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

Today MSF is an international medical humanitarian movement with national sections in 19 countries. In 2008, over 26,000 doctors, nurses, and other medical professionals, logistical experts, water and sanitation engineers and administrators provided medical aid in over 65 countries.

MSF ACTIVITY REPORT 2008

MEDECINS SANS FRONTIERES

MSF ACTIVITY REPORT 2008

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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 that might help in achieving its aims.
All of its members agree to honour the following principles:

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

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

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

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

The country texts in this report provide descriptive overviews of MSF work throughout the world between January and December 2008. Staffing figures represent the total of full-time-equivalent positions per country in 2008. Reasons for Intervention classify the initial event(s) triggering an MSF medical-humanitarian response as documented in the 2008 International Typology study. Country summaries are representational and, owing to space considerations, may not be entirely comprehensive.

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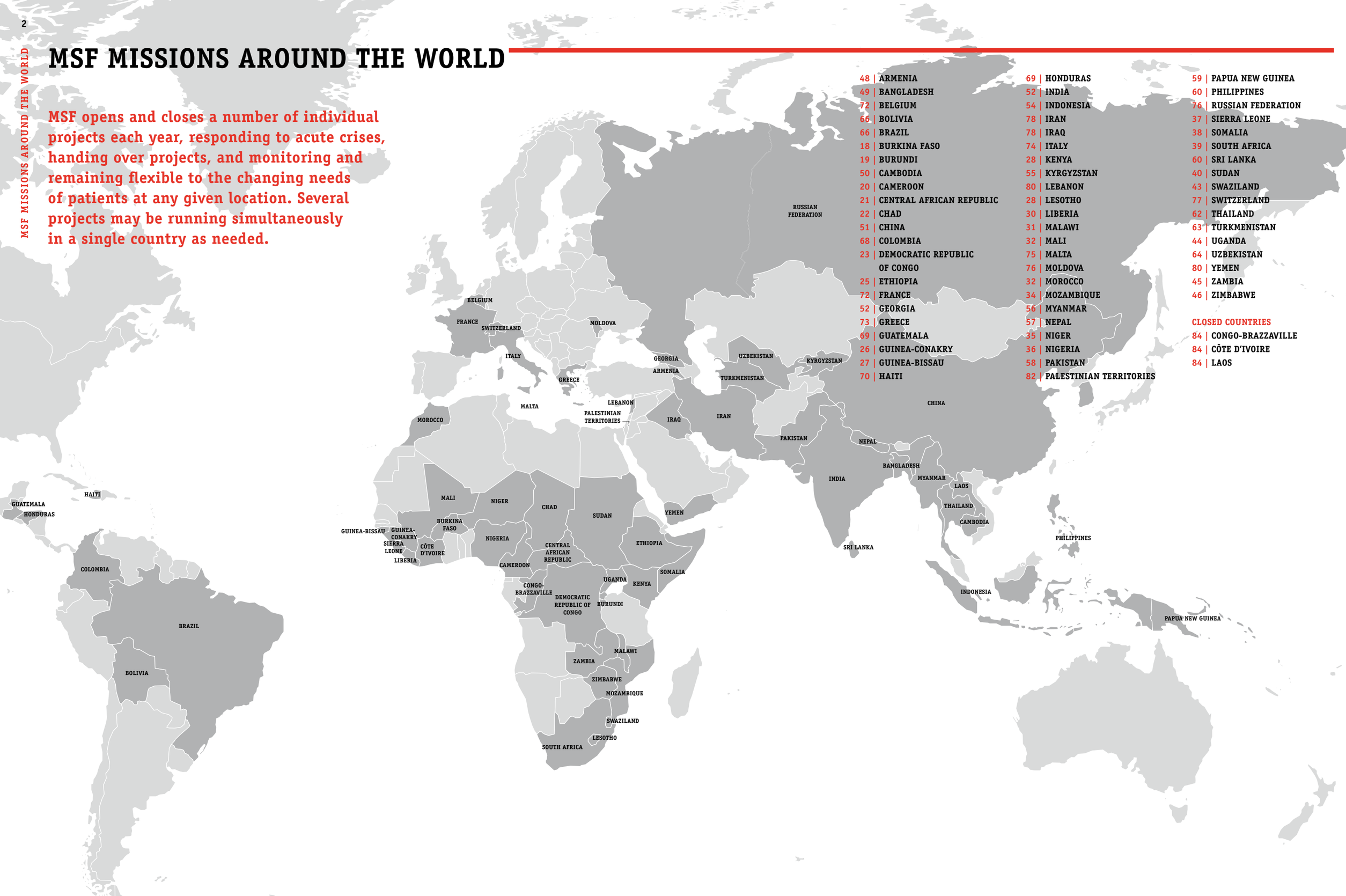
MSF MISSIONS AROUND THE WORLD

MSF opens and closes a number of individual projects each year, responding to acute crises, handing over projects, and monitoring and remaining flexible to the changing needs of patients at any given location. Several projects may be running simultaneously in a single country as needed.



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The year in review

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


© Kris Torgeson

2008 was a year of achievement as well as frustration for MSF. While advances in malnutrition treatment allowed more children to be helped, teams trying to reach victims of some of the most acute conflicts in the world faced considerable obstacles.

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

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

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

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

These emergencies made the world news in 2008, if only briefly. But most of what MSF teams accomplished during the year – and even more disturbingly, what they were unable to accomplish – did not make it into the headlines and is difficult to summarise in statistics or brief reports.

Accessing the victims of armed conflicts in countries such as Somalia, Iraq, Pakistan, Sudan, and the Palestinian Territories posed a tremendous challenge throughout the year. Insecurity and administrative barriers – sometimes raised intentionally – contributed to these challenges. MSF relied heavily on national staff to help provide independent humanitarian assistance to those most in need in these conflict zones.

In Somalia, the kidnapping and release of two members of staff over the 2008 New Year, and then the brutal killing of three colleagues in January, forced MSF to close programmes and reassess how to deliver assistance in this highly violent conflict. MSF Somali staff kept working: they treated 2,300 people wounded by gunshots or mortar rounds and cared for 10,000 children suffering from acute malnutrition in camps for people displaced by the violence. In Iraq, MSF continued to provide medical assistance at the periphery of the conflict through reconstructive surgical programmes and by providing training and supplies to hospitals in the country.

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

In Sudan, increasing administrative obstacles and insecurity hindered MSF's response to those most in need in Darfur and other regions. For example, in August, after a series of attacks against staff, teams were forced to leave projects in Tawila, North Darfur, where 35,000 displaced people had gathered, and in Shangil Tobaya, where MSF had provided medical care for 28,000 displaced people. Leaving so many people without access to medical care, even if only temporarily, was extremely hard, but without a guarantee of minimum security for humanitarian workers, MSF had no option but to suspend activities for several weeks. Despite this, 70,000 consultations where carried out in these two areas in 2008.

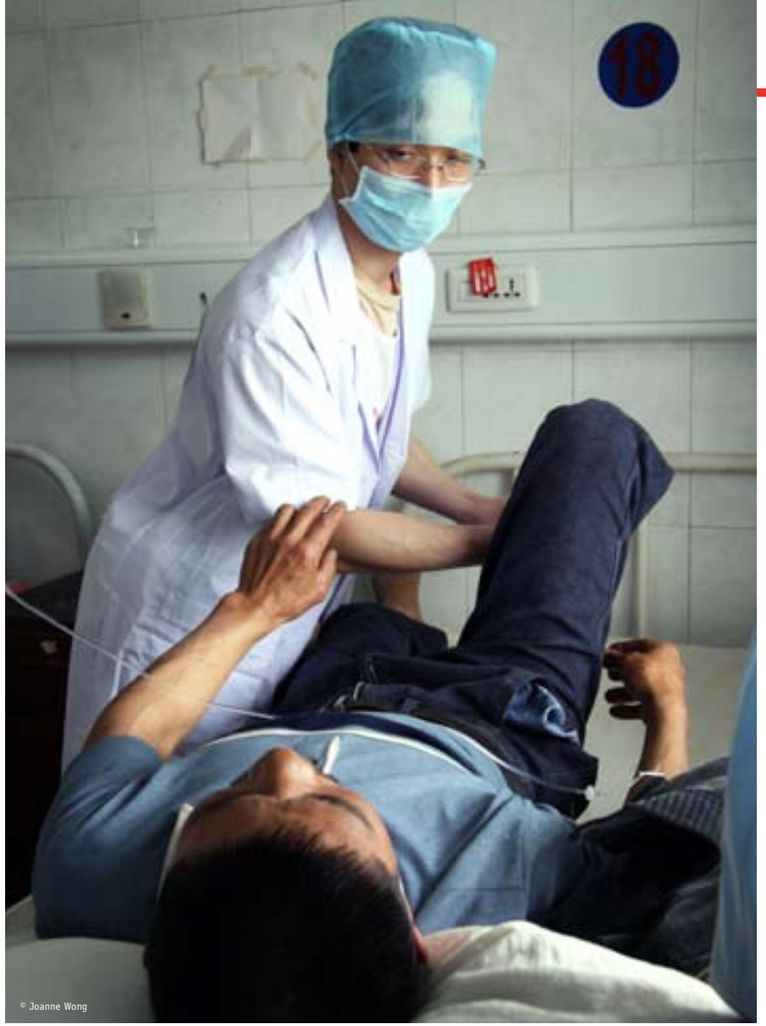
In December, Israel launched the 'Hard Lead' offensive in the Gaza Strip. During the fighting, MSF struggled to send in additional medical teams due to Israeli restrictions on the movement of people and aid. However, teams already in Gaza were able to respond immediately by supporting the local hospitals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

Another key objective in 2008 was to find new ways to fight malnutrition and neglected diseases. Throughout the year, MSF lobbied to improve the standards of international food aid so that young children would receive the nutrients they need. In the areas most chronically devastated by malnutrition, such as South Asia, the Sahel, and the Horn of Africa, many families cannot afford nutritious food. However, food aid provided by international agencies and donors is mainly cereal-based and does not include animal-source foods, such as milk, which contain essential nutrients. In 2008, MSF committed to treating undernourished children with the animal-source food they need and lobbying for wider availability of appropriate food aid for children around the world.

In Ethiopia, between May and August, MSF conducted a large programme treating more than 28,000 people for acute and moderate malnutrition. In Niger, work was threatened in July when local authorities suspended MSF projects in some regions. This decision was based largely on the authorities' desire to re-integrate activities into the national healthcare system and to avoid independent action and public awareness campaigns. MSF believed this decision was taken prematurely, considering the number of children affected, and after two months of discussions, teams were able to partially restart some nutritional activities. In 2008, MSF treated 97,600 children under five who were moderately or severely malnourished.

In Southern Africa, where TB/HIV co-infection is endemic, MSF stepped up efforts to increase access to diagnosis and treatment. In recent years, the number of people with TB alone has more than tripled in countries where HIV prevalence is high. Worldwide, an estimated one third of all HIV sufferers have TB, but only one per cent receive treatment. Most people are not tested for TB and even if they are, the standard diagnostic method is a century old and ineffective for most people living with HIV. In addition, the current treatment protocols are difficult for people on antiretroviral therapy (ART) to use. MSF repeatedly called on governments and donors to invest in TB research and the development of new diagnostic and therapeutic tools, estimating that current investment falls at least four times below what is needed to combat the resurgence of this deadly, but treatable, disease.

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

MSF also continues to support the search for new treatments for neglected diseases and in 2008 an important step towards improving treatment options for sleeping sickness was taken. The Drugs for Neglected Diseases Initiative (DND*i*), together with MSF and Epicentre, pioneered a new, less toxic and easier-to-administer treatment for sleeping sickness, called NECT (Nifurtimox-Eflornithine Combination Therapy). This ten-day treatment is of particular interest to MSF since most of the 50,000 patients currently needing treatment are in remote and unstable areas.

Challenging the deliberate exclusion from healthcare that many people experience remained a focus of MSF's work in 2008 and teams in Europe, the Middle East and Africa sought to help refugees and migrants in need of medical assistance. Restrictive entry policies in Europe have not stopped people from arriving in search of refuge, protection, or better living conditions. In response to their health needs, MSF is running emergency medical programmes in a number of countries including Malta, Italy and Greece. In South Africa, too, teams provided these services to a mostly Zimbabwean migrant population. It is clear that migration and displacement is a global challenge – MSF assisted displaced people in 37 countries in 2008.

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

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

Thank you.

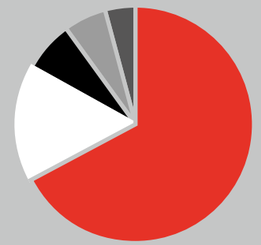
OVERVIEW OF MSF OPERATIONS 2008

Largest interventions based on project expenditure

1 Democratic Republic of Congo
2 North Sudan
3 Somalia
4 Ethiopia
5 South Sudan
6 Niger
7 Chad
8 Myanmar
9 Kenya
10 Zimbabwe
11 Haiti
12 Central African Republic

Project locations

- Africa | 68%
- Asia | 16%
- Americas | 7%
- Europe | 6%
- Middle East | 4%



Context of interventions

- Stable | 41%
- Armed conflict | 34%
- Internal instability | 19%
- Post-conflict | 6%

Event triggering intervention

- Armed conflict | 42%
- Epidemic/Endemic disease | 33%
- Social violence/Healthcare exclusion | 21%
- Natural disaster | 4%

Activity highlights

(Non-exhaustive and inclusive only of activities with MSF direct patient care. Activity may involve diagnostics, treatment and follow up.)

ACTIVITY	DEFINITION	TOTAL
Outpatient	Outpatient consultations	8,814,813
Inpatient	Admitted patients	312,509
Malaria	Confirmed cases treated	1,178,679
Therapeutic feeding centres	Severely malnourished children admitted to inpatient or mobile centres	212,565
Supplementary feeding centres	Moderately malnourished children admitted	119,353
Deliveries	Women who delivered babies, including by Caesarean section	101,858
Sexual violence	People affected by sexual violence who were medically treated	15,145
Surgical interventions	Major surgical interventions including obstetric surgery, under general or spinal anaesthesia	47,515
Violence trauma	Medical and surgical interventions in response to direct violence	48,871
HIV/AIDS	HIV/AIDS patients registered under care	227,591
Antiretroviral therapy (first line)	Patients on first-line treatment	130,214
Antiretroviral therapy (second-line)	Patients on second-line treatment (first-line treatment failure)	1,761
Prevention of mother-to-child transmission (mothers)	HIV-positive pregnant women who received preventive treatment	8,664
Prevention of mother-to-child transmission (babies)	Babies who received post-exposure treatment	8,807
Tuberculosis (first-line)	New admissions to first-line treatment	29,369
Tuberculosis (second-line)	New admissions to second-line treatment	971
Mental health (individual)	Individual consultations	126,831
Mental health (group)	Counselling or support-group sessions	22,173
Cholera	People admitted to cholera treatment centres or treated with oral rehydration solution	68,293
Measles vaccinations	People vaccinated for measles in response to an outbreak	1,913,793
Measles treatment	People treated for measles	32,652
Meningitis vaccinations	People vaccinated for meningitis in response to an outbreak	706,787
Meningitis treatment	People treated for meningitis	7,188

UNDER-REPORTED CRISES OF 2008

1. Somalia's humanitarian catastrophe worsens

Somalia has some of the worst health indicators in the world, and its people have little or no access to even basic healthcare services. An estimated one in ten women die during child-birth, and more than one in five children die before their fifth birthday.
In 2008, violence in the country escalated to levels not seen in over a decade. Since fighting began in December 2006, a million Somalis have fled their homes. More than 250,000 people from Mogadishu now live in appalling conditions on the road out of the capital, and have little prospect of respite.
Some Somalis head for Kenya where, according to the UN refugee agency UNHCR, some 200,000 live in three camps. Others go north and board boats to be smuggled across to Yemen. More than 43,500 people – mostly Somalis, but also Ethiopians – attempted the journey in 2008. Crammed into small vessels, many of these would-be refugees suffocate; many others drown in the Gulf.
Targeted attacks against aid workers have also increased. Staff have been kidnapped and some, including three MSF staff, have been killed. MSF and others have been forced to withdraw teams and curtail medical activities, exacerbating the chronic difficulty of delivering urgently needed help.

2. Outside the spotlight, Myanmar's critical health needs are still ignored

In May, Cyclone Nargis devastated the Irrawaddy Delta, leaving around 130,000 people missing or dead. As news broke, MSF teams and others brought emergency assistance to the worst-affected areas. Most of MSF's help was provided by local staff, who were diverted from other programmes in the country to respond to the emergency.

But beyond the media's focus, the country's chronic health needs are barely acknowledged. State health expenditure was $0.70 per person in 2007; international humanitarian aid amounted to about $3 per person, the lowest rate worldwide. HIV/AIDS claimed 25,000 lives in 2007, yet fewer than 20 per cent of the estimated 75,000 people who need antiretroviral therapy (ART) in Myanmar can access treatment. MSF provides around 80 per cent of the country's freely available ART: an unsustainable situation that already forces teams to restrict admissions to the HIV/AIDS programme.
Other treatable epidemics contribute to the country's woeful health statistics: deaths from malaria, the number-one killer, account for more than half those in all Southeast Asia. More than 80,000 people are diagnosed each year with tuberculosis (TB), and multi-drug-resistant TB is on the rise. More action by the national authorities and agencies is urgently needed to protect thousands more vulnerable people from unnecessary suffering and death.

3. Violence and economic collapse exacerbate Zimbabwe's growing health crisis

In 2008, inflation in Zimbabwe reached 231 million per cent. Political violence escalated and, in the lead up to contested elections in June, additional restrictions constrained the work of humanitarian organisations even further.
There are two million people living with HIV in the country. The violence and economic meltdown has forced many of those undergoing antiretroviral therapy to interrupt or abandon their treatment, risking grave health consequences. Some can no longer afford to eat properly or to travel to clinics for treatment, others are afraid to leave their homes or have been forced to flee.
A huge number of Zimbabweans – including much-needed medical staff – have left the country. About three million have fled to neighbouring South Africa. Every day, thousands more cross the Limpopo river to reach the border town of Musina, risking attacks by bandits. Many of those who reach the other side have to live outside the law to avoid arrest and deportation.
In May, violent xenophobic attacks in South Africa displaced more than 100,000 people.
A cholera epidemic centred in Harare began in August and quickly spread. New outbreaks were detected even before the rainy season – when cholera spreads more easily – had arrived. A national emergency was declared and MSF responded, treating more than 11,000 patients.

4. Civilians trapped as war rages in eastern Democratic Republic of Congo

Renewed fighting among armed groups and the Congolese armed forces (FARDC) have driven hundreds of thousands of people to flee from North Kivu, leaving them with little or no access to food, water, basic shelter or healthcare.
The UN peacekeeping force MONUC has been largely unable to protect people trapped by the violence. It did lead an armed 'humanitarian relief' convoy into Rutshuru after rebel forces took control of the town, but such moves can make the work of independent aid agencies even harder, by blurring the distinction between military and humanitarian action.

Out of the spotlight, people in Haut-Uélé district, some 50,000 of whom had already been driven from their homes, fell prey to cross-border raids by the rebel group Lord's Resistance Army. Here as elsewhere, the fighting renders some areas inaccessible to humanitarian organisations while overcrowding, poor sanitation and the lack of clean water in many camps for displaced people leave thousands vulnerable to easily treatable conditions and recurring epidemics.

5. Ready-to-use food could bring swift recovery to millions of malnourished children

The World Health Organization estimates there are 178 million undernourished children across the globe. According to UNICEF, the situation is actually getting worse in 16 countries. Up to five million children under five years old die each year of complications related to malnutrition.
Combating hunger depends on having food in sufficient quantity, but conquering malnutrition depends on having foods of adequate nutritional quality and quantity. Tens of millions of children receive assistance from nutrition programmes – but many of these programmes are using the wrong foods. Fortified blended flours made from either corn or wheat plus soya are not enough: foods rich in nutrients, vitamins, and minerals are essential to the healthy development of babies and children.

At any given moment, 20 million children are suffering from severe acute malnutrition, yet only seven per cent of them receive UN-recommended treatment with nutrient-dense ready-to-use food (RUF). These energy-dense dairy-containing pastes and biscuits contain the nutrition children need for catch-up growth and to ward off infection, and severely malnourished children can recover rapidly by being given a short course at home.
MSF has successfully treated more than 300,000 malnourished children in 22 countries in the last two years. If RUF were more widely used, community-based and outpatient feeding programmes worldwide could treat millions more.

6. Nomadic people isolated and in critical danger in Ethiopia's Somali region

Drought has already helped to destroy harvests, food stocks, grazing lands and livestock in Ethiopia's Somali region, making life a continual struggle for the country's indigenous herders and bush-dwellers. But these largely nomadic people are now also caught between battling rebel groups and government forces. Some have been directly exposed to the violence; many more are becoming increasingly isolated.

Soaring prices and restrictions on importing goods have rendered food and other staples unaffordable. A limit on movement in some zones has not only left people unable to find food for their livestock, but also prevented MSF and other aid agencies from assessing and responding to the situation. Administrative hurdles radically increase the difficulty of providing desperately needed assistance.

There has been a significant increase in the number of children with severe acute malnutrition in the region, and inadequate water and sanitation have contributed to rising levels of disease, yet MSF estimates that in at least one of Somali's nine zones, three-quarters of the people have no access at all to healthcare.

7. Civilians pay dearly as fighting intensifies in northwest Pakistan

Fighting intensified between government forces and militants in the North West Frontier Province and the Federally Administered Tribal Areas of Pakistan throughout 2008. Air strikes by the US military added to the destruction and in August, thousands of Pakistanis fled, many of them to Afghanistan. Hundreds of people in the Bajaur Agency, Swat and Mohmand regions in the North West Frontier Province were killed or injured in suicide bombings, air attacks, and shootings. Thousands more were displaced.

In October, more violence sent hundreds of thousands of people into neighbouring regions in just a few days. Many found refuge in private homes, mosques, schools, and makeshift camps. Local health clinics were forced to close because of the violence and, in Kurram Agency, danger posed by sectarian armed groups prevented all but the most critical patients from travelling to reach medical services. MSF ambulances, sometimes the only vehicles allowed to travel during the regular curfews, were attacked, forcing teams to seek refuge.
Conflict has also been simmering in the eastern region of Balochistan for more than 30 years, with grimly predictable consequences. In October, a magnitude 6.4 earthquake that shook the mountainous regions to the northwest brought further devastation, killing some 300 people and leaving 40,000 more without homes.

8. No end in sight to violence and suffering in Sudan

One-third of the people of Darfur have been displaced by the bitter civil war. Although more than 80 humanitarian organisations provided assistance in 2008, it was still difficult to access and assess the needs of thousands of people.
Even the help that did get through was in danger of being withdrawn because of unstable front-lines, shifting alliances and the attacks and increasing government restrictions on aid workers. Eleven were killed in Darfur in 2008 and 189 abducted, according to the UN.

In February, bombings, attack helicopters and ground troops returned to West Darfur's northern corridor. Villages were burned and emptied, affecting some 50,000 people. After an attack near Abyei, South Kurdufan, thousands fled to camps in northern Bahr-el-Ghazal state and an estimated 10,000 fled into the bush. In May, fighting virtually destroyed Abyei, forcing another 60,000 people to flee.

An estimated 1.2 million people returned to southern Sudan after 20 years of civil war to find the infrastructure, services, and healthcare of their former homeland had all but disappeared.
Malnutrition is endemic, maternal mortality rates remain among the highest in the world, tuberculosis and kala azar (visceral leishmaniasis) are common and large-scale outbreaks of meningitis, measles, cholera, and malaria are relentless.
And now, though violence could reignite at any time, the number of humanitarian agencies is declining as some important donors redirect their funds.

9. Thousands of Iraqis left with nowhere to turn

One of the many challenges facing humanitarian organisations is reaching people caught up in armed conflicts. Since 2003, efforts in Iraq have been frustrated not only by the usual physical and administrative obstacles, but also by military and political factions' using humanitarian action for political purposes, so making workers themselves targets for attack.
Four million people have been displaced by the war in Iraq, and half of them are trapped within the country itself, according to the UN refugee agency (UNHCR) and the Norwegian Refugee Council.
Bombings and sectarian violence kill and cause injuries that often require immediate and intensive attention, but the long-neglected healthcare system leaves thousands of Iraqis with little or no medical care, even at primary level. Diseases spread easily in the overcrowded camps, and drug-resistant bacterial infections thrive.
The Iraqi government has tried to develop health services, but many medical staff have fled the country and there are still enormous gaps to fill.
MSF provides surgical programmes, training for Iraqi professionals, supplies, emergency response, education campaigns and psychological support – but it can reach only a tiny fraction of those in increasingly urgent need.

10. Better tools and techniques vital to combat HIV/tuberculosis co-infection

Every year, tuberculosis (TB) kills about 1.7 million people. It is one of the leading causes of death for people with HIV/AIDS, roughly a third of whom (11 million worldwide) are infected with latent TB. Yet in 2006 less than one per cent of those living with HIV/AIDS were screened for TB.
Diagnosis of TB is difficult: a standard test, invented more than a century ago, cannot detect the disease in most people who are HIV-positive. Rapid culture tests achieve better results, but are too complex to perform in the places where most patients live.

Treatment for TB is outdated, complicated, and not adapted to the specific problems of co-infected patients. At least four TB drugs are required initially. Sometimes they have serious side-effects; sometimes they compromise the patient's HIV medication. No new TB drugs have been developed for large-scale use in decades, and the increasing incidence of drug-resistant TB complicates matters even further.
In 2006, investment in the development of TB medicines, diagnostic tools, and vaccines amounted to an estimated $429 million, according to the Treatment Action Group: a sum woefully short of the $2 billion annual investment urgently needed to give millions of co-infected people a fighting chance of survival.

Three neglected killers

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

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

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

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

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

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

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

In 2008, MSF committed 18 million Euros to the Drugs for Neglected Diseases initiative (DND*i*). At the same time MSF will continue to support operational and clinical research through its field programmes, will call for new research into more efficient drugs and demand that governments, companies and agencies take action so that these diseases receive the urgent attention and funding they need.

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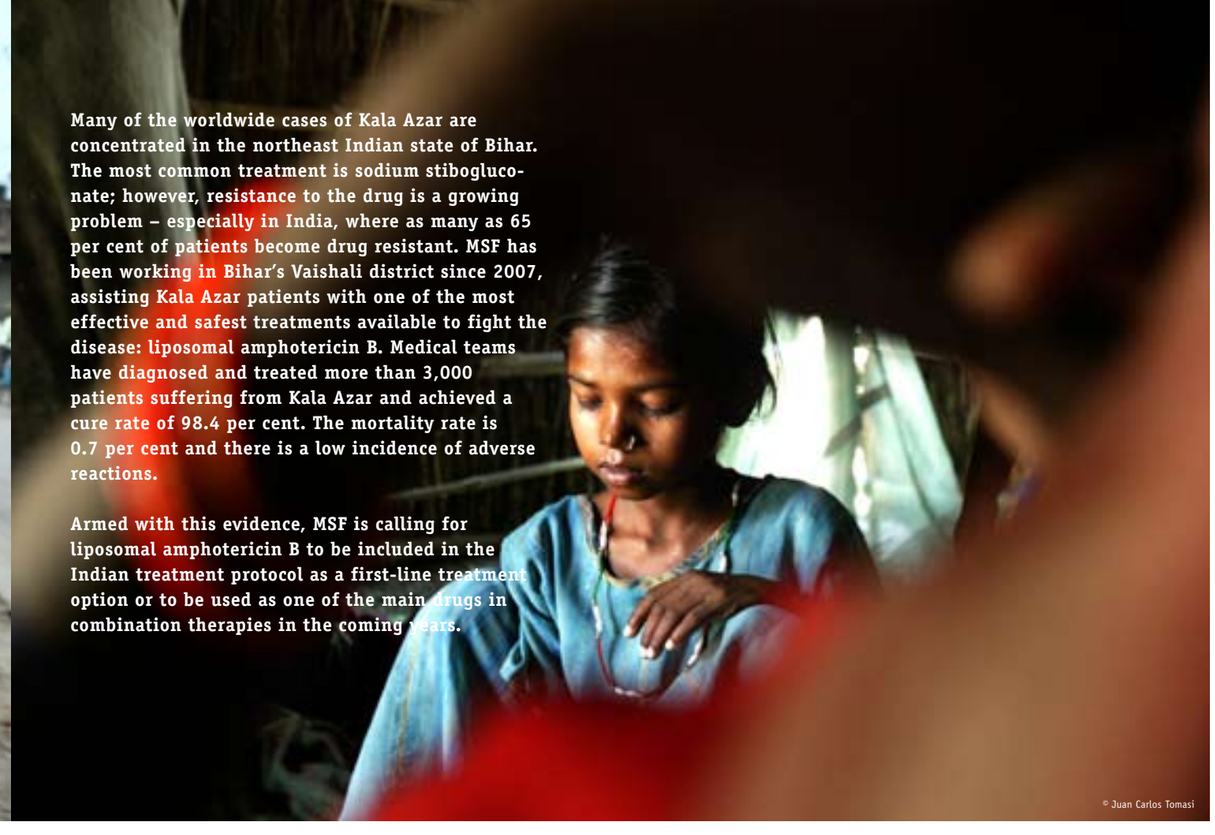
Kala Azar in India

© Juan Carlos Tomasi

Many of the worldwide cases of Kala Azar are concentrated in the northeast Indian state of Bihar. The most common treatment is sodium stibogluconate; however, resistance to the drug is a growing problem – especially in India, where as many as 65 per cent of patients become drug resistant. MSF has been working in Bihar's Vaishali district since 2007, assisting Kala Azar patients with one of the most effective and safest treatments available to fight the disease: liposomal amphotericin B. Medical teams have diagnosed and treated more than 3,000 patients suffering from Kala Azar and achieved a cure rate of 98.4 per cent. The mortality rate is 0.7 per cent and there is a low incidence of adverse reactions.

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



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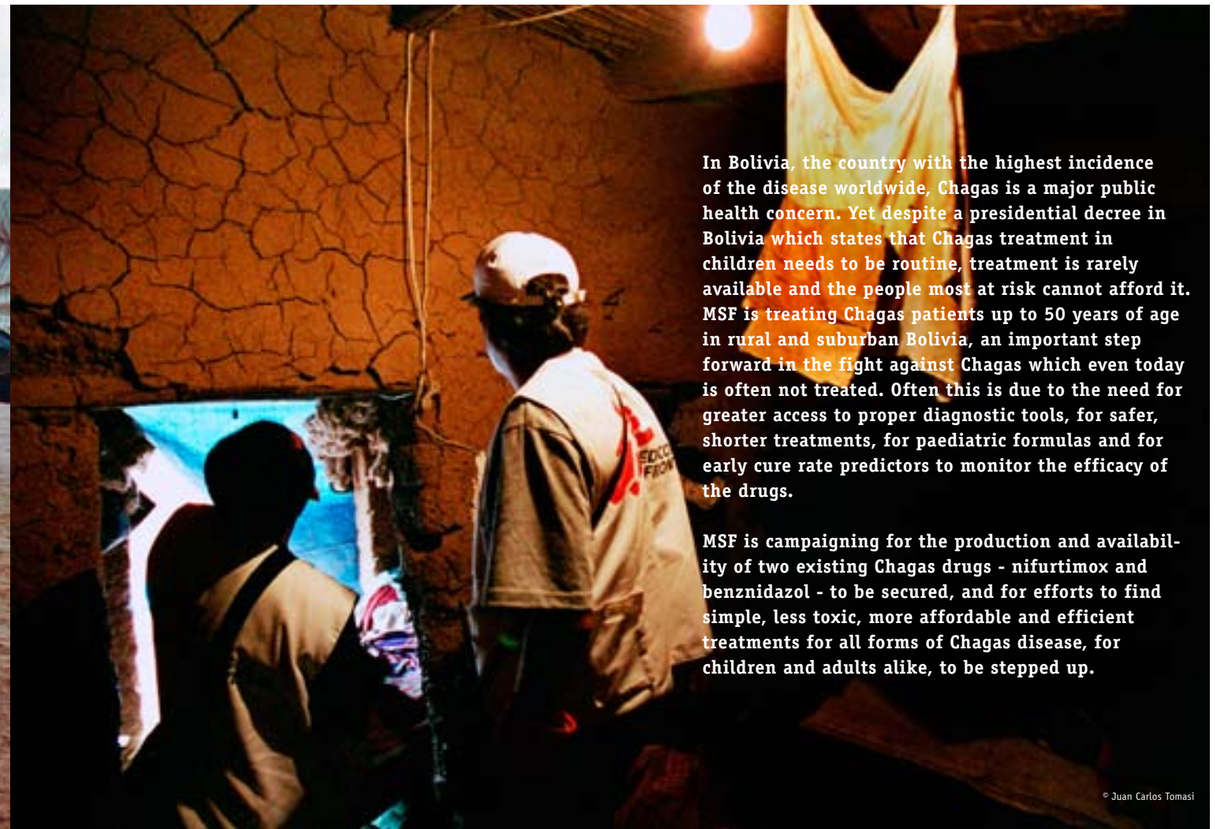
Chagas in Bolivia

© Juan Carlos Tomasi

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

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



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Sleeping sickness in Democratic Republic of Congo

In Doruma, Ando and Bili, located in northeastern Democratic Republic of the Congo, MSF has been treating more than 1,500 patients with sleeping sickness since July 2007. Disease prevalence in the region is high, above 10 per cent in some villages. Word of MSF's work quickly spread, and people travelled from up to 90 miles away to receive treatment. The treatment of patients in the second stage of the illness relies on eflornithine, a safe but complicated treatment that requires 56 infusions over 14 days. Over the past 20 years, MSF has screened more than two million people for the disease which is spread by the tsetse fly, and treated 48,000 in several African countries.

In a major step forward in improving treatment options, MSF, Epicentre and DND*i* have pioneered a new and easier-to-administer treatment for sleeping sickness based on a combination of intravenous eflornithine and oral nifurtimox. However simpler, preferably oral treatments are still needed.

GLOSSARY OF DISEASES

CHAGAS DISEASE

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

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

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

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

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

CHOLERA

The Greek word for diarrhoea, cholera is a water-borne, acute gastrointestinal infection caused by the *Vibrio cholerae* bacterium and spread by contaminated water or food. The infection can spread rapidly and cause sudden large outbreaks.

Although most people infected with cholera will have only a mild infection, the illness can also be severe, causing profuse watery diarrhoea and vomiting that lead to severe dehydration and, without rapid treatment, death. Required treatment is the immediate replacement of fluid and salts with a rehydration solution administered orally or intravenously.

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

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

HIV/AIDS

The human immunodeficiency virus (HIV) is transmitted through blood and body fluids and gradually weakens the immune system – usually over a three- to ten-year period – leading to acquired immunodeficiency syndrome or AIDS. A number of opportunistic infections such as candidiasis, pneumonia, and various kinds of tumours are able to flourish as the immune system weakens. Some opportunistic infections can be treated, whilst others are life-threatening. The most common opportunistic infection leading to death is tuberculosis.

Many people live for years without symptoms and may not know they have been infected with HIV. A simple blood test can confirm HIV status. Combinations of drugs known as antiretrovirals help combat the virus and enable people to live longer, healthier lives without rapid degradation of their immune systems. It is simplest and easiest to take these drugs properly when they are combined into single pills (fixed-dose combination). MSF's comprehensive HIV/AIDS programmes generally include education and awareness activities so people understand how to prevent the spread of the virus; condom distribution; HIV testing along with pre- and post-test counselling; treatment and prevention of opportunistic infections; prevention of mother-to-child transmission; and provision of antiretroviral therapy for patients in advanced clinical stages of the disease.

MSF provided care for more than 227,000 people living with HIV/AIDS and antiretroviral therapy for more than 130,000 people in 2008.

HUMAN AFRICAN TRYPANOSOMIASIS (SLEEPING SICKNESS)

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

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

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

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

Drugs for Neglected Diseases initiative (DND*i*) and supported by Epicentre and MSF. Some studies have demonstrated that NECT, a co-administration schedule of oral nifurtimox and intravenous eflornithine, is a better treatment option for people with advanced-stage sleeping sickness, because it is safer than melarsoprol and easier to use than eflornithine.

MSF admitted more than 1,900 patients for treatment for human African trypanosomiasis in 2008.

LEISHMANIASIS (KALA AZAR)

Largely unknown in the developed world, leishmaniasis is a tropical, parasitic disease caused by one of more than 20 varieties of *Leishmania* and transmitted by bites from certain types of sand flies. The most severe form, visceral leishmaniasis, is also known as kala azar, Hindi for 'black fever'. Over 90 per cent of cases occur in Bangladesh, Brazil, India, Nepal and Sudan. Without treatment, this form of leishmaniasis is fatal in almost all cases.

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

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

MSF treated more than 4,400 people for leishmaniasis in 2008.

MALARIA

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

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

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

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

MENINGITIS

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

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

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

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

TUBERCULOSIS

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

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

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

MSF treated more than 29,000 people for TB, including 971 for MDR-TB, in 2008.

MSF projects around the world

Africa

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BURKINA FASO

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
• **Social violence/Healthcare exclusion** FIELD STAFF **471**

DECENTRALISING HIV/AIDS CARE
MSF is decentralising care for people living with HIV/AIDS in two districts in Ouagadougou, and increasing the number of care sites. As MSF's head of mission, Francois Giddey, explains, 'Task shifting, the process of allowing trained health workers other than doctors to perform clinical tasks when doctors are scarce, has allowed decentralisation of services in some primary health structures. Decentralisation, combined with task shifting within secondary health structures, spreads the workload among more of the health staff, helping to overcome the shortage of medical doctors. Decentralised care helps more people to have easier access to treatment.'

By September 2008, MSF was treating 4,275 patients, 3,410 of whom, including 126 children, had started antiretroviral therapy. On average there are 100 new cases a month.

Helping street girls and their children

MSF has been providing healthcare to girls living on the streets of Ouagadougou and their young children since 2005. Street girls are particularly vulnerable because most are separated from their families. They are minors with very little education and have no one to protect them. To survive, many of the girls engage in prostitution. They are at physical and psychological risk and are often victims of sexual exploitation. They also suffer from stigmatisation and discrimination. Because of their marginal situation, they don't have access to health services, but even if they did, 'standard' medical care would not meet their particular needs.

MSF provided treatment for sexually transmitted infections, and reproductive, obstetric, and antenatal care. MSF also cared for victims of sexual violence, and gave psychological support. During 2008, MSF conducted more than 2,500 consultations – 500 of which were psychological – with street girls, and treated about 160 children.

MSF handed over the programme in December to a local NGO, Keoogo, which has been helping street children in Burkina Faso for several years. Keoogo will continue the programme and in time expand it to include more services.


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Treating acute malnutrition and malaria in the north

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

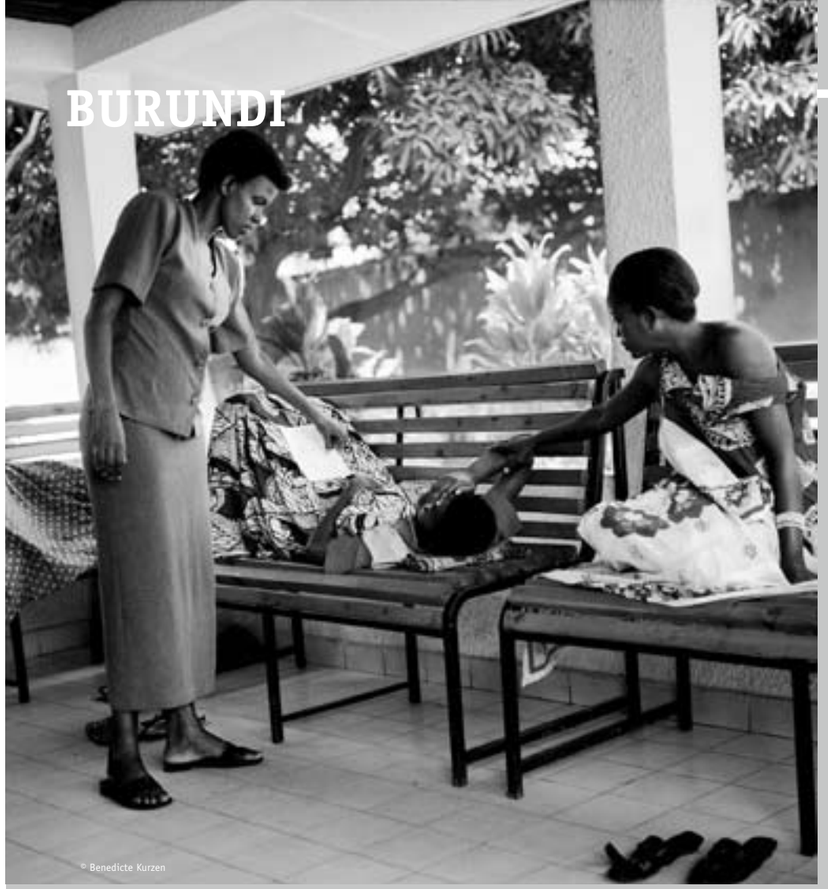
MSF provided ready-to-use food that families could use at home to feed their malnourished children, ensuring that only the children with more complicated cases needed to be hospitalised. During the peak emergency period in September, MSF admitted an average of 600 malnourished children each week to its clinics.

'We are focusing on children under five, as they are the most vulnerable to malnutrition,' says Jean-Luc Anglade, MSF programme manager for Burkina Faso. 'Childhood malnutrition is an underlying cause of death for so many children, yet it receives little public attention. Young children need the right amount of both macro and micro-nutrients in their diet.'

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

Many children in Burkina Faso also suffer from malaria: between 65 and 70 per cent of the children admitted to MSF malnutrition programmes also have malaria during the annual malaria peak in the last months of the year. MSF provided malaria treatment to more than 10,700 children, including those not suffering from malnutrition.

MSF has worked in Burkina Faso since 1995.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BURUNDI

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

REASON FOR INTERVENTION • **Armed conflict • Social violence/Healthcare exclusion**
FIELD STAFF **101**

In April, two years after a peace deal was signed to end more than a decade of conflict in Burundi, rebels of the National Liberation Forces (FNL) launched an offensive against the capital, Bujumbura, prompting fears of a return to war. In June, the government and the rebels signed a ceasefire.

However, the long years of war have weakened the country's health system. Therefore MSF teams constantly monitor potential health emergencies, such as epidemics or nutritional crises.

Maternal healthcare

In June, MSF opened a new centre for obstetric emergencies in Kabezi, in the vast province of Bujumbura Rural, which has around 565,000 inhabitants. Every month, this specialised centre provides medical care, including caesareans, to an average of 100 women presenting with complications during pregnancy or delivery who cannot be treated in health centres.

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

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

MSF intends to use this project to draw attention to the scale of mother and baby mortality in Burundi and emphasise the importance of accessible and free medical care in this domain. A presidential decree adopted in 2006 guarantees free healthcare for pregnant women and children under five in Burundi. Yet this free access remains hypothetical for the population of Bujumbura Rural, due to the poor state of roads and the lack of specialised staff, material and medicine.

Treating sexual violence

Despite the end of years of open conflict, sexual violence has remained a concern in Burundi. In 2008, the MSF's Seruka centre – seruka means 'coming out of the dark' in Kirundi, the national language – provided medical and psychological treatment to victims of sexual violence in Bujumbura Mairie. Since the opening of the centre in 2003, more than 7,000 victims have been cared for. The Seruka team has seen an increasing number of young patients visiting the centre. In 2008, 60 per cent of the victims had not yet turned 19 years old; half of these were under 12 years old. Statistics clearly show that a large proportion of aggressors are civilians known to the victims.
The Seruka centre remains an exception in Burundi: it is difficult for the victims of sexual violence to find appropriate care, in spite of the fact that rape represents a medical emergency.
In 2008 the Seruka Initiative for Rape Victims was created by local medical staff and is due to take over all activities of the Seruka centre from MSF in 2009.

MSF has worked in Burundi since 1992.

CAMEROON

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

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

The Buruli ward in Akonolinga hospital in Cameroon's Centre Province offers free and comprehensive care for patients affected by this disease. More than 700 patients have been treated since the opening of the project.

Most patients come from the Akonolinga district, but others come from different provinces and regions.

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

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

During 2008, on average 54 patients every month were hospitalised. The hospital bed occupancy rate reached 77 per cent.

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

MSF also closed its projects in Baturi, eastern Cameroon, which provided humanitarian assistance to refugees from the Central African Republic.

MSF has worked in Cameroon since 2000.


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CENTRAL AFRICAN REPUBLIC


© MSF

REASON FOR INTERVENTION • Armed conflict
FIELD STAFF 1,188

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

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

Treating conflict patients

MSF focused on providing medical assistance to populations affected by the conflict through a network of mobile clinics, hospitals, and health centres across the northwest in Kabo, Batangafo, Markounda, Paoua, Bocaranaga, Boguila, and in the northeastern areas of Birao and Gordil. More than 385,000 outpatient consultations were conducted and more than 14,800 patients were hospitalised. Patients are being treated for diseases such as malaria, tuberculosis, HIV/AIDS, sleeping sickness, and for malnutrition.

Helping mothers and children

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

MSF has worked in the Central African Republic since 1997.

IN MEMORY

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

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

Stéphane Hauser, MSF coordinator, Batangafo

CHAD

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion**
FIELD STAFF **1,155**

The various armed conflicts that marked the first half of 2008 left Chad fearing a troubled year ahead. In fact the rest of the year proved less tense, but Chad remained a highly unstable country. Insecurity continued to affect many of the people living there and to hamper humanitarian work.

Violence and displacement

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

In eastern Chad alone, an estimated 185,000 Chadians who have been forced to flee their homes and 250,000 refugees from neighbouring Darfur still live in camps, and there is no short-term prospect of their returning to their villages.

MSF worked to meet the basic medical needs of people in Iridimi and Touloum refugee camps, in Iriba hospital and in the Tine health centre. More than 71,000 consultations, 140 surgical interventions and 1,000 deliveries were carried out. In the refugee camps in Arkoum, Farchana and Breijing, more than 44,300 consultations, including nutritional interventions, took place. As the health emergency subsided, MSF was able to hand over projects in Farchana, Arkoum and Breijing in June 2008, and will hand over the Iridimi and Touloum projects to partners in 2009.

In Adre, Guereda, and Abéché however, despite MSF's continuing interventions, healthcare for Chadian people and Sudanese refugees is still inadequate. MSF focused its efforts in these areas on healthcare for women and children, and implemented a surgical programme to treat obstetric fistula. MSF continued to provide assistance at Adre's health facilities, where almost 2,400 people were admitted. More than 56,000 outpatient consultations were provided in Guereda district's health centres, including in Birak, where approximately 10,000 new Sudanese refugees arrived early in the year.

Further south, MSF provided healthcare to 80,000 displaced people and residents in the villages of Gozbeida, Kerfi and Ade. The mobile clinics in Kerfi and Ade began providing inpatient facilities in early 2008. More than 81,800 consultations were carried out and an additional 1,700 people were treated for malnutrition. The situation in Gassire camp in Gozbeida has stabilised, so MSF will hand over the camp's clinic to partners in 2009.

In Dogdoré, a remote village in the district worst-affected by the internal conflict, MSF has been providing medical assistance to the 27,000 displaced people and 3,000 residents since July 2006. In 2008, 25,000 primary health consultations were carried out, 1,000 patients were admitted to hospital, and 600 severely malnourished children were admitted to the MSF nutritional centre. In addition, 3,000 antenatal consultations took place and 350 deliveries were performed. However, repeated security incidents forced MSF to reduce the size of the team and eventually evacuate all international staff from the projects in October. Local staff were able to maintain some basic health services during this time, and international staff began returning at the beginning of 2009.

Support in the southwest

In the southwest of the country, MSF continued to support Goré's hospital, responding to the secondary healthcare needs of about 30,000 refugees from Central African Republic (CAR) and 137,000 residents of the Goré district. Overall, MSF provided 20,000 consultations, 4,300 hospital admissions and 1,000 surgical interventions.

Following the arrival of about 5,000 refugees from CAR, MSF provided, between May and October, emergency water supply, primary and perinatal health consultations, and preventive measles vaccinations for children under five years old. Patients in need of secondary care were referred to a nearby Ministry of Health hospital.

After 25 years, MSF left Bongor in December 2008, handing the city hospital over to the Ministry of Health. In 2008 alone, around 154,000 malaria cases were treated, 5,815 patients came for medical consultations, 1,440 deliveries and 850 surgical interventions were conducted.

In 2008, MSF also responded to epidemic outbreaks throughout the country. Following outbreaks of measles, MSF immunised more than 11,000 children in Goré and approximately 15,000 children in Adre. The population of Abéché was also vaccinated in early 2009.

MSF has worked in Chad since 1981.


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DEMOCRATIC REPUBLIC OF CONGO

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion**
FIELD STAFF **2,465**

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


© Cedric Gerbehaye

In a highly insecure and rapidly changing situation, running mobile clinics, assessing new areas, and quickly re-locating teams are key to providing an effective response.

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

MSF opened a programme in Kabizo to manage a measles epidemic and provide healthcare to internally displaced people who had recently arrived in the area. The MSF team had to evacuate from Nyanzale several times for security reasons during the last four months of 2008. An MSF team started working in April in a hospital in Mweso. A team was already working in Kitchanga hospital, northwest of Goma. Between them, they conducted more than 550 major surgeries, 120 of which were war related. In Masisi town, about 50 miles northwest of Goma, MSF admitted more than 500 patients a month to the hospital.

Further south, MSF worked in the hospitals of Kirotshe and Minova in North Kivu, and Kalonge in South Kivu. In Minova, MSF had carried out 34,000 consultations by the time the project closed in December. By the end of the year, MSF had admitted more than 4,000 patients to Kalonge hospital, providing among other things surgery, deliveries and treatment for malnutrition.
In a highly insecure and rapidly changing situation, running mobile clinics, assessing new areas, and quickly re-locating teams are key to providing an effective response. MSF teams ran mobile clinics and supported health centres in villages and camps around Rutshuru, Nyanzale, Kabizo, Kayna, Mweso, Kitchanga, Pinga, Masisi, Kirotshe, Kalonge, and Minova. MSF also provided latrines and access to clean water in various locations such as Kitchanga, where more than 70,000 displaced people had gathered in camps.

In 2008, more than 6,700 victims of sexual violence received specialised medical care and counselling in various MSF programmes across North and South Kivu. In Nyanzale alone, more than 3,500 victims were treated; 1,450 in the areas of Kitchanga and Mweso.

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

The weak healthcare system in South Kivu was further stretched by large groups of Congolese refugees returning from camps in Tanzania and Burundi. MSF continued support to the hospital and a cholera treatment centre in Baraka, Fizi region. In Minova, MSF responded to a cholera outbreak by treating more than 800 patients.

In North Kivu, MSF teams also treated malnourished children in various supported health structures, and vaccinated more than 215,000 children against measles.

While years of conflict in the district of Ituri, in northeast DRC, had come to an end in 2005, renewed fighting between militias and the Congolese army forced up to 100,000 civilians to flee. MSF teams have worked in Gety hospital and launched mobile clinics in Songolo and Soke to bring healthcare to about 50,000 displaced people and refer patients to Bunia hospital. In Bunia, 11,500 patients and 26,000 children under five years were admitted to Bon Marché hospital.

In December 2008, Uganda, DRC and Sudan launched a joint offensive against Ugandan rebels of the Lord's Resistance Army (LRA). In response to military operations against them, LRA fighters started in September to perpetrate acts of extreme violence on the civilian population of Haut-Uélé district. Hundreds of men, women, and children were killed and many young men were enrolled by force into the LRA. By the end of the year, more than 100,000 people were displaced and left largely unprotected from assailants.

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

In Opienge, Tshopo district, an MSF team provided some 5,500 consultations for civilians affected by fighting between the national army and local militias.

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

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

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

MSF has worked in DRC since 1987.

CONDITION CRITICAL

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

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

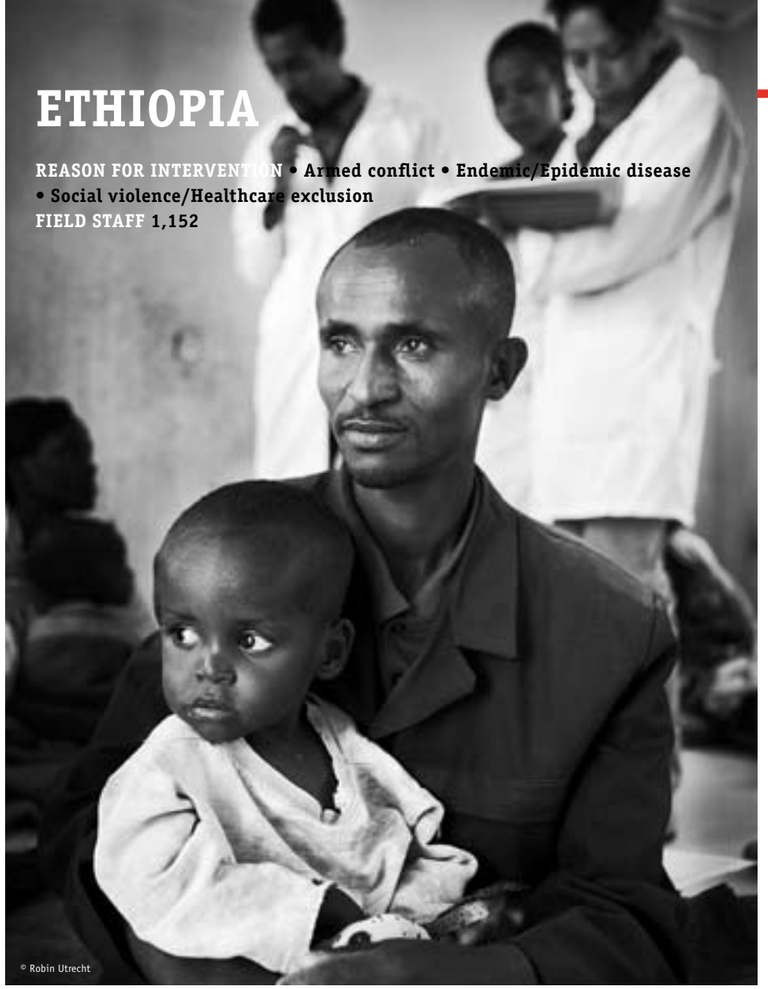
MSF challenges in Eastern Congo

Making the decision to intervene in Eastern Congo implies the understanding of a complex and volatile situation. The conflict has its roots in access to land, the scramble for power and a sense of ownership and entitlement of the land by some groups who perceive others as foreigners. These problems are exacerbated by the economic recession and social precariousness as well as the disintegration of state authority. These realities and perceptions reflected in local opinions had only to be mobilised by political leaders or armed groups for the eastern part of the country to be set ablaze.
The two Congolese wars from 1996-1997 and from 1998-2002 that followed the Rwandan genocide were the work of a number of armies (notably the Rwandan, Ugandan and Burundian) for political and economic gains. However this coalition would not have found Congolese allies if they hadn't known how to rally certain populations around local divisions. In the same way, the powers that be in Kinshasa, aided by local politicians, applied these same antagonisms to mobilize other populations at the heart of the resistance army movements. It is not surprising therefore that the peace accords of 2002 did not lead to peace.

It is in this context that MSF works to help those most in need. It is crucial not to assume the situation in the Nyanzale zone is similar to that in Lubero, Bunia or Baraka. The problems are complex and diverse. Armed groups allied in one zone could declare war on those in another. Rebel movements could collaborate with the national army in some places and oppose them in others. MSF must understand these parameters and be able to identify reliable sources of information as well as the leaders of armed forces or militias who influence their troops. However the Congolese army is in decline. Deserters are numerous and have swelled the ranks of all sorts of bandits.
Extortion by army soldiers, armed men in rebel movements and those operating independently occur daily.

Attacks on the road, recurring rape, pillaging and murders almost systematically go unpunished because the state lacks virtually all authority. The justice system and the army do not function. The resulting impunity only serves to increase the level of insecurity. In Eastern Congo, taking up arms to meet personal needs, to settle accounts often linked with local rivalries and to escape the intolerable living conditions has become a way of life for a small part of the population. The other part of the population, the vast majority, flee, sleep in the bush, suffer from hunger and the cold, sustain gunshot wounds, and all too often die without ever having their voice heard.

Romain Gitenet, head of mission,
Democratic Republic of Congo



ETHIOPIA

REASON FOR INTERVENTION • Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion
FIELD STAFF 1,152

© Robin Utrecht

A nutritional crisis that devastated a number of regions in the south of the country struck Ethiopia in 2008. A combination of several factors, including droughts and a dramatic rise in food prices, left hundreds of thousands of people without food, struggling to survive. MSF teams, were able to launch an immediate emergency response.

Initially teams could care only for those suffering from severe malnutrition, and focused on children since they were the most at risk. In mid-July feeding programmes for moderately malnourished children and their families were opened. By September, more than 700 staff were working in MSF's nutritional programmes. By the end of the emergency intervention they had treated more than 34,800 severely malnourished and more than 37,600 moderately malnourished people. A targeted feeding programme had also provided food to 14,000 children who were at risk of being malnourished. In February and March a measles vaccination campaign was also carried out in Oromiya region and around 93,000 children were vaccinated.

Although the nutritional crisis hit hardest in the south, other areas were also affected.
In August a nutritional intervention was launched in the Afar region of northeast Ethiopia. In September MSF teams reported a deteriorating humanitarian situation around Wardher in the conflict-affected area of the Somali region. Thousands of people who had fled their homes gathered on the town's outskirts in search of food and water. With a clinic in Wardher town, MSF was able to provide medical care to the displaced people and the town inhabitants. However, from September, teams could no longer use mobile clinics throughout the wider Wardher area due to insecurity in the region.

Projects continued in Cherrati and Degahbur, also in the Somali region. In Cherrati MSF provided primary healthcare and treatment for tuberculosis (TB). Over the course of the year more than 18,500 outpatient consultations were undertaken and nearly 700 people were started on TB treatment. In December the Cherrati project was handed over to the local health authorities.

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

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

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

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

MSF has worked in Ethiopia since 1984.

GUINEA-CONAKRY

REASON FOR INTERVENTION
• Endemic/Epidemic disease
FIELD STAFF 229


© Julie Rémy

MSF continued to carry out HIV/AIDS programmes in the eastern city of Guéckédou in the Guinée Forestière region, and in the capital.

MSF remains the main provider of care for the country's HIV-positive patients. To allow patients to be treated closer to their homes, MSF started to decentralise HIV/AIDS care to smaller health centres in Conakry and in Guinée Forestière. Treatment, voluntary testing, and psychosocial counselling were provided, medical staff trained and supervised and the medical units upgraded.

More than 3,500 patients were receiving antiretroviral therapy (ART) at the end of 2008, including many HIV patients co-infected with tuberculosis. It seems unlikely that MSF will be able to hand over the HIV/AIDS care programmes to local agencies, as it has in other countries, owing to the health department's lack of resources and a shortage of qualified staff.

Pushing for better malaria treatment

In Dabola, MSF handed its malaria treatment programme over to the local authorities. Having lobbied the national health authorities for the use of artemisinin-based combination therapy (ACT), a more efficient treatment for malaria, MSF pushed in 2008 for the use of ASAQ, a combined single-dose easy-to-use, efficient and non-costly formula developed by the Drugs for Neglected Diseases initiative (DND*i*).
A film aimed at promoting the use of this combined drug was produced in partnership with Guinean actors in three languages, in French, Malinké and Peulh. The health authorities of Dabola, which integrated the use of the ASAQ formula in its health structures, took over MSF's programme in November 2008.

Unacceptable prison conditions

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

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

Combating cholera

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

MSF has worked in Guinea Conakry since 1984.

GUINEA-BISSAU

REASON FOR INTERVENTION • Endemic/Epidemic disease
FIELD STAFF 7

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


© Clara Tarrero

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

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

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

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

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

MSF worked in Guinea-Bissau from August to November 2008.

KENYA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion**
FIELD STAFF **659**

At the beginning of 2008, disputes over Kenya's presidential election sparked two months of violence, leaving more than 1,000 people dead and, according to the Kenyan Red Cross, as many as 300,000 displaced. MSF medical staff, who normally focus on providing treatment to thousands of people living with HIV/AIDS and tuberculosis (TB) in the capital, Nairobi, and western Kenya, were on hand to respond.


© Juan Carlos Tomasi

Emergency medical care was provided to the victims of violence. Mobile clinics for Kenyans fleeing violence in their communities were also established and activities started in some camps for people who had fled their homes. MSF reinforced its teams on the ground with extra surgeons, emergency physicians, nurses, and logistical specialists.

The violent protests and clashes that erupted throughout Kenya during the crisis left hundreds injured. In Nairobi, teams adapted long-running HIV/AIDS projects to provide basic first aid for the victims. Because many people were unable to move, MSF sent ambulances around the slums to assist the injured. For the most-seriously injured, a referral system was set up involving both public and private hospitals.

In early January an MSF surgical team worked in Eldoret and Nakuru hospitals to help treat victims of violence, many of whom had machete wounds or burns. Later in the same month MSF teams supported Kenyan Ministry of Health staff as violent clashes erupted in Nakuru and Naivasha, two popular tourist destinations close to Nairobi. In Nakuru MSF teams helped treat more than 150 wounded patients in two days.

The violence prompted thousands of people to flee their homes. The Rift Valley region was particularly badly affected. Many people sought refuge in large sites such as stadiums and showgrounds. In a number of sites that housed thousands of displaced people, including Eldoret, Nakuru and Kitale, MSF teams provided medical care and relief supplies. Other Kenyans sought protection at police stations, prisons and churches or stayed in small groups in remote areas. In parts of the country people moved around regularly, so sites that were once filled with people were empty just a few days later. Faced with such a mobile population, MSF had to be flexible in its response. Medical teams travelled to numerous different locations in the Rift Valley every week to provide care to those with little or no aid.

Mount Elgon displaced

As the political situation stabilised towards the end of February, MSF gradually phased out its emergency response. Yet activities continued in the Mount Elgon region of western Kenya where tens of thousands of people had been displaced by the violence that started in August 2006. Trapped between a number of different warring parties, people living in the Mount Elgon region were struggling to survive. MSF first started providing assistance in the region in April 2007, focusing on primary and mental-health care, referrals and the distribution of non-food items such as blankets.

In 2008, more than 23,000 outpatient consultations were provided, including nearly 1,600 antenatal consultations. MSF also treated 110 victims of sexual violence, and 349 patients suffering from violent trauma wounds. By the end of the year, as the security situation improved, MSF was able to hand over its activities to the Ministry of Health.

Specialised healthcare

For many years MSF teams in Nairobi and the Nyanza, Western and Rift Valley provinces of Kenya have provided specialised care for people suffering from chronic and neglected diseases.

By the end of 2008, more than 18,600 people living with HIV/AIDS were cared for in MSF projects, and 14,000 were receiving life-saving antiretroviral therapy. In projects in the capital's slums of Mathare and Kibera as well as in the rural areas of Busia and Homa Bay, MSF staff tested 17,250 people for HIV/AIDS.
In the Pokot region of northwestern Kenya, medical teams tested more than 1,700 people for the deadly disease kala azar (visceral leishmaniasis) and treated some 640 patients.

MSF has worked in Kenya since 1987.

LESOTHO


© Eva-Lotta Jansson

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
FIELD STAFF **9**

In the 'Mountain Kingdom' of Lesotho, life expectancy is only 35 years. HIV/AIDS is a significant killer and over 23 per cent of the adult population live with the disease. Most HIV/AIDS-related deaths are due to co-infection with tuberculosis (TB). The country urgently needs more health workers, having just five doctors and 62 nurses per 100,000 people.

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

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

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

Decentralised care

Because the hospital-based ART clinics are so full, there are so few staff and many patients find it hard to reach or afford healthcare, MSF's goal from the outset was to decentralise all HIV/AIDS care and treatment services to health-centre level. The objective has been to bring care and treatment as close as possible to those in need, and to ensure HIV/AIDS care is free. Nurses were trained to assume high levels of clinical responsibility for HIV/AIDS care, including initiating and managing ART for adults and children. Lay counsellors (primarily people living with HIV/AIDS) were recruited and trained to reinforce clinic capacity and provide essential support in the delivery of HIV/AIDS and TB services, particularly treatment adherence. As of December 2008, there were 45 lay counsellors working across the 15 facilities.

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

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

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

MSF has worked in Lesotho since 2006.

LIBERIA

REASON FOR INTERVENTION • **Endemic/Epidemic disease • Social violence/ Healthcare exclusion**
FIELD STAFF **875**

Though Liberia has made significant moves towards stability and reconstruction following its brutal 14-year civil war, many Liberians still live in crushing poverty, and the weak health sector cannot provide adequate healthcare. Women and children remain particularly vulnerable.

© Alessandra Vilasboas

Maternal healthcare

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

MSF also provided free access to healthcare in a paediatric hospital, Island Hospital, in Bushrod Island. This overcrowded area in Monvrovia is home to more than 500,000 people: admissions exceeded 12,600 in 2008. Care was focused particularly on mothers and children, on malnourished children who have medical complications and on integrating care for chronic diseases such as HIV/AIDS and tuberculosis into the system. MSF teams helped deliver more than 3,900 babies.

MSF also helped provide primary care in two centres run by the Ministry of Health in Clara Town and New Kru Town. Teams supported a range of services for mothers and children such as antenatal and postnatal care, vaccinations and prevention of mother-to-child transmission of HIV. Together the centres provided more than 122,300 consultations in 2008.

Sexual violence

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

Victims of sexual violence were offered medical and psychosocial support at Island Hospital as well as at both health centres. In 2008, MSF teams treated more than 770 people in Bushrod Island, more than 70 per cent of whom were younger than 19 years old. Some 11 per cent were younger than four years old.

Primary care handover

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

Treating Lassa hemorrhagic fever

In 2008, some 80 people with Lassa hemorrhagic fever were admitted to Saclepea's special hospital unit for treatment. The fever is deadly if not treated quickly with ribavirine, a costly medicine protected by a pharmaceutical monopoly. As part of its planned 2009 withdrawal from Saclepea, MSF is trying to ensure that ribavirine becomes affordable in Liberia. Teams are also lobbying health officials for continuity of care for HIV-positive patients after the withdrawal. It has now been agreed that HIV-positive patients will be able to receive treatment at Ganta hospital in northern Nimba county, and that screenings for HIV and tuberculosis will continue in Saclepea.

Lobbying for free healthcare

In 2006, the government introduced a policy of free healthcare across Liberia. Not all the country's health structures are able to offer services free of charge, however, so in some places people cannot afford to be treated. MSF is lobbying for consistent implementation of free care throughout the country.

MSF has worked in Liberia since 1990.

© Isabelle Merny

MALAWI

REASON FOR INTERVENTION
• Endemic/Epidemic disease
FIELD STAFF 700

In recent years the Malawi government has made increasing efforts to provide more antiretroviral therapy (ART) in response to the spread of HIV/AIDS. An estimated 12 per cent of the adult population are infected. But there is still an acute shortage of nurses and doctors, which means many people are still going untreated.

Tackling the HIV/AIDS problem

MSF has been providing ART in two southern rural districts: Chiradzulu (since 2001) and Thyolo (since 2003). Since these projects began, MSF has started more than 28,000 patients on ART – 12,000 in Chiradzulu and 16,000 in Thyolo. In 2007, MSF achieved its goal of providing universal access to ART in Thyolo, starting 11,520 people on the therapy. In 2008, MSF placed more than 4,300 new patients on ART in Chiradzulu, and more than 4,400 in Thyolo.

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

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

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

MSF is collaborating with local health authorities to implement a national HIV/AIDS treatment plan. Through technical working groups at national level, MSF has participated in the development of healthcare protocols and guidelines that have been disseminated nationwide.

'HIV/AIDS is not just a medical problem. It is also a cultural, social problem. We want to enable people to take responsibility themselves. To do this we have started giving communities a lot of information about HIV/AIDS, such as where to find services, how to address problems associated with taking the drugs, how to stay healthy,' explained Jomah Kollie, MSF community programme manager.

Task-shifting and decentralisation of services

To retain existing patients and to cope with an increasing caseload, MSF has focused on training nurses to prescribe ART – a responsibility previously carried out only by clinical officers, medical assistants and doctors.

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

Cholera epidemic

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

MSF has worked in Malawi since 1986.

MALI

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease**
FIELD STAFF **143**

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

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

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

Comprehensive approach to treating fistulas

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

Providing care in Kidal

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

MSF has worked in Mali since 1992.

© Bruno De Cock

MOROCCO

REASON FOR INTERVENTION • **Social violence/Healthcare exclusion**
FIELD STAFF **27**

© MSF

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

Jorge Martín, MSF head of mission.

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

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

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

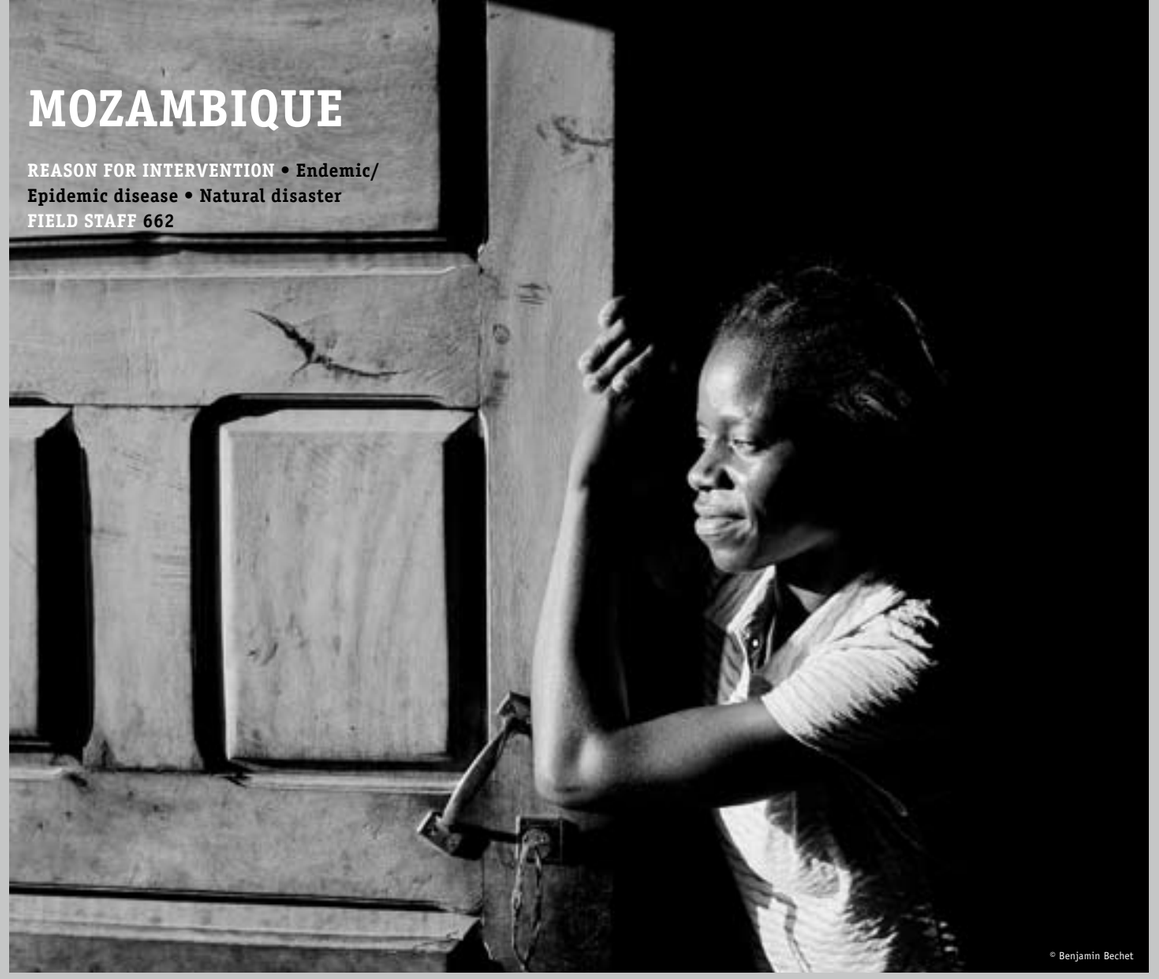
MSF has worked in Morocco since 1997.

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

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

MOZAMBIQUE

REASON FOR INTERVENTION • Endemic/Epidemic disease • Natural disaster
FIELD STAFF 662


© Benjamin Bechet

Mozambique is still recovering from a 17-year civil war that ended in 1992. The country's healthcare system has been left weak and understaffed, its facilities overwhelmed by the HIV/AIDS epidemic. Around 16 per cent of people over 15 years old are HIV-positive, and 68 per cent of tuberculosis (TB) patients are co-infected with HIV. MSF is helping patients with these two diseases in the rural provinces of Niassa in the north, Tete in the centre of the country, and the capital Maputo in the south.

In Niassa, MSF provides care in the provincial hospital, in health centres in the town of Lichinga, and in three other rural areas. In Maputo, MSF operates in the Alto Mae and Primeiro de Maio hospitals in the city centre as well as in nine health centres outside the main towns.

In Tete, MSF provides HIV/AIDS care in three districts and encourages the local communities to support patients – by helping them to adhere to treatment, for example. Equipping health facilities in remote locations also reduces the time many patients have to take and the distances they have to travel for medication and routine consultations.

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

Decentralisation of health services

MSF has been working with local authorities to transfer to local health units responsibility for first-line HIV treatment. This includes counselling services, prevention of mother-to-child transmission and tracing patients who allow their treatment to lapse. Such decentralisation is especially valuable in rural areas where resources are limited. It helps bring treatment closer to patients' homes and helps to reduce the pressure on the central healthcare structures.

To support the local treatment centres, MSF has strengthened the staff's clinical knowledge, provided management and staffing support, ensured a steady drug supply to pharmacies, and upgraded medical facilities.

MSF is lobbying to allow local paramedical staff to prescribe ART drugs and to administer repeat prescriptions, and to use lay counsellors. Such measures would allow nurses to devote more time to their medical responsibilities.

MSF has worked in Mozambique since 1984.

NIGER

REASON FOR INTERVENTION • Endemic/Epidemic disease • Social violence/Healthcare exclusion
FIELD STAFF 1,810

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

In 2008, the health authorities took steps to fight malnutrition by registering as essential medicines a ready-to-use, vitamin-enriched paste, and therapeutic milks. New growth standards established by the World Health Organization that allow malnourished children to be identified and treated at an earlier stage were also adopted.

Providing nutritional support

MSF has been running programmes to combat malnutrition since 2001. In 2008, teams worked with the national and local health authorities in the regions of Maradi, Zinder, and Tahoua (Madaoua and Bouza).

MSF treated some 97,600 children under five years old who were moderately or severely malnourished. Other high-risk groups, such as pregnant and lactating women, were also targeted for nutritional care. Care is provided mostly through a network of more than 40 mobile nutritional centres, which allow children to be treated closer to where they live. Many are treated at home with ready-to-use food and come to the centre once a week for a check-up while their families collect further supplies. This approach makes it possible to treat a large number of children with good results: in Zinder for example, the cure rate reached 72 per cent in 2008.

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

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

Challenges

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

Responding to emergencies

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

MSF has worked in Niger since 1985.


© Olivier Asselin

NIGERIA

REASON FOR INTERVENTION • **Endemic/Epidemic disease • Social violence/ Healthcare exclusion**
FIELD STAFF **518**


© William Martin

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

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

Trauma care and primary healthcare in the Niger Delta

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

Port Harcourt is prone to peaks of violence and this year MSF teams have treated more than 9,300 patients in its emergency room and performed more than 3,000 surgeries. MSF has also recently begun offering support to victims of sexual violence. A team of specialists treated 265 people, and will continue focusing on this issue in a city where victims often have nowhere to go for care.

Last October, MSF opened a health centre in Oloibiri, in the south of Bayelsa state, in order to provide primary and mother-and-child healthcare to people there. The ten-bed centre has been fully occupied. In December, more than 800 consultations were carried out, 31 per cent of which concerned children under five. The main pathologies treated include malaria, respiratory infections and diarrhoea. The centre where pregnant women come for antenatal care will also provide assisted deliveries.

Improving maternal healthcare and reacting to epidemics in the north

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

MSF opened a new surgical programme focusing on emergency obstetrics and women suffering from fistulas in Jahun, Jigawa state. Fistulas are usually a consequence of poor obstetric care: a woman develops a fistula after being in labour for many hours, or even days. In 2008, 63 women underwent surgery to correct fistulas, and the team helped more than 530 women to deliver. In 2008, around 480 women with obstetric complications were admitted to the hospital.

MSF has responded to various medical emergencies in the northern states, dealing with cholera outbreaks in Sokoto state, undertaking vaccination programmes for meningitis in Katsina and Kebbi state (more than 71,000 people vaccinated), measles in Niger state (more than 11,000 people vaccinated) and a nutrition campaign in Yobe state. MSF also provided non-food items after riots in Jos and carried out an assessment of the condition of refugees from Bakassi peninsula (disputed territory between Cameroon and Nigeria) located in the Nigerian Cross River state.

Handing over the HIV/AIDS programme in Lagos

In September 2008, after five years of activity, MSF completed the handover of its HIV/AIDS programmes in Lagos. When MSF started providing free, life-prolonging antiretroviral therapy (ART) and comprehensive care for HIV-positive patients in 2003, there were no other agencies offering that medical support in Nigeria. In 2006, a presidential decree launched a national programme offering free ART to all HIV/AIDS patients in Nigeria. Over the last few years, MSF has cared for more than 1,900 HIV-positive patients. By 2008, when it was clear that the Nigerian government had made substantial progress in providing free ART, MSF handed over the programme to local partners and the Lagos general hospital.

MSF has worked in Nigeria since 1996.

SIERRA LEONE

REASON FOR INTERVENTION
• **Social violence/Healthcare exclusion**
• **Endemic/Epidemic disease**
FIELD STAFF **402**

In Sierra Leone the main barriers to accessing healthcare are cost and distance. MSF has been active in the country since 1986 and is currently focusing on combating malaria, providing maternal and paediatric healthcare, and treating malnutrition.

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

Malaria: the number one killer

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

During 2008 MSF built up a network of 140 community malaria volunteers and taught them how to diagnose and treat the disease. As the volunteers are based in their own villages, they help overcome the geographical barrier to accessing malaria treatment.

Jabaty, a 31-year-old man chosen to be a volunteer by his village, says: *'I feel very happy to be a volunteer because I am saving lives, especially the lives of children. My village has benefited very much because our people no longer have to walk for miles to the nearest clinic.'* Through the use of a rapid diagnostic test it is easy for Jabaty to make a diagnosis. If malaria is detected, he will provide ACT to the patient. *'I have treated people every day, and we have had 44 malaria cases in the last three weeks. They are all very happy because they got treatment quickly and they are all well.'*

Maternal health and malnutrition

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

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

MSF has worked in Sierra Leone since 1986.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SOMALIA

REASON FOR INTERVENTION • Armed conflict • Endemic/Epidemic disease
FIELD STAFF 1,348


© MSF

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

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

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

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

In Mogadishu, staff in the surgery department of Danilye hospital treated 5,250 patients in the emergency room, including more than 3,000 people wounded in the conflict. More than half the patients were women and children under the age of 14. At an outpatient clinic in Mogadishu North, a further 1,400 patients who had been operated on for war-related injuries were provided with dressings. Nutrition was also a key concern: early in the year MSF teams started a programme for severely malnourished children and 1,800 patients were admitted and treated. Throughout the country, MSF treated more than 18,400 children for severe malnutrition and more than 16,000 children for moderate malnutrition.
Although most international attention focused on the capital and its surroundings, MSF teams responded to huge needs in nine regions of south and central Somalia. To the north in Galcayo, medical staff treated 470 victims of violence over the course of the year. In Galgaduud, more than 600 people were operated on.

Yet it is not just victims of violence who need assistance in Somalia. Curable and preventable diseases such as diarrhoea, malaria and respiratory tract infections cause many thousands of deaths every year. Basic healthcare such as antenatal consultations and vaccinations were crucial to MSF's efforts to save lives. Medical staff provided more than 727,000 outpatient consultations, 55,000 antenatal consultations, 82,000 vaccinations and, in Jowhar, 1,500 deliveries.

MSF has worked in Somalia since 1991.

IN MEMORY

On Monday, January 28 2008 a brutal attack took place as the MSF team returned from lunch after another productive morning of emergency surgery in the Kismayo hospital. A roadside bomb ripped through the second vehicle in the team's convoy, killing three international staff inside.

Victor Okumu, 51, was a surgeon; Damien Lehalle, 27, a French logistician; and Mohamed Abdi Ali (Bidhaan) was the driver.

Both Victor and Damien were relatively new to the Kismayo project but not new to the MSF family. Victor will always be remembered for his dedication to his patients in Sierra Leone, Darfur and for many years in South Sudan.
Damien also had joined the Kismayo team recently, after finishing his first mission in Democratic Republic of Congo. He will be remembered for his hard work and his warmth of character.
Bidhaan will be remembered for his committed service to MSF.

SOUTH AFRICA

REASON FOR INTERVENTION • Endemic/Epidemic disease • Social violence/ Healthcare exclusion
FIELD STAFF 92

An estimated 18 per cent of adults in South Africa are HIV-positive, and many urgently need antiretroviral therapy (ART). Tuberculosis (TB), including drug-resistant TB (DR-TB), is the main cause of death and illness among those living with HIV/AIDS.

Khayelitsha, a township on the outskirts of Cape Town, is home to half a million people and has one of the highest incidences of HIV/AIDS in the country. Since May 2001, MSF has been running an ART programme there in partnership with local health authorities. This was the first such programme in the South African public sector and has prompted similar initiatives in other parts of the country. More than 11,000 patients are now benefiting from the ART services in Khayelitsha.

A high proportion of HIV/AIDS patients are co-infected with TB. The case notification rate for TB here is at least 1,500 per 100,000 people per year – among the highest incidence in the world. As in the rest of South Africa, increasing numbers of people are being diagnosed with drug-resistant tuberculosis (DR-TB). MSF has been piloting a project to provide decentralised care and treatment for patients with DR-TB in Khayelitsha. The project is based on the theory that more patients will be diagnosed and successfully treated if they are encouraged to follow treatment in their homes, rather than being isolated in specialised hospitals. This model of integrated care for HIV/AIDS and TB patients has been replicated in many other settings and is promoted by the World Health Organization as a model for best practice.

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

Medical and humanitarian assistance for Zimbabwean refugees

Since December 2007 MSF has been working in central Johannesburg and in Musina to provide Zimbabweans with medical care.

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

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

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

MSF responded to this emergency in more than 15 locations in Johannesburg, Pretoria and Cape Town. Teams treated injuries such as gunshot wounds, head traumas and wounds resulting from beatings, lacerations and burns. They provided primary healthcare to those who had been forced to flee, and distributed hygiene kits, blankets and plastic sheeting.
In Johannesburg, where the violence was most extreme, MSF incorporated mental-health activities into the work of the medical teams. MSF also pressured the South African authorities to improve basic services such as shelter, water and sanitation in temporary camps.

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

Cholera outbreak

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

MSF has worked in South Africa since 1999.


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SUDAN


© Brendan Bannon

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion**
FIELD STAFF **3,240**

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

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

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

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

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

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

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

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

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

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

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

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

MSF has worked in Sudan since 1979.

Darfur

MSF has provided medical and humanitarian aid in the Sudanese region of Darfur since 2003. This is when government forces and allied militia began fighting the rebel groups who sought greater autonomy and resources for the arid and impoverished region. Since the start of the conflict the political environment has become increasingly complex. The armed groups have fragmented, leading to further outbreaks of violence and heightened insecurity. Harassment from armed groups, increased banditry and clashes between nomadic tribes have forced more people to leave their homes to seek refuge.


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In 2008, Darfur remained one of the largest humanitarian aid operations in the world. More than 80 organisations and 15,000 aid workers – including 2,000 MSF staff – provided assistance here, where an estimated one-third of the population has been displaced. Yet despite all these efforts, hundreds of thousands of people remain cut off from aid. Thousands more are at risk of losing assistance as a result of unstable frontlines, shifting alliances among armed factions, targeted attacks on aid workers, and increasing government restrictions on the provision of humanitarian assistance.

Insecurity challenges

The security situation deteriorated throughout the year. In February, a military offensive around Seleia, in West Darfur, left 300 people dead and caused another 10,000 to flee to neighbouring Chad. MSF teams had left Seleia before the attacks. After a month they were able to return to provide medical care through mobile clinics.

In August, after a series of attacks against MSF staff, teams were forced to leave projects in North Darfur: Tawila, where about 35,000 displaced people have gathered in three camps since August 2007, and Shangil Tobaya, where MSF provided medical care for about 28,000 displaced people in the Shangil and Shadat camps and about 5,000 people in the sur-


© Jan-Joseph Stok

rounding villages. Leaving so many people without access to medical care, even if only temporarily, was extremely hard, but without a guarantee of minimum security for humanitarian workers, MSF had no option but to suspend activities. The team was able to return to Shangil Tobaya in September. In 2008, almost 45,000 consultations where carried out and more than 4,000 women received antenatal care. The team returned in October to Tawila, where 25,000 consultations were conducted in 2008, but had to leave again in December.

In August, attacks on Kalma camp, home to more than 90,000 displaced people, resulted in many injuries. At least 65 patients were admitted to the camp clinic and MSF ambulances evacuated 49 patients suffering from gunshot wounds to a hospital in the region's capital, Nyala.

MSF also had to relocate the staff from Kaguro project in the Jebel Si in mid-September during an aerial bombardment campaign by the government. The team returned ten days later.

Fatima, who lives in Motorwat camp in the Muhajariya town area with her husband and four children, told MSF that she and her family have had to move eight times so far, from town, to forest, to camp, and back again.
'Every time we moved, we lost our property', she says. 'It is exhausting, but if you don't move quickly, you could be killed, or you and your children could be killed. Anger is pointless: even if I get angry, there's nothing I can do.'

Mental-health care

In order to help people traumatised by the conflict and repeated and prolonged displacement, MSF introduced mental-health care in 2006. Staff provided 9,380 counselling sessions for more than 1,600 patients. In 2008, 84 per cent of these patients reported improvements in their symptoms or a full recovery. However later in the year MSF was ordered by the Sudanese Humanitarian Aid Commission and the federal Ministry of Health to stop mental-health counselling in South Darfur, or risk expulsion.

MSF teams treated 64,000 patients, provided care to 19,000 pregnant women and delivered 1,750 babies. Despite this, MSF was given no choice by the authorities but to end the intervention.

In West Darfur, new projects in Golo and Killin, in the Jebel Mara region, were opened in April. Medical teams provided primary and secondary healthcare, focusing on women's health and combating malaria and malnutrition. In 2008 around 3,800 consultations were performed each month.

Teams also worked in Niertiti and Zalingei in West Darfur, providing healthcare services to around 170,000 people. Most of the 130,000 people who live in Zalingei have fled there from their homes. MSF works in three departments of Zalingei hospital, supporting paediatric surgery and the emergency room. The increase in malnutrition prompted teams to distribute supplementary food to 11,000 children aged from six to 36 months during the 'hunger gap' before the new harvest. In Niertiti, MSF provided outpatient and inpatient care: 86,000 consultations were performed and 4,900 people were admitted to hospital. In response to a meningitis outbreak in February, MSF vaccinated over 28,000 people.

In nearby Serif Umra medical staff provided primary and secondary healthcare, including antenatal and inpatient care, vaccination and the treatment of malnutrition. Each month around 4,000 consultations were carried out. More than 45 children received nutritional care and 110 patients were admitted to the clinic. In Jebel Si, MSF ran a clinic in Kaguro and five health posts in the surrounding area. These provide medical care to around 40,000 people who had been cut off from assistance since 2003, when the area was attacked and most villages were burned down. In the rural town of Kebkabiya, 90 miles west of North Darfur's capital El Fasher, MSF supports two clinics and five health posts providing basic healthcare including vaccination and the treatment of malnutrition. Teams also support the obstetric department of Kebkabiya hospital and provide comprehensive emergency obstetric care.

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

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

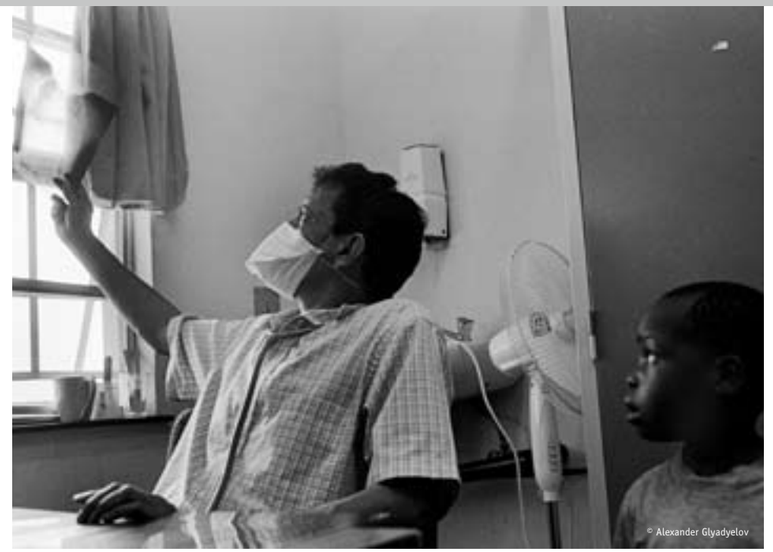
MSF has worked in Darfur since 2003.

SWAZILAND

REASON FOR INTERVENTION
• **Endemic/Epidemic disease**
FIELD STAFF **55**

In Swaziland it is estimated that HIV/AIDS affects one adult in four, and 80 per cent of patients with tuberculosis (TB) also have HIV. Since November 2007 MSF has been working in the Shiselweni region with public health staff to treat these two diseases.

MSF is decentralising the services offered to HIV-positive people and TB patients in the Shiselweni region. The goal is to establish a one-stop system, to give patients the opportunity to be treated for these two diseases at the same time in the same location by the same health workers. Screening and treatment are now offered at Hlatikulu hospital and in the Nhlangano and Matsanjeni health centres, as well as in nine out of 20 other health centres in the region. In 2008 in the Shiselweni region, nearly 2,300 patients received TB treatment, and 1,870 TB patients co-infected with HIV/AIDS received antiretroviral therapy.


© Alexander Glyadyelov

In 2008 an estimated 12,000 new cases of TB were identified in Swaziland, including 200 people who had contracted a form resistant to treatment. Of these, 42 were diagnosed and monitored in Shiselweni. Identifying and treating resistant forms of TB is a priority because of the dangerous and complex nature of the disease.

MSF works directly with communities and people living with HIV/AIDS on prevention and education, research and detection of cases and patient follow-up. Encouraged by their good adherence to treatment, 'expert patients' who have personal experience of chronic disease help other patients to gain control of the disease and live positively with HIV/AIDS.

MSF has worked in Swaziland since 2007.

UGANDA

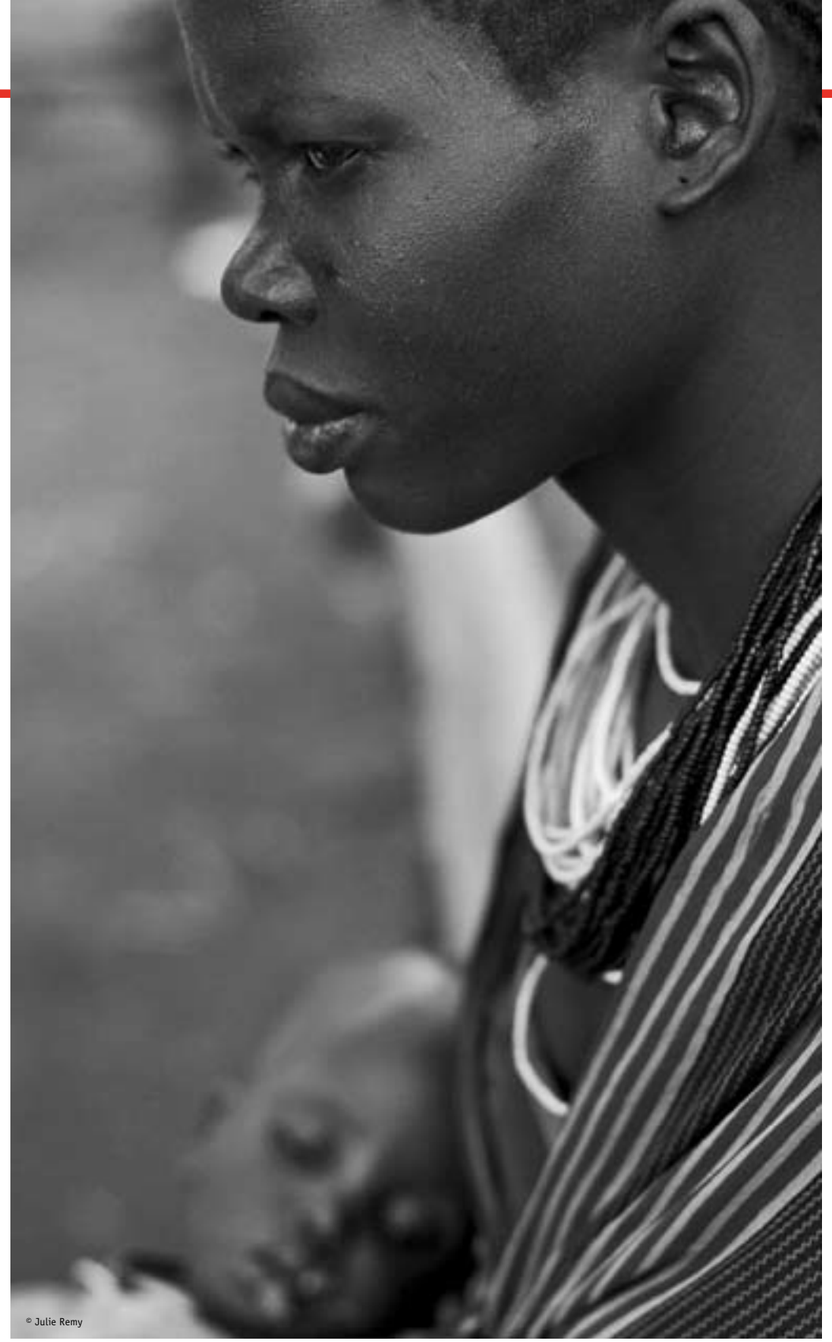
REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease**
FIELD STAFF **719**

HIV/AIDS affects an estimated eight per cent of the population. According to the World Health Organization there are more than one million people living with HIV or AIDS in Uganda, including 312,000 who need antiretroviral therapy (ART). It is estimated that 42 per cent of patients are on ART nationally, but the percentage is much lower in northern Uganda.

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

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

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

In November 2007, hepatitis E appeared in Kitgum as a consequence of the deplorable sanitation in the camps. Hepatitis E is a virus spread through contaminated water or food. There is no cure or vaccine, therefore MSF teams focused on case management of infected patients and prevention of the spread.

Pregnant women and children are at greatest risk so were particularly targeted. By the end of 2008, MSF had treated more than 1,500 patients in Kitgum. MSF also implemented prevention and referral activities to prevent the spread locally and to other districts.

At the end of 2007 into the beginning of 2008, MSF responded to an outbreak of Ebola haemorrhagic fever in western Uganda in the two key areas of Bundibugyo and Kikyo.

At the height of a cholera outbreak between January and April in Arua district, up to 40 patients were being admitted each day to an MSF cholera treatment centre.

Refugees fleeing fighting in the Democratic Republic of Congo at the end of 2008 have been assisted by MSF in Ishasha/Matanda and in Nakivale through a health clinic and the improvement of water and sanitation facilities in the camps.

Malnutrition in Kaabong and Karamoja

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

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

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

MSF has worked in Uganda since 1980.

ZAMBIA

REASON FOR INTERVENTION
• **Endemic/Epidemic disease**
FIELD STAFF **68**

HIV/AIDS is still highly prevalent in Zambia and a significant health problem. The disease and related deaths are laying a heavy burden on society. The impact of the pandemic in the country is attested by the decrease in life expectancy at birth which, according to the World Health Organization, was 52 in 1990 but by 2003 had dropped to 35.

However, the government of Zambia has raised awareness of HIV/AIDS over the years and has implemented policies to increase the provision of treatment. In July 2005, the government started providing HIV/AIDS care free of charge and in 2006 abolished the national cost-sharing system of healthcare.

MSF has focused on providing assistance to people with HIV/AIDS through a project in the district of Kapiri M'Poshi. Kapiri is a fast-growing town with little infrastructure, situated in a transit area. Because of the central position and transit character of the town, the population of Kapiri is particularly exposed to diseases such as sexually transmitted infections, HIV/AIDS, tuberculosis (TB) and cholera. It is estimated that 20 per cent of the city's general population is affected by HIV/AIDS.

Access to healthcare in general and HIV/AIDS care in particular is limited for the 250,000 inhabitants of Kapiri district, who are spread over a vast area that has no roads or means of transport. The care provided through the existing facilities is poor due to lack of medical supplies and human resources. MSF has shown that some of the tasks and responsibilities, such as HIV testing and counselling, that were formerly undertaken by doctors can be handed over to clinical officers or nurses.

MSF runs an HIV/AIDS clinic inside Kapiri district hospital and works in 14 rural and four urban health centres. By implementing such a decentralised model of HIV/AIDS care, people living outside large urban centres can receive care and treatment. MSF is also involving the community in preventing the spread of HIV and the treatment and support of people living with HIV/AIDS.

At the end of December, MSF had enrolled more than 10,500 patients in the project, more than 5,000 of whom were receiving antiretroviral therapy. During 2008, MSF teams carried out more than 2,600 medical consultations a month. At the same time, and in preparation for the handover of the HIV/AIDS programme, MSF started to integrate the project with the Ministry of Health's activities.

MSF has worked in Zambia since 1999.

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ZIMBABWE

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

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

One in five adults in Zimbabwe is infected with HIV/AIDS, and too few of those in urgent need of treatment can access antiretroviral therapy (ART). In its HIV/AIDS programmes in Bulawayo, Epworth, Gweru, Tshlotshlo and various locations in Manicaland province, MSF is supporting free care for 40,000 people. In 2008, 26,000 of these people began ART. But increasingly, patients are missing their appointments and risk interrupting their treatment because they cannot get to the few functioning clinics. This is due mostly to the high cost and unreliable nature of the transport system, but sometimes it is because patients have had to flee to neighbouring countries. In response to this problem, MSF has started to decentralise treatment, making its services more accessible, especially in rural areas.


© Joanna Stavropoulou

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

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

Combating Cholera

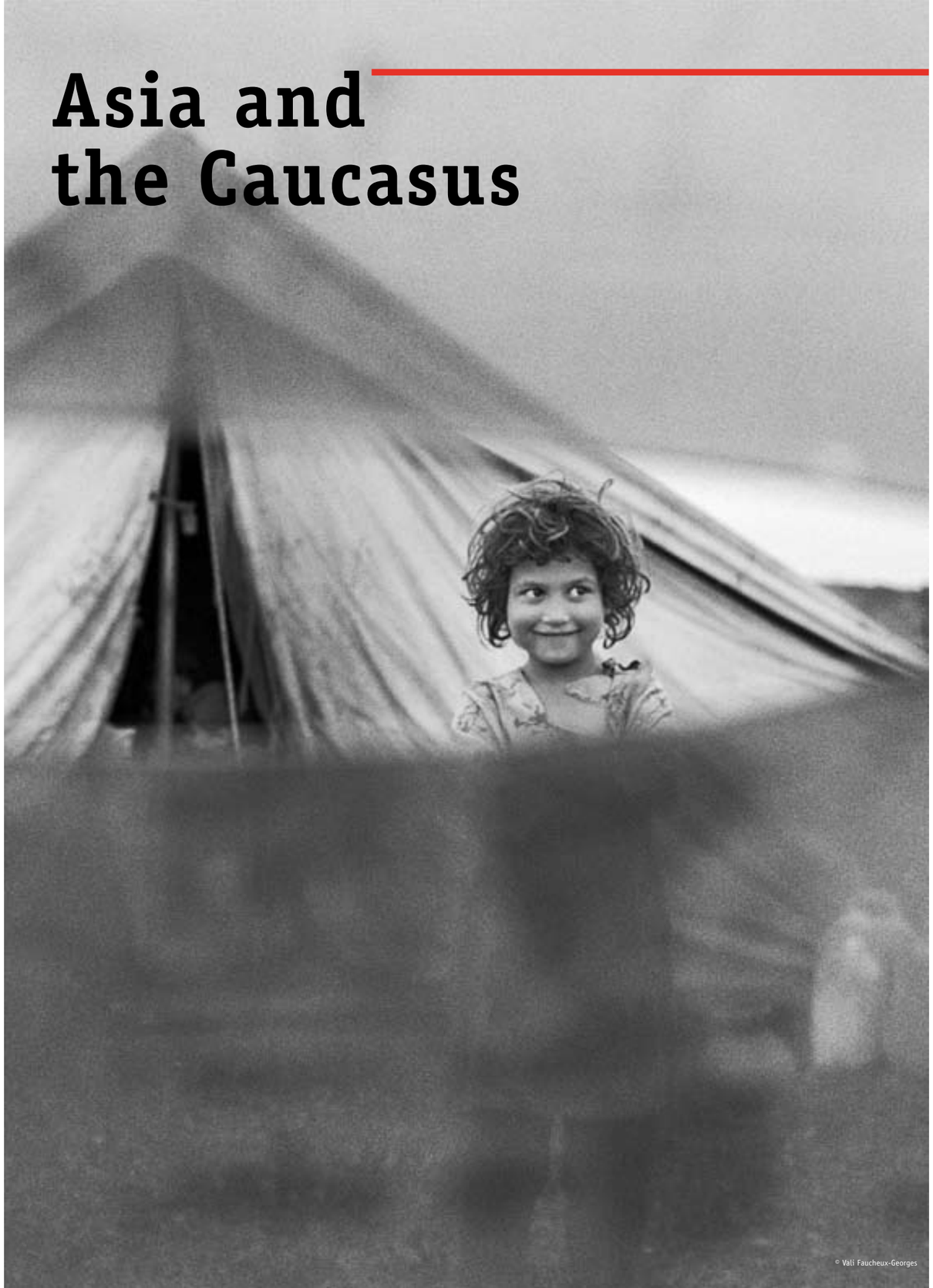
By December 31, MSF had helped more than 30,000 people suffering from cholera and more than 1,500 deaths had been recorded. MSF medical teams supported government structures with supplies, staff incentive payments and training, and established separate cholera treatment units in areas that had no other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

MSF has worked in Zimbabwe since 2000.

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

Manuel Lopez, MSF head of mission

Asia and the Caucasus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ARMENIA


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REASON FOR INTERVENTION
• Endemic/Epidemic disease
FIELD STAFF 56

Armenia has one of the world's highest incidences of drug-resistant tuberculosis (DR-TB). In September 2005, in collaboration with the Armenian Ministry of Health, MSF started a pilot programme for diagnosis and treatment of DR-TB in the capital city, Yerevan, where almost half the country's population lives. Since then, response to the DR-TB epidemic in the country has improved, with support from international agencies and donors helping to strengthen local capacity. At national level, MSF is advising on the setting up of a 'directly observed treatment short course'.

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

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

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

MSF has worked in Armenia since 1988.

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

Auxiliary TB nurse

D and her family lived in difficult conditions. D had had pneumonia twice, and then was diagnosed with TB. All she knew about TB was that it was infectious. When they knew she had the disease everybody was scared of her, even her close family. She spent a long time in hospitals, but was discharged because the drugs were not working. At home she became sick again and was taken to hospital in Nor-Nork by ambulance. She was operated on and diagnosed with DR-TB. After the surgery she was moved to Abovian and was included in the MSF programme. She stayed in hospital for a few months and, after making good progress, was discharged. She continued her treatment via a mobile clinic. In all, the treatment lasted two years. In the beginning, D found it hard to take the drugs because of the side-effects, but she persevered. Now she is cured and can get on with life again.

BANGLADESH

REASON FOR INTERVENTION
• Social violence/Healthcare exclusion
• Natural disaster • Endemic/Epidemic disease
FIELD STAFF 150

'The Chittagong Hill Tracts have a long history of unrest and the growing population seems to be exacerbating disputes over land and property rights. For everyone, land means the ability to feed one's family and to earn a living.'

MSF project coordinator, Yvonne Cuppens

In the area bordering Myanmar (Burma), thousands of Rakhine Muslims, often referred to as Rohingya, struggle to survive. Denied citizenship at home, many escaped persecution only to find themselves living in appalling conditions in Bangladesh, with poor access to healthcare and inadequate protection.

In 2008, MSF continued to deliver healthcare to more than 7,500 Rakhine Muslims living in Tal makeshift camp, as well as to those in the neighbouring community. The camp, positioned next to flood-prone waters and a dangerously busy road, was appallingly overcrowded and insanitary. In the primary healthcare clinic, MSF staff regularly treated people who had diarrhoea, skin infections and respiratory tract infections that were due to the squalid living conditions. Services also included a therapeutic feeding centre for severely malnourished children, a mental-health programme and projects to improve drinking water and sanitation. After months of intense lobbying led by MSF, the camp was eventually moved to a new site in Lada Bazaar in July and other agencies stepped in, allowing MSF to hand over activities.

In the isolated districts of the Chittagong Hill Tracts, the least-developed area within Bangladesh, the ethnically diverse population is especially vulnerable. Years of conflict, discrimination and marginalisation have forced the standard of the area's healthcare far below that of other areas of the country. During 2008 people faced increased food insecurity. This was worsened by a plague of rats that badly affected supplies of rice – the main staple of people's diets.

Tensions between established tribal groups, the more recently arrived (and arriving) Bengali settlers, the large government military presence and local opposition groups keep the area prone to outbreaks of violence and cause some people to flee their homes. One of the main markets in the area remained empty for much of the year as a result of fear, boycotting and intimidation.

In response to the increased levels of food insecurity and a 13 per cent incidence of acute malnutrition in children under five years old, MSF set up an emergency nutritional intervention programme in the Sajek Union area of Chittagong Hill Tracts. The intervention, which ran from April to December, sought to assist those already affected by malnutrition and to prevent the situation from worsening. A mobile feeding programme was set up, as well as an inpatient stabilisation centre for treating children who needed closer medical attention. MSF began to provide essential food items such as such as oil, fish-paste and salt to around 28,000 people. Alongside the nutritional programme, MSF set up a basic health clinic and eight health outposts, which were supported by a laboratory service for tests such as malaria.

While the nutritional situation steadily improved, MSF continued to treat around 200 people a week, largely for diarrhoea, upper-respiratory-tract infection and malaria, in the clinics.

MSF has worked in Bangladesh since 1985.


© William Martin

'I don't think I'll ever get back to Myanmar. It is clear that things are still very bad there and even if we live with minimal support and help here, at least we do not have to live in fear.'

Thirty-year-old woman, Tal Camp

CAMBODIA

REASON FOR INTERVENTION
• Endemic/Epidemic disease
FIELD STAFF 334


© Lauren Cohen

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

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

'In Cambodia, care for people with HIV/AIDS is expanding and attracts a lot of attention from the international donor community. However, care for people with diabetes, arterial hypertension and other treatable chronic diseases remains limited and the level of government spending on drugs is insufficient,' says Philippe Berneau, head of mission. *'Some sufferers even say that they "wish they had AIDS", since the HIV/AIDS care provision is much better. MSF's approach of integrating care for HIV/AIDS with care for hypertension and diabetes has resulted in satisfactory outcomes for patients and efficiency gains for the services.'*

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

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

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

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

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

MSF has worked in Cambodia since 1979.

CHINA

REASON FOR INTERVENTION • Endemic/Epidemic disease • Natural disaster
FIELD STAFF 70

Last year, HIV/AIDS became the top fatally infectious disease in China for the first time. According to the Ministry of Health, 44,839 new cases were reported between January and September 2008. UNAIDS, the United Nations programme on HIV/AIDS, estimates that 700,000 people were living with the disease in China at the end of 2007, 190,000 of whom need antiretroviral therapy (ART). Fewer than 20 per cent of them are receiving the treatment they need.

Although the Chinese government provides ART medication through its national programme, HIV testing and the management of opportunistic infections are not free, so people can die from HIV-related illness before being able to access the treatment. Stigma caused by association with the disease also prevents people from visiting national facilities to be tested and receiving treatment at an earlier stage.

While some important second-line antiretrovirals were eventually registered in 2008, many essential medicines are still inaccessible. The cost of many anti-opportunistic infection drugs is still too high and paediatric formulations of drugs to treat HIV and tuberculosis are unavailable within the country.

In collaboration with the Guangxi Public Health Bureau and Guangxi Centre for Disease Prevention and Control, MSF has been providing free and confidential care and treatment for HIV/AIDS patients in Nanning since 2003. This comprehensive programme provides voluntary counselling and testing (VCT), diagnosis, management of opportunistic infections, ART, and outreach activities in some communities. In 2008, more than 3,000 people received free VCT and around 300 patients were started on ART. At the end of 2008, 1,550 patients had been enrolled in this programme, more than 900 of whom had been started on ART.

Emergency assistance

On May 12, a magnitude 8.0 earthquake hit Sichuan province, leaving more than 80,000 people dead and ten million homeless. In collaboration with the Sichuan Red Cross, MSF donated 4,310 family-size winter tents and medical supplies to Mianzhu city. MSF also provided support to hospital patients suffering from 'crush syndrome' in Chengdu, and assisted a triage centre in Guanghan City, Deyang. However getting access to the area and population affected by the earthquake proved difficult due to government restrictions.

MSF provided psychological care to survivors of the earthquake in Hanwang, Mianzhu County and Long Men Shan, Pengzhou City. *'In the aftermath of the earthquake, people were in shock and intensely afraid. They clearly needed psychological care,'* said Dr Misa Sugawara, who worked as the MSF field coordinator in Sichuan. MSF continues to provide psychological care in Mianzhu and Beichuan County, where 238 consultations were conducted between November and December of 2008.

In response to the snowstorms that hit Maocao village in Guizhou province in February, MSF distributed 9,000 kg of rice as well as cooking oil and water to villagers.

In June, in response to floods in Guangxi, MSF provided 115,000 kg of rice, 1,900 bottles of cooking oil and 140 sets of plastic sheets to victims in Zhongdu Township, Luzhai County in Guangxi.


© MSF

Project handover

In May 2003, MSF began providing care and treatment in Xiangfan, targeting the estimated 45,000 people living with HIV/AIDS in Hubei and the neighbouring Henan province. This programme was handed over to Chinese authorities in March 2008.

Blocked from the Inner Mongolia region

MSF tried to open a multi-drug-resistant tuberculosis programme in the Inner Mongolia region, where an estimated 6.5 per cent of people who tested TB-positive and haven't received treatment are infected with a drug-resistant strain. Repeated negotiations with Chinese authorities aimed at signing a memorandum of understanding were unsuccessful. In early 2009, MSF gave up trying to open the programme.

MSF has worked in China since 1988.

GEORGIA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion**
FIELD STAFF **164**

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

TB is the scourge of the Caucasus region: it is estimated that ten per cent of new cases are drug resistant, but that as many as half the people who have already been treated have developed DR-TB. In 2008, an average of six to seven new patients with DR-TB were admitted every month to the Zugdidi project. Since the opening of the programme in November 2006, more than 150 patients have been treated. They have adhered well to the treatment, but it is still lengthy and difficult and the drugs cause many side-effects. The war in August 2008 briefly interrupted treatment for 30 per cent of the patients.

In July 2008, the first Zugdidi programme patient completed his treatment, having taken handfuls of medicine daily for 20 months. Although it is still too early to declare him fully cured, given the risks of relapse, the fact that he finished the course is encouraging. Since then, nine further patients in Zugdidi have finished the treatment programme.

In Abkhazia, MSF treats patients in Gulripsh, near the capital Sukhumi. MSF has supported the national TB programme in Abkhazia since 1999 and, since 2001, has focused on DR-TB. Since then, 204 patients with DR-TB have begun treatment, 38 of those in 2008. MSF refurbished the hospital near Sukhumi and supplied it with drugs, materials and laboratory equipment. A third of the MSF patients have few material resources and, without the psychological and social support, firewood, clothes, proper nutrition and other necessities that MSF provides, many of them would be unable to follow their treatment correctly.

MSF introduced life-prolonging antiretroviral therapy (ART) in Abkhazia for HIV/TB co-infected patients. Currently nine patients are on ART. MSF also supports the newly opened national DR-TB programmes in the Georgian cities of Tbilisi and Abastumani, providing training for local nurses and adherence counsellors.

The health access programme for vulnerable people in Abkhazia has been downsized. In 2008, 143 vulnerable people, mainly elderly, were registered in the programme.

Assisting those displaced

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

MSF has worked in Georgia since 1993.

'These first recoveries are very encouraging for the 93 patients undergoing treatment. For doctors, nurses and all the staff, it's a daily struggle to ensure that patients retain the strength to continue their treatment.' Jocelyne Madrilène, head of mission

© Julie Damond

INDIA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **394**

© Sami Siva

Despite India's fast economic growth, millions of people have limited or no access to healthcare. MSF provides medical assistance to people affected by conflicts or natural disasters in rural India and offers tuberculosis (TB) and HIV/AIDS treatment to marginalised groups in Mumbai and Manipur.

MSF provides free care and treatment to groups who can become marginalised from society, such as transgender, commercial sex workers or homosexuals who have not been able to access HIV/AIDS healthcare through the public health system. Working in a clinic in south Mumbai, MSF also offers services preventing mother-to-child transmission of HIV, and has trained NGOs and Ministry of Health staff in HIV testing and counselling. Throughout the year, MSF conducted more than 4,200 consultations in Mumbai and more than 300 patients started antiretroviral therapy (ART).

In the northeastern state of Manipur, which has been affected by a chronic low-intensity conflict, MSF runs four clinics providing basic healthcare, HIV/AIDS and TB treatment and counselling as well as maternity services.

In 2008, MSF conducted more than 50,000 consultations in Manipur. MSF has so far put 781 HIV-positive patients on ART, about a quarter of them have now been transferred to the national HIV/AIDS programme.

Primary healthcare in Chhattisgarh and Andhra Pradesh

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

Kala azar (visceral leishmaniasis) in Bihar

MSF provides free diagnosis and treatment for people suffering from kala azar in Vaishali district in Bihar state. In 2008, more than 4,800 patients were screened for the disease and 1,974 received treatment with liposomal amphotericin B – a relatively new therapy for the disease. The success rate for treatment is very high: more than 98 per cent of those treated recover.

Mental health in Kashmir

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

Emergency response

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

MSF has worked in India since 1999.

'Most people have heard little if anything about visceral leishmaniasis. This serious disease is best known as kala azar, and the incidence in India is amongst the highest in the world. Up to 90 per cent occurs in just one state – Bihar. This disease mainly affects the lowest castes, the poorest of the poor. The most frequent treatment for kala azar in Bihar is old, painful and, to cap it all, barely effective. But without treatment the disease is almost always fatal. The MSF team working in Bihar, at Hajipur hospital, are using for the first time on a large scale a drug that shortens treatment to just ten days and has a success rate of over 98 per cent. Our patients are living proof. Seeing how they improve day after day is a marvellous experience.'
Dr Gaurab Mitra, MSF doctor

INDONESIA

REASON FOR INTERVENTION • Social violence/Healthcare exclusion • Natural disaster • Endemic/Epidemic disease
FIELD STAFF 137

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

Responding to emergencies

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

When the powerful cyclone Nargis struck nearby Myanmar in May 2008, the MSF emergency team in Indonesia reacted rapidly: within a month, eight chartered flights containing 39,000 tarpaulins, 14,400 hygiene kits and other items – 260 metric tonnes altogether – were sent from Jakarta, to assist the victims.

Treatment for a neglected disease

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

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

Focus on mother and child

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

MSF has worked in Indonesia since 1995.

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KYRGYZSTAN

REASON FOR INTERVENTION • Social violence/Healthcare exclusion
FIELD STAFF 48

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

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

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

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

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

MSF has worked in Kyrgyzstan since 2005.

'The main difficulties faced by released prisoners who need to continue their treatment for TB involve the lack of interaction and information between the prisons and the outside world. TB is a complex, multi-faceted problem in society, and it cannot be handled by medical treatment alone. We can see the political will to resolve these problems, but in reality not much is being done.'

Markus Frits, head of mission

MYANMAR

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **1,427**

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


© Eyal Warshawski

Emergency relief after Cyclone Nargis

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

Between May and November, around 450 staff assisted a population of more than 520,000 people throughout four townships - Laputta, Ngapudaw, Phya Pon, Bogaley (comprising more than 1,100 villages), until emergency needs had been met. However a number of MSF activities, primarily nutrition and mental health, continued in some of the harder to reach areas which lacked adequate assistance. These programmes have now finished. Meanwhile, ongoing support for reconstruction, especially livelihoods, nutrition, and water & sanitation remains crucial throughout the Delta.

Assisting Myanmar's vulnerable

For the hundreds of thousands of people suffering from treatable infectious diseases such as malaria, tuberculosis and HIV/AIDS, the chronically under-resourced healthcare system provides little assistance. The government spends just 0.3 per cent of its gross domestic product on healthcare, the lowest proportion worldwide. Official development aid to Myanmar is also one of the lowest per person worldwide.

HIV/AIDS: a preventable fate

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

HIV/TB co-infection

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

Malaria

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

MSF has worked in Myanmar since 1992.

NEPAL

REASON FOR INTERVENTION • **Armed conflict • Natural disaster • Endemic/Epidemic disease**
FIELD STAFF **114**

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

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

Patients in mobile clinics

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

Safe deliveries

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

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

Responding to malnutrition and cholera

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

Koshi floods

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

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

MSF has worked in Nepal since 2002.


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PAKISTAN

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

FIELD STAFF 478

Throughout 2008, there were increasing numbers of attacks on civilians leading to the displacement of hundreds of thousands of people. People's overall health and living conditions have greatly deteriorated in a country that already had high infant and maternal mortality rates. Women and children in the rural areas of North West Frontier Province, the Federally Administered Tribal Areas and Balochistan are particularly vulnerable due to a shortage of medical staff and unaffordable health services. While needs have increased dramatically, insecurity and targeted attacks on aid workers have made it extremely difficult to provide assistance.

IN MEMORY

On February 1, 2009 two MSF staff were killed during fighting in Swat district, north-western Pakistan. Riaz Ahmad, 24, and Nasar Ali, 27, had left Mingora, the main town in Swat valley, in two ambulances to collect people injured during fighting in nearby Charbagh and bring them to the hospital for treatment. Tragically their ambulances, though clearly identified as medical vehicles, came under fire inside Charbagh and both men were killed.

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


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

As local health clinics began to close due to fears of insecurity, MSF opened mobile clinics in partnership with local providers and established a clearly identifiable ambulance service to bring patients safely to hospitals. During the many curfews imposed by the military, the MSF ambulance was one of the only vehicles allowed to travel around, transporting 700 patients over a five-month period – primarily women in labour and victims of violence. However in Swat this service was suspended after two MSF staff members were caught in cross fire and killed.

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

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

Earthquake response

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

Treating infection

In Mansehra district MSF set up a programme to respond to the parasitic infection cutaneous leishmaniasis. MSF teams estimate that in some villages 60 to 70 per cent of children are infected. Cases are referred to the hospital in Darband in Mansehra district, where an MSF medical team works in the outpatient department and hospital wards and supports the management of emergency cases.

Refuge assistant

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

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

MSF has worked in Pakistan since 2000.

PAPUA NEW GUINEA

REASON FOR INTERVENTION • Social Violence/Healthcare exclusion

FIELD STAFF 32

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


© MSF

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

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

MSF has worked in Papua New Guinea since 2007.

Naomi is a 30-year-old single mother and HIV/AIDS activist who lives in Lae.
'I was a victim of a robbery and rape. They took my bag then one chased me and when I fell down he tried to stab me with a knife and he raped me. After it happened I had flashbacks and nightmares and when I came to see the counsellor she talked to me and told me it wasn't my fault. She helped me – I did what she said and it helped me, I'm happy now. As a patient here, I'll try to make women and abused children aware of treatment and counselling.'

PHILIPPINES

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **2**


© Andrew Caballero-Reynolds

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

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

MSF has been providing medical treatment, clean water and sanitation services to displaced people in Region XII and ARMM (Autonomous Region of Muslim Mindanao).

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

MSF teams also ran mobile healthcare clinics in ten locations for the displaced population, and carried out some 3,000 medical consultations. Most of the cases were directly related to the harsh living conditions – respiratory tract infections from sleeping outside and diarrhoea from drinking contaminated water.

MSF started in the Philippines in 2008.

SRI LANKA

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

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

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

In 2008, MSF supported local hospitals in the government-controlled areas close to the conflict in Point Pedro, Vavuniya and Mannar. MSF also worked in Kilinochchi (Vanni area), an LTTE-held territory, until the government ordered all NGOs to leave the conflict area in September 2008. The projects offered medical and surgical support as well as obstetric and gynaecological treatment and emergency care. In 2008, MSF conducted 2,550 deliveries and assisted in 1,885 surgical interventions in partnership with the Ministry of Health. MSF has been asking the authorities for access to the area since it was expelled, to provide medical assistance to the thousands of trapped civilians.

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

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

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

MSF has worked in Sri Lanka since 2007.


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THAILAND


© Espen Rasmussen

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

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

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

REASON FOR INTERVENTION **• Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion**
FIELD STAFF **221**

MSF is providing medical assistance to displaced people and vulnerable groups, ethnic minorities and migrants who would not otherwise be able to access healthcare.

HIV/AIDS: handover of projects

MSF introduced antiretroviral therapy (ART) in Thailand in late 2000. This played a key role in showing that lifelong and complex HIV/AIDS care and treatment can be implemented in settings that are less developed. Working closely with the Ministry of Health and local partners, MSF has offered treatment and care to thousands of patients over the years. MSF has also supported HIV/AIDS patient groups and Thai civil society in their fight for access to high-quality and affordable treatment through the production of generic drugs. Widely praised for its universal access to ART, Thailand has progressively improved its capacity and the quality of the treatment and care available. The Thai government has been able to include an increasing number of patients from ethnic minority groups and migrants in its national health scheme, and MSF progressively handed over all its HIV/AIDS projects throughout 2008.

Tuberculosis: Mae Sot

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

Malaria: Sangklaburi/Mon State

In Sangklaburi, along the border with Myanmar, MSF is running a cross-border malaria project that supports ethnic Mon living in resettlement sites and villages inside Mon State (Myanmar). Malaria is endemic in the area and MSF carried out more than 13,542 consultations in 2008, confirmed 4,360 cases of malaria and distributed 8,381 bed nets, meeting the needs of 16,698 inhabitants. MSF has also provided essential drugs to nine health posts in Mon State, and runs small vaccination campaigns regularly.

Providing primary healthcare to Lao Hmong refugees

MSF has been providing primary healthcare to the Lao Hmong in Huai Nam Khao village, Petchabun province, northern Thailand, since July 2005. In 2008, the Thai government repatriated more than 2,000 people to Laos, leaving only 5,700 Hmong in Petchabun by the end of the year. In protest the Hmong staged a march, hundreds began a hunger strike and the camp was set on fire. This left the displaced with limited access to safe drinking water and inadequate sanitary conditions for weeks. MSF is the only health organisation active in Petchabun and has repeatedly denounced the forced repatriation of Hmong people. In 2008, MSF conducted more than 27,600 consultations, mainly for respiratory infections, diarrhoea, and skin infections. This also included more than 2,500 antenatal care consultations, an important focus for the project. Three psychologists are providing mental-health support and MSF is in charge of the distribution of food and non-food items in the camp.

In Phang Nga, MSF has been providing healthcare to undocumented migrants crossing from Burma to work in Thailand. MSF runs mobile clinics at migrants' work sites and supports the local hospital and health posts. In 2008, more than 3,600 medical consultations were carried out at the hospital's outpatient department and 235 patients were hospitalised. MSF also conducted over 1,500 antenatal consultations and 222 deliveries. In December MSF began the handover of its activities, which should be finalised by mid-2009.

MSF has been working in Thailand since 1985.

TURKMENISTAN

REASON FOR INTERVENTION
• Social violence/Healthcare exclusion
• Endemic/Epidemic disease
FIELD STAFF **65**

The MSF mission in Turkmenistan operates in a restrictive context that limits its ability to implement effective medical programmes. There is little reliable data on death and disease in the country: officially, diseases such as HIV/AIDS do not exist in Turkmenistan, and the true prevalence of other infectious diseases is extremely difficult to establish. Meanwhile, people suffering from such diseases have no access to treatment, so their condition worsens and the risks to public health grow.

MSF has been in Turkmenistan since 1999 and is currently working in Magdanly, in the remote eastern Lebap Velayat region. There, MSF is supporting paediatric and maternal health, and laboratory activities at the local district hospital.

MSF works in an advisory capacity and carries out visits to nearby health posts. One of the main activities is the training of local doctors and nurses up to international standards to treat diseases. Teams also refurbished the local medical facilities, and provided drugs, medical materials, and laboratory equipment.


© James Kambaki

MSF is negotiating to start a new project in Turkmenabad, the second-largest city in the country. This project will focus on treating patients with TB, including drug-resistant strains, and patients who are co-infected with HIV. These will be the first such services to be available in Turkmenistan.

MSF has worked in Turkmenistan since 1999.

UZBEKISTAN

© Stephan Grosse Rueschkamp

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
FIELD STAFF **96**

In Karakalpakstan, an autonomous region of Uzbekistan, MSF treats multi-drug-resistant tuberculosis (MDR-TB). Many patients need to be admitted to hospital. MSF is in its second year of handing over treatment to the Ministry of Health. Patient management for new admissions was formally handed over in July 2008.

The incidence of MDR-TB in the region is one of the highest in the world – estimated at 13 per cent among new cases of tuberculosis and 40 per cent among people who have been treated previously. Some patients develop strains of TB that are resistant to the second-line drugs designed to treat drug-resistant TB.

In 2008, more than 230 people were admitted to the MSF hospital in Nukus, the regional capital. The number could have been higher but the Ministry of Health had to restrict admission of new patients due to delayed approval to supply second-line TB drugs. Overall, 830 patients were enrolled in the MSF programme.

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

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

MSF has worked in Uzbekistan since 1997.

Makset, 36, has been being treated for MDR-TB since August 2006. He was supposed to complete his treatment in May 2009. After his sputum smear test showed that he was no longer infectious he was discharged from the hospital to start the outpatient phase – only to return shortly afterwards. He lived too far away to get to his treatment regularly and had no food to eat; he was moved to the TB-negative ward of the hospital to be cared for. In early 2009 he became contagious again and had to move back to the regular TB ward. For over two years, Makset has hardly left the hospital. Like him, many patients spend months in the negative ward because they have nowhere suitable to go. Some have no home; others are rejected by their family due to the stigma and fear associated with the disease.

The Americas

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BOLIVIA

REASON FOR INTERVENTION • Endemic/Epidemic disease
FIELD STAFF 33

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

MSF opened a project in Sucre in 2005, and improved access to diagnosis and treatment for under-18s in this semi-urban setting. The project was finally closed in March 2008.

In Cochabamba, MSF worked in five health centres with the Ministry of Health, aiming to integrate the diagnosis and treatment of Chagas into the health system. Weekly follow-ups allow side-effects to be detected in time to transfer patients to the hospital if necessary. In 2008, more than 500 patients were treated.

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

MSF has worked in Bolivia since 1986.

Pamela from Cochabamba is the 21-year-old mother of Griselda, one, and Kevin, three.
'One day I was in the health centre waiting for the doctor and a woman approached me and started talking about Chagas. I did not pay attention to her until she mentioned that the vinchuca was the insect that transmitted the disease. I realised my house was full of them when I was a girl. She persuaded me to take the test. I was positive, and my children were, too. I cried a lot. I had transmitted the disease while I was pregnant. We were all treated and now we are fine. I am very grateful I could get the medication free, since few health centres give it freely and even fewer give it to people over 15 years old.'

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

Rosario, patient from the Cerro Verde health centre

© Roberto (Bear) Guerra

BRAZIL

REASON FOR INTERVENTION
• Social violence/Healthcare exclusion
FIELD STAFF 45

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

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

Living permanently surrounded by violence has a serious impact on people's mental health. MSF provided psychological support to approximately 900 people in 2008. Most of them had been caught up in fighting or had directly witnessed acts of violence. One in ten has had a family member murdered.
To promote the services available at the centre, a team of four community health workers liaises with schools, churches and other local institutions, organises activities in the streets and conducts home visits.

MSF has worked in Brazil since 1991.

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

Patient at the MSF emergency unit in Complexo do Alemão

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

Gianfranco De Maio, medical doctor

COLOMBIA


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REASON FOR INTERVENTION
• Armed conflict • Social violence/Healthcare exclusion
FIELD STAFF **294**

Territorial conflicts linked to the narcotics trade caused increasing numbers of people to flee their homes in Colombia in 2008, aggravating the country's alarming humanitarian crisis. Assistance for those most affected, including the provision of healthcare, is limited. Mental-health care for victims of violence is needed across the country. People living in rural areas and in marginalised urban areas continue to suffer from diseases that could be easily prevented and treated.

There are MSF programmes in 17 of Colombia's 32 departments. The range of services includes: primary healthcare, mental-health programmes, mobile clinics in urban and rural areas, reproductive healthcare, emergency obstetric care and assistance to victims of sexual violence, antenatal care, water sanitation, basic refurbishment of health structures, voluntary counselling treatment, pregnancy termination and emergency response.

In the Uraba region, mobile clinics provided medical access to the most isolated communities in the rural areas surrounding Saiza and in Rio Sucio. Here MSF also supported hospital services, offering mental-health and reproductive services and carried out more than 14,700 consultations. In the Norte de Santander department, the teams assisted communities isolated by conflict in El Tarra and La Gabarra. Through mobile clinics, they provided more than 8,400 consultations to rural people who had been forced to flee their homes.

In the Sucre and Bolivar departments, MSF gained greater access to the disputed Montes de Maria region. MSF provided basic healthcare in mobile clinics and carried out more than 10,550 consultations. Services in Sincelejo focused on the basic and reproductive health of people who had been forced to flee their homes, supporting those affected by sexual violence and providing access to HIV testing and counselling.

In the urban area of Buenaventura, MSF set up a fixed health post, mobile clinics in the neighbourhood and a referral system to the state's healthcare facilities. The programme has offered care for victims of sexual violence, reproductive healthcare, paediatric care and psychological assistance, providing 8,375 medical consultations. A mobile medical team also works on the border between Meta and Guaviare, where the team gave 4,650 medical consultations.

In Tolima's southwest areas, where access to healthcare has improved significantly, MSF gave more than 6,470 medical consultations.

There were also 8,670 medical and 180 psychological consultations conducted through mobile clinics in Barbacoas, Magui Payán and Roberto Payán. The medical activities were closed in October 2008. However a reduced team remained in the area attending to displaced people who continued to arrive in Barbacoas. MSF provided medical care (including psychological care and health promotion) in the Piamonte municipalities of Cauca and Puerto Guzman in Putumayo. In 2008, 5,860 medical and 755 psychological consultations were conducted in mobile clinics.

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

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

In the municipality of Tame, MSF teams provided more than 15,000 consultations, giving primary, family planning and antenatal healthcare and psychological support.

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

MSF has worked in Colombia since 1985.

GUATEMALA

REASON FOR INTERVENTION **• Social violence/Healthcare exclusion**
FIELD STAFF **21**

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

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

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

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

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

MSF has worked in Guatemala since 1984.


© Marcell Nimfuehr

HONDURAS

REASON FOR INTERVENTION **• Social violence/Healthcare exclusion**
FIELD STAFF **46**

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


© Claude Mahoudeau

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

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

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

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

MSF has worked in Honduras since 1988.

HAITI

REASON FOR INTERVENTION
• Social violence/Healthcare exclusion • Natural disaster
FIELD STAFF 813

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

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

MSF provides surgical care at the centre. In 2008 more than 17,950 patients were treated, and more than 6,100 underwent surgical interventions.

Pacot rehabilitation centre

MSF operates a physical rehabilitation centre where patients in need of specialised post-operative treatment receive physiotherapy and psychological care. Here, more than 600 patients were hospitalised and more than 10,900 people were given orthopaedic consultations.

Treatment for victims of sexual violence

MSF increased its capacity to treat victims of sexual violence in the capital, offering comprehensive psychological and medical care. The programme treated 468 people in 2008, 51 per cent of whom were under 18 years old. Awareness campaigns in the shantytowns and city centre continued, emphasising that women need to receive treatment within 72 hours of an attack.

Jude Anne emergency obstetric hospital

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

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

Martissant emergency rooms and mobile clinics

Since December 2006, MSF has worked in the slum of Martissant, in Port-au-Prince, to assist a population that is heavily affected by armed violence. The medical team has an emergency room where patients are stabilised, and refers those in need of surgery to other hospitals in the city. Until December 2007, mobile clinics offered first medical assistance in different parts of the slum, but now patients are coming directly to the clinic. In 2008 MSF teams received 25,445 patients – 16,942 of whom were trauma patients.

Emergency response after hurricanes

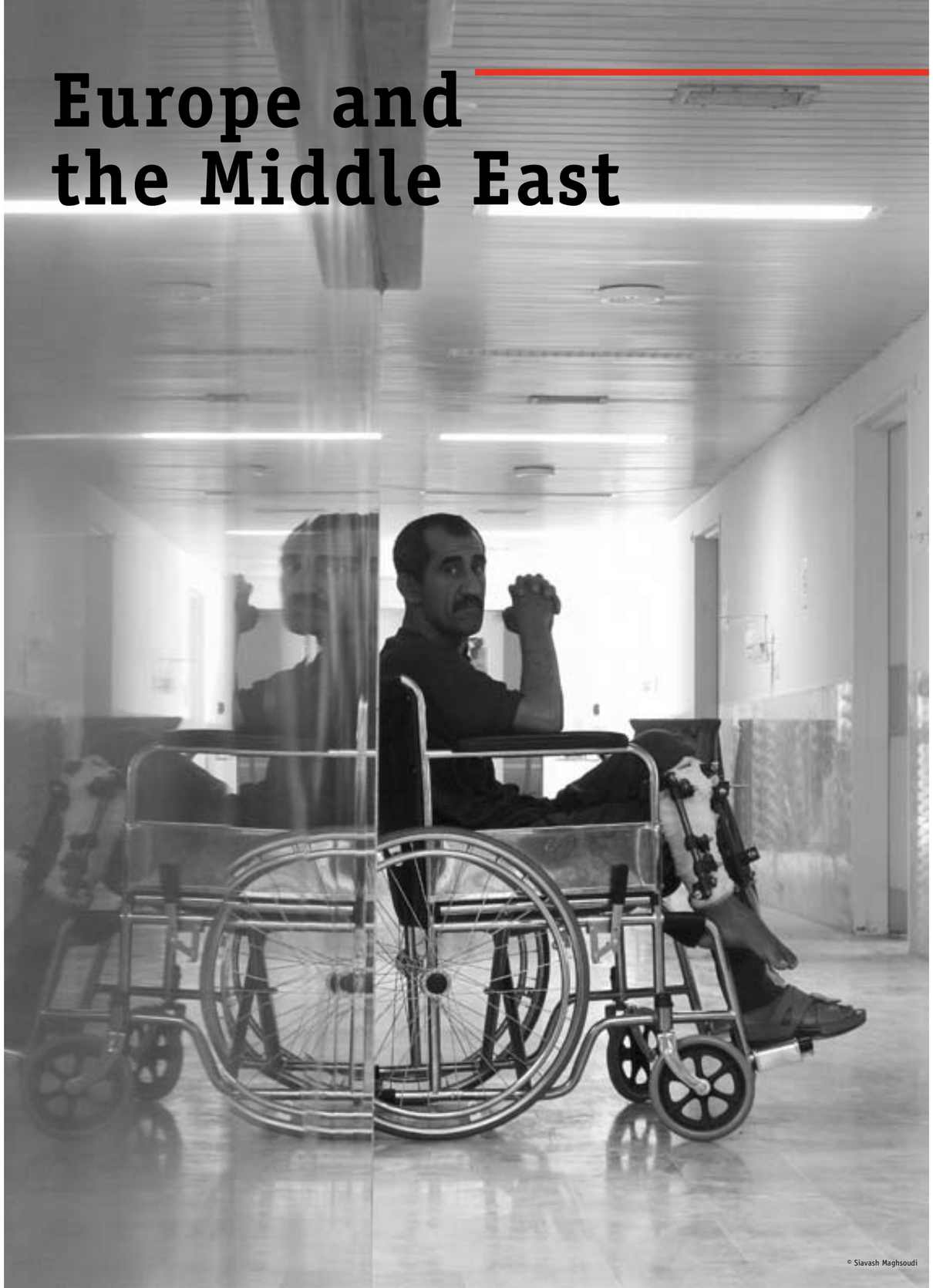
Following two tropical storms and two hurricanes that hit Haiti at the end of August and beginning of September, MSF launched an emergency intervention in the town of Gonaïves in the north of the Artibonites. MSF re-opened an 80-bed hospital in Gonaïves in cooperation with the Health and Population Ministry. This structure is the only one in the region that can respond to emergencies and provide obstetric and paediatric services. During the last three weeks of 2008, 675 patients were admitted to the emergency room and more than 110 deliveries and 50 surgical interventions were performed.

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

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

MSF has worked in Haiti since 1991.

Europe and the Middle East



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BELGIUM

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

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

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

In Antwerp, MSF continues to provide medical and psychosocial consultations to people who cannot access them through normal channels. More than 2,000 consultations were conducted in 2008: most of the patients were undocumented migrants and asylum seekers. Rather than create a parallel system, MSF aims to direct people towards the national system responsible for providing the service. MSF will hand over its activities in Antwerp at the end of April 2009.

MSF has worked in Belgium since 1987.

FRANCE

REASON FOR INTERVENTION • Social violence/Healthcare exclusion
FIELD STAFF 11

In response to the difficulties some asylum seekers and non-French-speaking patients face in accessing psychological care in France, MSF set up a new programme in Paris in 2007. It aims to provide medical and psychological care to these people, as well as social support.

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

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

The precarious conditions in which people without valid immigration papers live, combined with what they went through in their home countries, make them extremely vulnerable. They are likely to suffer from high levels of anxiety. Psychological care is therefore essential to avoid a deterioration of their condition, which can lead to suicide attempts. Of the patients attending the centre, 41 per cent have reported that they have had suicidal thoughts.

MSF has worked in France since 1987.

L was born in Afghanistan, some 30 years ago. Like most Afghans, he reached France after a long and painful journey across Afghanistan, Iran, Turkey, Greece and Italy. Part of his family died in a bombing in Afghanistan. He fled his country with his wife and children to seek refuge in Iran because he was scared. L travelled alone to France. He is in constant fear of being sent back to Afghanistan. He has applied for asylum, but his request has been rejected, and he no longer has the right to remain on French territory.
L has been receiving healthcare at the MSF centre for a year, supervised by an MSF psychologist. The violence he shows towards himself reveals his distress. Every day, his thoughts are haunted with what he suffered in Afghanistan.

© Julien Lévêque

GREECE


© Giorgos Moutafis

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

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

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

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

Lesvos island

In June, MSF started work at the detention centre of Lesvos island and at the port landing point, providing medical, psychological and humanitarian assistance. However, MSF decided to end the intervention in September due to limited access to the detention centre, which severely affected efforts to provide medical assistance and improve the undocumented migrants' living conditions. 'There were many occasions when the medical team had to examine patients through bars, since the migrants were not allowed to leave the rooms,' explained Yorgos Karagiannis, head of the MSF mission in Greece. Despite the limited access, MSF carried out more than 1,700 consultations at the Lesvos detention centre, addressing pathologies such as respiratory infections, dermatological diseases, anxiety, post-traumatic stress disorders and depression.

Makeshift migrant camp in Patras

Patras is the main exit port to Italy. During the past ten years there has been a constant influx of migrants crossing to Italy hidden inside trucks. The makeshift migrant camp in Patra is a shantytown of cardboard, plastic and wood structures that have no heating or electricity. It hosts mainly people from Afghanistan and Iraq. In May MSF opened a clinic inside the camp, providing primary healthcare services and psychosocial support to the undocumented migrants. The teams also carried out regular educational activities to improve good hygiene, sanitation and disease prevention practice. The people's main medical problems were skin diseases, respiratory infections and gastrointestinal disorders. Bruises and other injuries were also common, resulting from migrants' frequent attempts to board ships leaving the port, or from resisting arrest. By the end of December, MSF teams had carried out 6,000 consultations, and more than 400 cases were referred to the local hospital.

MSF has worked in Greece since 2008.

ITALY

REASON FOR INTERVENTION • **Social violence/Healthcare exclusion**
FIELD STAFF **23**

Italy has experienced a growing influx of undocumented migrants and asylum seekers since 2002. Looking for refuge, jobs or better living conditions, these people bear the brunt of increasingly strict measures designed to deter migration. As these measures are tightened, so reception conditions deteriorate. As a result, these already vulnerable people face a system unable to meet their basic needs, including protection and healthcare.


© MSF

MSF provides healthcare to the migrant population, including seasonal migrant workers, and lobbies for better access to services and living conditions for them.

Naples is the third largest city in Italy. It attracts large numbers of migrants: an estimated 25,000 live there unofficially, outside the state system. They are excluded from society and public services. In order to improve their access to healthcare, MSF has set up clinics integrated into the country's national health services with a view to handing them over to authorities in the future. To reduce barriers created by the patients' irregular situation, assistance is provided in a way that ensures their anonymity. In 2008, MSF provided nearly 5,000 consultations in the clinics. To respond to the high incidence of sexually transmitted infections amongst female undocumented migrants, MSF also launched a sexual and reproductive healthcare programme that provided more than 1,000 consultations in 2008.

'The health problems we find are mainly osteomuscular, dermatological, respiratory and gastro-intestinal, all related not only to harsh working conditions but also to the unhygienic situation in which the people live. Seasonal migrant workers in southern Italy also have scant access to primary healthcare.'

Francesca Faraglia, MSF medical coordinator

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

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

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

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

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

MSF has worked in Italy since 1999.

MALTA

REASON FOR INTERVENTION • **Social violence/Healthcare exclusion**
FIELD STAFF **4**

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

© Elisa Finocchiaro

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

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

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

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

MSF has worked in Malta since 2008.

18-year-old S, a woman from Eritrea, arrived in Malta on August 24, 2008
'I escaped from Eritrea because I wanted to avoid being recruited to fight in the endless war against Ethiopia. In Libya I was put in a detention centre, where I was harassed, beaten, abused and raped several times. For two years, I was treated as a slave for the guards and soldiers.

'When I arrived in Malta I thought I would be free at last. As soon as I realised that I was going to be kept in a detention centre again, I lost hope and became severely depressed. I had difficulty in sleeping and had gastric and heart problems. Memories of the rapes, fears of guards and soldiers resurfaced and it was difficult to be crowded together with so many others.'

The MSF psychologist found S collapsed in the toilet zone and referred her to the hospital. After a few days in the hospital she tried to hang herself. After more than a month in the psychiatric hospital, she was sent back to the detention centre. Twenty days later, she tried to hang herself again. In mid-November, she was finally recognised as a vulnerable person, released from the centre and accommodated in an open centre.

MOLDOVA


© Alexander Gyadyelov

REASON FOR INTERVENTION • **Social violence/Healthcare exclusion**
FIELD STAFF **33**

Transnistria, a politically isolated and predominantly Russian-speaking region, is a strip of land separated from Moldova by the River Dniester. Once the scene of a violent separatist war, Transnistria is not recognised by the international community and little international aid has reached it despite the enormous assistance Moldova receives from international institutions to tackle the HIV/AIDS epidemic.

MSF, working with the Transnistria Ministry of Health, established the region's first HIV/AIDS programme in early 2007. Owing to the urgency of the situation, the first patients started receiving life-prolonging antiretroviral therapy (ART) four months before the first outpatient department opened in the main hospital of the capital, Tiraspol. MSF also extensively refurbished the hospital's laboratory and installed a new waste disposal system. The programme's activities were extended to weekly visits to Bender tuberculosis (TB) hospital for people co-infected with both diseases; to Slobozia, the region's only inpatient facility for HIV/AIDS patients; to Ribnitza in the north of the country to operate a weekly clinic in the city's polyclinic; and into the prison system where the incidence of HIV/AIDS is around 13 times higher than in civil society. The incidence of co-infection is also much higher, particularly co-infection with tuberculosis (TB). Previously prisoners had no access at all to specialised HIV care and treatment.

By December 2008, MSF was able to hand over all activities in the civil sector to the Ministry of Health. At this point, MSF and the ministry were jointly providing HIV care to around 860 patients – more than half the HIV-positive people registered in Transnistria. More than 180 of these people had been initiated on ART. MSF also trained hospital staff to ensure high-quality services. Most importantly, MSF's lobbying resulted in an extension of HIV/AIDS resources from Moldova to Transnistria. The prisoners' programme is scheduled to be handed over to the Ministry of Justice and the Ministry of Health early in 2009.

MSF has worked in Moldova since 2007.

Once a week the MSF team goes to Ribnitza, in the north of the region. On the way the team stops to see an HIV-positive young mother, who lives alone in a remote village. She comes to the mobile clinic every week to have her baby checked by the MSF doctors. The baby has not tested HIV-positive so far, but it will be some time before she can be certain her baby has not contracted the disease. She cannot buy food and essentials for her baby and cannot breastfeed, so MSF provides not only her ART drugs, but also food for the infant.

RUSSIAN FEDERATION

REASON FOR INTERVENTION • **Armed conflict • Social violence/Healthcare exclusion**
FIELD STAFF **292**

The MSF programmes in the North Caucasus, in Chechnya and Ingushetia provide surgery, mother-and-child healthcare, mental-health support, and tuberculosis (TB) care.

In the post-conflict region of Russian North Caucasus, the situation remains volatile. Security in Chechnya has improved, while in neighbouring Ingushetia it has worsened dramatically. For security reasons, visits by MSF international staff to the project sites remain short if regular, and much of the responsibility for running the programmes lies with the national staff.

Thousands of people who lost their homes during the wars are still living as refugees in Ingushetia or Dagestan, or in Grozny itself. MSF ran a medical centre in Nazran, Ingushetia, which provides medical and mental-health consultations for these people. The clinic conducted up to 1,200 consultations a month in 2008. Doctors provided women's and paediatric healthcare in clinics in Grozny. On average, more than 1,300 gynaecological consultations were provided each month in the Staropromyslovsky area. MSF also supported the Republican Women's Hospital in Grozny and district hospitals in the mountainous villages of Shatoy, Sharoy and Itum-Kale, supplying drugs and medical materials.

In 2006, MSF opened a surgery project in the republic's main hospital, Grozny Hospital Number 9, to treat long-standing injuries and chronic disabilities sustained in the war, and victims of road traffic accidents. In 2008, MSF operated on 445 patients and conducted 11,056 physiotherapy consultations here.

TB became a problem for the region after patients' treatment and follow-up were interrupted because of the war. MSF restored the remaining TB hospitals, set up waste-disposal facilities, trained the local medical staff and started treating patients. Early in 2008, the programme expanded to include a TB dispensary in the capital, Grozny. MSF will provide TB treatment throughout Chechnya, including to patients in the remote mountainous regions who had no access to TB care. Since the beginning of the programme in 2004, 1,800 patients have been treated.

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

Because MSF does not aim to duplicate the existing or emerging local services, a few MSF programmes in the region were closed down or handed over in 2008. MSF handed over the two refurbished polyclinics in Grozny in which teams had run free pharmacies and a reproductive health and family-planning clinic. Mobile medical teams no longer serve temporary accommodation centres in Grozny. In 2009, MSF will stop its emergency surgery programme in Grozny, since the number of interventions performed there each month is declining.

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

Magomed, 59, is on intensive TB treatment in the Grozny TB hospital. He feels weak and is partially deaf as a side-effect of TB medicines. Magomed first contracted TB five years ago when he was in prison. At the time, war was ravaging the land and there was no place and no means to treat people like Magomed effectively. Magomed didn't complete his treatment and this caused his current relapse. 'This disease is treacherous – it comes out of the blue, and takes a long time to get rid of,' he says.


© Misha Friedman

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

SWITZERLAND

REASON FOR INTERVENTION • **Social violence/Healthcare exclusion**
FIELD STAFF **4**

Meditrina, a project launched in 2006 in Zurich, provides medical care to people excluded from the state system. In late 2007, MSF decided to expand it by establishing contacts with the city's communities of illegal immigrants. The new strategy, which also involved diversifying the medical services offered, was aimed at boosting attendance at the centre. It quickly brought results: Meditrina staff provided an average of 120 consultations a month in 2008, approximately 60 per cent of which were for new patients.

Once Meditrina's services had been diversified, people suffering from chronic ailments such as hypertension, diabetes, tuberculosis, and HIV/AIDS were able to gain access to the care they needed.

To make the changes possible, the staff paid closer attention to the work done by mediators. The seven mediators belong to several communities of different origin, including Latin America, Southeast Asia, and East Africa.

They form a direct link between Meditrina and the people who use the service. Thanks to them, the necessary trust was more easily established and the benefits were considerable.

The medical work carried out through Meditrina revealed, as much for city officials as for local associations, how difficult it is for many people in Zurich to find treatment. The interest being shown by other institutions and associations makes the withdrawal of MSF and the handover of Meditrina's medical and social efforts in 2009 a possibility.

MSF has worked in Switzerland since 2003.

IRAN

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **96**

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

Iran is in economic crisis, and resentment towards refugees has increased. In November 2007, officially for security reasons, the government declared the regions next to the border 'no-go areas'. This included areas such as Sistan-Baluchistan, where more than half a million Afghans still remain illegally.

Iranian authorities estimate that most Afghans are economic migrants, and therefore are not entitled to legal status or access to free healthcare. In Sistan-Baluchistan, MSF continues to provide primary and secondary healthcare to this population, which has little or no access to the Iranian healthcare system. In 2008, the teams visited an average of 23 newly arrived families a week at Zahedan – an increase from an average of eight families a week in 2007.

MSF runs three medical clinics in Shirabad, Karimabad and Besat, offering free medical consultations and nutritional support for children. In 2008, MSF carried out an average of more than 7,000 consultations a month. MSF also refers patients to secondary structures and covers costs for specialist consultations, treatments and hospitalisation. A team of social workers is in place in the refugee community to identify people in need of medical care and to ensure they can access consultations. The team distributes material goods such as blankets and heaters where needed.

MSF has worked in Iran since 1996.

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IRAQ

REASON FOR INTERVENTION
• **Armed conflict**
FIELD STAFF **489**

In the sixth year of war the overall level of violence has decreased. Nevertheless, bombings and killings continue in many regions, causing dozens of deaths and injuries every week. Owing to security constraints, MSF cannot give direct assistance in the worst-affected areas. Aid to the Iraqi population is therefore delivered mostly from more secure parts of the country or from outside the border.

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

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

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

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

Cross-border support

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

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Reconstructive surgery

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

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

Psychological support

In Baghdad, central and south Iraq, MSF supports eight hospitals by providing medical material, equipment and training. Emergency psychological counselling has been introduced for victims of violence in four of these hospitals. In the northern governorates of Tameen and Ninewa, MSF supports five hospitals by providing medical supplies and emergency responses after violent incidents.

While the situation in Iraq remains violent and highly volatile, MSF hopes to seize the opportunity presented by some relative improvements in security to extend medical humanitarian assistance in 2009.

MSF has worked in Iraq since 2006.

New humanitarian concerns in Iraq

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

Nevertheless, the situation is still tense, especially in Baghdad and in northern areas: Kirkuk's future is still undecided, for example, and Mosul is still volatile. The withdrawal of foreign troops is increasing fears of a rise in violence, which will certainly have operational consequences for MSF.
MSF has worked hard to find the most appropriate approach in Iraq: the best way to balance serious security concerns against the medical needs of the people. The organisation has had to adapt quickly to establish networks and build trust with its counterparts in Iraq. For security reasons, MSF's operations are restricted to urban settings, so it is difficult to make an accurate assessment of the medical and humanitarian needs in rural areas. Teams have had to find ways to reach vulnerable people without endangering the organisation's reputation and the security of its staff. Many western NGOs, as well as the United Nations, are perceived to be allied with the American forces. This has blurred the important distinction between the armed coalition and humanitarian agencies, creating a challenge for MSF and underlining the critical importance of its neutrality, independence and impartiality in operational matters.
Since the Iraqi Ministry of Health has begun to take over healthcare provision, MSF has reduced the quantity of drugs it supplies and scaled down its support to health structures. MSF is now turning its attention towards more technical medical projects in Iraq, such as complex reconstructive surgery.

Caroline Abu-Sada, interim head of mission

LEBANON

REASON FOR INTERVENTION • **Social violence/Healthcare exclusion**
FIELD STAFF **8**

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

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

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

MSF has worked in Lebanon since 2008.

YEMEN

© Michael Goldfarb

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **352**

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

Healthcare for those affected by the conflict

MSF opened a project in Saada governorate in July 2007 to provide healthcare to people affected by the conflict, develop a capacity to treat war-wounded, and respond to the needs of displaced people during periods of fighting.

When the Fifth War broke out in 2008, MSF was running hospital and outreach activities in Haydan and in Razeh; and in Al Tahl, hospital and mobile primary health consultations for the nearby village of Dahyan. Although the security conditions during the war forced all expatriate teams to evacuate Saada governorate, some activities were maintained thanks to the Yemeni staff. International staff were able to return to Saada governorate in September 2008. At the end of the year, MSF still supported Al Tahl and Razeh hospitals as well as consultation activities in Dahyan, and operated a referral system to MSF secondary care facilities.

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

Assisting refugees from the Horn of Africa

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

MSF provides medical, psychosocial and humanitarian assistance to the refugees when they arrive. A mobile team attends to those in most urgent need on the shore before they are transferred with other new arrivals to a reception centre in the city of Ahwar. Refugees stay here for a few days to be registered. MSF has set up a health centre where medical assistance is available to everyone and vulnerable groups (women and children) are especially encouraged to attend consultation and undergo screenings and vaccination. In 2008, the MSF team in Ahwar helped almost 10,000 people.

MSF has worked in Yemen since 2007.

PALESTINIAN TERRITORIES


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‘It is essential that civilians, the health authorities and the humanitarian workers be respected by all parties to the conflict. That has not been the case thus far. Humanitarian law exists to be applied in all conflicts and to be respected by everyone, including governments.’
Dr Marie-Pierre Allié, president of the French section of MSF

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **127**

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

In the Gaza Strip

In three clinics MSF offers post-operative and physiotherapy treatment. The many wounded have no other access to this specialised care to help them regain their mobility and independence. In 2008, more than 480 patients were followed up via this programme.

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

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

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

The shortage of fuel seriously hindered MSF’s activities as well as those of the entire health system. In addition, the contradictory policies of the two Palestinian Ministries of Health, the internationally recognised Palestinian authority in Ramallah, and that of the de facto Hamas government in Gaza, led to the general strike of health workers that started on August 30.

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

In the West Bank

In 2008, at Nablus – which did not experience the same degree of violence as Gaza – MSF’s activities remained concentrated on mental health and medical and social support. Cooperation was established with the other local mental-health care providers and continued with mutual referral of patients. In 2008, more than 300 patients received care.
In Hebron, MSF aims to provide psychological, medical and social assistance to people suffering from the violent consequences of the Israeli-Palestinian conflict, especially those in the Hebron governorate.

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

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

The psychological services available to respond to the mental-health needs of the people living in the camp were inadequate. In response, in June 2008, after months of negotiations, MSF teams arrived to start a project to remedy this. Unfortunately the lack of cooperation and the hostility in the camp forced the closure of the project when it was still in its start-up phase.

MSF has worked in the Palestinian Territories since 1988.


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

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


© Frederic Sautereau / Oeil Pub

‘When I woke up at the hospital in Al Shifa, my leg had been amputated. I screamed. Everything seemed so unreal. But after all, it is not so serious. I am not sad. Naturally, when I see other people with two legs, it’s difficult, but it could have been worse. I am not going to stay at home. I intend to regain my independence and get a job.’

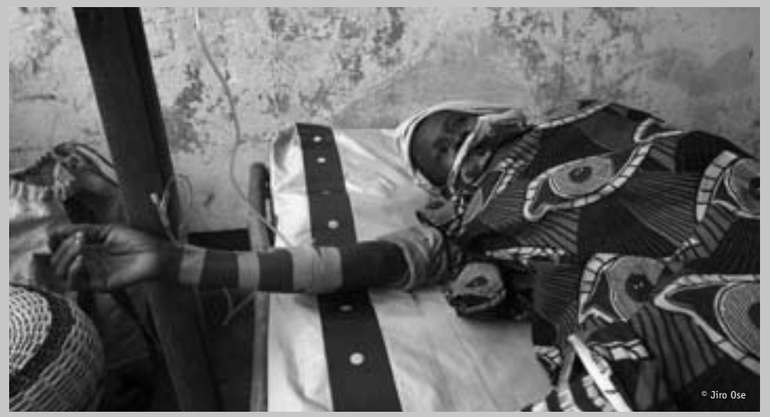
MSF COUNTRY PROGRAMME CLOSURES

CONGO-BRAZZAVILLE

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

MSF's hospital services included outpatient, maternity and emergency surgical care, treatment of infectious diseases such as tuberculosis and HIV/AIDS, and psychosocial counselling. Teams also provided healthcare through mobile clinics to communities near the towns of Mindouli and Kindamba. MSF provided 12,825 consultations in 2008.
MSF handed over its programmes at Mindouli and Kindamba hospitals in 2008. Those in Kindamba were handed over to the Ministry of Health and local partners, such as Psy Sans Frontières and Global Outreach Mission. Although those activities were closed in June, MSF returned to Congo for a three-month period later in the year to provide treatment for patients with human African trypanosomiasis (also known as sleeping sickness).

MSF worked in Congo-Brazzaville from 1997 to 2008.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CÔTE D'IVOIRE


© Thierry Oricot

After 18 years, MSF ended all its programmes in Côte d'Ivoire in October 2008.

Following the peace agreement signed in 2007, the dismantling of the *Zone de Confiance* and the gradual return of staff to medical facilities in the north and west, MSF carried out successive withdrawals from Bouaké, Guiglo, Man, Danané and Bangolo, although teams responded to a short-term nutritional crisis in Odienné, in the northwest of the country.

In March, teams handed over the mobile clinics and the mobile nutrition programme they had managed in the western region of Côte d'Ivoire to the local authorities.

Handing over the Bangolo programme, where 400 hospital admissions, 8,000 consultations and 130 deliveries had been provided each month, MSF lobbied for the free healthcare to continue.

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

LAOS

Five years ago, MSF was one of the first organisations in Laos to treat HIV/AIDS patients with antiretroviral therapy (ART). At the time, it was necessary to demonstrate that ART could be used effectively in remote, impoverished settings. The strategy included lobbying at national level for the adoption of ART, and the aim from the beginning was to hand the programmes over to Laotian health officials.
MSF's programmes were based at Savannakhet provincial hospital and at Setthathirath hospital in Vientiane.
In 2008, nearly 850 patients benefited from the ART provided free of charge by MSF. During the year the teams finalised the handover to local medical staff, who had been trained to work independently.

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

MSF worked in Laos from 1989 to 2008.


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Other information

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AUDITED FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, medical humanitarian organisation that is also private and not for profit. It comprises 19 national offices in: Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the UK and the US, and has an international office in Geneva.

The search for efficiency has led MSF to create specialised organisations called satellites to take charge of specific activities such as humanitarian relief supplies, epidemiological and medical research studies, and research on humanitarian and social action. They include: MSF-Supply in Belgium; MSF-Logistique, Epicentre, Fondation MSF, Etat d'Urgence Production, MSF Assistance, SCI MSF, SCI Sabin in France; Artze Ohne Grenzem Foundation in Germany and MSF Enterprises Limited in the UK. Because these organisations are controlled by MSF, they are included in the scope of the financial statements presented here.

The figures presented here describe MSF's finances on a combined international level. The 2008 combined international figures have been set up in accordance with MSF international accounting standards that comply with most of the International Financial Reporting Standards. The figures have been jointly audited by the accounting firms KPMG and Ernst & Young in accordance with international auditing standards. A copy of the full 2008 financial report may be obtained from the International Office upon request. In addition, each MSF national office publishes annual audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these reports are available from the national offices. The figures presented here are for the 2008 calendar year.
All amounts are in millions of Euros.

NB: Figures in these tables are rounded off and this may result in slight addition differences.

Programme expenses by country/region

Countries/Regions	in M€
Africa	
Sudan	47.2
Democratic Republic of Congo	43.8
Somalia	22.7
Ethiopia	22.1
Niger	21.1
Chad	20.4
Kenya	17.1
Zimbabwe	14.4
Central African Republic	12.8
Nigeria	9.7
Malawi	8.8
Uganda	8.7
Mozambique	8.6
Liberia	7.6
Burkina Faso	6.0
South Africa	5.1
Sierra Leone	4.3
Cameroon	3.9
Côte d'Ivoire	3.2
Guinea-Conakry	3.2
Mali	2.5
Burundi	1.9
Zambia	1.5
Swaziland	1.4
Congo-Brazzaville	1.0
Other countries*	2.0
Total	301.0

Countries/Regions	in M€
Asia/Middle East	
Myanmar	17.6
Iraq	12.2
India	6.2
Pakistan	5.2
Cambodia	4.4
China	4.4
Thailand	4.0
Yemen	3.8
Palestinian Territories	3.5
Iran	3.0
Georgia	2.9
Uzbekistan	2.0
Sri Lanka	1.8
Nepal	1.8
Bangladesh	1.5
Armenia	1.4
Indonesia	1.4
Other countries*	4.1
Total	81.2
Americas	
Haiti	14.3
Colombia	9.0
Brazil	1.0
Other countries*	2.4
Total	26.7
Europe	
Chechnya / Ingushetia / Dagestan	6.1
Russia	2.0
Italy	1.5
Other countries*	2.5
Total	12.1

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

Where did the money go?

Programme expenses* by nature

- National Staff | 28%
- International Staff | 23%
- Medical & nutrition | 22%
- Transport, freight, storage | 14%
- Logistics & sanitation | 7%
- Operational running costs | 5%
- Training & local support | 1%
- Other expenses | 1%

Programme expenses* by continent

- Africa | 70%
- Asia | 19%
- Americas | 6%
- Europe | 3%
- Non-allocated | 1%

project and coordination team expenses in the countries

Income

	2008 In M€	2008 In %	2007 In M€	2007 In %
Private	587.4	86.9%	518.7	87.6%
Public institutional	67.7	10.0%	54.2	9.1%
Other	20.3	3.0%	19.8	3.3%
Total income	675.4	100.0%	592.7	100.0%

How was the money spent?

Operations*	*494.8*	*76.3%*	*439.1*	*76.1%*
Témoignage	*24.7*	*3.8%*	*19.4*	*3.4%*
Other humanitarian activities	*7.2*	*1.1%*	*9.1*	*1.6%*
Total social mission	526.8	81.2%	467.6	81.0
Fundraising	81.2	12.6%	76.9	13.3%
Management, general & administration	40.2	6.2%	32.8	5.7%
Total expenditure	648.2	100.0%	577.4	100.0%
Net exchange gains & losses (realised and unrealised)	-4.7		-3.2	
Surplus/deficit	22.5		12.1	

* Programmes & HQ programme support costs

Balance sheet

(year-end financial position)	In M€	In M€
Non-current assets	37.0	37.1
Current assets	73.3	61.0
Cash & equivalents	375.6	350.2
Total assets	485.9	448.4
Permanently restricted funds	*2.5*	*2.5*
Unrestricted funds	*423.8*	*402.2*
Other retained earnings	*-13.9*	*-14.6*
Total retained earnings and equities	412.4	390.1
Non-current liabilities	4.6	3.5
Current liabilities	66.6	52.5
Unspent donor-restricted funds	2.3	2.3
Total liabilities and retained earnings	485.9	448.4

HR Statistics

International departures (full year):	4,617	100%	4,134	100%
Medical pool	1,052	23%	1,117	27%
Nurses & other paramedical pool	1,452	31%	1,303	32%
Non-medical pool	2,113	46%	1,714	41%
First time departures (full year):	1,142	* 25%	1,152	* 28%
* in % of total international departures				
Field positions:	25,973	100%	24,348	100%
International staff	2,029	8%	1,994	8%
National staff	23,944	92%	22,354	92%

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 2008, 89.9% of MSF's income came from private sources. More than 3.7 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF include ECHO (the European Commission's Humanitarian Aid Office), the governments of Belgium, Denmark, Germany, Ireland, Luxembourg, Spain, Sweden and the UK.

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

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

Unrestricted funds are unspent non-designated donor funds expendable at the discretion of MSF's trustees in furtherance of our social mission.

Other retained earnings represent foundations' capital as well as technical accounts related to the combination process, including the conversion difference.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. As of the end of 2008, the available part (the unrestricted funds decreased by the conversion difference) represented 7.6 months of activity. The purpose of maintaining retained earnings is to meet the following needs: future large-scale emergencies for which sufficient funding cannot be obtained, and/or a sudden drop of private and/or public institutional funding, sustaining long-term programmes (such as antiretroviral therapy), and pre-financing operations to be funded by forthcoming public funding campaigns and/or by public institutional funding.

Unspent temporarily restricted funds are unspent donor-designated funds that will be spent by MSF strictly in accordance with the donor's wishes (for example specific countries or types of interventions).

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

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