water and 2,450 jerry cans in three districts. To prevent the spread of disease, staff assisted in waste collection. After two weeks, and a vast improvement in the situation, MSF withdrew from Bulacan.

At the end of 2011, MSF had 2 staff in the Philippines. MSF first worked in the country in 1987.



Staff provide medical assistance to people whose homes were destroyed by flooding.

RUSSIAN FEDERATION



Years of conflict in the north Caucasus region of the Russian Federation have left gaps in many areas of the health system.

Médecins Sans Frontières (MSF) works to fill some of these gaps in Chechnya and Ingushetia.

Resurgence of tuberculosis (TB)

The destruction and displacement resulting from years of conflict – primarily between Russian state authorities and Chechen separatists – have stimulated a resurgence of TB in the north Caucasus, particularly drug-resistant TB.

MSF continued its TB programme in Chechnya, improving access to treatment and facilities. There was a shift in focus towards decentralising treatment and offering patients direct care at home. Patients take their medication under observation, to help make sure they take the right dosage regularly, in order to prevent the development of drug resistance. Between January and December, approximately 500 patients were admitted to the TB programme.

Supporting people caught up in violence

In 2011, MSF closed its assistance programme in the city of Khasavyurt, Dagestan, where it had provided healthcare and counselling to migrants, and instead focused on programmes in Chechnya and Ingushetia, in particular the mountainous areas most affected by violence and the government's counter-insurgency measures.

The psychological effects of conflict have been far-reaching. The teams held approximately 8,000 individual and 1,700 group counselling



A doctor examines a patient during a ward round at Grozny's Republican TB Dispensary.

sessions in Chechnya, as well as almost 5,100 individual and 1,020 group counselling sessions in Ingushetia.

Healthcare for women and children

In Grozny, the capital of Chechnya, MSF offered outpatient gynaecological and paediatric care. Staff also ran mobile clinics offering similar services in Shelkovskoy and Naursky districts, north Chechnya, and Shatoy, south Chechnya.

An average of 1,500 women visited clinics each month, 60 per cent of whom were diagnosed and treated for sexually transmitted infections. Teams held 1,620 paediatric consultations per month, 62 per cent with children under five years of age.

Cardiac emergency response

Cardiovascular disease is the cause of around two-thirds of deaths in Chechnya. In the first six months of 2011, MSF teams worked on renovating the cardiac emergency programme in Grozny's Republican Emergency Hospital. By mid-2011, the clinical laboratory was functional, and staff were able to start assisting patients. By the end of the year, there had been more than 800 admissions, 72 per cent for acute coronary syndrome, which can lead to a heart attack.

In July, MSF carried out thrombolysis, the first cardiac emergency intervention in the organisation's history. By the end of the year, this procedure, which involves breaking down blood clots, had been successfully performed on 17 patients.

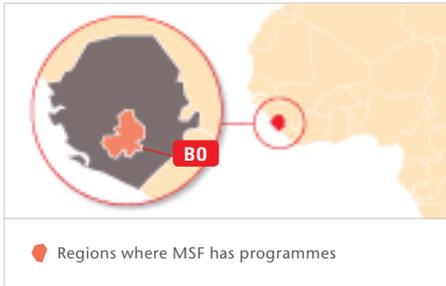
At the end of 2011, MSF had 179 staff in the Russian Federation. MSF has been working in the Russian Federation since 1988, and in the north Caucasus since 1995.

Malika

28 years old, Grozny

"Since I was a child I have been afraid of TB. I heard stories of people dying from the disease, and then I got sick myself." When Malika was diagnosed with TB, her condition was serious, and she had to spend four months in a TB hospital, followed by more treatment afterwards. "I never missed a tablet, I took all the medicines," Malika says. "Elisa, from the TB adherence team, called me every day and supported me emotionally." After six months of treatment, the results of the tests were good, and Malika was free of TB.

SIERRA LEONE



A decade after the end of the civil war, Sierra Leone is still recovering. Médecins Sans Frontières (MSF) is working to improve maternal and child health.

The network of community malaria volunteers, who diagnose and treat simple cases of malaria among their neighbours, was not as large as in previous years. The MSF team continues to support the network, while refocusing its malaria activities towards the provision of specialist treatment at Gondama.

hospital more quickly. Three ambulances are on standby 24 hours a day at health centres around the district to transport people free of charge to Gondama. People with more complicated conditions are referred to the capital Freetown.

At the Gondama referral centre, a 200-bed hospital outside Bo, the second-largest city in the country, MSF offers specialist obstetric and paediatric care. Staff at the centre tended to more than 8,700 children in 2011, and assisted over 1,300 births, 723 of which were by caesarean section.

Healthcare in local health centres

An outreach team supports five community health centres in Bo district. Staff offer basic healthcare, antenatal care and treatment for malnutrition and malaria, and carry out health promotion activities.

Lassa fever

Lassa fever is a viral haemorrhagic fever that occurs in west Africa. It is an acute illness that affects several organs in the body, including the liver, spleen and kidneys. Sierra Leone has a specialist ward for Lassa patients at Kenema hospital, 300 kilometres east of Freetown. MSF operates an ambulance to transport people with Lassa fever to Kenema.

MSF also treated more than 1,600 children with severe malnutrition at its nutrition programme at Gondama. Severely malnourished children with medical complications were referred to Bo government hospital, where an MSF nurse supports the centre's staff.

A lack of qualified health staff and inadequate health facilities mean that people in need of specialist medical assistance often do not get hospital treatment until the very late stages of their illness or pregnancy. MSF operates an ambulance service to help people reach the

At the end of 2011, MSF had 484 staff in Sierra Leone. MSF first worked in the country in 1985.



A ward round at Gondama referral centre, in Bo district.

SOMALIA

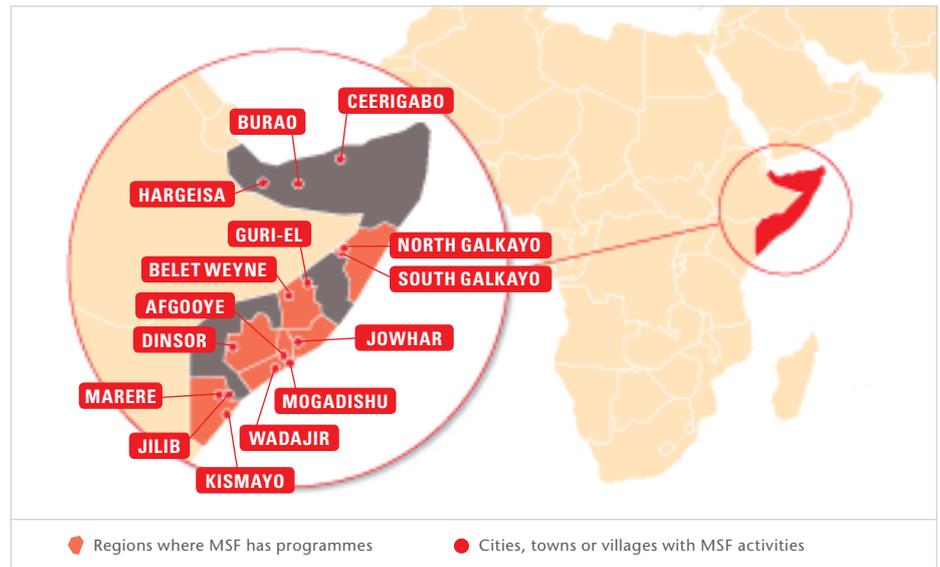
A devastating drought, protracted war, a collapsed health system and restricted access for relief organisations worsened the humanitarian crisis in Somalia in 2011.

Hundreds of thousands of Somalis fled to the capital Mogadishu, or across the border to Kenya or Ethiopia, in search of help. Weakened and malnourished, many were living in unsanitary, crowded conditions, with little access to safe water.

Nutrition crisis

As victims of the conflict and drought flocked to Mogadishu, Médecins Sans Frontières (MSF) scaled up its activities, opening health facilities in 12 new locations. Staff provided a full range of health services, from basic healthcare to surgery, nutritional support, cholera and measles treatment, vaccinations and maternal care. They also distributed relief items to both displaced and local people. At the peak of its activities, MSF was running programmes in 22 places across the country.

Given the scale of medical needs, MSF took the decision to send international staff to take up permanent posts in south-central Somalia for the first time since 2009. Tragically, on 29 December 2011, two long-serving MSF staff members, Philippe Havet and Dr Andrias Karel Keiluhu, were shot dead



in their Mogadishu compound. This forced MSF to close down two programmes, which had been serving a population of 200,000 displaced people and local residents, halving the medical assistance provided by MSF in Mogadishu.

A paediatric inpatient department and maternity ward were opened in the town of North Galkayo, Mudug region. Staff managed tuberculosis (TB) programmes in Galkayo, and in Mahadaay and Gololey in Jowhar, Middle Shabelle region. In total, MSF treated more than 864,000 patients in Somalia, nearly double the assistance provided in 2010.

Measles and cholera

Malnourished children are more vulnerable to measles infection, which in turn aggravates malnutrition. Between May and December, MSF vaccinated 102,000 children against measles. However, in some parts of the country, permission to undertake vaccination campaigns was not granted by local authorities.

Unhygienic living conditions provide a breeding-ground for water-borne diseases like cholera. When the rainy season began in November, teams struggled to contain a cholera epidemic. Treatment sites were set up in five districts, and in Hodan, over 100 patients per week were admitted to MSF's 120-bed treatment centre.

Access blocked

Limited or no access at all for relief organisations to vast swathes of the country meant that hundreds of thousands of Somalis remained in desperate need, despite the aid that was being sent to the country.

The fighting, restrictions on supply flights and international support staff, as well as administrative hurdles, all hindered the delivery of assistance. In areas controlled by Al-Shabaab, gaining access for medical supplies and personnel to provide vital medical aid was a major challenge. It proved extremely difficult for MSF to work beyond the gates of established health facilities. Even in existing programmes, MSF faced obstacles. Attempts to open new emergency operations in south-central Somalia failed. One of the few exceptions was the port city of Kismayo, where MSF was granted access in December after lengthy negotiations. Within a few weeks of opening, MSF had treated 200 children for malnutrition.



© Martina Baççalupo

Thousands of severely malnourished children received treatment at clinics in Mogadishu.



Food distribution in Rajo camp for displaced people, Mogadishu.

High security risks

Access problems were compounded by insecurity. In March, MSF suffered two consecutive grenade attacks on its compound in Wadajir district, west of Mogadishu, in less than a week. MSF was forced to suspend activities temporarily, putting at risk the lives of 414 children enrolled in the nutrition programme.

In North and South Galkayo, MSF treated patients wounded in separate incidents, and in Daynile, nine kilometres northwest of Mogadishu, of the more than 3,500 patients admitted to the emergency room, 44 per cent had war-related injuries.

Thousands of Somalis were trapped between battle lines. In the Afgooye corridor, where close to half a million people have sought refuge, MSF supported the district hospital, covering the needs of 180 surrounding villages. Staff conducted more than 27,000 consultations and treated over 3,300 malnourished children in Afgooye.

In October, two MSF staff members were abducted from a refugee camp in Kenya, where thousands of Somalis had fled. Insecurity in Somalia increased after the Kenyan army's intervention that month. In Marere, dozens of injured civilians were rushed to the MSF hospital following an aerial bombardment that hit a nearby

camp for the displaced in Jilib. Five people were killed and 45 wounded, including 31 children.

Overcoming obstacles to access

MSF is increasingly using telemedicine to bring specialised care to Somalis in areas where the risk is too high to fly doctors in. Via an audiovisual link, specialist doctors based in Kenya support medical staff in Somalia during consultations. More than 500 new patients received medical attention through this technological innovation in 2011.

Healthcare in Somaliland

In the self-declared republic of Somaliland, MSF expanded operations, providing support in Burao (Burco) general hospital, the only public health facility in the Togdheer region. Admissions have tripled and mortality rates have dropped in the maternity ward since MSF started operating there. In Ceerigabo, MSF continued to provide full support to the district hospital, while in Somaliland's capital Hargeisa, MSF closed its basic health services in camps in June, as the needs could be covered by the Ministry of Health and another agency working in the area. In total, more than 4,000 children under five were seen at outpatient consultations. Staff assisted more than 2,700 births and carried out 671 surgical procedures.

At the end of 2011, MSF had 1,729 staff in Somalia. MSF has been working in the country since 1991.

For more on the challenges faced by MSF's teams working in Somalia, see pages 16–17.

Ali Ahmed*

7 years old, and his mother, Burao hospital

"My boy was very sick and was swollen all over his body.

"He was a very healthy boy before. When it started, it started with a fever and the boy complained about his hands. I live in Talahabed. It is very far from here. It usually takes one day to get to the hospital.

"I have been here for a long time; it is too far to travel home. Where I come from there isn't even a network to call from. I was told by the villagers that the hospital might be able to help me. I took public transportation to get to the hospital – I had to pay to get here. As soon as I arrived the doctors were ready to help me. They took Ali straight to surgery. They put him on medication. Slowly, slowly, after the surgery, he was improving every day. We carried him here. Now he can walk, he is beautiful."

*The patient's name has been changed.

SOUTH AFRICA



In 2011, the Médecins Sans Frontières (MSF) programme in Khayelitsha celebrated its 10th anniversary. More than 20,000 people have started antiretroviral (ARV) treatment since 2001.

The HIV treatment programme in Khayelitsha, a township on the outskirts of Cape Town, was the first to provide ARV treatment in South Africa's public sector. MSF is now focusing on new models of care, including decentralising treatment for drug-resistant tuberculosis (DR-TB) to local clinics and bringing HIV treatment even closer to patients by offering services in community halls, libraries and private homes, in what are referred to as adherence clubs.

In 2011, the provincial government began piloting adherence groups – a concept initiated by MSF in 2007 – across the township, setting up 218 clubs in 16 facilities. Adherence clubs make living with HIV,

and sticking to treatment, easier. Instead of a one-to-one appointment at the health centre every month, club members go to 'meetings' every two months, where they are screened for symptoms and receive drug refills, and can also ask questions and share experiences, providing each other with mutual support. Club members are two-thirds less likely to experience treatment failure. More than 5,000 patients joined an adherence club in 2011.

Over the course of the year, some 50,000 people were tested for HIV, and more than 450 began ARV treatment each month, bringing the total on treatment in Khayelitsha to more than 21,800.

A new TB test

As HIV weakens the immune system, the body is more susceptible to opportunistic infections, including TB. South Africa has seen a 400 per cent increase in TB cases over the past 15 years, and more than 70 per cent of patients are co-infected with HIV.

In 2011, the South African government approved the use of a new automated test for TB, which can provide results far more rapidly, thus enabling people to start treatment earlier. The test can also detect TB much better than tests previously used and detect resistance to rifampicin, one of the most potent drugs used in the treatment of the disease. Following the introduction of this test in MSF's project in rural Eshowe, KwaZulu-Natal province, MSF has seen TB diagnoses increase from 13 to 40 patients a month. About 13 per cent of the patients diagnosed with TB were resistant to rifampicin.

Treatment for DR-TB is far more complex, expensive and arduous than drug-sensitive TB. In 2010, there were 7,386 confirmed multidrug-resistant TB (MDR-TB) patients in South Africa. More than 700 patients had confirmed extensively drug-resistant TB (XDR-TB), which is even more difficult to treat.

Screening for HIV and TB in KwaZulu-Natal

The eastern province of KwaZulu-Natal has the highest prevalence of HIV in the country. At the end of 2011, MSF launched a mobile 'one-stop-shop', which travels around the province offering testing for TB and HIV. In its first month of operation, more than 1,000 people were tested for HIV, and 50 were screened for TB. Future activities will include promoting prevention, such as through condom use and supporting male circumcision. The aim is to reduce HIV and TB incidence by 50 per cent, in line with South Africa's national strategic plan for 2011–2016.

Assisting migrants and asylum seekers

One-fifth of all applications for asylum worldwide are made in South Africa. The vast majority of people claiming asylum in South Africa come from Zimbabwe. In Musina, at the Zimbabwean border, MSF offered medical assistance to new arrivals outside the offices of the Department of Home Affairs and visited migrant workers on farms in the area during the day and at shelters in Musina town at night. Staff provided basic healthcare, treatment for HIV and TB – testing just under 1,900 people for HIV – and assistance for 120 victims of sexual violence, many of whom had been attacked on their journey to Musina.

Health screening in Johannesburg

Having observed that most patients attending MSF's clinic near a church in Johannesburg came from nearby slums, in 2011 the team transferred activities from the clinic to mobile screening trucks, which visited some of the most deprived areas of the city.

Before closing the clinic in August, staff conducted more than 1,100 consultations, mainly treating upper respiratory tract infections, skin diseases and sexually transmitted infections (STIs). Mobile activities began in May, and by the end of the year, some 11,100 people had been screened for conditions such as HIV, TB and STIs, and had either received treatment or been referred to public health facilities.

At the end of 2011, MSF had 149 field staff in South Africa. MSF has been working in the country since 1999.



© Jose Cendon

A peer counsellor helps fit a mask to prevent tuberculosis infection, Khayelitsha township, near Cape Town.

SRI LANKA



In 2011, Médecins Sans Frontières (MSF) continued to support people affected by the civil war in Sri Lanka's Northern province, which ended in 2009.

National health authorities worked to restore the health system in places damaged in the conflict, and by September, MSF found that general health services, though suffering shortages, were managing to meet basic needs. The team therefore focused on specialist medical care and mental health services.

Reconstructive surgery and rehabilitation

In 2009, a specialist team began performing reconstructive orthopaedic surgery in Vavuniya general hospital. In 2011, the team operated on 150 people with complicated

war-related injuries. The programme was closed in December, and medical equipment, drugs and surgical supplies were handed over to the Ministry of Health.

People with spinal injuries received care at MSF's rehabilitation programme in Pampaimadhu hospital, in Vavuniya. Rehabilitation has a positive impact, not only on people's quality of life, but also on their life expectancy. The team at the hospital provided medical treatment, physiotherapy and mental healthcare. Physiotherapy increases patients' mobility, and coaching helps prepare them for life outside the unit. Staff also helped patients to find training or work when they left the unit. In October, when 90 patients had completed their treatment and left the programme, MSF withdrew, handing all facilities and equipment over to the Ministry of Health.

Surgery and emergency care

At the hospitals in Point Pedro, in the far north, and Mullaitivu, on the northeast coast, MSF staff assisted in the provision of emergency care, surgery and gynaecological and obstetric services.

Surgeons performed 1,720 major operations and 1,600 minor procedures. Medical staff held over 6,900 emergency consultations. Approximately 5,300 women received

antenatal care, and 929 births were assisted. At Point Pedro, MSF also offered training to hospital staff in laboratory hygiene, sterilisation and infection control, before withdrawing at the end of the year.

The team in Mullaitivu continues its activities, which include improving local people's access to healthcare by operating mobile clinics at five different sites around the district. Staff carried out more than 11,500 consultations over the course of the year.

Mental healthcare

MSF expanded its psychological support services in Mullaitivu district substantially during 2011. Most patients were women who had been living in the displaced people's camps after the war. Staff worked at eight different sites in the district and conducted almost 3,600 individual and group counselling sessions. A psychiatrist treated patients diagnosed with post-traumatic stress disorder, depression, epilepsy and psychosis.

Staff also offered mental healthcare in Kilinochchi. More than 433 patients, many of whose relatives had died during the conflict, attended counselling sessions.

At the end of 2011, MSF had 310 staff in Sri Lanka. MSF first worked in the country in 1986.



Surgical consultation at Point Pedro Base hospital, Northern province.

SOUTH SUDAN

The Republic of South Sudan only came into existence on 9 July 2011, but the country has already faced multiple crises.

According to the UN, some 350,000 people returned home to South Sudan between November 2010 and the end of 2011, while violence displaced around 300,000 people. Médecins Sans Frontières (MSF) continued to focus on emergency response.

MSF works in South Sudan as well as in the transitional area of Abyei, providing a range of medical services, from maternal healthcare and nutrition programmes, to surgery and treatment for tuberculosis (TB), malaria and kala azar.

In September, MSF started negotiations with the authorities to construct a hospital in Juba, the capital city. The intention is to provide paediatric and surgical care and emergency obstetric services.

Conflict and emergency response in Jonglei

Since 2009, violent, intercommunal cattle-raiding has become more intense in the eastern state of Jonglei, and entire villages have been destroyed.

In the last week of December 2011, the MSF hospital in the town of Pibor was looted and

ransacked, and MSF's clinic in Lekwongole was burned, with only the walls and roof left standing. Among the many people killed were an MSF watchman and his wife. MSF treated 108 people for violence-related wounds in the first weeks after the attack. Many frightened people hid in the bush for weeks on end and MSF consequently saw an increase in the number of patients suffering from malnutrition and malaria.

MSF is the only provider of healthcare for the 160,000 people who live in Pibor county, as the nearest alternative health services are over 150 kilometres away. In 2011, the team

carried out around 12,500 consultations in Pibor, and more than 11,800 in the villages of Lekwongole and Gumuruk. Staff treated approximately 2,500 patients for malaria, 1,000 children with severe malnutrition, and 500 people with violence-related injuries.

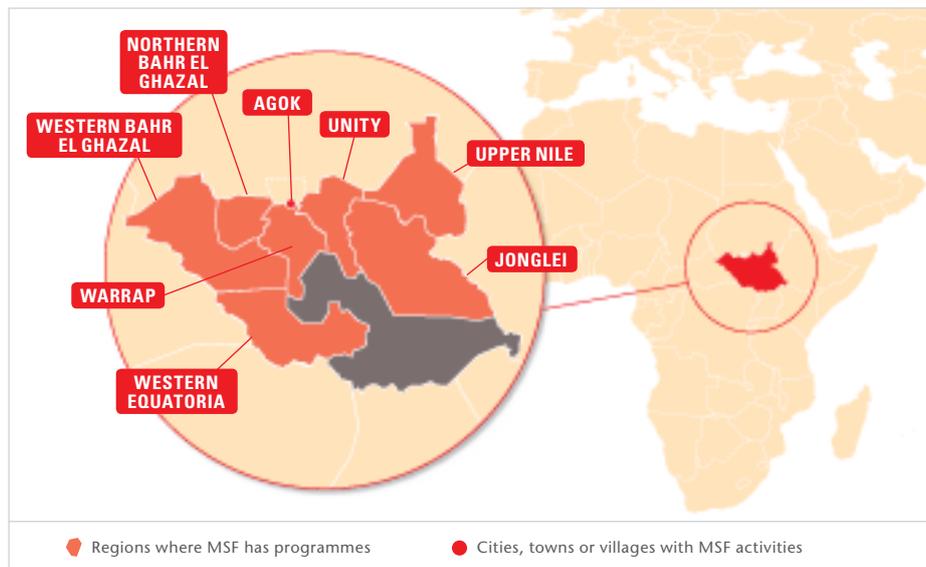
Further north, the MSF clinic in Lankien serves around 127,000 people. With outreach sites in Pieri and Yuai, teams provide all kinds of medical care, from treatment for respiratory tract infections to spear wounds. In 2011, they treated more than 74,600 outpatients.

In August, there was a raid on Pieri and 12 surrounding villages; MSF treated over 100 people for injuries and referred another 57 to hospitals in Leer and Nasir. The majority of the victims were women and children with gunshot wounds. One MSF staff member was killed, along with her entire household. The raiders looted MSF's compound and clinic in Pieri and burned down parts of it.

In early December, teams expanded their outreach activities in Lankien, Pieri and Yuai in response to an increase in the number of people suffering from malaria. Staff treated 3,160 patients for malaria in just one month, when the average is usually 300 to 400 cases a month.

Emergency response in Abyei and the surrounding area

The area of Abyei, contested by Sudan and South Sudan, was the scene of violent clashes in May. The MSF hospital in Agok, 40 kilometres south of Abyei, received 42 wounded in less than 48 hours and treated at least 2,300 patients in the first two weeks of the fighting. As most people had fled with just the few belongings



A child is vaccinated against measles in Abathok.

© Avril Benoît/MSF



© Corentin Fohlen

Refugees who fled fighting in the disputed Abyei area receive relief items.

they could carry, MSF distributed medical supplies and basic relief items such as shelters, plastic sheeting, mosquito nets and soap. Staff also set up a rehydration point in Agok hospital. Mobile teams attended to the wounded and displaced in several small villages outside Agok. In 2011, MSF carried out a total of 26,000 outpatient consultations at the hospital.

A nutrition assessment in November prompted MSF to start offering supplementary food for all children under five years old. The first batch was distributed to 10,200 children in December.

Refugees from Sudan

In late November, MSF launched an emergency response when thousands of refugees fled from Blue Nile state in Sudan to several locations in Maban county, Upper Nile.

By the end of 2011, around 35,000 refugees had arrived in Doro and Jamam camps, and the number would swell to over 90,000 by April 2012. As well as setting up a field hospital in Doro camp, MSF teams provided urgently needed healthcare for refugees arriving at the border-crossing point at El-Fuj, carried out measles vaccination campaigns and distributed emergency supplies of food.

MSF water specialists also took steps to ensure a minimum amount of safe water was available and lobbied water organisations to implement more permanent solutions.

In December, MSF began providing medical assistance to some 20,000 refugees who had arrived in Yida, Unity state, just south of the border with the extremely volatile Sudanese state of South Kordofan.

Maternal healthcare in Aweil

Despite the eruption of violence along the northern border with Sudan, Northern Bahr El Ghazal remained relatively stable. In 2011, MSF handed over its basic healthcare activities and paediatric outpatient services at its hospital in Aweil to the Ministry of Health so that staff could focus resources and expertise on specialist maternity and paediatric care and nutrition. In 2011, over 1,200 children were enrolled on the nutrition programme and almost 3,800 children were admitted to the paediatric ward. Staff assisted more than 3,400 births in the hospital.

In Western Bahr El Ghazal, staff supported the maternity, paediatric and surgery departments of Raja civil hospital, carrying out more than 12,000 paediatric consultations

and admitting over 1,600 children to the hospital for treatment. In Western Equatoria state, MSF tended to some 24,000 patients in Yambio state hospital – working in the maternity and paediatric departments as well as treating malaria and malnutrition – and conducted outreach activities among people displaced by violence.

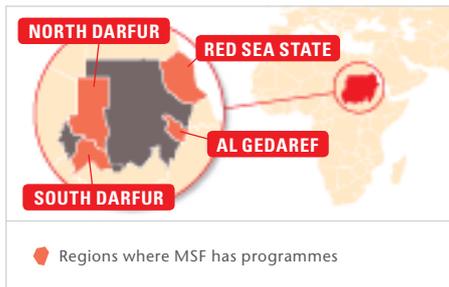
At the end of 2011, MSF had 1,872 staff in South Sudan. MSF has been working in the country since 1983.

Wathou

displaced from Lekwongole

"They started shooting and I tried to run away, but I fell over and hurt my back. It is still not OK now. When I sleep, I have no blankets or things to cover me; I just sleep in these clothes I'm wearing. And I am hungry; I have had no food, nothing to eat. My mother is old and cannot walk, so she has to be carried. But she is still alive. There is malaria attacking children and there are very few mosquito nets here. When children get malaria, we take them to the MSF hospital."

SUDAN



In Sudan, Médecins Sans Frontières (MSF) concentrates on providing medical assistance for people living in conflict zones and in remote regions with poor access to healthcare, and on treating kala azar (visceral leishmaniasis).

providing free treatment to more than 19,600 patients with other conditions. At the end of the year, a decision was made to expand the programme to nearby Sennar state, and a new programme was opened in November.

Darfur

Sporadic fighting and banditry continue in Darfur, making it difficult to reach those in need of medical care. Many people who have fled violence are still unable to return to their home villages. In 2011, MSF maintained five medical programmes, despite insecurity and bureaucratic difficulties that forced international staff to limit their presence to short 'flash visits' to train, assist and ensure standards of medical care.

In South Darfur, after an assessment in the Shaeria area, a nutrition programme was opened in March and 469 children received treatment. Against a background of intercommunal tensions, it quickly became apparent that there were wider needs for support to the hospital and surrounding abandoned rural clinics. MSF set up a comprehensive programme to support the Ministry of Health in Shaeria. The team started treating patients in early 2012.

Across North Darfur state, MSF carried out more than 150,000 outpatient consultations. MSF's hospital in Shangil Tobaya provides

both basic and specialist healthcare, including paediatric, reproductive and counselling services, and operates a mobile clinic by donkey to neighbouring villages that do not have access to medical care. The team in Tawila works with the local health facilities to provide comprehensive healthcare, including 24-hour emergency services, for the local community and the inhabitants of three camps for displaced people. In Abushok and Al Salam camps, near the state capital of Al Fashir, MSF ran a therapeutic feeding programme, treating more than 1,000 children on an outpatient basis and a further 239 inpatients between January and July, when the project was transferred to the Ministry of Health. In Dar Zaghawa, near the Sudan–Chad border, the team supports five health centres and responds to emergencies arising from outbreaks of violence.

MSF provided specialist healthcare and surgery in the hospital in Kaguro, an area held by opposition forces, as well as basic health services in five rural clinics. The team conducted more than 39,000 consultations and performed 119 major surgical procedures. However, difficulties in obtaining authorisation to supply the programme with drugs and other essentials are jeopardising activities.

Response to other emergencies

Between November 2010 and March 2011, MSF supported the Ministry of Health's response to extensive flooding in Marafit and surrounding areas in Red Sea state, close to the border with Eritrea. Staff distributed relief kits to 200 households and one ton of special nutritious food to approximately 1,500 children at risk of malnutrition. In June, after MSF had recorded high numbers of patients with measles, the team in Tabarak Allah hospital conducted a measles vaccination campaign with the national authorities. In total, 44,800 children were vaccinated and 620 were treated for measles.

At the end of 2011, MSF had 853 staff in Sudan. MSF has been working in the country since 1979.

Bureaucratic constraints, however, continue to hamper the provision of high-quality healthcare in some areas. MSF has made repeated offers to set up medical services in the states of Blue Nile and South Kordofan, where violence is rife, but these have been declined.

Kala azar

Since 2010, MSF has been running a programme in collaboration with the Ministry of Health to treat kala azar, an under-researched disease that is fatal if left untreated. Kala azar is endemic around the Atbara river area in Al Gedaref state, eastern Sudan. Last year, 3,090 people were screened for the disease and 729 patients who tested positive were treated in Tabarak Allah hospital.

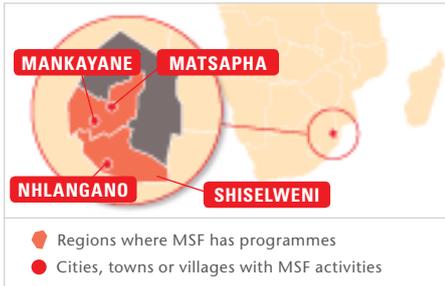
As Tabarak Allah hospital treats so many kala azar patients, it is one of the few locations where operational research into this neglected disease can be conducted. In July, the team introduced a new regime, developed by the Drugs for Neglected Diseases initiative (DNDi) and Sudanese scientists, which reduced the duration of treatment from 30 to 17 days. MSF also supported hospital staff in



Displaced people line up for medical assistance, North Darfur.

© Juan-Carlos Tomasi

SWAZILAND



Swaziland is struggling with a dual epidemic of HIV/AIDS and tuberculosis (TB). The scale-up of treatment has been made even more difficult by a national financial crisis.

Throughout 2011, there were strikes and demonstrations, and the government had difficulties securing funds to buy drugs and supplies to respond to the national HIV emergency. Thousands of lives are affected. Almost 26 per cent of adults aged between 15 and 49 have HIV. At any one time, four in 10 pregnant women are HIV positive. Some 80 per cent of TB patients are co-infected with HIV.

HIV and TB care in Shiselweni

Swaziland is a rural country with many small, isolated villages. Health centres are often far from people's homes, making journeys for medical attention long and expensive.

Shiselweni, in the south, is the poorest and most remote region. Since 2007, Médecins Sans Frontières (MSF) teams have been focusing on facilitating free access to HIV and TB services at the closest point of care. Today, 22 rural clinics in Shiselweni offer HIV and TB care. This means that people with both diseases can receive all their treatment at their local health centre. More than 2,000 patients are treated for TB every year, and at the end of 2011, 18,000 patients were receiving antiretroviral (ARV) treatment.

In 2011, MSF introduced new staff, based in the community, who offer testing and counselling. They now work in every clinic, and since the scheme started, the number of people tested has more than tripled, to over 2,300 per month.

In addition, MSF works in a health centre in the town of Matsapha, in central Swaziland, where 378 people received treatment for TB and 705 patients are on ARV treatment. Staff also offer comprehensive healthcare



A community treatment supporter prepares an injection for an MDR-TB patient.

to local workers – holding consultations outside of working hours so that textile workers can see medical staff. In Mankayane, not far away, the MSF team assisted Ministry of Health staff in improving the diagnosis and treatment of 664 patients co-infected with HIV and TB, and treated 60 patients with drug-resistant tuberculosis (DR-TB).

New DR-TB facilities

The management of DR-TB is a growing challenge in Swaziland. DR-TB can be caught from someone with the disease, but can also develop when a person with TB grows resistant to standard treatment. The treatment regime for DR-TB is very difficult, and causes a range of side effects. Patients receive daily injections for at least six months, and have to take as many as 18 pills a day for up to two years.

Almost eight per cent of new TB cases are drug-resistant. MSF supported the National Reference Laboratory for Tuberculosis in carrying out diagnoses. At the end of 2011, 172 people were being treated for DR-TB in the region of Shiselweni alone.

In September, a new DR-TB ward, built by MSF, was inaugurated in Nhlengano, in the presence of King Mswati III. Nhlengano is a large town in the south of the country. The ward complements the community-based approach to treatment by offering inpatient care to those who are very sick closer to home. It is run by the Ministry of Health and MSF teams together.

Eleven rural clinics were also rehabilitated. They were fitted out with new, well ventilated waiting areas and additional consultation rooms. In Matsapha and

Mankayane, MSF introduced a new TB testing machine, which significantly reduces the time it takes for diagnosis, and which can test for some forms of drug resistance.

Task-shifting to go national

Very few Swazi medical doctors are working in public health outside of the capital Mbabane, and many who train in the country leave for places where employment conditions are better. A lack of medical human resources is recognised as the main obstacle to expanding health service capacity. MSF uses task-shifting in its programmes to enable more people to receive care. Nurses, rather than doctors, are trained to initiate ARV treatment, or administer drugs for uncomplicated, non-resistant TB, while counsellors are taught how to test people for HIV, thus freeing up nurses for other work. In 2011, the Ministry of Health began developing a national framework for task-shifting, which should significantly increase staff capacity across the country.

Shortages of medicines

Although the HIV and TB epidemics have been declared emergencies in Swaziland, MSF contingency stocks of ARV drugs had to be used by thousands of patients in 2011 due to shortages in national stocks. MSF appealed to King Mswati III to make sure all measures are taken to guarantee the timely procurement, supply and distribution of drugs and laboratory supplies to health facilities and patients.

At the end of 2011, MSF had 246 staff in Swaziland. MSF has been working in the country since 2007.

SYRIA



From early 2011, Médecins Sans Frontières (MSF) was unable to operate in Syria, and was therefore obliged to suspend its work with migrants and refugees in the capital Damascus.

In August 2009, MSF launched a healthcare project in the capital Damascus, in partnership with a local organisation, known as the Migrant's Office. Based in a clinic, a team consisting of doctors, gynaecologists and a psychologist provided free basic healthcare, antenatal care and mental health services for unregistered refugees and migrants, focusing specifically on the most vulnerable, including women and children.

Between January and March 2011, 1,965 patients received medical attention. Staff held more than 220 antenatal consultations and over 140 patients received mental healthcare through individual consultations and group sessions.

Withdrawal amid growing unrest

The widespread unrest in the country, which began in March 2011, made it very difficult for MSF to continue its work inside Syria, and the team had to suspend collaboration with the Migrant's Office. MSF continued to try

to gain access to Syria in order to respond to the humanitarian and medical needs resulting from the violence.

From neighbouring countries, MSF supported Syrian doctors' work by providing them with medical supplies and essential drugs. In Amman, Jordan, where MSF has a reconstructive surgery programme, surgeons operated on 23 wounded Syrians who had managed to cross the border.

In Lebanon, MSF donated emergency supplies to health centres near the border with Syria. In November, a team set up a mental health programme in the northeastern region of Wadi Khaled, where staff conducted individual consultations and group sessions with Syrians who had fled their country.

At the end of 2011, MSF had 48 staff in Syria. MSF has had operational activities in Syria since 2009.

In April, as unrest and violence increased, teams started to provide Syrian doctors with medicines and other medical supplies. In June, the MSF surgical team in Amman, Jordan, received their first Syrian patient. In November, teams began offering mental healthcare to Syrians who had fled to Lebanon.

Unregistered migrants in need of healthcare

Syria is host to hundreds of thousands of migrants and refugees, many of whom have fled poverty or conflict in Afghanistan, Egypt, Iraq, Lebanon, Somalia and Sudan. A large proportion of them are living in the country unregistered, in precarious conditions, with limited access to medical care.

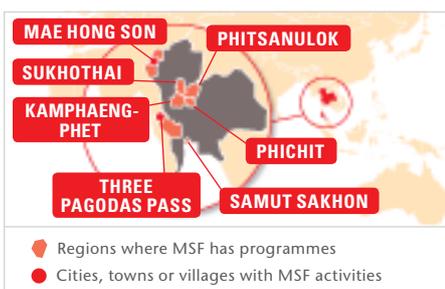


Orthopaedic surgery at MSF's centre in Amman, where 23 wounded Syrians received treatment in 2011.

THAILAND



Staff distribute relief items to people affected by flooding.



After working in Thailand for 35 years, Médecins Sans Frontières (MSF) has reluctantly closed its final remaining project in the country.

It has proved impossible to obtain permission to offer medical attention to undocumented migrants and vulnerable people who are not entitled to basic healthcare. In September, MSF came to the conclusion that there was no choice but to close its longest-running mission, which started with the provision of assistance to Cambodian refugees fleeing the Khmer regime in 1976.

In the 1980s, MSF supported refugees from Myanmar, and since the mid-1990s, it has played a key role in providing and advocating comprehensive care and treatment for people living with HIV. Thailand was one of the first countries to introduce free antiretroviral treatment for HIV patients. In the past decade, MSF has responded mainly to emergencies and offered healthcare to Hmong refugees from Laos. For more on MSF's history in Thailand, see pages 18–21.

Assistance to migrants halted

Early in 2011, MSF was forced to close its programmes in the central industrial zone of Samut Sakhon and in the Three Pagodas Pass, on the border with Myanmar, depriving 55,000 vulnerable people of access to healthcare. In the Three Pagodas Pass area, MSF had been operating a mobile clinic, providing basic medical services. Staff carried out 795 antenatal consultations, referring pregnant women to Ministry of Health hospitals for delivery. Some 4,200 people received general health education.

At the MSF clinic in Samut Sakhon province, where thousands of undocumented migrants live and work, staff conducted more than 1,380 medical consultations. Over 4,200 people attended health education sessions.

Mae Hong Son

In Mae Hong Son, in the north of Thailand, MSF staff trained 'backpackers' to work as mobile medical teams in the Myanmar–Thailand border area. In 2011, more than 48,470 medical consultations and almost 1,590 antenatal care consultations were carried out by these mobile teams. In the same period, staff assisted some 420 births and distributed more than 6,750 mosquito nets.

Flood response

The monsoon season began at the end of July and caused severe flooding in northern, northeastern and central Thailand. In October, floodwaters reached the mouth of the Chao Phraya river, and inundated parts of the capital city, Bangkok. Of Thailand's 77 provinces, 65 were declared flood disaster zones. Approximately 800 people died and 13.6 million were affected.

MSF teams supplied 66,000 people with relief items – mainly food, water and mosquito nets – and carried out more than 1,400 medical consultations in the most affected areas of Sukhothai, Phitsanulok, Phichit and Kamphaeng-Phet provinces.

At the end of 2011, MSF had 42 staff in Thailand. MSF has been working in the country since 1976.

TUNISIA



Healthcare for third-country nationals

In late February, the health authorities and local non-governmental organisations were able to cover most of the people's medical needs. MSF identified a gap in mental healthcare, and a team began offering mental health services in Shousha refugee camp, close to Ras Ajdir, in March, later extending assistance to people staying in two other transit camps in the area.

By June, more than 600,000 migrants, refugees and asylum seekers had left Libya, and although many were rapidly repatriated to their country of origin, thousands remained stranded in Egypt, Italy, Niger or Tunisia, with great uncertainty for their future.

For many, this stress, added to the traumatic experiences they had been through or witnessed while fleeing the conflict in Libya, and the persecution and ill-treatment some of them had survived prior to the conflict, was too much.

In Shousha, the largest camp, some 4,000 people, mainly sub-Saharan Africans, had still not been repatriated, months after arriving, mainly because of dangerous situations in their countries of origin. Poor living conditions in the camp, inadequate for a long-term stay, and growing security issues, led to violent clashes in May. MSF expanded its activities, to provide medical care, and distribute food, water and relief items, as well as offer mental healthcare. The violence exacerbated feelings of despair among people living in the camp. Some refugees chose to risk their lives by attempting to cross the Mediterranean Sea, in the hope of finding a better reception in Europe.

Violent clashes in Libya in early 2011 forced hundreds of thousands of people to leave the country, many across the Tunisian border.

Médecins Sans Frontières (MSF) staff in Ras Ajdir, a small coastal town on the border, were blocked from crossing into Libya to assist the victims of the conflict, and witnessed thousands of people arriving in Tunisia in search of safety.

Assisting Libyan refugees

Health centres in towns and villages bordering Libya were under enormous pressure. In the town of Dehiba, just a few kilometres from the border, MSF set up a stabilisation centre, caring for people who had been injured in the conflict. The team treated nearly 60 emergency patients in March and April. Other teams set up mobile clinics in Dehiba, Remada and Tataouine, offering medical care as well as psychological support to refugees.



A health promoter talks to people in Shousha camp about mental health services.

MSF called on the countries engaged in the war to better receive, assist and protect its victims. In *From a Rock to a Hard Place: The Neglected Victims of the Conflict in Libya*, MSF reminded all warring parties and neighbouring countries of their responsibility, under international law, to keep their borders open and offer protection to those fleeing Libya.

Handover of activities

By August, the majority of Libyan refugees had returned home, and MSF began to scale down activities, stopping them completely in September. Thousands of third-country nationals remained stranded in Shousha, but there were enough organisations working in the camp to cover medical needs. MSF therefore handed its activities over to these organisations.

Between March and September, staff carried out 10,500 medical consultations and 21,000 mental health consultations. Before leaving, medical supplies and equipment were donated to health facilities in the towns of Tataouine and Medenine.

Medical evacuation by boat

In April, the Libyan city of Misrata was the scene of heavy fighting: residents were cut off from external assistance and hospitals and clinics were overwhelmed with casualties. MSF carried out two medical evacuations from Misrata to Tunisia. A team removed 135 patients by boat, with medical staff providing urgent assistance on board. Upon arrival, the Tunisian health authorities and the Tunisian Red Crescent transferred the patients to medical facilities in Sfax and Zarzis, and on the island of Djerba.

At the end of 2011, MSF had 6 staff in Tunisia. MSF started working in the country in 2011.

Mouhaydin

27 years old, from Somalia

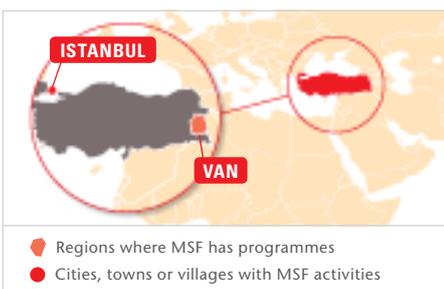
"I left Somalia in 1994 because of the war. When my father was killed, my family fled to Ethiopia. They still live there. I am the eldest child and need to support my family. I decided to go to Libya and beyond, to find work and build a future.

"I arrived in Libya eight years ago. I was working as a labourer and a cleaner and life was difficult. We were treated like slaves. When the war broke out, the situation became very frightening for foreigners. I had to flee this country too, and I arrived in Shousha camp on 6 March."

TURKEY



Victims of the earthquakes that struck eastern Turkey in October and November.



In 2011, Médecins Sans Frontières (MSF) teams in Turkey provided mental health support to migrants in Istanbul and survivors of the earthquakes in Van.

Undocumented migrants have no access to health services in Turkey. In June 2011, MSF signed a partnership agreement with a Turkish non-governmental organisation (NGO), the Helsinki Citizens' Assembly, to provide assistance to undocumented migrants living in Istanbul. Teams provide aid to the most vulnerable, including women, children and the elderly, in 10 of Istanbul's municipalities. The majority of patients have been through traumatic events and are now facing problems relating to integrating in a new environment.

Psychologists provided mental health support, while community health workers and interpreters assisted the clinical team and conducted outreach with the migrant communities, community organisations and Turkish health facilities. Almost 940 group counselling sessions were held in 2011.

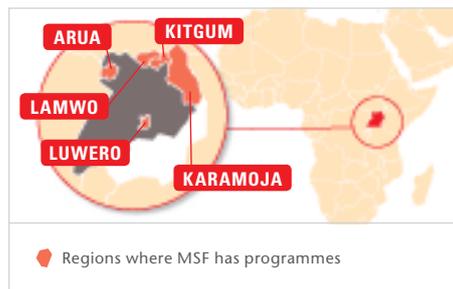
Earthquake response

The two earthquakes that struck eastern Turkey in October and November killed at least 500 people and injured 2,500. An MSF team in Van worked with local authorities and two Turkish NGOs, Hayata Destek and the Helsinki Citizens' Assembly, distributing 2,000 winter tents and 2,000 cooking kits to 12,000 people in 37 villages in Van.

MSF started a two-month psychological support programme in 31 villages in December. By the end of the programme, 3,470 women and 1,850 men had benefited from group sessions, and 53 people received individual counselling. Patients in a more serious condition were referred to Van hospital.

At the end of 2011, MSF had 8 staff in Turkey. MSF first worked in the country in 1999.

UGANDA



In Uganda, Médecins Sans Frontières (MSF) operates HIV and tuberculosis (TB) programmes and assists people recovering from years of conflict in the north of the country.

in the programme was declared cured. MSF has been lobbying for other organisations to provide treatment for MDR-TB.

HIV care in Arua

The Ugandan Ministry of Health decided that it would start implementing nationwide MSF's treatment protocol for preventing mother-to-child transmission (PMTCT) of HIV in 2012.

MSF continued to provide treatment at Arua regional referral hospital, in the northwest of the country. Each month, an average of 25 women gave birth through the PMTCT programme. Nearly 2,000 new patients were registered at MSF's HIV programme and more than 6,400 received antiretroviral (ARV) treatment.

Being close to the border with the Democratic Republic of the Congo (DRC), where access to ARV treatment is very limited, a significant proportion of the people living with HIV in the Arua area come from the DRC. MSF has been supporting an HIV clinic at a health centre in Oli, on the outskirts of Arua. At the end of 2011, more than 780 patients were receiving care in Oli. This programme will be handed over to the Ministry of Health in 2012.

The Oli and Arua programmes both offer integrated care for HIV patients suffering from other conditions associated with the

infection, including TB and malnutrition. More than 700 patients co-infected with TB and over 550 children suffering from severe malnutrition received treatment in 2011.

Sleeping sickness

Sleeping sickness (human African trypanosomiasis) is endemic in Uganda. MSF had been supporting Ministry of Health programmes, but in the middle of the year, after an assessment revealed prevalence to be less significant than suspected, the team decided to focus instead on lobbying for the opening of treatment centres and on providing training to national and regional programmes.

Research to improve testing and treatment

A number of research projects were carried out in Uganda in 2011. With the London School of Hygiene and Tropical Medicine, MSF undertook operational field research into TB and drug-resistant TB patients' acceptance of home-based care through village health teams. In Karamoja, researchers embarked on a study of how children's recovery from malaria, diarrhoea or respiratory infections is affected by their nutrient intake. MSF also started a study on rapid diagnostic testing methods for HIV.

At the end of 2011, MSF had 613 staff in Uganda. MSF has been working in the country since 1986.

MSF supports hospitals and health centres in the districts of Kitgum and Lamwo and the subregion of Karamoja in northern Uganda. In 2011, staff conducted close to 17,000 outpatient consultations and 3,365 antenatal consultations, and admitted 506 people to hospital.

Since the conflict ended, the general health situation has improved, and this has prompted MSF to switch the focus of its activities in Kitgum and Lamwo to supporting victims of sexual violence: there are now 18 centres in the two districts that can care for survivors of sexual violence.

In Karamoja, fighting persists, and a number of patients needed treatment for injuries. When yellow fever and hepatitis E broke out in the region, MSF assisted the health authorities, and also supported the response to an outbreak of Ebola in Luwero, central Uganda.

MSF continued to run its TB programme, and more than 500 new patients started treatment in 2011. In December, the first patient to start treatment for multidrug-resistant TB (MDR-TB)



Patients wait outside a clinic in Kaabong district, Karamoja region.

Opira

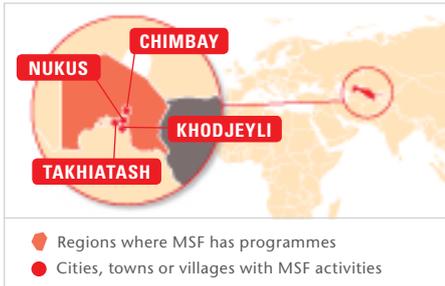
34 years old, has MDR-TB

"For quite some time now, I have been taking 18 tablets a day... Sometimes when I take the drugs, I feel weak because the drug starts working on me immediately and I cannot go anywhere; I have to take some time. Sometimes, I can take the drugs and, when I have eaten well, I may not feel like vomiting. Sometimes, I might feel like vomiting but I can still walk around. But most of the time when I take the drug, I feel like I should first have a rest in bed because I cannot walk."

"In the end I will go back to Gulu. That is my plan. I lived there during the conflict and didn't leave until last year, 16 May. That is the day I came to Kitgum, because of my illness."

Opira writes a blog as part of MSF's TB&ME project. See his and others' accounts of what it means to live with TB at blogs.msf.org/tb/

UZBEKISTAN



Drug-resistant tuberculosis (DR-TB) is widespread in Uzbekistan. Médecins Sans Frontières (MSF) is introducing a comprehensive treatment and support programme.

DR-TB can be transmitted from person to person just like drug-sensitive tuberculosis, but it can also develop when a TB patient, either through mismanagement or misuse of medication, becomes resistant to the standard TB drugs. DR-TB treatment is arduous – side effects are common, and include nausea, headaches and sleep disturbances – and takes up to two years. Understandably, it can be very difficult for patients to complete the course of treatment.

Implementing comprehensive TB care

In the Autonomous Republic of Karakalpakstan, northwest Uzbekistan, MSF expanded its programme from two to five of 16 districts: Chimbay, Khodjeyli, Takhiatash town, Nukus town and Nukus region, and tripled the number of patients. By the end of the year, some 780 patients were receiving treatment for DR-TB, and almost 200 were receiving treatment for drug-sensitive TB.

MSF's programme includes a range of approaches, which all contribute to improving adherence. Treating people as outpatients from day one, instead of imposing a stay in hospital, can make treatment more bearable. Educating patients about DR-TB, the medication and the side effects enables them to better understand and manage their disease. Psychological assistance, in the form of individual, group and family counselling sessions, supports patients in coping



A daily dose of drugs for a patient with MDR-TB, including TB antibiotics and drugs to counter the side effects of treatment.

with the physical and social effects both of having TB and being on treatment. More practical social support, such as help with transport and food, is also provided. Amid signs that Uzbekistan's commitment to tackling TB is strengthening, MSF plans to expand its programme to three more districts in 2012.

At the end of 2011, MSF had 157 staff in Uzbekistan. MSF has been working in the country since 1997.

MSF treated
780
PATIENTS
for DR-TB

Rakhatay

Multidrug resistant TB patient

"I had been treated for TB in our local hospital for over a year. There was no effect. Then I was lying at home. I guess God had pity on me, for you [MSF doctor] came to my house and told me that treatment is available. At that time I couldn't even talk to you, I could only listen.

"It's my daughter Kunduz, it's thanks to her I started my treatment anew. She convinced me; she told me that I should go for this treatment. Now I am taking drugs. Before, I could not eat: I could only drink black tea from a spoon. I couldn't even raise my head. Thanks to God, now I can sit and even move around.

"I never miss even one day of drugs. There are nurses – Amangul, Umyt, Muhabbat – they bring me medicines. They are all such nice people; they coax me like a child, and make up different tricks so I don't even notice how I have swallowed the medicine. I am so thankful to them; I have reached such a good state of health now."

YEMEN

In 2011, protests in Yemen's main cities regularly ended in violent clashes.

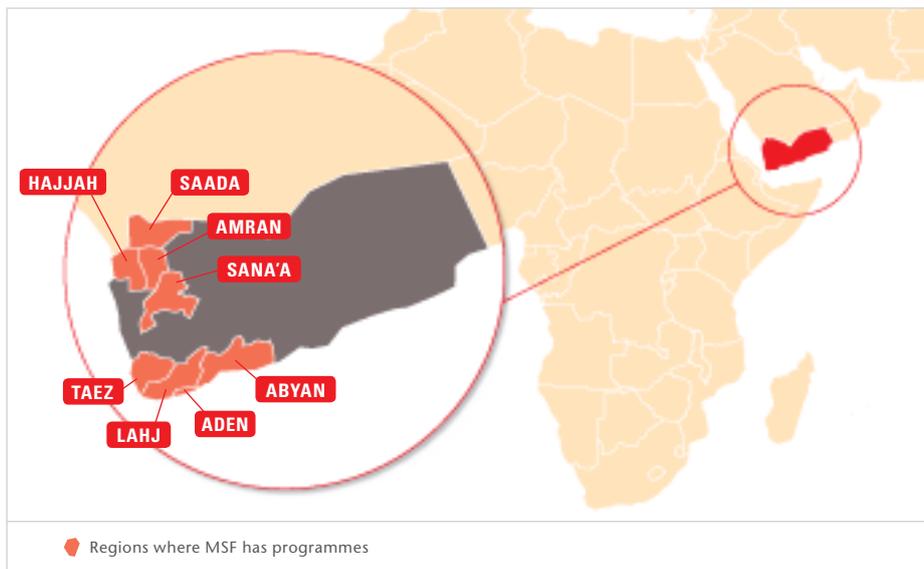
On the whole, national health facilities were able to care for the increased number of patients. Médecins Sans Frontières (MSF) supported medical staff, filling gaps in supplies and offering ad hoc support.

Violence in the south

Fighting between opposing Islamic militant groups and government forces in Abyan governorate, southern Yemen, began to escalate in May. Healthcare facilities were severely damaged in the violence, and MSF staff were prevented from reaching some places.

At a health post in Jaar, MSF provided basic medical and emergency assistance and set up stabilisation and ambulance referral systems. Some 2,000 people received emergency care and more than 200 were referred to a private hospital in Aden, 70 kilometres away.

In Ad-Dali hospital, northwest of Aden, MSF supported staff in the emergency



department, carrying out some 4,400 consultations and referring 120 patients to facilities in Aden.

MSF continued the activities it had begun in July 2010 in Radfan district hospital, Lahj governorate. More than 9,500 patients were admitted for emergency care and surgeons

performed over 1,160 operations. MSF also assisted in the pharmacy and laboratory.

Around 100,000 people were displaced by violence. Some found shelter with residents in the town of Al-Hosn, where MSF staff supported a clinic. Most people, however, headed towards the city of Aden. In the



An emergency consultation at Huth hospital, Amran governorate.

© MSF



A doctor examines a young patient, Huth hospital, Amran governorate.

second half of the year, MSF conducted outpatient consultations in three city clinics, donated drugs and trained medical staff.

In the capital Sana'a, MSF donated drugs and medical supplies to public and private health facilities, and provided additional training for the management of incidents involving large numbers of injured patients. Staff also ran an ambulance service and, for two months, carried out surgery at a private health centre.

Working conditions compromise activities in the north

Civil conflict in Saada persisted, despite a ceasefire agreement in 2010. Conditions became increasingly difficult for relief organisations, and MSF had to reduce its activities.

In September, the Executive Council in charge of humanitarian affairs in Saada announced new conditions for all humanitarian and non-governmental organisations working in the governorate. Among these were the termination of all independent assessments of medical needs and the obligation to replace all Ministry of Health staff working with MSF with staff proposed by the Executive Council.

Having considered the consequences of these new conditions on the quality and effectiveness of its work, MSF suspended activities in Al Talh and Razeh hospitals, as well as in five health centres in the area.

Al Talh and Razeh are the only facilities outside Saada city providing specialist care. MSF staff in Al Talh held 48,000 outpatient consultations, performed 459 surgical interventions and admitted 1,900 inpatients during the first nine months of the year. In March and April, MSF also provided support to Al Jamouri hospital in Saada city, concentrating on strengthening paediatric and nutrition services.

Violence was still rife in the neighbouring governorate of Amran in 2011. MSF worked in Khameer and Huth hospitals and ran mobile clinics in the surrounding area. Staff carried out more than 40,000 consultations, treated some 1,250 children for severe malnutrition and assisted 500 births. Due to growing insecurity, surgeons were able to work for only three months of the year. Nonetheless, they performed around 325 operations, and MSF teams cared for more than 800 inpatients.

Many Yemenis fleeing violence in Saada made their way south to Al Mazraq, Hajjah governorate. MSF provides general healthcare to people living in the camps around Al Mazraq, focusing particularly on treating children for malnutrition, assisting victims of sexual violence and supporting people in need of mental healthcare.

MSF also manages the only hospital in Al Mazraq, which was built by the Organization of the Islamic Conference and the Qatar Red Crescent Society. There is an emergency department and an operating theatre, and staff offer basic and specialist healthcare for displaced people and the local community. In 2011, staff carried out more than 30,000 consultations, treated over 4,200 patients for emergencies and provided sexual and reproductive healthcare to 3,900 people. Some 270 surgical procedures were performed, and 2,700 children were treated for severe malnutrition.

At the end of 2011, MSF had 574 staff in Yemen. MSF first worked in the country in 1994.

ZIMBABWE

Plans to further improve HIV care in Zimbabwe were frustrated in 2011, when the Global Fund to Fight AIDS, Tuberculosis and Malaria – one of the major donors supporting the country's fight against HIV and tuberculosis (TB) – announced the cancellation of its next funding round.

According to the Zimbabwean government, 63 per cent of people in need of antiretroviral (ARV) medication are currently receiving treatment.

Médecins Sans Frontières (MSF) works within public facilities, mainly delivering HIV and TB – including drug-resistant TB – care. The programme covers the testing, diagnosis, treatment and counselling of patients with HIV and/or TB, and for pregnant women, antenatal care and prevention of mother-to-child transmission (PMTCT) of HIV. In 2011, MSF was supporting about 48,430 people on ARV treatment. Laboratory services, health promotion activities and assistance for victims of sexual violence were also available.

Scaling up treatment

Teams have been providing care for people with HIV and TB in Buhera district, in the

eastern province of Manicaland, since 2004. Today, 86 per cent of the people who need ARV treatment are receiving it. Scale-up has been possible thanks to new models of care. MSF has implemented task-shifting, so that trained nurses, instead of doctors, initiate ARV treatment and follow-up. Staff have also been working in rural health centres so that people living far from urban areas have better access to HIV care: 75 per cent of the 18,590 patients who have started ARV treatment since the programme began live in rural areas.

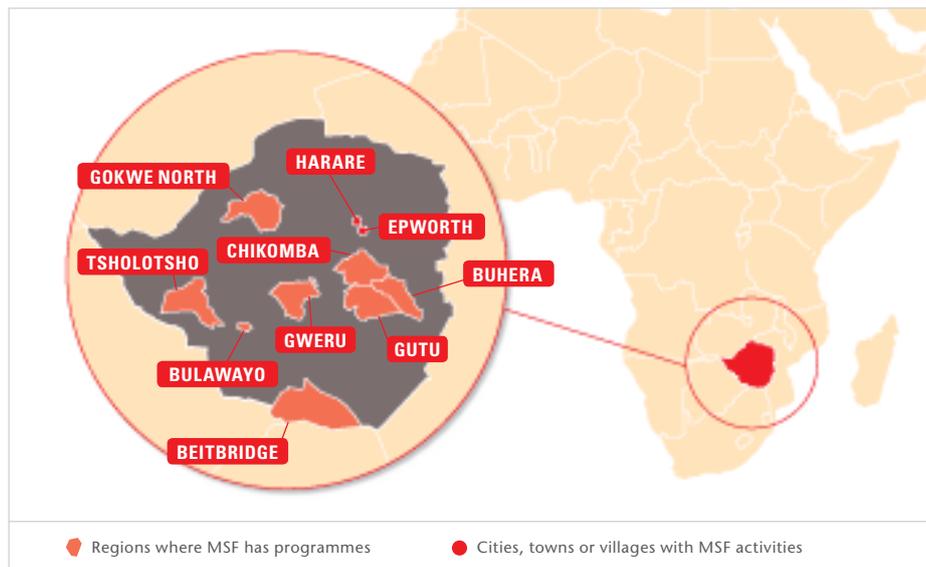
In an effort to rapidly extend services elsewhere in the country, MSF trained

26 Ministry of Health staff to provide support in HIV care to clinics in Gutu district, Masvingo province, and Chikomba district, Mashonaland East province.

In Tsholotsho, in the west of the country, teams focused on treating adolescents and children and pregnant women with HIV, and providing PMTCT. By the end of the year, more than 9,000 patients were on ARV treatment.

Successful and sustainable handovers

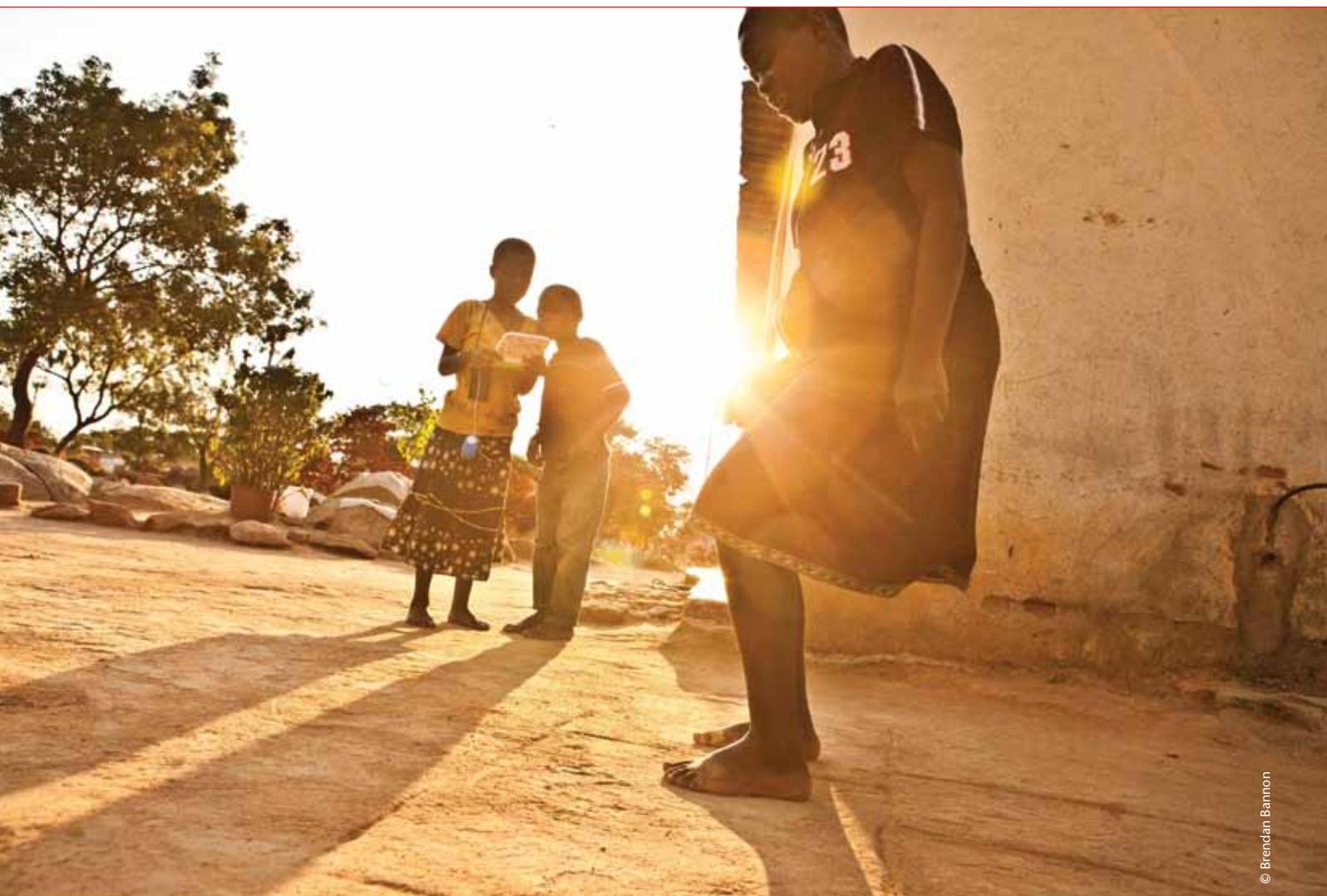
Being integrated into public health facilities has enabled MSF to offer training and transfer expertise, including PMTCT services, and therapeutic feeding for children. In 2011,



An 18-month-old and his mother wait for a consultation at Overspill clinic, Epworth, near Harare.

Guide

"I was first diagnosed with TB, but both first- and second-line treatment failed. My cough and weight loss continued, I couldn't walk any more and was soon bedridden. In December 2010, I was put on treatment for multidrug-resistant TB (MDR-TB) and have since much improved. Unfortunately, my wife contracted the bacteria from me and is now also suffering from MDR-TB – it is difficult to keep a couple separate! Now she is also being treated, and is staying overnight in a separate room. Our kids are staying with their grandparents down the road until it is safe enough for them to move back home."



© Brendan Bammon

An HIV patient plays with her siblings outside her home in Epworth, near Harare.

nearly 4,000 patients were transferred from Domboramwari clinic in Epworth to a new clinic built by MSF in Overspill, on the outskirts of Epworth. The Overspill clinic was handed over to the Ministry of Health, whose staff now run most services there.

MSF continues to work at the Domboramwari clinic. In total, more than 26,600 people were tested for HIV in Epworth, of whom 7,116 tested positive. At the end of the year, MSF was treating 14,220 patients for HIV, with just over 10,500 receiving ARV medication. MSF also treated 1,353 patients for TB, including 11 for DR-TB.

Another 11,000 HIV patients from MSF programmes in Gweru and Bulawayo were also fully integrated into the national health system.

Reaching vulnerable groups

MSF opened a new clinic in Caledonia Farm, a settlement on the outskirts of Harare that sprang up following the clearance of urban 'squatters' several years ago. The clinic provides basic healthcare, counselling and HIV testing, ARV treatment and treatment for TB.

In Mbare, a densely populated suburb of the city, MSF set up a new programme in October, offering support to victims of sexual violence.

Working with local non-governmental organisations, clinics and national health staff, MSF provides medical and psychological care. By the end of the year, the programme had already assisted 125 people.

In January, the MSF project in Beitbridge, close to the South African border, which had been offering basic healthcare, changed its focus to provide local people with HIV and TB treatment, targeting those at particular risk of infection. By the end of the year, staff had seen around 2,500 patients in Beitbridge district hospital, a clinic within the town and four rural clinics in the area.

Emergencies

MSF continued to assist in responding to emergencies and outbreaks of disease. When cholera broke out in Buhera, and typhoid in Harare, teams supported the national health services, treating more than 950 people for typhoid and nearly 70 for cholera. Staff also carried out rapid assessments and response following the declaration of an anthrax outbreak and a measles alert in Tsholotsho.

In 2011, MSF had 886 staff in Zimbabwe. MSF has been working in the country since 2000.

More than
48,000
PATIENTS
on ARV treatment

ZAMBIA



The number of people being treated for HIV in Zambia has increased and, according to the latest UNAIDS report, between 70 and 80 per cent of those who need antiretroviral treatment are receiving it.

However, prevention is still an issue, especially outside the big cities. A key component of the Médecins Sans Frontières (MSF) programme in Luwingu district, in the isolated and hard-to-reach Northern province, is the prevention of mother-to-child transmission (PMTCT) of HIV.

In collaboration with the Ministry of Health, the MSF team offers counselling and testing to pregnant women, and close to 4,800 were tested in 2011. Women diagnosed

with HIV are then referred to the district hospital in Luwingu for treatment, where MSF supports the PMTCT programme.

Simply offering counselling and testing is not enough, however. The stigmatisation of HIV-positive people is still strong in rural areas, and there is a reluctance to use testing services. In response, an MSF team travels regularly to villages in the district to raise awareness and increase understanding of HIV and its treatment. The objectives are to encourage people to come for testing, so that if they do have HIV, they can seek treatment, and pregnant women can prevent their children being born with the virus.

Maternal care

In seven rural health centres in Luwingu, MSF also supports general maternal health services. Staff offer family planning, ante- and postnatal care, and assist births. In 2011, they assisted an average of 110 births and held some 700 antenatal consultations every month. As part of the antenatal care package, the team test women for sexually transmitted infections, anaemia, HIV and malaria. If infected when pregnant, malaria can put a woman's life at risk, and increases the chances of premature delivery, low birth weight or stillbirth.

MSF also provided training to Ministry of Health staff and donated medical supplies and vaccines.

Measles vaccination campaign

At the beginning of May, MSF launched an emergency response to a measles epidemic that had affected thousands of Zambian children, especially in the north of the country. Teams worked with the health authorities to carry out a vaccination campaign targeting some 558,800 children aged between six months and 15 years in Luapula and Northern provinces. MSF also treated people suffering complications such as pneumonia, dehydration and malnutrition.

Cholera preparedness and prevention

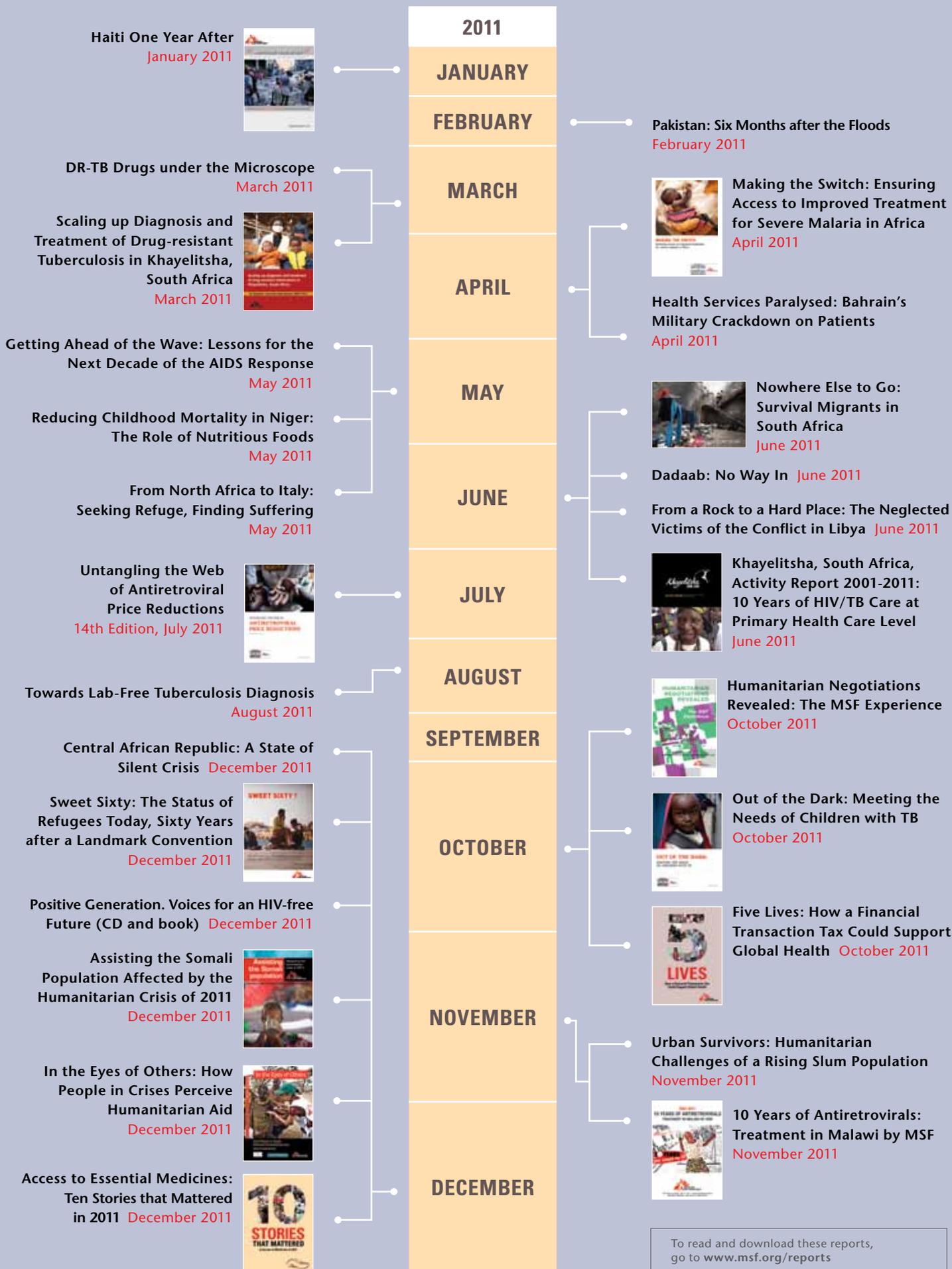
MSF carried out a cholera prevention programme in Lusaka over the rainy season, when incidence is highest. This involved chlorinating water at distribution points, delivering soap door to door, and organising activities to inform people about how to help prevent transmission, how to spot signs of the disease and where to seek help. Following this model, international agencies and non-governmental organisations have carried out further prevention activities in the country.

At the end of 2011, MSF had 87 staff in Zambia. MSF has been working in the country since 1999.



Health workers conduct measles vaccinations in northern Zambia.

MSF SPECIAL REPORTS 2011



To read and download these reports, go to www.msf.org/reports

FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, independent, private and non-profit organisation.

It comprises 19 main national offices in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States. There are also offices in the Czech Republic, Ireland and South Africa. MSF International is based in Geneva.

The search for efficiency has led MSF to create 10 specialised organisations, called 'satellites', which take charge of specific activities such as humanitarian relief supplies, epidemiological and medical research, and

research on humanitarian and social action. These satellites, considered as related parties to the national offices, include: MSF-Supply, MSF-Logistique, Epicentre, Fondation MSF, Etat d'Urgence Production, MSF Assistance, SCI MSF, SCI Sabin, Ärzte Ohne Grenzen Foundation and MSF Enterprises Limited. As these organisations are controlled by MSF, they are included in the scope of the MSF Financial Report and the figures presented here.

These figures describe MSF's finances on a combined international level. The 2011 combined international figures have been prepared in accordance with MSF international accounting standards, which comply with most of the requirements of the International Financial Reporting Standards (IFRS). The figures have been jointly audited by the accounting firms of KPMG and Ernst & Young, in accordance

with International Auditing Standards. A copy of the full 2011 Financial Report may be obtained at www.msf.org. In addition, each national office of MSF publishes annual, audited Financial Statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

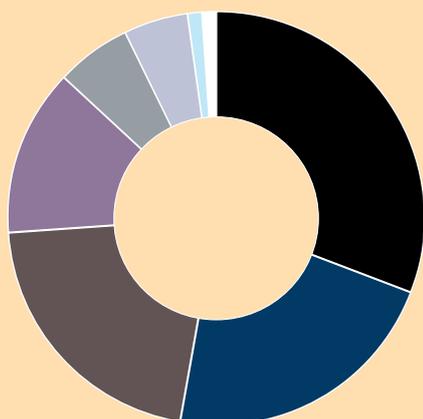
The figures presented here are for the 2011 calendar year. All amounts are presented in millions of euros.

Note: Figures in these tables are rounded, which may result in apparent inconsistencies in totals.

WHERE DID THE MONEY GO?

Programme expenses by nature

| | |
|----------------------------------|------|
| ■ Locally hired staff | 31 % |
| ■ International staff | 22 % |
| ■ Medical and nutrition | 21 % |
| ■ Transport, freight and storage | 13 % |
| ■ Logistics and sanitation | 6 % |
| ■ Operational running expenses | 5 % |
| ■ Training and local support | 1 % |
| ■ Consultants and field support | 1 % |



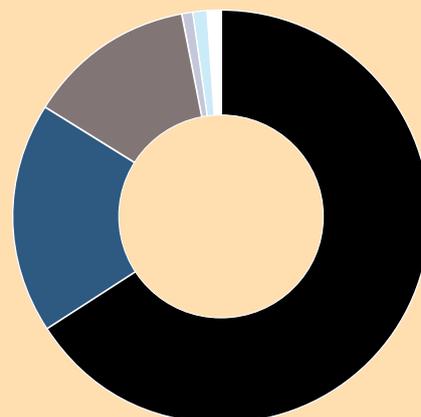
The biggest category of expenses is dedicated to staff working in the field: about 53 per cent of expenditure comprises all costs related to locally hired and international staff (including plane tickets, insurance, accommodation, etc.).

The medical and nutrition category includes drugs and medical equipment, vaccines, hospitalisation fees and therapeutic food. The delivery of these supplies is included in the category of transport, freight and storage.

Logistics and sanitation comprise building materials and equipment for health centres, water and sanitation and logistical supplies.

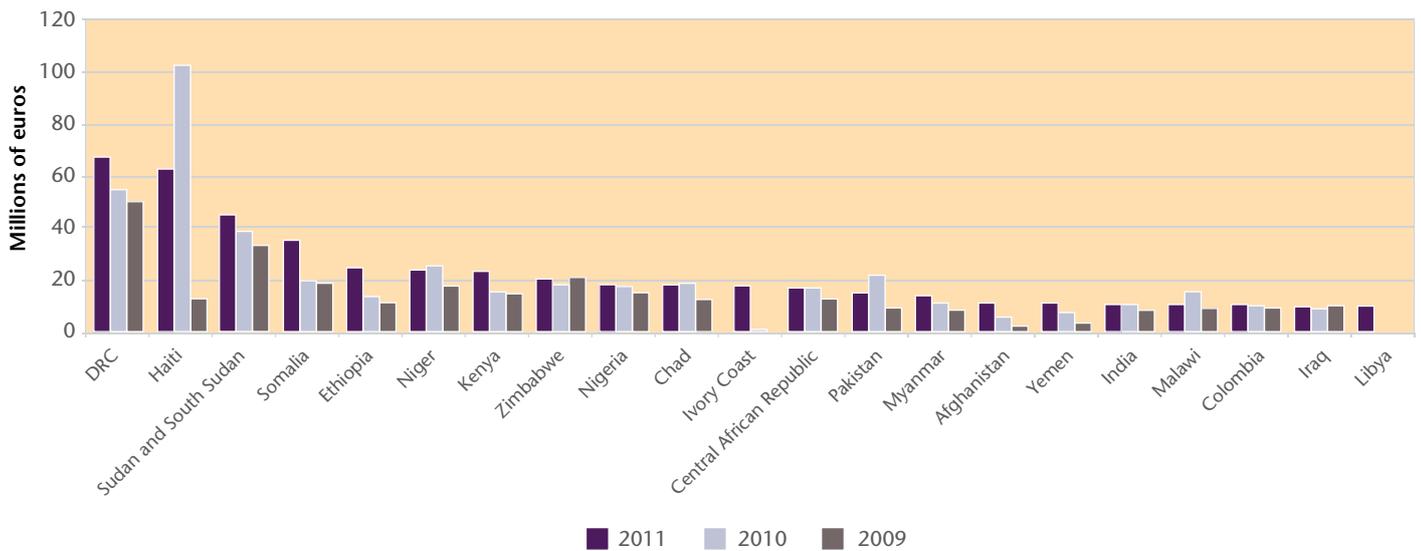
Programme expenses by continent

| | |
|---------------|------|
| ■ Africa | 66 % |
| ■ Asia | 18 % |
| ■ Americas | 13 % |
| ■ Europe | 1 % |
| ■ Oceania | 1 % |
| ■ Unallocated | 1 % |



COUNTRIES WHERE WE SPENT THE MOST

Countries where MSF expenditure was more than 10 million euros



AFRICA

| | <i>in millions of €</i> |
|----------------------------------|-------------------------|
| Democratic Republic of the Congo | 67.4 |
| South Sudan | 35.7 |
| Somalia | 35.1 |
| Ethiopia | 24.8 |
| Niger | 24.2 |
| Kenya | 22.9 |
| Zimbabwe | 20.3 |
| Nigeria | 18.0 |
| Chad | 17.9 |
| Ivory Coast | 17.4 |
| Central African Republic | 17.0 |
| Malawi | 10.5 |
| Libya | 10.0 |
| Swaziland | 9.6 |
| Sudan | 9.2 |
| Guinea | 8.4 |
| Mozambique | 8.0 |
| Uganda | 7.5 |
| South Africa | 6.9 |
| Sierra Leone | 6.2 |
| Mali | 4.6 |
| Burundi | 3.8 |
| Zambia | 3.6 |
| Liberia | 3.2 |
| Cameroon | 3.1 |
| Congo | 3.0 |
| Burkina Faso | 2.7 |
| Egypt | 2.2 |
| Djibouti | 1.5 |
| Madagascar | 1.0 |
| Other countries* | 1.2 |
| Total | 406.9 |

ASIA AND THE MIDDLE EAST

| | <i>in millions of €</i> |
|-------------------------|-------------------------|
| Pakistan | 15.0 |
| Myanmar | 13.9 |
| Afghanistan | 11.5 |
| Yemen | 11.0 |
| India | 10.9 |
| Iraq | 10.1 |
| Uzbekistan | 5.1 |
| Palestinian territories | 4.1 |
| Bangladesh | 4.0 |
| Sri Lanka | 3.6 |
| Japan | 2.5 |
| Iran | 2.1 |
| Kyrgyzstan | 2.1 |
| Armenia | 2.0 |
| Syria | 2.0 |
| Thailand | 1.4 |
| Cambodia | 1.4 |
| Lebanon | 1.3 |
| Turkey | 1.3 |
| Georgia | 1.2 |
| Other countries* | 2.7 |
| Total | 109.2 |

THE AMERICAS

| | <i>in millions of €</i> |
|------------------------|-------------------------|
| Haiti | 62.3 |
| Colombia | 10.4 |
| Bolivia and Paraguay** | 1.6 |
| Guatemala | 1.0 |
| Other countries* | 1.7 |
| Total | 77.0 |

EUROPE

| | <i>in millions of €</i> |
|--------------------|-------------------------|
| Russian Federation | 5.5 |
| Ukraine | 2.1 |
| France | 1.2 |
| Other countries* | 0.9 |
| Total | 9.7 |

OCEANIA

| | <i>in millions of €</i> |
|------------------|-------------------------|
| Papua New Guinea | 3.8 |
| Total | 3.8 |

UNALLOCATED

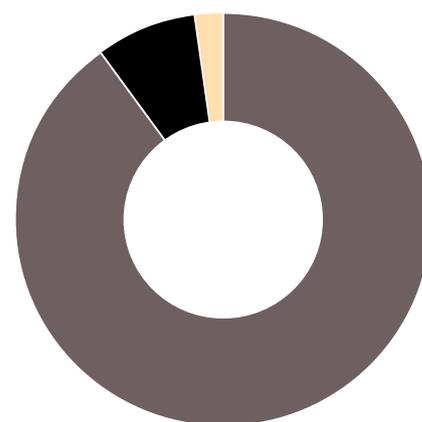
| | <i>in millions of €</i> |
|------------------------|-------------------------|
| Transversal activities | 1.4 |
| Other | 1.8 |
| Total | 3.2 |

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

** Bolivia and Paraguay are operated as a joint programme.

WHERE DID THE MONEY COME FROM?

| | 2011 | | 2010 | |
|----------------------|-------------------------|-------------------|-------------------------|-------------------|
| | <i>In millions of €</i> | <i>Percentage</i> | <i>In millions of €</i> | <i>Percentage</i> |
| Private | 791.6 | 89% | 858.9 | 91% |
| Public institutional | 75.2 | 9% | 69.3 | 7% |
| Other | 18.7 | 2% | 15.1 | 2% |
| Income | 885.5 | 100% | 943.3 | 100% |



| | |
|-----------------------------|-----|
| Private income | 89% |
| Public institutional income | 9% |
| Other income | 2% |

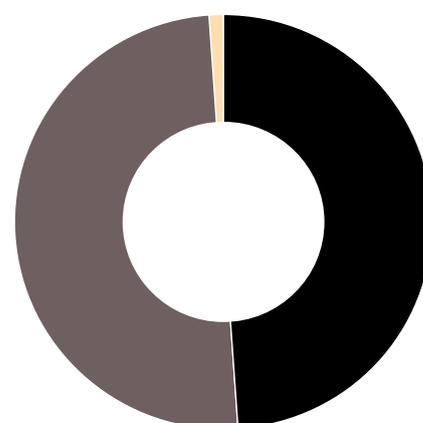
HOW WAS THE MONEY SPENT?

| | 2011 | | 2010 | |
|---------------------------------------|-------------------------|-------------------|-------------------------|-------------------|
| | <i>In millions of €</i> | <i>Percentage</i> | <i>In millions of €</i> | <i>Percentage</i> |
| Programmes | 609.8 | 68% | 555.3 | 68% |
| Headquarters programme support | 92.3 | 10% | 78.7 | 10% |
| Témoignage/awareness-raising | 27.5 | 3% | 26.4 | 3% |
| Other humanitarian activities | 7.0 | 1% | 5.7 | 1% |
| Social mission | 736.6 | 82% | 666.1 | 82% |
| Fundraising | 110.9 | 12% | 103.7 | 13% |
| General management and administration | 52.4 | 6% | 43.1 | 5% |
| Other expenses | 163.3 | 18% | 146.8 | 18% |
| Expenditure | 899.9 | 100% | 812.9 | 100% |
| Net exchange gains/losses | -1.6 | | 2.1 | |
| Surplus/deficit | -16.0 | | 132.5 | |

4.5
MILLION
private donors

YEAR-END FINANCIAL POSITION

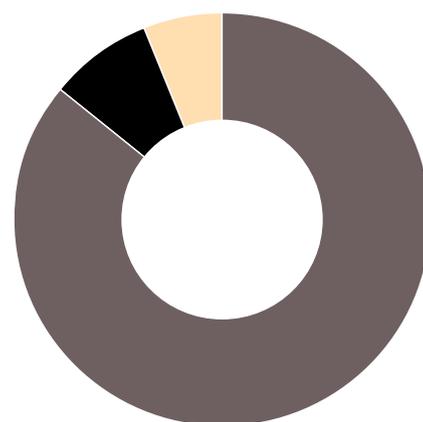
| | 2011 | | 2010 | |
|--|-------------------------|-------------------|-------------------------|-------------------|
| | <i>In millions of €</i> | <i>Percentage</i> | <i>In millions of €</i> | <i>Percentage</i> |
| Cash and cash equivalents | 572.9 | 81% | 600.9 | 84% |
| Other current assets | 84.4 | 12% | 71.1 | 10% |
| Non-current assets | 49.6 | 7% | 43.2 | 6% |
| Assets | 706.9 | 100% | 715.2 | 100% |
| Permanently restricted funds | 2.5 | 0% | 2.5 | 0% |
| Unrestricted funds | 592.3 | 84% | 608.1 | 85% |
| Other retained earnings and equities | 16.1 | 2% | 8.7 | 1% |
| Retained earnings and equities | 610.9 | 86% | 619.3 | 86% |
| Current liabilities | 96.0 | 14% | 95.9 | 14% |
| Liabilities and retained earnings | 706.9 | 100% | 715.2 | 100% |



| | |
|-------------|-------|
| Income | 885.5 |
| Expenditure | 899.9 |
| Deficit | -16.0 |

HR STATISTICS

| | 2011 | | 2010 | |
|---|------------------|-------------------|------------------|-------------------|
| Medical pool | 1,734 | 27% | 1,672 | 25% |
| Nurses and other paramedical pool | 1,935 | 30% | 2,002 | 31% |
| Non-medical pool | 2,707 | 43% | 2,887 | 44% |
| International departures (full year) | 6,376 | 100% | 6,561 | 100% |
| | <i>No. staff</i> | <i>Percentage</i> | <i>No. staff</i> | <i>Percentage</i> |
| Locally hired staff | 29,302 | 86% | 25,185 | 85% |
| International staff | 2,580 | 8% | 2,465 | 8% |
| Field positions | 31,882 | 94% | 27,650 | 93% |
| Positions at headquarters | 2,062 | 6% | 1,907 | 7% |
| Staff | 33,944 | 100% | 29,557 | 100% |



| | |
|---------------------|-----|
| Locally hired staff | 86% |
| International staff | 8% |
| Headquarters staff | 6% |

Sources of income

As part of MSF's effort to guarantee its independence and strengthen the organisation's link with society, we strive to maintain a high level of private income. In 2011, 89 per cent of MSF's income came from private sources. More than 4.5 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF included, among others, the European Commission's Humanitarian Aid Department (ECHO) and the governments of Belgium, Canada, Denmark, Germany, Ireland, Luxembourg, Norway, Spain, Sweden, Switzerland and the UK.

Expenditure is allocated according to the main activities performed by MSF. All programme expenditure categories include salaries, direct costs and allocated overheads.

Social mission includes all costs related to operations in the field (direct costs) as well as all the medical and operational support from headquarters directly allocated to the field (indirect costs). Social mission costs represent 82 per cent of total costs for 2011.

Permanently restricted funds may be capital funds, where donors require the assets to be invested; funds retained for actual use, rather than expended; or the minimum level of retained earnings that is compulsory for certain sections of MSF.

Unrestricted funds are unspent, non-designated donor funds expendable at the discretion of MSF's trustees in furtherance of our social mission.

Other retained earnings represent foundations' capital as well as technical accounts related to the combination process.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. At the end of 2011, the available portion (excluding permanently restricted funds and capital for foundations) represented 8.1 months of the preceding year's activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, a sudden drop in private and/or public institutional funding, the sustainability of long-term programmes (e.g. antiretroviral treatment programmes), and the pre-financing of operations to be funded by forthcoming public fundraising campaigns and/or public institutional funding.

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

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Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation.

MSF is a non-profit organisation. It was founded in Paris, France in 1971. Today, MSF is a worldwide movement of 23 associations. Thousands of health professionals, logistical and administrative staff manage projects in more than 60 countries worldwide. MSF International is based in Geneva, Switzerland.

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