

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 nongovernmental 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 branch offices in 19 countries. In 2006, over 27,000 MSF doctors, nurses, other medical professionals, logistical experts, water and sanitation engineers and administrators provided medical aid in over 60 countries.

MSF ACTIVITY REPORT 06|07

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THE MEDECINS SANS FRONTIERES CHARTER

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

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

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

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

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

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The country texts in this report provide descriptive overviews of MSF work throughout the world between July 2006 and July 2007. Staffing figures represent the total of full-time equivalent positions per country in 2006. Reasons for Intervention classify the initial event(s) triggering an MSF medical-humanitarian response as documented in the 2006 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.

GUATEMALA HONDURAS

HAITI

COLOMBIA

ECUADOR

PERU

BOLIVIA

MOROCCO

BELGIUM

FRANCE

SWITZERLAND

ITALY

MALI

NIGER

CHAD

GUINEA

BURKINA FASO

NIGERIA

CENTRAL AFRICAN REPUBLIC

SIERRA LEONE

IVORY COAST

CAMEROON

REPUBLIC OF CONGO

DEMOCRATIC REPUBLIC OF CONGO

ANGOLA

ZAMBIA

SOUTH AFRICA





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© Sven Tomlin, Sudan

The Year in Review

Medical practise does not and cannot have double standards. So as health professionals we're constantly looking to provide the most effective healthcare possible for our patients. This is no easy task, and even if we're continually making progress, there's still a lot to do.

In 2006, MSF provided treatment for almost two million people with malaria. This disease is all too common in poor, tropical areas and remains responsible for large-scale loss of life, particularly among young children. In March 2007, we were pleased to see the launch of a new medicine combining two of the most effective molecules for treating this disease in one tablet. Named ASAQ, because it combines Artesunate and Amodiaquine, this new formulation is the work of the DNDi (Drugs for Neglected Diseases Initiative), of which MSF is one of the co-founders*. The DNDi should allow us access to another medicine in the next few months, this time combining Artesunate and Mefloquine – a combination required for the numerous regions where the most serious form of the malarial parasite has been highly resistant for some years.

At present we are treating 100,000 HIV/AIDS patients with daily anti-retroviral therapy (ART) in over 30 countries. This is obviously insufficient given the rising needs generated by the pandemic. AIDS is a disease that currently necessitates lifelong treatment. The virus' resistance to drugs after some years is a major concern for each of our patients and presents limitations to us as medical practitioners attempting to treat them. We have already observed this complication in South Africa, where 17 percent of our patients require a second line of medicines after only five years of ART. We need new medicines, and affordable ones, whether secondline drug regimens or access to a firstline that will remain effective over a longer period of time. This explains our mobilisation every time we have the impression that access to new medicines at affordable prices is under threat – such as when the laboratory Novartis launched a lawsuit against the Indian government this year to try to strengthen patent rules that would effectively reduce generic production capacity. We buy 80 percent of our anti-retroviral drugs from Indian generic producers and would not be able to find an equally affordable source in the immediate future.

In our daily practise of medicine in the field, the domain of maternal-infantile health remains a cause for concern and requires considerable innovative efforts. Therapeutic nutrition is a good example. In last year's report, we mentioned the increased number of nutrition cases treated in an emergency utilising

ready-to-use therapeutic food based on a nutrient-dense peanut-milk paste. With this we initiated an outpatient strategy, treating the vast majority of children affected by severe malnutrition in an area of Niger. We now know that the number of children we were able to treat increased about ten-fold and the cure rate was better than previous protocols requiring systematic hospitalisation and using therapeutic milk or enriched flour. We now apply this strategy everywhere, from West Africa, where severe infant malnutrition is recurrent in countries such as Niger, through to the displaced or refugee populations in Darfur and Chad. A lot still has to be done to extend the use of these new therapeutic

“We now know that the number of children we were able to treat increased about ten-fold.”

foods; to reduce the price of the raw materials they are made with, especially milk; and to get new compositions specifically for pregnant women and those with chronic illnesses. The availability of such a product is bringing a potential revolution for nutrition in resource-poor settings.

Overcoming this hurdle in the domain of nutrition should not, however, mask accumulated delays in the domain of preventive medicine, and two examples particularly stand out. First, vaccinations that could prevent deadly diseases such as meningitis are still too costly, or developed from pathogenic strains that bear no relation to those most commonly found in the poorest countries. Second, there is prevention of mother to child transmission of HIV. This issue is different in that the therapeutic protocol is known, involving medicines to be taken by mother and baby, but difficult to implement because of a lack of follow-up for pregnant women in countries with a limited health infrastructure. This presents a challenge for us, Médecins Sans Frontières, and we must take it on, because so far this prevention has been introduced in less than 15 percent of our missions involving more than 500 deliveries a year.

In addition to paediatrics and gynaecology-obstetrics, we are trying to explore and make fuller use of technical advances in other medical specialities, such as surgery. Over the past few years, we have progressed from practising a rather basic, so-called war and emergency surgery, to more programmed acts



© Francesco Zizola / Noor, Sierra Leone

targeting reconstruction – a specialty of particular interest in the case of large-scale orthopaedic or facial damage, or obstetric fistulas. This theme is developed further in the pages that follow in this report. The domain of infectious diseases is also important and takes up a large share of our practise, particularly in tropical areas. Here again, we need to revise our therapeutic tools. The antibiotic therapies currently in use should be reviewed to ensure ongoing and maximum effectiveness. This will require facilitating access to drug-sensitivity testing, whether for allowing the revision of protocols or for having a more specific impact on emerging and particularly drug-resistant strains of disease, such as tuberculosis (TB). We currently treat only one patient out of three for resistant forms of TB. This subject is also developed in the following pages as it amounts to a real emergency, including for our patients co-infected with HIV in Africa.

Whatever progress we bring to our medicine, it comes to nothing if we don't manage to access people who need it. We constantly have to adapt ourselves to the contexts in which we work, particularly armed conflicts. We are currently absent from, or our presence is too sparse in certain major contemporary crises, including Iraq, Afghanistan and Chechnya. The difficulty in accessing victims of conflict is nothing new for us, but the so called 'war on terror' and launching of military/humanitarian integrated interventions, even by the UN, is hampering the independence of humanitarian action. We don't consider this observation to be definitive, but we need to take it into account for the security of our teams and its impact on our ability to assist victims. Assisting populations caught in crossfire remains the core of our mandate, and there will be no way for us but to continue doing our best to reach them. Christopher Stokes offers an analysis of the situation in the following pages.

Darfur is incontestably one of the crises in which we have limited possibilities of deployment. This is despite the 2,000 people working in our different programmes there. We've had to evacuate certain of our missions over the past year, and many of the roads where we underwent targeted attacks have become impassable, especially since the number of parties to the conflict has increased following the partial signature of a peace agreement in May 2006. It's true we still cover the health needs of approximately half a million displaced persons throughout the region and that in the camps there has been no major outbreak because of an unprecedented deployment of aid. But, and Bruno Jochum



© Brendan Bannon, Kenya

reviews this situation in the following pages, most of these IDPs remain fully dependant on this external support and are subjected to a continuous threat of violence, both outside and even inside the camps. Moreover, we have only a limited access to the dispersed populations or those who stayed in their villages. This is one of our main concerns.

Our interventions will continue to focus on countries emerging from war and in emergency situations, despite the fact it is not easy to keep our maximum reactivity in these contexts. We have bigger but limited capacities. The association of our emergency specialty and our willingness to reach first and foremost the populations caught in crisis, leads us to hand over our activities when other actors are able to come in. Our actions and interventions are by essence temporary, and we have thus withdrawn from several countries this year. This does not mean these countries no longer need aid, but that we consider that the time has come for our responsibilities towards defined populations to shift into other hands, whether private aid organisations or public services. When the organisation has had a massive presence in a country for many years, as was the case in Angola, these departures require a great deal of planning, and represent another area where we intend to make improvements.

In 2006, Médecins Sans Frontières undertook over 9 million medical consultations, and hospitalised almost half a million patients. For this work and commitment to remain constant, the massive support we receive from individual donors worldwide remains crucial. It allows us to preserve our humanitarian identity and to maintain our independence to make decisions about where and how we will work, guided by the needs of our patients and independent from any power other than the medical-humanitarian imperative. It allows us to carry on our *actions de secours* in more than 60 countries. We are at work, wholly committed but always conscious of our own limitations - and always trying to push them back.

Dr. Christophe Fournier
President, MSF International Council

*alongside the Pasteur Institute, the Kenyan Medical Research Institute, the Indian Council of Medical Research, the Oswaldo Cruz Foundation in Brazil and the Ministry of Health in Malaysia.

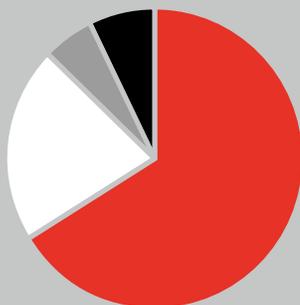
OVERVIEW OF MSF OPERATIONS

Largest Interventions Based on Project Expenditure

- 1 Democratic Republic of Congo
- 2 Sudan-North
- 3 Sudan-South
- 4 Niger
- 5 Liberia
- 6 Angola
- 7 Kenya
- 8 Chad
- 9 Somalia
- 10 Ivory Coast

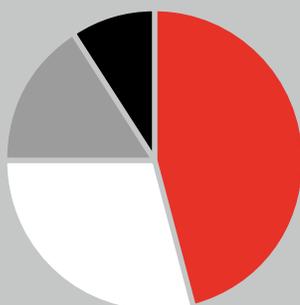
Project Locations

- Africa | 66%
- Asia | 21%
- America | 5.5%
- Europe | 7%



Context of Interventions

- Stable | 46%
- Armed Conflict | 29%
- Internal Instability | 16%
- Post Conflict | 9%



Event Triggering Intervention

- Armed Conflict | 37%
- Epidemic, Endemic Disease | 41%
- Natural Disaster | 5%
- Social Violence, Healthcare Exclusion | 17%



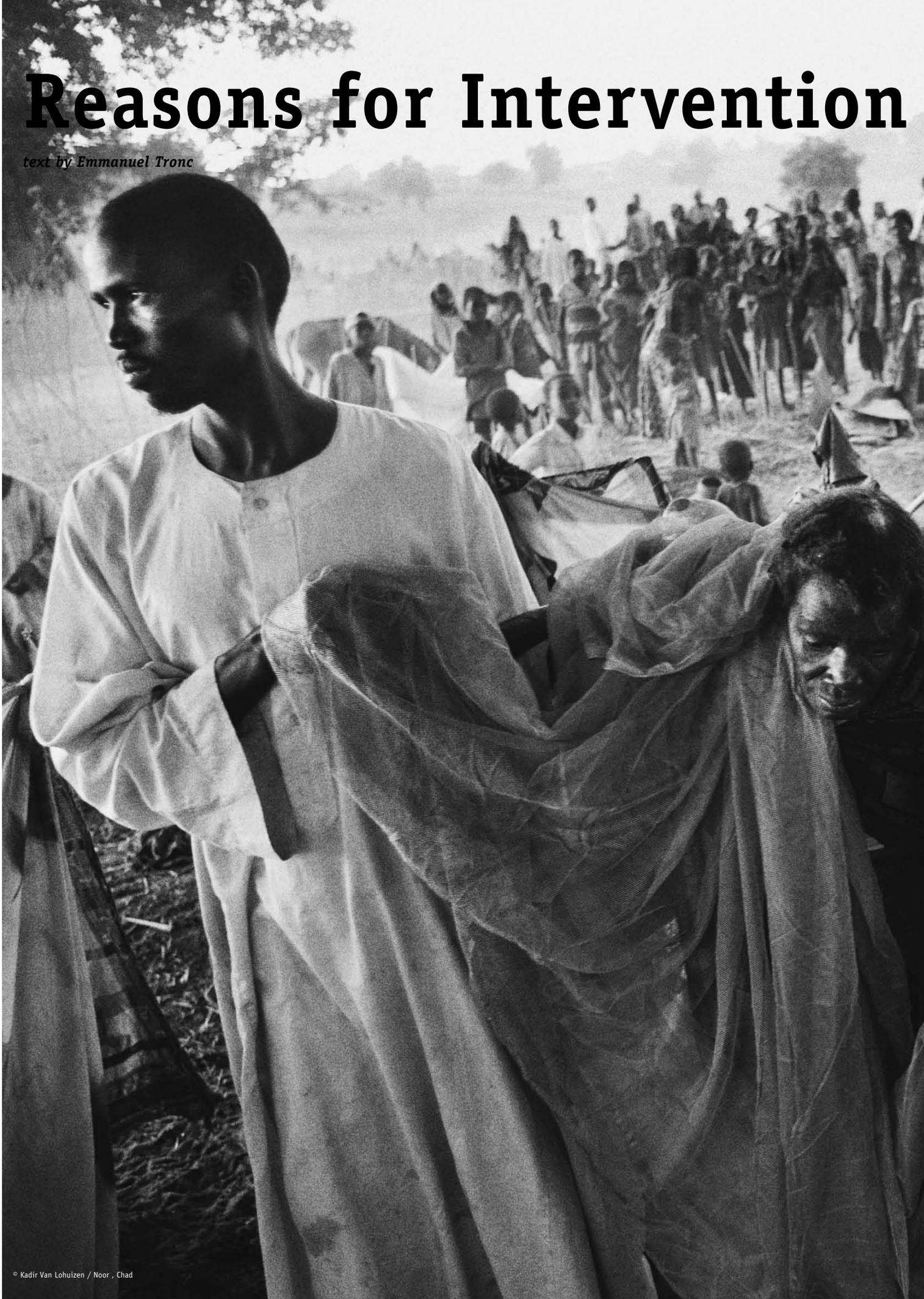
Activity Highlights

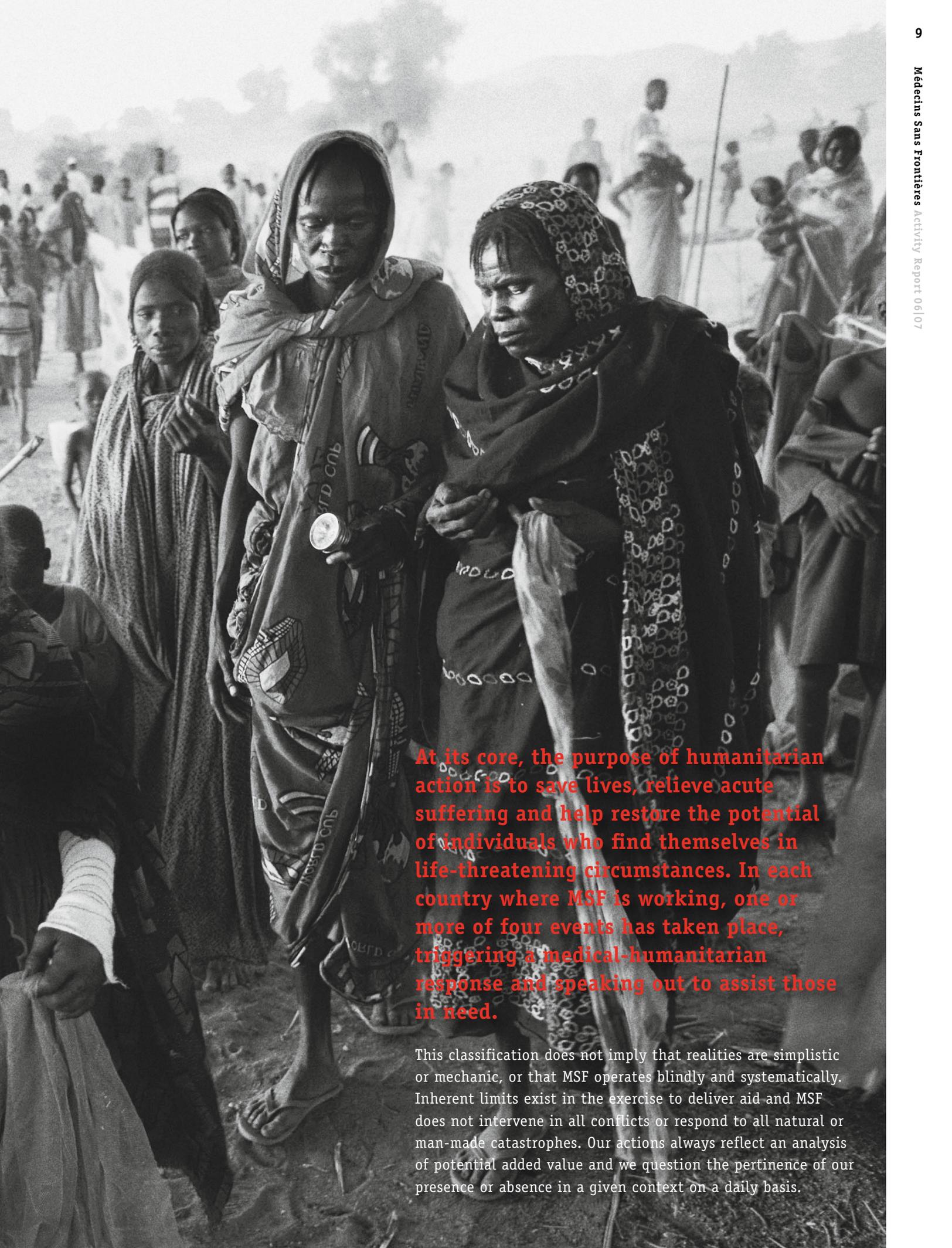
(Non-exhaustive and inclusive only of activities with MSF direct patient care. Activity may involve diagnostics, treatment and follow up.)

| ACTIVITY | DEFINITION | TOTAL |
|---------------------------------|---|-----------|
| Outpatient | Total number of outpatient consultations | 9,665,241 |
| Inpatient | Total number of admitted patients | 459,580 |
| Malaria | Total number of confirmed cases treated | 1,873,212 |
| TF | Number of children admitted to therapeutic feeding at a therapeutic feeding centre or hospitalised for malnutrition | 52,229 |
| SF | Number of admissions to supplementary feeding centre or ambulatory malnourished children | 135,990 |
| Deliveries | Total number of women who delivered babies, including Caesarean sections | 99,793 |
| Sexual Violence | Total number of cases of sexual violence medically treated | 11,126 |
| Surgical Interventions | Total number of surgeries held in an operating theatre, including war trauma and Caesarean sections | 64,416 |
| War Trauma | Total number of war trauma. All wounds treated. | 9,325 |
| HIV | Total number of HIV patients registered under care at end 2006 | 178,211 |
| ARV | Total number of patients on firstline anti-retroviral treatment) at end 2006 | 88,547 |
| ARV secondline treatment | Total number of patients on secondline anti-retroviral treatment at end 2006. Firstline treatment failure. | 853 |
| TB | Total number of new admissions to tuberculosis firstline treatment in 2006 | 28,904 |
| TB secondline treatment | Total number of new admissions to tuberculosis treatment in 2006, secondline drugs | 241 |
| Mental Health-Individual | Total number of individual consultations | 93,066 |
| Mental Health-Group | Total number of counseling or support group sessions | 12,665 |
| Cholera | Total number of people admitted to cholera treatment centres or treated with oral rehydration solution | 88,732 |
| Measles Vaccinations | Total number of people vaccinated for measles as a response to outbreak | 764,314 |
| Measles Treated | Total number of people treated for measles as a response to outbreak | 7,985 |
| Meningitis Vaccinations | Total number of people vaccinated for meningitis as a response to outbreak | 1,845,541 |
| Meningitis Treated | Total number of people treated for meningitis as a response to outbreak | 5,337 |

Reasons for Intervention

text by Emmanuel Tronc





At its core, the purpose of humanitarian action is to save lives, relieve acute suffering and help restore the potential of individuals who find themselves in life-threatening circumstances. In each country where MSF is working, one or more of four events has taken place, triggering a medical-humanitarian response and speaking out to assist those in need.

This classification does not imply that realities are simplistic or mechanic, or that MSF operates blindly and systematically. Inherent limits exist in the exercise to deliver aid and MSF does not intervene in all conflicts or respond to all natural or man-made catastrophes. Our actions always reflect an analysis of potential added value and we question the pertinence of our presence or absence in a given context on a daily basis.

Armed conflict

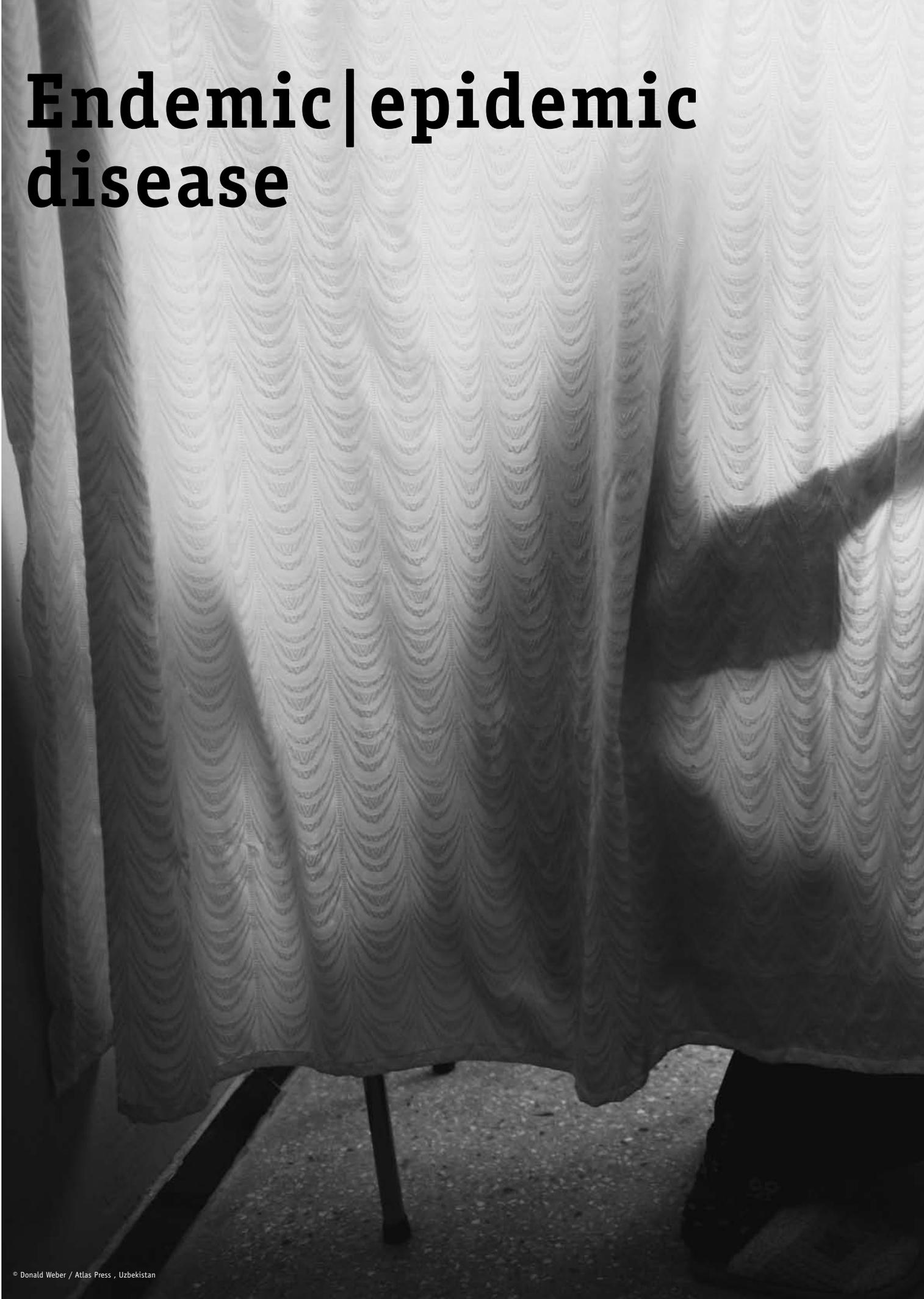
Populations affected by armed conflict require comprehensive medical and humanitarian support. These are victims of violence, civilian populations harassed and affected directly or indirectly through attacks, rapes and killings. They are weakened, instrumentalised and may be forcibly displaced from their homes, looking for refuge within or outside their home countries.

Medical, surgical or psychological care is needed - daily help in an environment of massive destruction and disruption of health systems. Suffering arises also from the indirect effects of conflict and instability, including a collapse of general infrastructures and a ruined economy. *De facto*, people are excluded from essential medical care and services, and can be devastated by epidemics of AIDS, tuberculosis or malaria, but also lesser-known diseases such as sleeping sickness.

MSF operations are based on medical teams working in health structures/hospitals and are devoted to offer medical services and to cover the range of medical crises inherent to a conflict, such as malnutrition or mental healthcare. When needed, MSF also constructs wells and dispenses clean drinking water and offers shelter materials.



Endemic | epidemic disease





Populations affected by endemic/epidemic disease arise in variable contexts of stability or conflict. Emergency capacity and innovative medical actions are imperative to ensure a viable response in complex environments.

These people live in precarious regions, remote and/or under-developed areas, suburbs of capitals or cities, camps or shantytowns, and do not receive strong support from local and international authorities. They are often minority groups, refugees or nomads. They are at increased risk in situations of economic and social dependency or fragile independence. Women and children are the most worrying categories. Exposed to infectious and communicable diseases, immunocompromised in pregnancy, and traditionally with less space to express their pains and concerns, women's realities go unnoticed in many countries. The dependency of infants and children increases their vulnerability.

MSF works in existing medical structures and also establishes structures as needed. Raising awareness about the risks of an epidemic; training, and prevention initiatives are essential. Collaboration with local governments and concerned ministries is a condition for implementing activities and rapidly improving the situation. Engaging in advocacy to support medical action, as in the case of HIV/AIDS, appears crucial to identify responsibilities, understand political intentions and mount effective responses.

Social violence and healthcare exclusion



Populations affected by social violence and healthcare

exclusion suffer from what they are as a group and the characteristics that create their shared identity. They are minorities, ethnic groups, migrants, displaced people or refugees. Particularly at risk are children such as street kids or the night commuters. They are socially excluded as prisoners or the unemployed; medically excluded because of a drug addiction or mental illness; they may be sex workers or simply a contagious patient with AIDS or tuberculosis.

Living in environments where their conditions and rights are limited or nonexistent, they cannot expect adequate support from local authorities and suffer the limits of international support.

MSF becomes directly involved to alleviate victims' daily suffering with medical, psychological and social activities. Healthcare exclusion requires projects that bring attention to healthcare access and the absence of medical services. MSF's identity includes the act of speaking out, and united with patient care is a commitment to bringing attention to the causes of suffering and the obstacles to providing effective assistance, raising the concerns and the realities of our patients to national and international bodies.

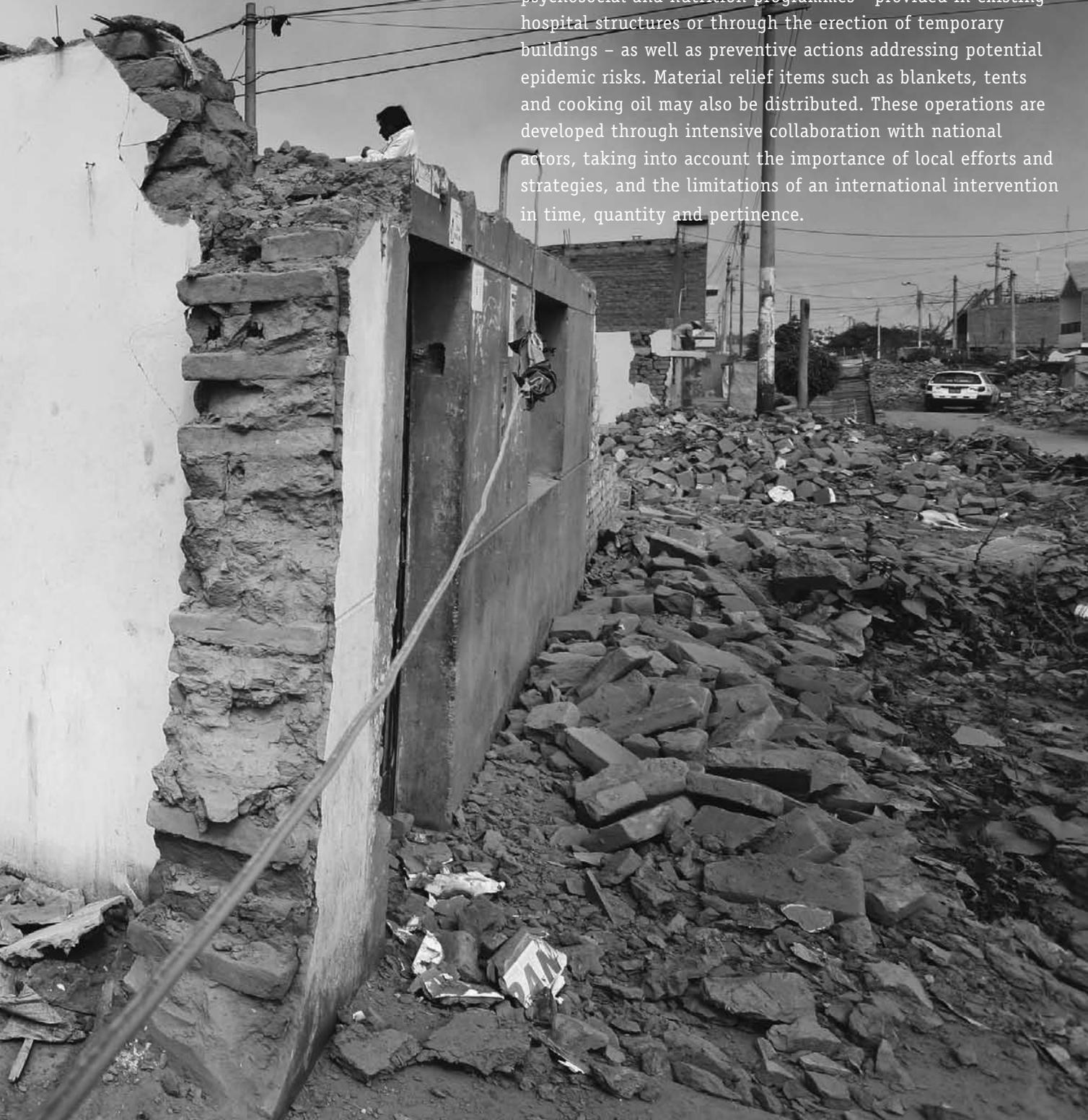


Natural disasters



Populations affected by natural disasters require an immediate medical-humanitarian response. They find themselves in desperate conditions, having suddenly lost homes and material goods, family members and relatives. They are highly traumatised, in need of rapid and diverse medical and social support. Access to the disaster area and the victims is usually complex and demands fast identification of multiple needs.

The poorest people are particularly affected, having precarious habitats and living conditions. MSF supplies a large range of answers: numerous required medical supports such as surgery, psychosocial and nutrition programmes - provided in existing hospital structures or through the erection of temporary buildings - as well as preventive actions addressing potential epidemic risks. Material relief items such as blankets, tents and cooking oil may also be distributed. These operations are developed through intensive collaboration with national actors, taking into account the importance of local efforts and strategies, and the limitations of an international intervention in time, quantity and pertinence.





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Humanitarianism... in the meantime

By Christopher Stokes, *Secretary General, MSF International*

Humanitarian aid saves lives today, until peace, until reconstruction, until development, maybe. But humanitarian action never builds much; it concentrates on saving lives now until they can be rebuilt tomorrow. It is not hopeful, it is immediate and it has to be judged on its capacity to be with victims in their hour of need and to help them survive the crisis, the war or the epidemic. On this count, Iraq more than any other conflict today shows-up the limits of humanitarian assistance.

With conflict at the heart of MSF's self-determined mandate, we constantly have to assess the effectiveness of our assistance, methods of intervention and the need for improvement. For MSF, this year was marked by a return, of sorts, to the Iraq war with teams from several MSF sections. After the attacks on the International Committee of the Red Cross (ICRC) and UN com-

pounds, the assassination of British aid worker Margaret Hassan and the growing number of security incidents in Baghdad, we withdrew all international teams at the end of 2004, whilst assisting some of our most threatened Iraqi colleagues to leave the country. The option to continue running minimal aid programmes from the safety of neighbouring countries was quickly dropped, though there was a heated internal debate amongst those in favour of keeping an 'external' support and those favouring a clear break because of the seemingly impossible security environment. Iraq triggered a wider debate about the risks the MSF movement was or was not prepared to take. Though risk-taking was acknowledged to be an inevitable part of humanitarian work given the environments in which the association operates, there was a willingness to set a limit: loss of life of MSF staff was unacceptable, it was not a sacrifice - presumably for the greater imperative of saving lives in an extreme conflict situation - that



© Geert Van Kesteren, Iraq

the movement was prepared to accept. Given the associative nature of MSF, this is perhaps not surprising: each part of the movement is accountable to a series of distinct national associations that are fundamentally egalitarian in their membership and way of deliberating and making decisions.

The problem is the spread of the conflict in the last three years, and particularly since 2006, across central and southern Iraq and gaining ground in the north around Kirkuk and Mosul. In cold statistical terms - the number of deaths directly caused by armed conflict - Iraq is the most ferocious conflict in the world today, including Darfur. Whilst meeting Iraqi refugees this summer in Jordan, Lebanon and Syria to assess health needs, I was struck by how their families had been scattered by the war and the heavy casualties they had suffered. The international reporting of the suicide bombings masks the heavy toll of daily assassinations, the almost casual execution at checkpoints that disappear as quickly as they were set-up in many parts of the country, the continued kidnappings and disappearances of relatives. These crimes are committed against patients in hospitals. There are no sanctuaries for civilians in Iraq.

Yet the war has also been marked by the stark absence of international humanitarian aid agencies delivering effective assistance on the ground. MSF is certainly not one of those delivering effective humanitarian assistance in Iraq.

Insecurity is the cause of our absence. The principle of acceptance by the population and local authorities is the foundation of MSF field teams' security. But there are other ways to ensure the delivery of aid, such as protection: bullet-proof jackets, cars, and even deterrence, the use of armed escorts. The deterrence option would require MSF to work under heavily armed, close protection

“The international reporting of the suicide bombings masks the heavy toll of daily assassinations.”

of, say, the coalition forces, an option chosen by some a few years ago but abandoned by practically all today. In our view, mounting a heavily armed response in order to provide medical assistance is very hard to reconcile with the fundamental principles of humanitarian assistance such as neutrality and independence. Further, the ability to provide assistance in the long term is compromised by the use of deterrence that alienates local communities and authorities.

The alternative, working thanks to a widespread acceptance of our medical assistance, is very hard to put in place and difficult to sustain in this war. For independent humanitarian aid to work, a minimum level of acceptance is needed, people on the ground have to support the basic objectives. Security assurances by those with the public monopoly of violence have to be forthcoming. In wars where there are no clear frontlines, where no single force establishes a public monopoly of violence over a set territory, the negotiated circulation of aid supplies and aid workers is compromised. To make things worse, the subsequent absence of effective visible aid agencies working side by side with Iraqis, has reinforced the mistrust towards foreigners and western organisations in general. The multiple layers of violence in Iraq today prevent effective assistance to civilians. Conversely in Somalia, where the minimum conditions necessary for a real humanitarian space are also not very high, MSF has been able to work across large swaths of the country for the past decade, deploying numerous medical teams to deliver lifesaving assistance. The country is fractured along clan lines and alliances, but there is a precarious space within each area of clan control that allows the careful organisation and implementation of aid programmes. 'Humanitarian space' – the space required to assess needs, deliver aid and control its use – is never a given, it is something we have learned, sometimes painfully, to negotiate and maintain in unsafe places from Palestine to Liberia, from Ivory Coast to Colombia.

Multiple and shifting layers of violence require different strategies. One challenge will require ensuring that our strengths do not turn into weaknesses. The high turnover of committed international staff, the doctors, nurses and logisticians who question and challenge and shape new interventions across the many emergency operations MSF launches across the world, should not prevent the creation of strong networks of local Iraqis in war zones. Without them, assistance is impossible because to work in Iraq is to work blind: we can assist only with and through local counterparts, without MSF staff going to the field to discuss with beneficiaries, measure in person and subsequently adjust how the aid is organised. In effect, the first step on the road back to assistance is remote-controlled operations where MSF teams are based in neighbouring countries. Only later, and in the best of cases, will assessment visits be possible. The effective deployment of aid teams will come at a much later stage. MSF's important logistical and organisational capacities also count for less in an environment where aid is to be supplied piecemeal and often in a secretive manner, using local truck companies who can get through the numerous official, unofficial, insurgent and neighbourhood checkpoints. The clandestine supply of aid is requested by local counterparts such as hospital directors and surgical teams, who risk assassination if any link between them and a foreign entity, such as an international aid organisation, comes to light. Saving lives is a deadly occupation for Iraqis and foreign aid workers alike. Hundreds of doctors have been killed in this conflict.

More surprising still, independence, a fundamental principle to MSF, is not a clear-cut operational asset in this setting. For some countries in the region where we aim to assist refugees fleeing the fighting, there is a preference for aid agencies with strong ties to particular states through funding – use of institutional government funds – and close backing from their respective gov-

ernments. A country isolated by the label 'axis of evil' can well consider that an NGO with close foreign-state backing acts as a bridge to that country. Further, close state ties, even with a foreign state, are seen as an indication of the controllability of the so-called non-governmental organisation, especially in countries where the concept of a genuine, independent non-governmental agency is alien and suspicious.

To dilute basic principles is not an option. They are deeply embedded in the identity of MSF and there is no willingness to renegotiate them. In practice, the long-term benefits of a strong principled approach towards independence, impartiality and neutrality could outweigh the immediate gains of compromise. MSF will need to maintain the principles that have guided the movement and apply adapted and innovative operational strategies.

“Saving lives is a deadly occupation for Iraqis and foreign aid workers alike.”

MSF teams have managed to get a foothold through remote-controlled operations, providing much needed medical supplies to hospitals inside the war torn provinces via Jordan or Kurdistan. Additionally, along the lines of “doing what we can to help until we can go in,” patients requiring reconstructive and orthopaedic surgery, often as a result of the bombings, are painstakingly brought, thanks to networks of Iraqi doctors, to an MSF surgery project in Jordan. Here they can get the specialised medical care they cannot get in Iraq. A similar strategy will be established in Kurdistan. Both activities, supply and evacuation of patients, are useful in and of themselves, but they are also necessary steps to having teams on the ground and closer to where needs are most acute. The necessity of bringing in teams has become greater over the past year, as doctors working in overrun emergency departments have described the impact of the growing exodus of medical professionals and the consistently high patient caseload as a result of the fighting. The reversal of our questionable earlier decision not to attempt remote-controlled operations in 2005 is a result of this deterioration inside Iraq.

In the worst war-zone of the new century, international assistance is absent on the ground. In contrast, the deployment – albeit fragile and often threatened – of over one hundred MSF international aid workers in Darfur, compared to the sum total of zero in central and southern Iraq where the war rages, is a painful reminder of the impotence of humanitarian aid agencies.

The struggle to assist victims of conflict is not one MSF can abandon, but it will be a long, hard struggle to achieve a real operational space in Iraq. Humanitarian action here is not effectively saving lives today, in the meantime, until peace, until development. It is deploying in the periphery, on the margins of the main needs, until new strategies open the way back into the war-zones.



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What Borders for MSF Surgery?

By Caroline Veldhuis, *International Editor*

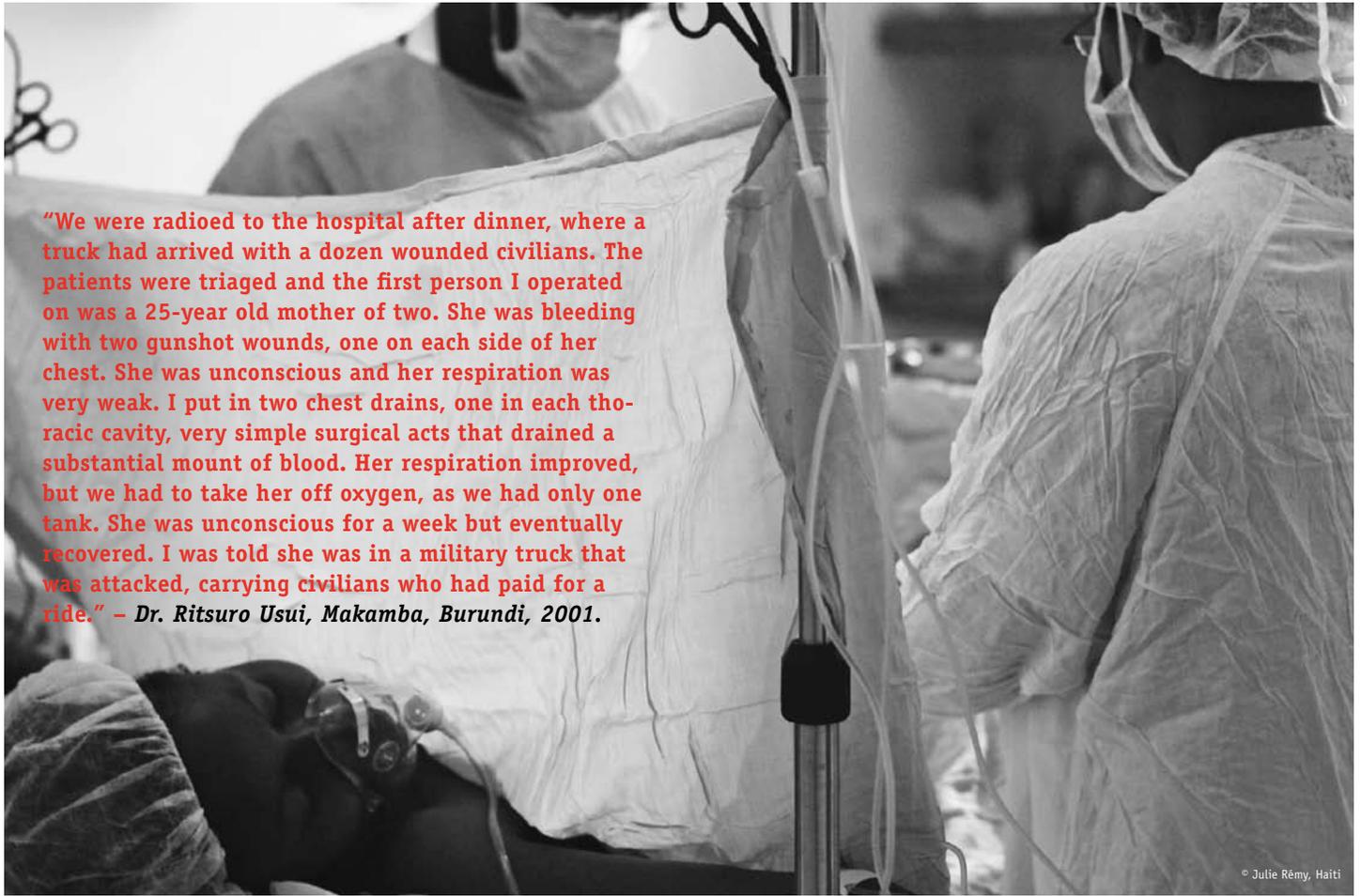
The idea of humanitarian field surgery, for many, conjures scenes of TV-show doctors performing crude operations, in chaotic environments at the frontlines of war. Whilst MSF's 30-year surgical history is inarguably illustrated with such images, surgical aid continues to evolve, adapting to new field realities and incorporating higher standards of medical practise. The only appropriate response to certain medical needs, surgery has become an inextricable component of MSF's medical aid. In 2006, surgeons departed on approximately 125 missions and over 64,000 surgical interventions* were carried out in some 20 countries worldwide.

MSF continues to perform surgery in areas of conflict where humanitarian space can be obtained, with teams working in volatile places such as Democratic Republic of Congo and Somalia. Posted at a new project opened in Kismayo, southern Somalia in 2007, British surgeon Dr. Paul McMaster describes his work, "We see lots of gunshot wounds in the abdomen, I just saw someone whose arm was shattered with a kalashnikov. The busiest day so

far, I was working on a skin graft for a burned child, when a bomb went off. There were about 15 casualties. It took an hour and a half to get people triaged and stabilised and I worked into the evening on various operations from serious facial wounds to sutures."

In war settings, it is documented that as many as 96% of deaths from trauma occur within four hours**, so proximity to patients is essential for doctors to perform lifesaving acts. Dr. Ritsuro Usui, surgeon and president of MSF Japan, emphasises the importance of this proximity, explaining that the type of injuries surgical teams see is a function of time and distance from conflict. "Twenty-four hours after trauma has been sustained," he says, "mainly limb injuries are seen, because most people with chest and abdomen trauma will have already died."

Massive needs for surgical care have led MSF to establish trauma centres in hospitals in Port Harcourt, Nigeria and Port-au-Prince, Haiti, both epicentres of violence, where over 3,000 surgeries were performed in 2006, many for gunshot and knife wounds,



© Julie Rémy, Haiti

“We were radioed to the hospital after dinner, where a truck had arrived with a dozen wounded civilians. The patients were triaged and the first person I operated on was a 25-year old mother of two. She was bleeding with two gunshot wounds, one on each side of her chest. She was unconscious and her respiration was very weak. I put in two chest drains, one in each thoracic cavity, very simple surgical acts that drained a substantial amount of blood. Her respiration improved, but we had to take her off oxygen, as we had only one tank. She was unconscious for a week but eventually recovered. I was told she was in a military truck that was attacked, carrying civilians who had paid for a ride.” – Dr. Ritsuro Usui, Makamba, Burundi, 2001.

beatings, road accidents and burns. These well-equipped trauma centres have developed rehabilitative services including physiotherapy, psychological counseling, and prosthesis referrals. In a context such as Iraq, however, soldiers may have access to good medical and surgical care and quick evacuations, but obtaining the proximity for medical-humanitarian organisations to save injured civilians is extremely difficult. Blurred frontlines present enormous security risks in some areas, transportation is hazardous and health infrastructure is increasingly destroyed.

Post-war reconstruction

When proximity is impossible, operations can be performed to help patients unable to receive proper care at time of injury. MSF's initial surgical response for people wounded in Iraq has been a reconstructive plastics, maxillofacial and orthopaedic project at the Red Crescent Hospital in Amman, Jordan. Here people are treated for severe facial disfigurement, bone and wound infections. Procedures take place in a well-equipped hospital with modern equipment, permitting MSF to use advanced techniques such as internal fixation and fiberoptic intubation, necessary to administer anaesthesia when a patient's facial anatomy is destroyed.

The doctors in Amman see patients such as Zeinab, 36, who in 2004 was traveling to the holy city of Najaf with a vanload of people that was caught in crossfire. The vehicle crashed, killing everyone but Zeinab, who not only lost her two-year old son and unborn child, but she also sustained two broken legs, a fractured arm and jaw. She received internal fixations in her broken legs from surgeons in Iraq, but the plate in her right leg later broke

because of a serious bone infection. In 2007, she was transported to Amman, where doctors treated her infection and re-set her internal fixations so she will be able to walk again.

A reconstructive programme was also established in 2005 for people with severe war wounds in Chechnya, some of them like Zeinab, having received the best possible, though insufficient, surgery and medical care when injured. Here, as in all settings, MSF's contribution also consisted of general measures to reduce risk of infection and implement safer surgery, including the supply of an oxygen concentrator to replace the unstable industrial oxygen previously employed.

In addition to these ongoing projects, surgery on an itinerant basis has been provided for people with war wounds. Extensive violence inflicted, not with bombs or bullets but machetes, left victims in Uganda with facial mutilation including loss of noses, ears, and lips. MSF in 2005 and 2006 coordinated with the surgical group Interplast Holland, to provide reconstructive surgery for 24 people with war-related injuries, burns and cleft lip and palate conditions in Kitgum.

Treating the effects of obstetric complications

Obstetric emergencies account for roughly one-third of MSF's volume of surgery, even in some conflict contexts. Reconstructive procedures are now increasingly offered to women suffering the consequences of poor pre-natal care and/or not having access to medically indicated Caesarean sections.

Utero-vaginal prolapse (UVP) and obstetric fistulas are two possible conditions resulting from obstetrical trauma, characterised not only by physiological damage and pain but also by social

ostracism. Both UVP and fistulas may result in incontinence, with some fistulas causing women to experience continuous leaking of faeces, and consequent rejection by their husbands, families and communities. Dr. McMaster says he sees many women with fistulas. “We have a woman on the ward, she came in two weeks ago in obstructed labour, with a ruptured uterus. The baby died, and we had to remove her uterus to save her life. Then we noticed she was losing urine because of a big hole in her bladder. This has been going on this for four years, since she had her first child. She leaks urine, stinks, and has been confined to home.”

Rare in more developed countries, fistulas require a specialised surgery that must be learned in Africa. Several MSF surgeons have now mastered the techniques and train others through MSF. Fistula repair has been provided in numerous countries including Liberia, Republic of Congo, Ivory Coast and Chad and interventions are now being considered for other locations. In Nepal, where there has been a special focus on women’s health needs in a project in Khotang, MSF in 2007 partnered with a Nepalese surgical NGO to help women with UVP, organizing and managing a “uterine prolapse camp”. 82 women received the operations they needed and a future collaboration is planned for 2008.

“The surgery went well, but the patient died”

Concomitant with the growth of surgery as a medical-humanitarian response is careful attention to the factors that complement surgical skills and will afford the best possible outcome for patients in any setting. Higher standards and updated protocols are increasingly implemented in projects to achieve better hygiene and more sterile environments, assure a range of drugs and proper equipment, and supply and/or train necessary human resources, such as nurse-anaesthetists.

In keeping with western medical practise, for example, MSF has been improving patient care through individualised anaesthesia and pain management. Dr. Matthew Mackenzie, an anaesthetist who has worked in Ivory Coast and Central African Republic, explains pain is more tolerated and perhaps undertreated in the African hospitals where he has worked, remarking that people never make a fuss when it is obvious they would be in excruciating pain. MSF is placing an increased emphasis on the awareness of pain and its treatment, and many projects have now implemented the use of pain scales, where nurses regularly check in with patients and adjust their drugs as necessary.

An essential part of surgical teams in developed countries, anaesthetists and nurse-anaesthetists have gained greater recognition on MSF surgical teams, whereas some early projects may have functioned without a dedicated anaesthetist. In addition to determining which type of anaesthetic is safest and most appropriate for a given patient and operation, these specialists are highly trained in airway management and intravenous lines, and can be indispensable beyond the OT. MSF trains local nurses in anaesthesia in some projects.

A widening skill gap

Outside the specialised and itinerant surgical missions, in many field settings the operations required in a district hospital – a fairly typical structure for many MSF projects – are broad and basic. Dr. Gary Myers, one of a handful of MSF headquarters’ surgical referents, estimates that in a surgical inpatient hospital

for a neglected population, “out of every 100 patients, 50 will be suffering from soft-tissue injuries that are a consequence of trauma and/or infection; 25 the complications of pregnancy or childbirth; 12 will have a variety of bone injuries or fractures and the remainder will need major surgery for conditions such as burns or sepsis or require laparotomies.”

The skills required to address this spectrum of needs fits well with the traditional general surgeon who has some facility in orthopaedic, obstetric and visceral interventions. The emerging generation of surgeons in developed countries, however, is trained with new technology and is increasingly compartmentalized in their skills. A growing gap is foreseen between surgical needs in remote field settings and the abilities of new surgeons schooled in a wealthier infrastructure to provide relevant assistance. Although they may be well-versed in endoscopic techniques and able to work in very specific projects, “In ten years,” says Dr. Nathalie Civet, surgical referent for MSF’s Belgian-run programmes, “we are going to have problems finding a surgeon who knows how to open an abdomen.” Organisations such as MSF will thus face an additional challenge in attempting to fill human resource gaps in countries with a dearth of skilled medical professionals.

Where to draw the line?

Particularly in conflict zones, the needs for medical and surgical care are extensive and demanding, and the question of what is and is not possible in field-based operating theatre is a daily one. Location and context are the all important factors. Sophisticated techniques such as internal fixation, for example, can be implemented in some locations, but the numerous requirements to implement this procedure safely and effectively means it may not be available in others.

Yet MSF continues to push forward. On a logistical level, inflatable tent hospitals, developed and first launched after the 2005 earthquake in Kashmir, have been modified to include adequate surgical capacity and are being tested. Gigantic surgical kits, veritable “operating theatres to go,” can be readied in enormous crates and quickly loaded onto planes. These kits comprise beds, rolling trays, respirators – in short, all the equipment and medicines required to provide effective lifesaving surgery. The difficult prerequisite is the humanitarian space in which to function.

Meanwhile, as poor access to healthcare in many parts of the world continues, so will the need for surgery to treat complications. Late presentation combined with the lack of drugs and diagnostics for buruli ulcer, a “neglected disease”, leads to severe osteomyelitis requiring a teenager in Cameroon to undergo a leg amputation. Lack of obstetric care in Sudan produces a fistula that finds a woman living alone and isolated, rejected from her community. And these are but two of many examples. Vigorous debates will continue to inform MSF surgical programming choices that attempt to balance the allocation of resources with what must be a select alleviation of suffering – in itself, a most difficult form of triage.

* Defined as interventions carried out in an operating theatre, including caesarean sections

** Clasper, Jon and Rew, David. Trauma life support in conflict (Editorial). *BMJ* 2003; 327:1178-1179.

Displaced in Darfur

By Bruno Jochum, *Director of Operations, MSF Switzerland*





In 2006/2007, the situation in Darfur remained one of the worst crises in the world, with over two million displaced people totally dependent on external aid, and regular fighting occurring in certain areas of the region leading to new episodes of violence and displacement.

The peace agreement signed in May 2005 between the government of Sudan and one of the rebel factions paradoxically reactivated warfare after a year of lesser intensity fighting, and significantly reduced the ability of humanitarian workers to deliver effective aid in remote rural areas. Furthermore, the conflict has become regional with spill-over effects in Chad and Central African Republic, leading to hundreds of thousands of civilians leaving their burnt villages in these countries. Civilian populations in Darfur are locked into an extremely vulnerable state and our field medical teams are confronted with significant limitations in terms of access and security. Within the field of international politics, the crisis in Darfur and its representation in the media has become a stake in itself and carries the risk of being instrumental to the various stakeholders.

In 2003/2004, an episode of extreme and sudden violence provoked the massive displacement of Darfuris to the surroundings of urban centres and smaller towns. It consisted of a government planned counter-insurgency offensive aimed at ensuring territorial control and punishing various tribes for their perceived links with the rebel forces. In the context of desertification, where tense competition for land between nomadic pastoralists and

sedentary farmers has been politically utilised by the central government, hundreds of villages have been reduced to dust and sometimes all traces of former dwellings erased. Terror techniques involving murder and rape have been used to deter any further resistance and to ensure the targeted populations flee their places of origin.

After an emergency phase in the first half of 2004, the situation of the displaced in the camps stabilised in terms of mortality and morbidity due to the implementation of a humanitarian assistance pipeline, one huge in scale and rather effective in producing results for the beneficiaries. Once the main offensive goals were achieved in February 2004, the government of Sudan, under international pressure, allowed the deployment of large numbers of humanitarian workers: in 2006, it was estimated that approximately 900 expatriates and 12,000 Sudanese staff were assisting in Darfur, making it the biggest humanitarian operation ever. Major towns are busy hubs from where aid is dispatched, and malnutrition and disease outbreaks have been prevented in most camp populations because of improved access to healthcare.

For MSF, operations in Darfur represented in 2006 a total of 19 projects and a budget of 16.95 million euros, employing approximately 1,700 national and 100 international staff. The activities, ranging from hospital care and surgery to primary healthcare centres and nutritional feeding centres, were mainly focused inside camps and initially completed by mobile clinics for outreach populations in rural areas. An effort was made in 2006 to

disengage certain sites to enable our teams to react more quickly to the ever-evolving needs in a conflict situation.

But the effectiveness of a pipeline coexists with another dimension of the crisis: the displaced families have no other future than to remain trapped inside camps where they are totally dependent on assistance and have lost their economic means of survival. Most have lost direct family members and witnessed the destruction of their homes and belongings. Outside camps, roads are often under the surveillance of armed militias and local defence forces control movement. Women, who have no other choice than to look for wood in the outskirts, are frequently victims of aggression and rape. In 2006, 250,000 more civilians were displaced because of raids and armed combat, and were forced to join the ever-growing camps. The discrepancy between viewing the camps as serving as a “safe haven” for fleeing populations and what one could describe as a “forced encampment policy” is not easy to comprehend: the reality probably encompasses both dimensions.

In the outskirts, the distribution of arms to proxy militias by the government on the one hand, and the fragmentation of rebel forces on the other, have led to extremely high levels of insecurity on the main access roads. Like many other NGOs, MSF was the victim of a critical incident near Niertiti in September, and elsewhere was forced to reconsider and then interrupt its mobile clinics due to the level of risk. Several projects were evacuated, such as in Sarif Omra, Kebkabiya and Seleia, near Jebel Moon. The borders between banditry, economy of war (with its lot of predators in 4x4 vehicles carrying satellite phones) and armed groups are very blurred in this context. Our medical teams have often highlighted the need to avoid simplistic clichés systematically opposing one side or the other: within the government administration, civil servants such as policemen and ministry officers have been regular victims of so-called “janjawees,” whereas on the other side rebels have been raiding each other and account for some of the attacks on humanitarian vehicles. Local tribal alliances switch occasionally and tension between local public authorities and the militias used by the central government are frequent.

However, such an image of chaos at a local level should not conceal a recurring pattern in Darfur. For humanitarian agents, insecurity on the roads tends to increase before and during military campaigns, cutting off civilian populations from any form of international witnesses or immediate assistance.

For example, there were the 2006 events north of El Geneina in which the roads leading to Seleia and Jebel Moon were under systematic threat of ambush. In an attempt to explore the situation of newly displaced people fleeing armed raids in the village of Tanjeke, an MSF representative went with a team to evaluate the medical and living conditions. Displaced people there had a tremendous need for basic supplies like jerry cans, blankets and plastic tarps for shelters, and were clearly living in fear because of the close presence of pro-government militias. On the way back, the MSF vehicle was stopped by armed men and a critical incident was only just avoided thanks to the negotiation skills of our national staff. Setting up effective assistance under these

conditions remains extremely hazardous. Like in many war situations, Darfur is a place where our teams are reaching their limits to provide effective assistance to civilians in remote areas who regularly voice that their first need is protection. Although the mass violence that left hundreds of thousands of victims in 2003/2004 is behind us, there are still areas suffering from the effects of similar military tactics: sudden raids, burning of villages, raping of women and retaliation against men.

A notable aspect of the crisis in Darfur has been the production of competing images of the conflict by the stakeholders. Not surprisingly, the government of Sudan is in a continuous state of denial of its direct responsibilities in the violence occurring in its western region, blaming the rebel forces for their behaviour and divisions. On the other hand, the description by the media of the reality on the ground has not really taken into account the fact that camps have stabilised and the number of deaths due to direct violence in 2006 was drastically reduced compared to 2003 and 2004 (according to UN data). Certain calls for a NATO military intervention, which could result in another layer of conflict, have endangered the acceptance of humanitarian work in the field by the different parties and put at risk the principles of independence and neutrality.

“the displaced families have no other future than to remain trapped inside camps”

MSF has on several occasions in the past been critical of the link made between humanitarian assistance and objectives of international policy like peace and justice, or the way governments use humanitarian aid as an argument to intervene or not. In 2003/2004, whilst massacres were occurring on a large scale in Darfur, the international community deliberately chose not to pressure the government of Khartoum in order to secure the Comprehensive Peace Agreement (CPA) in negotiation with the SPLA. Along with other countries, the U.S. and China, as Security Council members, have strategic stakes in Sudan, ranging from cooperation in the field of intelligence, to the development of oil production. In this context and despite the rhetoric, it has been clear from the beginning that obtaining Khartoum’s consent to any initiative in Darfur was a necessary condition. The deployment of a UN peacekeeping force might therefore take place almost four years after the peak of violence. Propositions to open “humanitarian corridors” in 2007 are almost irrelevant as they are already in place.

In the end, although access in Darfur remains highly regulated by the will of armed groups and authorities, humanitarian assistance has been lifesaving for the millions of people who depend on it. For MSF, being present carries a responsibility to gain access to areas that are cut off from any assistance and, when facing obstacles, to witness what our teams are confronted with. To achieve our social mission, impartiality and independence are absolute necessities.

GLOSSARY OF DISEASES

Chagas Disease

First described by the Brazilian doctor Carlos Chagas, this parasitic disease is found almost exclusively on the American continent, 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 symptoms for years. Developing over time, chronic Chagas causes 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 occur in early stages of the infection, and drugs are only effective in the acute and asymptomatic stage of the disease in children. Diagnosis is complicated, with doctors needing 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 is no treatment for chronic Chagas in adults.

MSF Chagas programmes in Bolivia and Guatemala focus on education, preventive measures and screening and treatment for children. MSF is also urging for more research and development on Chagas through its Access to Essential Medicines Campaign.

MSF treated 556 people for Chagas in 2006.

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 may cause sudden large outbreaks.

Although most people infected with cholera will have only a mild infection, the illness can also be very severe, causing profuse watery diarrhoea and vomiting and leading to severe

dehydration and death without rapid treatment. 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 (CTCs) 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 88,732 people for cholera in 2006.

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 (OIs) such as candidiasis, pneumonia, and various kinds of tumours are able to flourish as the immune system weakens. Some OIs can be treated, whilst others are life-threatening. The most common opportunistic infection leading to death is tuberculosis (TB). 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 anti-retrovirals 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 or FDC). MSF 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 counseling; treatment and prevention of opportunistic infections; prevention of mother-to-child transmission; and provision of anti-retroviral treatment for patients in advanced clinical stages of the disease.

MSF provided care for over 178,000 people living with HIV/AIDS and anti-retroviral therapy for more than 88,000 people in 2006.

Human African Trypanosomiasis (Sleeping Sickness)

Frequently known as sleeping sickness, this parasitic infection is seen in sub-Saharan Africa and is transmitted through the bite of certain types of the tropical tsetse fly. More than 90 percent of reported cases of sleeping sickness are caused by the parasite *Trypanosoma brucei gambiense* (T.b.g) 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. 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. People may also have difficulty sleeping during the night but are overcome with sleep during the day.

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 percent of patients in some areas of Africa. It also kills up to 5 percent of people who receive it. Eflornithine, though somewhat difficult to administer because it requires an IV and a complicated treatment schedule, is a safer, more recent alternative being used by MSF in its projects. MSF through its Access to Essential Medicines Campaign works to ensure the production and supply of Eflornithine and urges for research and development aimed at new, easy-to-use drugs and accurate diagnostic tests.

MSF admitted 1,348 patients for treatment for Human African Trypanosomiasis in 2006.

Leishmaniasis (Kala Azar)

Largely unknown in the developed world, leishmaniasis is a tropical, parasitic disease caused by one of over 20 varieties of *Leishmania* and transmitted by bites from certain types of sandflies. 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 100 per cent of 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 (SSG) 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, as 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 through its Access to Essential Medicines campaign is urging for more research into suitable diagnostic techniques and affordable drugs to treat this neglected disease.

MSF treated 5,010 people for Leishmaniasis in 2006.

Malaria

Caused by four species of the parasite *Plasmodium*, malaria is transmitted by infected mosquitoes, particularly during rainy seasons, and mainly strikes poor and rural communities, slum dwellers and refugees. Symptoms include fever, pain in the joints, headaches, repeated vomiting, convulsions and coma. Malaria caused by *Plasmodium falciparum*, if untreated, may progress 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 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 currently used by MSF in its projects.

Antimalarial 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 made the change in writing, in many cases the drug is still not available for their patients.

MSF treated 1.8 million people for malaria in 2006.

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 percent of people with meningitis will die and as many as one out of five survivors may suffer from after-effects ranging from hearing loss to learning disabilities.

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

MSF treated 5,337 and vaccinated 1.8 million people against meningitis in 2006.

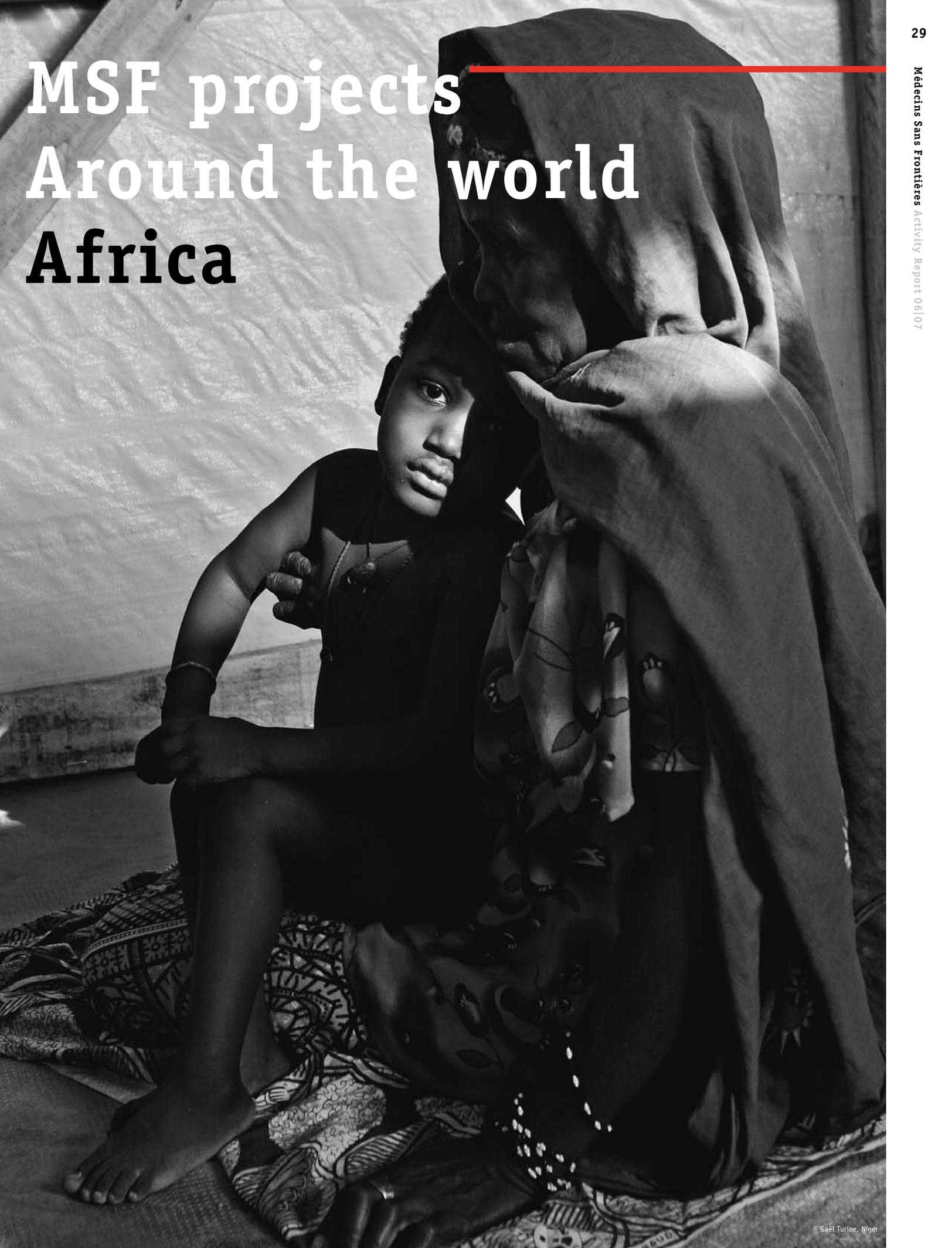
Tuberculosis

One-third of the world’s population is currently infected with the tuberculosis (TB) bacilli. Every year, nine million people develop active TB and 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, sneeze or talk. Not everyone will become ill, but ten percent of (HIV negative) infected people will develop active TB at some point in their lifetime, suffering from a persistent cough, fever, weight loss, chest pain and breathlessness in the lead up to death. TB is also a common opportunistic infection and leading cause of death amongst people with HIV.

Drugs used to treat TB are from the 1950s and a course of treatment takes six months. Poor treatment management and adherence has led to new strains of bacilla that are resistant to the drugs commonly used. Drug resistant TB is not impossible to treat, but the required regimen causes many side effects and takes up to two years.

MSF treated over 29,000 people for tuberculosis in 2006.



MSF projects Around the world **Africa**

AFRICA



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| 32 BURUNDI | 44 MOROCCO |
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ANGOLA

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease

• Social Violence/Healthcare Exclusion

FIELD STAFF 878

MSF first started working in Angola in 1983 to respond to conflict-related medical emergencies and expanded its activities both geographically and medically as unmet needs were identified. Broad support was provided for basic healthcare including medical attention for people with tuberculosis (TB), HIV/AIDS and Human African Trypanosomiasis (sleeping sickness). MSF regularly responded to outbreaks of diseases such as meningitis, measles, cholera, haemorrhagic fever, and other health problems including nutritional crises.

Five years have passed since the signing of a peace agreement that ended 27 years of civil war in Angola. As the state continues to rehabilitate the healthcare system and develops a proper healthcare infrastructure, MSF in 2006 and 2007 engaged in a gradual process of closing and handing over its activities to government, local and international development NGOs.

Prior to the final project closures, MSF was particularly active in responding to cholera outbreaks. Rapid urbanisation, inadequate water and sanitation systems and a disorganised public health system combined with heavy rains accelerated the country's worst ever recorded outbreak of cholera in February 2006. MSF treated more than 26,000 people during this intervention, which lasted until September.

In November 2006, more people presented with cholera in Lubango, Huila province and MSF launched another intervention that lasted until January 2007, treating approximately 6,000 people.

MSF transfers its remaining projects in 2006/2007

- In Kuito, Bié province, support ended for the TB programme at the provincial hospital, which had approximately 500 patients undergoing treatment. MSF had previously supported the overall management of the hospital, which was transferred to Angolan authorities at the end of 2003.

- A malaria treatment centre in Kuito was also handed over to local authorities. Following several studies conducted on resistance to various anti-malarial drugs, new malaria treatment protocols using artesunate-based combination therapy had been introduced both in the Kuito hospital and at health posts.



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- MSF has also supported the 80-bed hospital in Camacupa and four health posts for the treatment of TB, malaria and malnutrition. Approximately 200 people were receiving TB treatment at this project, which was taken over by the Ministry of Health (MoH) at the end of 2006.

- In Cuemba, Bié province MSF had upgraded a health centre to a municipal hospital, which provided quality primary and secondary healthcare to residents and returning populations, a total target population of 84,000. The Cuemba project was handed to the MoH at the end of 2006.

- The project in Mavinga, Province of Cuando Cubango was handed over to the MoH. MSF had supported the local hospital since the ceasefire in 2002. Approximately 80,000 people are living in this area, which is one of the most remote regions of Angola.

- In the city of Malanje, MSF had run a project for HIV/AIDS, TB and malaria since 2003. In 2006, 9,766 people were tested for HIV and 181 were enrolled in a treatment programme. Almost 20,000 people were treated for malaria during 2006. Health authorities took over this project in May of 2007.

- Between January 2006 and April 2007, MSF assisted an average of 270 pregnant women monthly in the Xa-Muteba clinic in Lunda Norte province. The project was transferred to the MoH in May 2007.

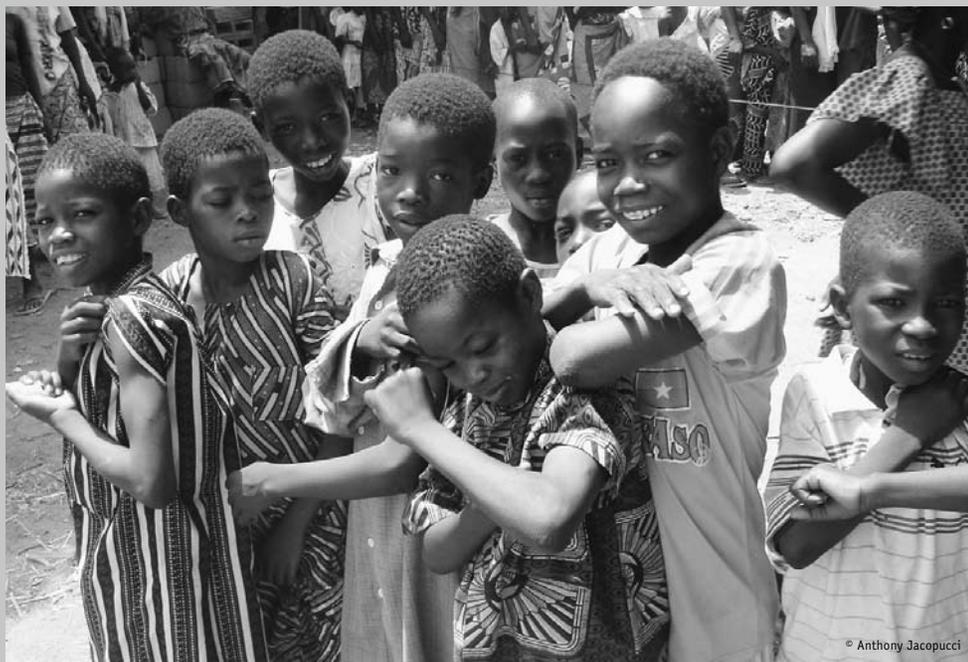
As of August, 2007, MSF had completely withdrawn from Angola.

MSF worked in Angola from 1983 until 2007.

BURKINA FASO

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 111

A meningitis epidemic started in Burkina Faso in mid-February 2007 and MSF began supporting health authorities and treating meningitis patients in the third week of February. By the end of this emergency intervention, MSF had treated 1,500 people in Burkina Faso's capital city, Ouagadougou.



© Anthony Jacopucci

Approximately one million people were vaccinated against meningitis

In March, MSF took charge of meningitis vaccinations in the Pissy health district in Ouagadougou, the most heavily populated district of the capital, where approximately 540,000 people were targeted for inoculations. The following month, MSF vaccinated the population of four rural districts: Manga, Po, Zabre in the south and Gorom-Gorom in the north of the country, representing approximately one million people.

Decentralising HIV/AIDS care

Throughout 2006/2007, MSF continued to run an HIV/AIDS project in Pissy, where an average of 1,600 medical consultations are provided monthly. Anti-retroviral treatment (ART) has been supplied to 2,556 patients since the project began in 2003. MSF is working at decentralising care for persons living with AIDS so they can receive treatment closer to home, and promoting patient autonomy through a community support approach.

Helping street girls in Ouagadougou

MSF operates a programme for street girls aged nine to 20 years in Ouagadougou. Activities include providing treatment for sexually transmitted infections (STI) and HIV/AIDS, reproductive and obstetrical care, psychological support for victims of sexual violence and efforts toward improving their legal protection. Close to half of the patients seen have or have had a child, and the project aims to improve the health of these children by educating the young mothers about child health and referring children to health services. The project has helped approximately 300 girls since it began in 2005.

MSF initially was only referring and accompanying the girls at public health facilities, aiming at reducing stigmatisation and upgrading quality of care by health staff. Since 2007, MSF has been more directly involved in providing medical services to the teenage street girls.

MSF has worked in Burkina Faso since 1995.

BURUNDI

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion
FIELD STAFF 364

Two years after elections brought Pierre Nkurunziza to power in 2005, all remaining rebel groups had signed truces with his government and in February 2007, UN peacekeepers were able to close down their operations. With the critical emergency phase over, MSF began focusing on filling gaps in healthcare, particularly in the area of women's health.

In November 2006, MSF launched a new project in the vast province of Bujumbura Rural (780,000 inhabitants), next to the capital. It uses radio, ambulances and qualified staff to refer women with obstetric problems from a dozen health centres to quality healthcare clinics in Bujumbura, where MSF pays the costs of their treatment. By the end of June

CAMEROON

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 90

Buruli Ulcer, an infection caused by mycobacterium ulcerans, is an emerging disease in several Western and Central African countries. Related to tuberculosis and leprosy, Buruli causes ulceration of the skin, primarily of the arms and legs, and destruction of underlying tissue and bone. Untreated, it may lead to permanent disability and limb amputation in those affected.

In Cameroon, this disease affects the inhabitants of several provinces situated in the Forest Equatorial Zone, with "nests" of high prevalence running alongside slow-flowing rivers. People in the Akonolinga and Ayos districts of Centre Province are among the worst affected. The two towns, which are focal points in their districts, are in the heart of the Buruli Ulcer (BU) epidemic zone and less than one hour's journey apart.

MSF has been developing the "Buruli Pavilion" in the District Hospital of Akonolinga since

2007, 481 women had been cared for through this project, with an increasing number of referrals. This is a temporary system guaranteeing free access to quality emergency obstetric care whilst an MSF clinic is constructed in the Kabezi area, which will be equipped to treat complicated deliveries.

In Bujumbura itself, MSF's Seruka Centre, a women's health clinic that opened in 2003, continues to provide medical and psychological care, treatment of sexually transmitted infections and services for family planning to survivors of sexual violence. An average of 300 consultations are carried out monthly and the centre has helped over 4,720 survivors of sexual violence since its inception. Even with the end of active conflict, rape remains extensive, and the MSF clinic treats approximately 120 new patients per month, 15 percent of whom are children less than five years of age.

Elsewhere in the country, MSF has worked since 1995 in the province of Karuzi to improve access to healthcare by supporting 12 health centres and the provincial hospital. Activities are also undertaken to safeguard people against

malaria. Following improvement of the health situation in the area and increased involvement of donors towards health initiatives, MSF will transfer the Karuzi project to the Ministry of Health (MoH) at the end of 2007.

In Ruyigi district, MSF provides primary healthcare through 11 health centres and support to two hospitals. Four clinics and a hospital in Musema, Kayanza province were handed over to the MoH at the end of May 2007, followed by seven clinics and a hospital in Kininya in July. A total of 370,000 consultations had been performed and 108,000 patients treated for malaria. MSF supported the care provided to patients admitted to hospital, including 4,300 pregnant women who gave birth. In addition, 600 people were tested for HIV/AIDS, many of whom were referred to the MoH for anti-retroviral treatment. MSF continues to lobby the Burundian government for improved access to low-cost healthcare, as most people cannot obtain access under the current cost-recovery system.

MSF has worked in Burundi since 1992.



© Jennifer Warren

MSF began focusing on filling gaps in health-care, particularly in the area of women's health



© Jean-Pierre Amigo

2002. The Pavilion has become a reference centre for managing BU free of charge and over 500 patients have been treated since the project began. Medical care for Buruli currently includes drugs and surgery.

The means of transmission and development of BU are still unknown. The prevention, diagnosis and treatment are complicated and compounded by the widely held perception of the disease as "mystical", resulting from a curse. There is an urgent need for affordable and rapid, non-invasive diagnostic tests to detect the disease in its early stages and newer

antibiotic treatment as an alternative to the anti-tuberculosis treatment currently being used.

Treating people with HIV/AIDS

MSF initiated an HIV/AIDS pilot project in 2000 and follows some 6,000 persons living with AIDS (PLWA) in its project in Nylon hospital, Douala, and more than 800 in Djoungolo hospital in Yaoundé.

MSF has concentrated on simplifying HIV/AIDS case management to help ensure care for patients in a country that now administers

treatment free of charge, but suffers from severe structural limitations in the domain of medical human resources. Simplification of care should help guarantee the continuity of anti-retroviral treatment and enable MSF to begin withdrawing from Yaoundé. MSF is also working on decentralising care for PLWA in Douala, Nylon district, to the health facility in New Bell and to the Catholic Church's medical facilities.

Assisting refugees from Central African Republic

By July 2007, a three year long civil war in neighbouring Central African Republic had led to the exodus of some 78,000 people. By July 2007 more than 26,000 had taken refuge at dozens of sites along Cameroon's eastern border. Insufficient protection and assistance and a deterioration in the medical and nutritional situation led MSF in July to urge more humanitarian actors to provide aid. MSF itself had been distributing supplementary food rations in the East province, where 12 tonnes of food had been supplied to 2,398 recipients (children and mothers). MSF was also implementing a medical and nutritional care strategy in collaboration with Cameroon's Ministry of Public Health for the most urgent cases.

MSF has worked in Cameroon since 2000.

CENTRAL AFRICAN REPUBLIC

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease
FIELD STAFF 448

Chronic insecurity, fuelled both by rebels and government forces, caused numerous disruptions in MSF medical aid in CAR during 2006/2007. On June 11, 2007, all activities came to an abrupt halt after the fatal shooting of MSF volunteer Elsa Serfass. Following discussions with all parties involved in ongoing conflict and a careful evaluation of humanitarian space, only a portion of activities had resumed one month later.

Ongoing fighting between government and various rebel forces in northern Central African Republic (CAR) since late 2005 has caused massive displacement of the population. Civilians, suspected of supporting one side or the other, are systematically targeted by armed groups or caught in the crossfire. Many villages have been looted or burned, forcing those that live there to flee. Bandits also take advantage of the general lawlessness to attack and rob civilians. By mid-2007, an estimated 70,000 people had sought refuge in neighbouring Cameroon and Chad, but 200,000 others remained hiding in the bush, exposed to harsh elements and lacking adequate shelter, food, clean water, and healthcare. People live in makeshift shelters with no blankets or mosquito nets.

The health risks are enormous. Those displaced are particularly vulnerable to respiratory infections, diarrhoeal diseases and general hazards such as snakebites. People live in fear, too afraid to venture far from their hideouts to visit health centres, most of which have long been abandoned. In 2006/2007 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, Kaga Bandoro, Markounda, Paoua, Boguila, and also in the northeastern areas of Birao and Gordil. In 2006, over 145,000 outpatient medical consultations were conducted and MSF carried out emergency surgery and treated patients for diseases such as TB, HIV/AIDS and sleeping sickness.

In many areas, MSF has been one of few aid organisations present, yet over 2006/2007, many mobile medical clinics were forced to suspend activities because of insecurity. At the end of October 2006, one rebel group (UFDR) launched an attack on Birao in northeastern CAR, rapidly heading southwards. For over a

month, it was impossible for MSF and other humanitarian agencies to assess the needs of the civilian population there. Access to Vakaga province was finally granted in mid-December and MSF offered the only healthcare available in the region.

Insecurity has continued with scattered attacks and constant intimidation in the northwest. During the first five months of 2007, MSF treated more than 95,000 patients, over a third of which were seen through mobile clinics. With threats and violence – including targeted attacks on humanitarian workers – reaching this population continues to be extremely difficult.

MSF has worked in the Central African Republic since 1997.



© Lena Westerberg

People live in makeshift shelters with no blankets or mosquito nets

CHAD

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion
FIELD STAFF 802



© Harald Henden

The need for humanitarian aid in eastern Chad has critically increased since July 2006. Ongoing confrontations between government forces and rebels, combined with border military incursions from Darfur, have fuelled a home-grown civil crisis leaving numerous Chadians killed or wounded and tens of thousands forced to flee their homes. Despite difficult security conditions, MSF has managed to increase its assistance toward internally displaced Chadians without hampering the aid provided to refugees from Darfur. In the southwest of the country, MSF assists refugees from Central African Republic, and has run a malaria treatment project since 2003.

Sustained assistance to Darfur refugees

Since 2003, some 200,000 refugees from Darfur have been living in camps in eastern Chad. Whilst many carry a heavy burden of psychological trauma from events in Darfur, they continue to fear attacks when straying from the camps, or of being forced back to Sudan. Although they receive assistance, their situation remains critical as they depend entirely on international aid, which is subject to variation if security or funding deteriorates.

MSF provides medical care, including paediatric and maternal care as well as psychosocial support, to more than 100,000 people living in Iridimi, Touloum, Farchana and Breidjing refugee camps and to the surrounding Chadian population. The teams also treat the

The area is often flooded and many places remain without access to medical care for long periods

REPUBLIC OF CONGO (Congo-Brazzaville)

REASONS FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion
FIELD STAFF 191

After more than a decade of war and unrest, a peace treaty was signed between rebels and the government of the Republic of Congo in 2003. Although remnants of civil war militias, known as Ninjas, remain active in the southern Pool region, the situation is no longer considered an emergency and MSF has started handing over its projects.



consequences of sexual violence, address malnutrition, provide health education and help control communicable diseases. In Adré and Iriba hospitals, MSF surgical teams also offer elective and emergency surgery to refugees from nearby camps, residents and displaced Chadians.

Ensuring care as violence flares

In Eastern Chad, the number of internally displaced people (IDP) increased dramatically from 40,000 in May 2006 to 170,000 by June 2007. Ongoing civil violence caused the population of the area to gather in camps and IDP sites around Goz Beïda, Koukou, Am Timan, Am Dam and Dogdoré. The displaced population has been deeply traumatised.

Poorly sheltered, lacking food, clean water and with limited access to healthcare, the displaced were long neglected by international assistance. This led to an emergency sanitary and health situation, particularly regarding malnutrition.

Despite difficult security conditions, MSF provided primary and secondary medical assistance, drinking water, food and material aid to improve shelters, whilst trying to follow people through their displacement. Between April and June, confronted with soaring malnutrition rates, MSF developed nutritional projects and increased its hospitalisation capacity. In July 2007, MSF is assisting displaced in camps and IDP sites around Goz Beïda, Adé, Koukou, Arkoum, Am Timan, Am Dam and Dogdoré.

Supporting refugees from Central African Republic

Since June 2005, increasing violence in neighbouring Central African Republic has prompted tens of thousands of villagers to flee. Many are still hiding in the bush, and more than 45,000 have gathered in southern Chad, around the city of Goré. MSF provided assistance including water, sanitation and healthcare in the camps until April 2007. MSF continues to work in Goré district hospital, supporting all wards to provide secondary medical care and surgery to refugees and local residents.

Treating malaria with innovative strategies

Malaria is a concern in the southern district of Bongor: in 2004 an MSF survey showed the number of deaths for children under five was close to emergency status during malaria season. When the project to prevent and treat malaria was launched in 2003, MSF faced a severe lack of local healthcare workers and a high resistance to the treatment usually available. Further, the area is often flooded and many places remain without access to medical care for long periods. To overcome these barriers, MSF introduced a therapeutic strategy using artemisinin combination therapy (ACT), and favouring decentralised care through the empowerment of the local population. Between July 2006 and June 2007, 88,000 people were treated in the project, representing over 20 percent of the total number of people treated for malaria within the country.

MSF has worked in Chad since 1981.

MSF has continued to provide support to hospitals and community health clinics in Kindamba, Mindouli and Vindza districts. Medical services include ante, post-natal and emergency obstetric care, health education, HIV counseling and treatment, tuberculosis and malaria treatment, and psychosocial counseling. Over 75,000 patients were treated in the outpatient departments in 2006 in both hospitals and mobile clinics, and over 4,300 patients treated in the hospitals.

Decrease in sleeping sickness

In 2006/2007, MSF treated patients affected by Human African Trypanosomiasis (sleeping sickness), through a mobile clinic. The team screened 22,059 people in the districts of Cuvette, Pool and Bouenza and found 220 patients requiring treatment. The programme was evaluated in 2007, as the disease was eradicated from many areas and fewer people were contracting sleeping sickness. MSF will continue to provide care in early 2008 for patients still affected by the disease.

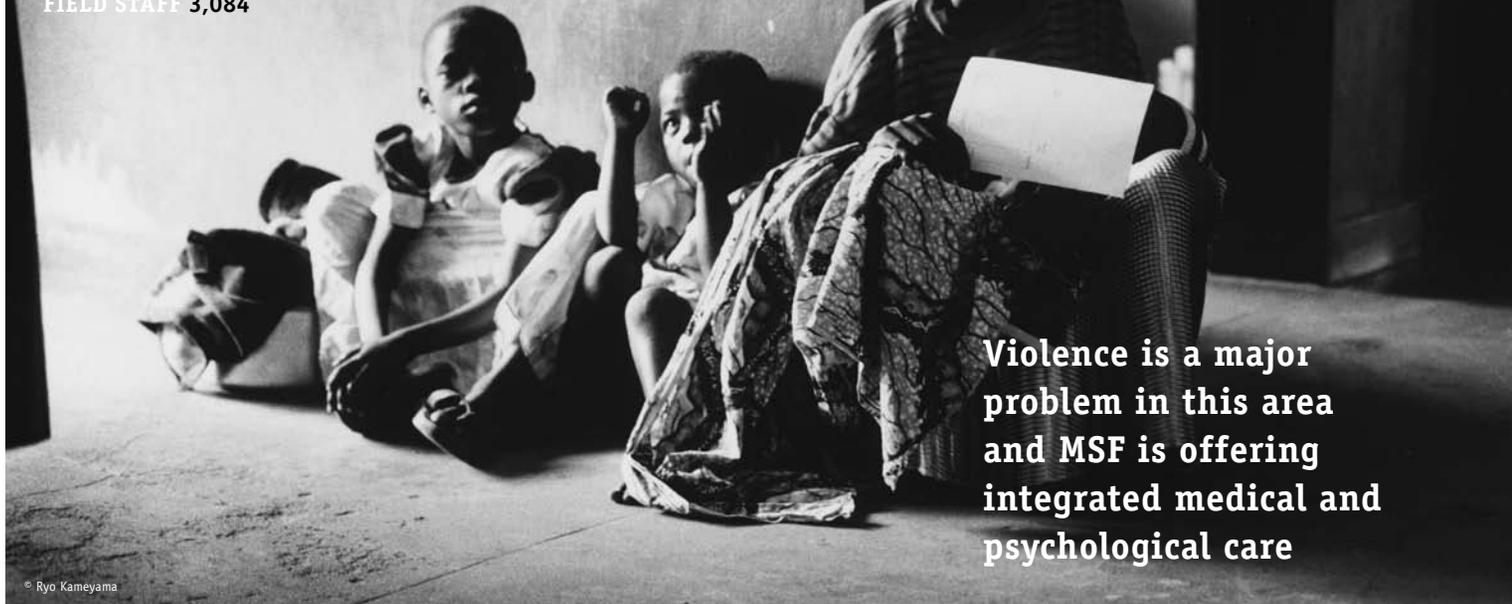
Cholera outbreak

MSF launched an emergency response to a cholera outbreak in Pointe Noire and Brazzaville at the beginning of 2007. MSF supported the Ministry of Health (MoH) by treating patients at the hospital, providing cholera treatment units and oral rehydration points. By April, MSF had treated approximately 4,000 people and trained MoH staff on how to run and manage a cholera treatment centre. In 2008, MSF will continue to transfer programmes to the MoH and other service providers wherever possible.

MSF has worked in Congo-Brazzaville since 1997.

DEMOCRATIC REPUBLIC OF CONGO

REASON FOR INTERVENTION • Armed Conflict • Endemic/
Epidemic Disease • Social Violence/Healthcare Exclusion
FIELD STAFF 3,084



Violence is a major problem in this area and MSF is offering integrated medical and psychological care

The peace process in Democratic Republic of Congo culminated in November 2006 with the election of Joseph Kabila as president. Although a degree of political stability has begun to seep into this vast nation, the country is left in pieces after 50 years of bloodshed and the scale of health needs is considerable. The great majority of the population have limited or no access to healthcare, epidemics break out with regularity and violence continues to have a devastating impact on people's lives, particularly in the east of the country.

Several years after full-scale war officially ended, MSF retains more than 3,000 staff on the ground, and across DRC, MSF continues to run the Congo Emergency Pool. With base stations in Lubumbashi, Kisangani and Kinshasa, teams can go almost anywhere and respond to approximately ten medical alerts every month.

As stability allows more development-oriented organisations to take root, however, MSF has been able to scale-down some of its activities. It was in 2002 that MSF first intervened in Ankoro, in the southeastern province of Katanga, on what was then the frontline. The aim was to bring medical care to people suffering from violence and epidemics. Following an aerial bombardment of the town, MSF renovated the hospital into a functioning reference centre. In June 2007, conditions were finally judged acceptable enough for MSF to withdraw.

Whilst the upsurge in fighting that took place between rebels and government soldiers in late 2005 and early 2006 has all but ceased, MSF continues to work in the Katanga region. Major

healthcare projects still running include Kilwa, Shamwana, Dubie and Pweto to the east of the region. The destitution of the area was epitomised by a string of epidemics over 2006/2007. In August 2006, MSF opened two cholera treatment centres and 14 treatment units in response to rampant cholera in Kikondja. Between January and May of 2007, MSF intervened for both cholera and measles in Kabundo, Dianga and vaccinated 120,000 children around Bukama and 37,000 in Nyunzu after a measles outbreak in May and June. In June MSF also started treating children with measles in Mukanga and in Kasenga.

Earlier, in January 2007, a meningitis epidemic was confirmed in Adi health zone, in the east of DRC. Within seven days of beginning the campaign, a 52-person team had vaccinated everyone from two to 30 years of age, covering 18 health areas and 80,000 residents.

It is not just short-lived epidemics that are a serious threat to health. AIDS continues to spread, and MSF continues to provide compre-

hensive care in the capital city, Kinshasa, as well as Kilwa in Katanga, Bukavu and Dungen in the east of the country. In July 2007, over 3,000 people were receiving anti-retroviral treatment.

Other diseases, such as the fatal parasitic disease "sleeping sickness", or Human African Trypanosomiasis (HAT), remain killers. In June 2007, MSF opened a new programme to combat HAT in heavily affected areas at the extreme north of the country, the Haut Uélé and Bas Uélé districts of Province Orientale. Since 2004, MSF has been running a programme against HAT in Isangi and managed to significantly decrease the number of cases of sleeping sickness in the area, allowing the programme to close in 2007.

In November 2006, MSF launched a new project in Lubutu, located in the North Maniema Province, where extremely high mortality rates were found during a survey conducted in late 2005. This region is indirectly affected by conflict and population displacement in the east and remains highly isolated.

In the provinces of North and South Kivu in the east of the DRC, there remains a steady flow of violence. In 2006, MSF opened three new emergency programmes in Linzo, Kanyabayonga and Nyanzale, and continued to work in the reference hospitals of Kayna and Rutshuru, providing surgical and secondary

care and treating victims of sexual violence. In collaboration with the Ministry of Health, MSF teams in 2006 carried out 12,200 emergency hospital admissions, 2,971 surgical interventions and treated more than 3,500 victims of sexual violence. In Rutshuru hospital MSF surgeons conducted approximately 120 operations per month, seven percent linked directly to violence, such as bullet wounds and the physical effects of torture.

In Bunia, the provincial capital of Ituri, MSF continues to work in the Bon Marché hospital. Seven wards were built in 2006 to increase capacity and allow patients to receive treatment in proper buildings rather than tents. The aim of the Bon Marché is to focus on emergencies and the care of children aged less than five years – more than 24,000 were seen in 2006. Nearly 12,000 patients were admitted to the hospital and approximately 10,000 surgical interventions were performed.

Violence is a major problem in this area and MSF is offering integrated medical and psychological care. At this location alone, MSF in 2006 treated 2,041 patients who were victims of sexual violence.

MSF has worked in Democratic Republic of Congo since 1981.



© Carl De Keyser / Magnum Photos

It is not just short-lived epidemics that are a serious threat to health

MSF works across the meningitis belt

Meningitis outbreaks are common in an area of sub-Saharan Africa known as the meningitis belt, where approximately 300 million people are at risk in an area stretching from Senegal in the west to Ethiopia in the east. Epidemics occur during the dry season (December to June) and tend to occur in a cyclical manner across the belt.

Meningococcal meningitis is an infection of the meninges, the membrane surrounding the brain and spinal cord, caused by the bacterium *Neisseria meningitidis*. There are several strains (A, B, C, X and W135), some of them responsible for epidemics.

As the bacteria is transmitted through droplets in the air, high concentrations of people and cramped living conditions facilitate the spread of the disease. Most individuals will be asymptomatic carriers of the bacteria and remain completely well; however when the bacteria crosses the mucosal barrier, a person will show signs of the disease, which usually manifests with fever, headache and neck stiffness as well as rash, convulsions and loss of consciousness.

Meningococcal meningitis is an infection of the meninges, the membrane surrounding the brain and spinal cord, caused by the bacterium *Neisseria meningitidis*

Without treatment for meningitis, 80 percent of patients can die, yet with early diagnosis and treatment the death rate can be reduced to 5-10 percent. As many as one in five survivors will suffer from neurological effects or hearing loss.

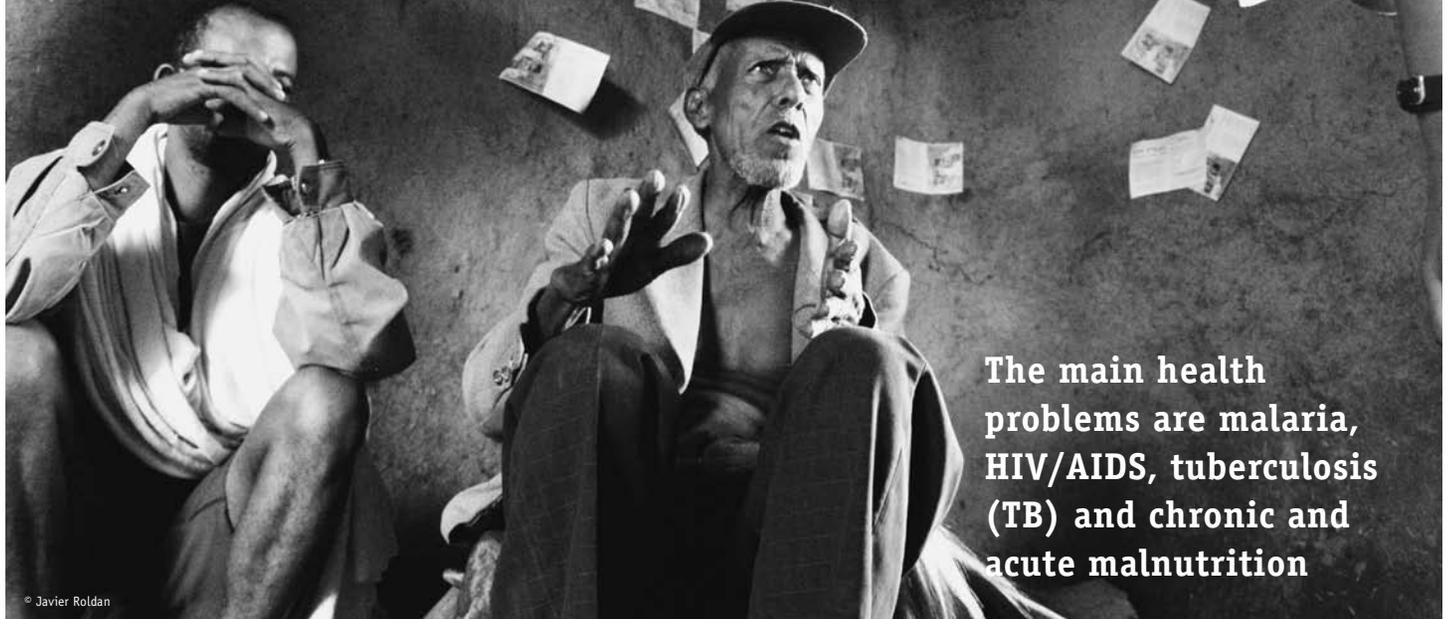
An epidemic is declared when 15 cases per 100,000 people per week have been detected in a region (10 cases per 100,000 people in special circumstances). Once an epidemic has been identified, health workers rely on clinical diagnosis and rapid, simple treatment at a facility close to the patient. The treatment consists of a single intramuscular injection of the antibiotic oily chloramphenicol or ceftriaxone. In most cases a single dose leads to full recovery - a second dose is given if there is no improvement after 24 hours. An alternative treatment of a daily injection of ceftriaxone for five days is used for children aged two months to two years old, due to the possibility of other bacteria causing the meningitis.

In the 2006 epidemic season, after several years of low incidence, there was a marked rise in meningitis outbreaks across the meningitis belt. This increase could signal the beginning of a new epidemic wave in the coming years. In 2006/2007, the overall number of cases reported was more than 50,000, a significant increase over the previous year, when 35,000 cases were recorded.

During the 2006/2007 epidemic season, MSF was active in 14 outbreak responses in five countries that experienced meningitis epidemics – Burkina Faso, Chad, Sudan, Uganda and the Democratic Republic of Congo (DRC). MSF activities included the initial evaluation of the epidemics, identifying the type of meningitis and supporting case management to ensure rapid treatment for those affected by the disease. MSF also participated in mass vaccination campaigns to prevent the deadly disease from spreading. In total, MSF was involved in the vaccination of 2.5 million people against meningitis and treated 10,500 patients affected by the disease.

ETHIOPIA

REASON FOR INTERVENTION • Armed Conflict
 • Endemic/Epidemic Disease • Social Violence/
 Healthcare Exclusion • Natural Disaster
 FIELD STAFF 828



The main health problems are malaria, HIV/AIDS, tuberculosis (TB) and chronic and acute malnutrition

Over 80 percent of Ethiopia's more than 79 million inhabitants live in rural areas, making the provision of health services in Africa's second most populous country a major challenge. The main health problems are malaria, HIV/AIDS, tuberculosis (TB) and chronic and acute malnutrition. There are also frequent epidemics and outbreaks of meningitis and measles, and diseases such as kala azar are endemic in some areas.

Cherrati, in Somali Region, is a semi-arid area that borders Somalia, where people live as pastoralists, trading in livestock. MSF established a primary healthcare centre in this region in 2004, offering general consultations, maternal healthcare, inpatient medical care, therapeutic feeding, wound dressings, vaccinations and drug distribution. More than 18,000 consultations were conducted here in 2006. Another primary healthcare centre is located in Itang, Gambella Region, which focuses on the treatment of malaria, HIV/AIDS and tuberculosis.

Responding to outbreaks of cholera and measles

Between August and October 2006, MSF responded to an outbreak of acute watery diarrhoea in the regions of Oromyia and Amhara as well as Addis Ababa. Teams assisted the

regional health authorities in SNNPR (Southern Nation Nationalities and People's Region) in their response beginning August 2006. Although there is no permanent team in the area, MSF reacted by setting up cholera treatment centres, providing materials such as tents, saline solution for rehydration and chlorine for disinfection; and sending mobile teams when necessary. Over 9,000 patients received medical consultations. In November and December 2006, MSF assisted people displaced by floods and responded to an outbreak of acute watery diarrhoea in the Somali region.

In June 2007, MSF is running an emergency programme in the Amhara region at resettlement sites in Awi Zone, Jawi District, responding to a measles outbreak and preparing for the malaria season. MSF teams started a vaccination campaign and set up mobile clinics to treat people with measles, malaria and other deadly pathologies. Nutritional support is also provided. As the rainy season approaches and many areas will become inaccessible, MSF teams are helping prepare health services through training, providing equipment and supplying drugs.

Treating an overlooked disease

Kala Azar (visceral leishmaniasis), also known as "black fever," is endemic in some parts of Ethiopia and appears to be spreading to new

areas. A parasitic infection, this tropical disease critically affects the immune system and has a mortality rate of almost 100 percent. With proper treatment, approximately 92 percent of people infected can be cured. MSF runs treatment centres in Tigray and in the Amhara region, where 657 patients were treated for kala azar in 2006. Although kala azar is a recognised disease, few resources are being allocated to it through the health system.

Handing over TB and HIV/AIDS programmes

MSF has closed its TB programme in Galaha and patients undergoing treatment have been transferred to the national TB programme. TB treatment continues in MSF's health centre in Cherrati. By the end of 2006, more than 400 people had received treatment and a TB hospitalisation ward had been constructed, as well as a "TB village", where patients live in a communal area under close medical supervision.

In Humera, Tigray Region, MSF has handed over its HIV/AIDS activities, where 750 patients were being treated with anti-retrovirals, to the Ministry of Health. The government was ready to continue care for the patients and provide the necessary medications free of charge.

MSF has worked in Ethiopia since 1984.

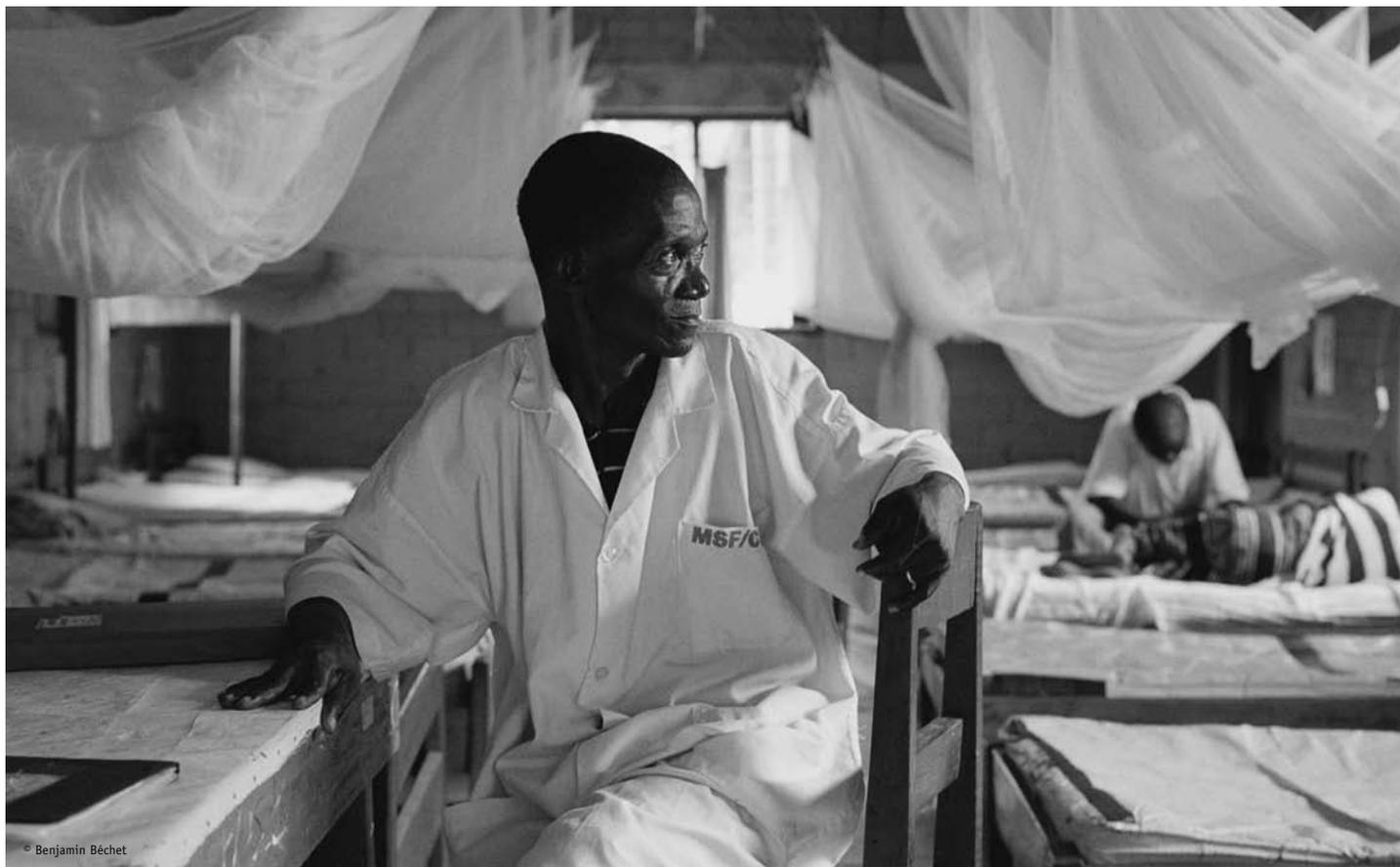
GUINEA

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease
FIELD STAFF 306

In early 2007, falling living standards sparked protests resulting in almost 100 deaths, reinforcing fears that Guinea could be on the brink of becoming Africa's next failed state. During this unrest, an MSF emergency team worked from the capital, Conakry, helping to treat the hundreds of wounded people admitted to Donka hospital and several urban health centres.

tion and treatment, and providing drugs. MSF activities now exclusively address HIV/TB co-infection. These patients are treated through outpatient consultations.

Malaria is endemic in Guinea, and responsible for 35 percent of medical consultations in the country. Despite the government agreeing to introduce the far more effective malaria drug ACT (artemisinin combination therapy) over



© Benjamin Béchet

It is not just civil unrest that killed people in 2006/2007 in Guinea, but also a general lack of healthcare. The shortcomings of the national health system are demonstrated by the inadequate treatment available for malaria, tuberculosis (TB) and HIV/AIDS. MSF has increased its efforts to address these diseases in the country and is using the experience of its programmes to lobby the government for improvements in the provision of treatment.

Treating malaria, tuberculosis and HIV

For over 98 percent of the estimated 127,500 people living with HIV/AIDS in Guinea, this manageable disease is likely to lead to death. Despite the development of an official national response and plans to put 25,000 patients on anti-retroviral (ARV) treatment, the reality is these lifesaving medicines lie out of reach for almost all patients.

MSF began treating patients living with HIV/AIDS in August 2003 through two projects: one in the capital, Conakry and the other in Guéckedou, on the Liberian border. From these two centres MSF offers voluntary counseling and testing - a much needed service in a country where only one percent of the population has access to such testing - and regular consultations for all people who test HIV-positive. Anti-retroviral drugs (ARV) have been provided since 2004 and by the end of November 2006, more than 1,200 MSF patients were benefiting from ARVs, representing almost half of all patients receiving treatment in the country.

Tuberculosis is one of the most common and lethal opportunistic infections for people living with HIV/AIDS. MSF has improved the diagnosis and treatment of TB in the capital by training medical staff, improving case detec-

two years ago, this drug is rarely available to the average Guinean. MSF is lobbying the authorities to rectify this whilst simultaneously providing ACT treatment in Dabola province from the hospital and surrounding health structures. In 2006 more than 13,000 patients were treated with ACT in this area.

Refugees leave Guinea

For the last 15 years, MSF's activities in Guinea have also included medical care for refugees fleeing fighting in neighbouring Sierra Leone and Liberia. By mid-2007 almost all these refugees have returned home and with their departure comes the closure of MSF's last remaining refugee project in the country, for Liberian refugees in Guinea Forestière.

MSF has worked in Guinea since 1984.

IVORY COAST

REASON FOR INTERVENTION • **Armed Conflict**

FIELD STAFF 1,100

In March 2007, a peace agreement was signed by former rebels in the north and the government-controlled south of the Ivory Coast, leading to significant improvements in a country divided by civil war. A national union government has been formed and many civil servants, including health staff, have returned to their places of work in the north. Access to health-care has improved in many areas.

Violence and banditry, however, continue to characterise the western part of the country. In April 2007, the withdrawal of UN and French soldiers from the neutral buffer zone left a power vacuum in which civilians soon became targets. Bangolo, a town close to the Liberian border, lies in the heart of the affected region. From April 16 onwards, an MSF team on the ground, treating patients from a series of mobile clinics and health centres, reported almost daily attacks on civilians in the area. Assaults on vehicles, robberies, assassinations and rapes significantly increased. As well as providing medical care, MSF spoke out about the situation on 25 April 2007 and released a collection of testimonies,

drawing attention to the fact that although political progress was being made with the peace process, civilian suffering continued. MSF has been in the region since 2004, providing approximately 4,300 consultations monthly through the Bangolo hospital and mobile clinics in neighbouring villages.

Throughout the conflict, MSF had run hospitals, health centres and mobile clinics in both rebel and government held areas, as well as in the neutral buffer zone. Innovative projects were opened in Man and Danané hospitals, where anti-retroviral (ARV) treatment was offered for the first time to people living with HIV/AIDS in the region. Over 1,100 people were registered for HIV care at the end of 2006. In Man hospital, a pilot programme was launched, offering surgery for women with painful and debilitating gynaecological injuries known as obstetric fistulas. Together the Man and Danané projects provided over 200,000 outpatient medical consultations in 2006.

Whilst some MSF projects, particularly those in violence affected areas or where there are still large numbers of displaced, such as Guiglo (48,000 consultations in 2006) continue, others, including Bouaké Hospital in the country's second capital, have been handed over. MSF is looking to withdraw from the country if stability and improvements in access to healthcare continue.

MSF has worked in Ivory Coast since 1990.

KENYA

REASON FOR INTERVENTION • **Armed Conflict • Endemic/Epidemic Disease • Natural Disaster**

FIELD STAFF 517

The primary focus of MSF in Kenya is on treatment for people with HIV/AIDS. In projects in the slums of Nairobi and in the rural areas of Busia and Homa Bay, MSF provides more than 12,000 people with anti-retroviral treatment (ART). Increasing emphasis is also being placed on an emerging and drug-resistant form of tuberculosis (TB).

Homa Bay, located in the western Nyanza province, was MSF's first HIV/AIDS programme in Kenya, opening in 1996. With an HIV prevalence of approximately 35 percent, the densely populated Victoria lakeshore is one of the worst affected areas in the country. Initially focusing on TB and on reducing HIV transmission through health facilities, free ART was first introduced in 2001.

In July 2007, 4,741 people are under care, with 3,567 of those receiving ART. With a planned merger of MSF and Kenyan Ministry of Health (MoH) activities, and the opening of three more HIV health facilities on the periphery of Homa Bay, this figure will continue to rise. MSF also provides resources and technical assistance in the piloting of a one-stop service for people with TB/HIV co-infection, including the development of the third TB culture laboratory in the country.

In Busia District, situated on the Kenyan border with Uganda, MSF runs an HIV/AIDS project in the main district hospital and nine rural health centres. In addition to the clinical services within these facilities, the project provides a system of home-based care, utilising over 140 volunteer community health workers and running an information and education programme that targets people living with HIV/AIDS and community groups. It is estimated that over 10,000 people from the district are in urgent need of treatment. The project began providing ART in July 2003 and treats 1,850 patients, 140 of them children.

In 2007 MSF is handing over three ART sites to a development partner and supporting the MoH in establishing two more in health centres, increasing the access to treatment and

MSF has been in the region since 2004, providing approximately 4,300 consultations monthly





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prevention of mother-to-child transmission in the most remote and highest HIV prevalence locations of Busia district.

In Nairobi, MSF also provides comprehensive HIV/AIDS care in the Mbagathi District Hospital. In early 2005, MSF built a clinic on the hospital grounds, allowing integration of the comprehensive MSF and MoH HIV/AIDS activities. Now more than 3,314 patients receive ART, with a further 811 being followed. MSF is gradually handing over this project to the MoH.

The number of people affected by drug resistant tuberculosis continues to rise

Linked closely with Mbagathi hospital in the sprawling Kibera slum, MSF runs a project that integrates HIV/AIDS and TB into primary healthcare in three clinics. A focus of this programme is the empowerment of people and communities living with the virus. Covering both Mbagathi Hospital and the slum, which has a population of over 600,000, MSF treats 4,744 people with ART and provided approximately 103,000 consultations in 2006/2007. In Mathare, a second slum with a population

of over 300,000 on the eastern outskirts of Nairobi, MSF runs a project known as the “Blue House,” located in a renovated old hotel building. The project offers free comprehensive treatment for HIV/AIDS and with a co-infection level of approximately 70 percent, MSF also treats patients with TB. In late 2006, an extension was added to the clinic to treat increasing numbers of patients with multi drug-resistant tuberculosis (MDR-TB), an emerging strain of the disease that cannot be cured with firstline TB drugs. The number of affected people continues to rise in slum conditions that create a perfect breeding ground for the spread of the disease. Approximately 2,751 people living with HIV/AIDS are under care and the clinic is testing approximately 300 people per month for HIV. MSF also provides many of its patients with health support in the form of key nutritional supplements.

New project in Kacheliba

In late 2006, MSF opened a new programme in the small town of Kacheliba in the West Pokot region of Kenya, treating visceral leishmaniasis, also known as kala azar – a Sanskrit term meaning ‘black fever.’ Leishmaniasis are parasitic diseases that principally affect poor communities in isolated regions, often in devastating epidemics.

Floods, fever and refugee needs

MSF continues to respond to emergencies in Kenya. In late 2006, MSF reacted to floods that struck the Somali refugee camps in the border area of Dadaab, providing medical care to residents and refugees.

At the beginning of 2007, MSF responded to an outbreak of the Rift Valley Fever virus, and in April teams set up medical clinics on both sides of the lines of conflict after clashes erupted between two rival ethnic groups by Mount Elgon, in the west of Kenya.

MSF has worked in Kenya since 1987.



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LESOTHO

**REASON FOR INTERVENTION • Endemic/
Epidemic Disease**
FIELD STAFF 13

With 23.2 percent of its adult population infected with HIV, Lesotho has the third highest HIV prevalence in the world after Swaziland and Botswana. Approximately 23,000 people die of AIDS-related causes each year. Tuberculosis (TB) is the leading cause of death among people with HIV/AIDS in Lesotho, more than 90 percent of TB patients are co-infected with HIV.

After 18 months in the country, MSF has provided anti-retroviral therapy (ART) for approximately 1,500 people in Scott Hospital Health Service Area, a rural health district with one hospital and 14 primary care clinics that serve a population of 220,000, 35,000 of whom are estimated to have HIV/AIDS. MSF works with hospital management and staff to

provide comprehensive care including HIV counseling and testing (13,323 tested by June 2007), prevention of mother-to-child transmission, and management of opportunistic infections and co-infections, particularly TB.

The programme achieved these results within a short timeframe by training and empowering nurses; ensuring weekly visits to each clinic from MSF mobile medical teams that provide direct clinical care as well as in-service training, support, and mentorship; creating new cadres of community health workers (most of whom are living with HIV/AIDS and are enrolled in the programme) to take on HIV counseling and testing, ART preparation, and other clinic support tasks to reduce the workload for nurses; strengthening laboratory and pharmacy capacity at the district hospital; and promoting openness about HIV and community involvement in service delivery.

A shortage of healthcare workers threatens further scale-up of activities and makes clinical challenges more daunting, particularly the diagnosis and treatment of TB, including

drug-resistant TB. There are fewer than 100 doctors in the entire country, most from other African countries and often awaiting certification in South Africa, where they can get higher paying jobs. In June 2007, over half the professional nursing posts were vacant in the 14 clinics supported by MSF and 30 percent of professional nursing posts at the district hospital were vacant.

Tuberculosis (TB) is the leading cause of death among people with HIV/AIDS in Lesotho

MSF made an exceptional decision to advocate at national and international levels for health staff. Adequate staff is necessary to expand and improve the quality of HIV-TB care and treatment for the thousands of people in need.

MSF has worked in Lesotho since 2006.

LIBERIA

**REASON FOR INTERVENTION • Endemic/
Epidemic Disease • Social Violence/
Healthcare Exclusion**
FIELD STAFF 1,634

Four years after the end of its devastating civil war, Liberia is slowly beginning to recover, but many Liberians are struggling to find even basic services, including healthcare.

Improving the health of mothers and children is a main focus of MSF's work in the country. Each month, more than 1,500 children are treated at Island and Benson hospitals in the capital, Monrovia. Benson Hospital also provides maternity care and obstetric surgery and runs a women's health centre that offers care before and after birth as well as family planning services. Also in Monrovia, two MSF-supported primary health clinics handle 12,000 curative consultations each month. A majority of the patients are pregnant women, new mothers and children. In Saclapea, Nimba County, MSF runs a special unit focusing on women's health in connection to a larger health centre with both outpatient and inpatient services. A new health structure with 30 beds is under construction and will be completed by the end of 2007.



Extensive sexual violence

Sexual violence continues to be a serious problem in Liberia. Between January and April 2007, MSF teams in Monrovia treated approximately 135 patients monthly. Over one third of these victims were younger than 12 years. Patients are provided with a medical certificate, a necessary requirement to bring a case to court.

Supporting cholera treatment

Cholera is common in Liberia, particularly in the capital, with outbreaks occurring annually. For several years, MSF has supported a cholera treatment centre in Monrovia during outbreaks. At the height of the outbreak in 2006, MSF treated 120 patients a week. In March 2007, when cholera cases began to increase, MSF again began supporting the

MALAWI

REASON FOR INTERVENTION

- Endemic/Epidemic Disease

FIELD STAFF 466



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centre. MSF had also responded to a cholera outbreak in Buchanan in August 2006, treating hundreds of patients.

Moving from relief to development

As Liberia moves toward increased stability, humanitarian organisations including MSF, with the mandate of providing assistance in emergency situations, are beginning to leave the country. But Liberia's public health services still require critical support and finding alternatives to humanitarian organisations is imperative. Days prior to an international donor conference in Washington D.C. in February, 2007, MSF released a report describing the healthcare situation in the country and outlining the challenges ahead.

Between December 2006 and July 2007, MSF gradually stopped working in health facilities in River Cess, Grand Bassa, Nimba and Lofa Counties. The majority of these facilities were handed over to the Liberian health authorities or to other NGOs. A treatment programme for HIV patients in Nimba County was handed over to local health authorities in April 2007. MSF has also withdrawn from Mamba Point Hospital in Monrovia.

MSF has worked in Liberia since 1990.

In Malawi, MSF's work has been devoted to people suffering with HIV/AIDS, where a dire shortage of health workers and sparsely spread populations in rural areas make the delivery of HIV treatment extremely challenging. MSF is supporting implementation of the national AIDS plan and has tried innovative approaches to increase the capacity for care.

Involvement of the community and people living with HIV is central to MSF's intervention. Patients and community members have been specifically trained to take over some of the nurses' duties including testing, counseling and providing support to help people adhere to their treatment. Involving community members in this way means that nurses can focus purely on medical issues and therefore better cope with the acute staff shortage affecting Malawi's health sector.

In the rural areas of Chiradzulu and Thyolo, MSF has been involved in the training of nurses, who are now able to initiate people on treatment, a job previously performed only by doctors. Shifting tasks and intense training of care providers have allowed patients to be followed closer to where they live through smaller health structures, or at home, without having to travel to hospitals for drugs and check-ups.

MSF also strongly focuses on detecting and treating both tuberculosis (TB) and malnutrition in HIV patients. Both conditions jeopardise the efficiency of treatment, and ultimately the lives of the patients. In 2006 MSF admitted over 400 people for TB treatment.

In the central district of Dowa, teams provide a wide range of HIV/AIDS services at the district hospital and two health centres, as well as preventive activities in five more health centres in the district. In addition, in a camp in Dzaleka, MSF provides basic HIV/AIDS care to refugees coming from different African countries. Support groups have also been created for HIV-positive children and adults, with high attendance.

In July 2007, MSF is providing anti-retroviral drugs to approximately 15,000 people in the country and almost 700 people are starting treatment in an MSF structure every month.

MSF has worked in Malawi since 1986.

MALI

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 69

In July 2005, MSF launched a project to help people with malaria in Kangaba, in southern Mali. A medical investigation conducted by MSF in 2004 had shown that, in addition to significant mortality rates, there were high levels of resistance to the chloroquine-based therapies used for treatment. Despite the government's implementation of a more effective artemisinin combination therapy (ACT) policy for malaria in 2004, quantities of these drugs were insufficient and too expensive for widespread use.

To support the implementation of this new treatment, MSF focused its efforts on seven community health centres and the reference health centre in Kangaba. The use of ACT in tandem with a rapid screening test (RST) has provided a technical response to the treatment of malaria and chloroquine resistance, where 7,784 people were treated for malaria through this project in 2006. Yet the project still faced two major problems: quality of care and access to the treatment.

Beginning in December 2006, MSF made these issues top priorities. At seven health centres in Kangaba, MSF succeeded in obtaining free healthcare (including malaria diagnosis and treatment) for children under five years of age, as well as free care for pregnant women suffering from malaria.

A flat rate policy was also implemented at three health centres in December 2006 for the care of febrile diseases (malaria and others), to replace the cost-recovery system; as of July

2007, this policy was in force at the seven health centres. Finally, additional human resources have been made available to oversee and improve the quality of diagnosis and care. Since July 2007, MSF has implemented a strategy for the free treatment of malaria by community groups equipped with the RST and ACT, for children under the age of ten, at sites located more than five kilometres from the health centre.

In northern Mali, in the regions of Gao, Kidal and Timbuktu, MSF in 2006/2007 responded to high rates of maternal mortality by developing a programme to care for pregnant women and their babies. After taking over obstetric-related surgical interventions, improving infrastructures and providing maternal health training to health groups and the population, MSF withdrew from the project in January 2007, handing it over to health authorities.

MSF has worked in Mali since 1992.



A flat-rate policy was implemented for the care of febrile diseases

MOROCCO

REASON FOR INTERVENTION • Social
Violence/Healthcare Exclusion
FIELD STAFF 18



A passageway between Africa and Europe, Morocco receives thousands of asylum seekers and illegal immigrants each year. Over 2006/2007 this population, which previously gravitated to precarious conditions in bush areas, increasingly relocated to the cities in search of safety.

Urban centres are propitious for subsistence strategies such as begging or prostitution that may contribute to improvement of immigrants' survival; however, settlement in the populated areas of Rabat and Casablanca also gives rise to new health and social problems and violence takes on a bigger dimension.

MSF provides primary care to sub-Saharan immigrants (SSIs) primarily in Tangier-Tetouan and Nador-Oujda, seeing patients in clinics and through field visits where medical staff consult with patients on-the-spot. MSF teams conduct a total of approximately 300 consultations monthly. Teams also make medical referrals in cooperation with public health centres and health authorities. MSF ensures a drug supply system to cover patients' needs and has established a supply of first aid material and basic hygiene kits in both suburban and isolated areas.

The evolution of the SSIs living situation is evident in presenting health problems: in



Morocco receives thousands of asylum seekers and illegal immigrants each year

Tangier, for example, MSF is now seeing less lesions and injuries (six percent of consultations in 2006, down from 26 percent in 2005), yet an increase in gynaeco-obstetric pathologies (11 percent in 2006, up from eight percent in 2005). Frequently treated medical conditions, such as respiratory infections and skin conditions, are related to difficult living conditions. There are always many cases of non-specific problems, usually referred to as “body pain” and clearly linked with the hard living conditions.

The medical needs of women are met through the implementation of ante-natal care activities and voluntary HIV screening tests are offered, with drugs to prevent mother-to-child transmission for women found to be HIV-positive. Educational activities and treatment are also provided for sexually transmitted infections.

During 2006 MSF observed an improvement concerning sub-Saharan immigrants accessing healthcare within the Moroccan public health system and its professional staff, mainly in Tangier-Tetouan and Nador-Oujda, and to a lesser extent in Rabat, Casablanca and the area of Layoune.

MSF has worked in Morocco since 1997.

MOZAMBIQUE

REASON FOR INTERVENTION • **Endemic/ Epidemic Disease • Natural Disaster**
FIELD STAFF 539

In early 2007 torrential rains fell in Mozambique and flooding in the Zambezi Valley forced about 250,000 people to leave their homes. Although heavy rainfall is a seasonal phenomenon in the country, floods were the worst since 2000/2001 and exacerbated by the landfall of Cyclone Favio. Already working in the country on longer-term HIV/AIDS projects, MSF launched an emergency intervention to assist people affected in Zambezia and Tete provinces in February.

Emergency relief comprised basic assistance to 50,000 people who had to evacuate flooded zones. The main priority was to provide clean and drinkable water, build latrines and distribute plastic sheeting for temporary shelters. Items needed to guarantee minimal hygienic conditions in temporary displacement camps such as soap, mosquito nets, jerry cans and blankets were distributed. MSF also supported the Mozambican health authorities by providing medical care in accommodation centres and helped implement a surveillance system at health posts to detect malnutrition and potential disease outbreaks of measles and diarrhoeal diseases, including cholera. MSF provided medical and emergency relief for a two-month period.

HIV/AIDS programmes

MSF has established longer-term projects in the country to help authorities respond to the AIDS epidemic. It is estimated that 16.2 percent of the population is infected with HIV.

The programmes are located in the capital city of Maputo, in Tete province (north-west), and Niassa Province (north). In July 2007, more than 11,000 patients were receiving anti-retroviral treatment (ART) through MSF projects. In addition to drug treatment, programmes include health education, counseling, testing and prevention of mother-to-child HIV transmission.

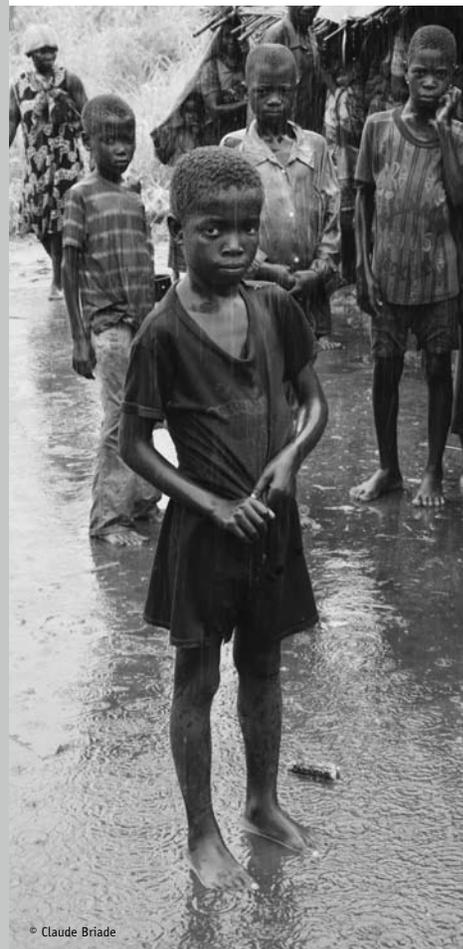
During 2006/2007, the main challenge was decentralisation of care from hospitals to health centres located closer to communities. This strategy increases access to HIV care, including ART, and helps prevent hospitals

and their staff from being overwhelmed by the number of HIV patients. The current human resources crisis in the health sector resulting from emigration and the effects of HIV on the workforce has been a major challenge.

MSF is providing intensive training to local medical staff in programmes and keeps simplifying treatments for patients with HIV and tuberculosis. MSF also lobbies the authorities to allow qualified paramedical staff, after proper training, to prescribe anti-retroviral drugs and to use “lay” counselors to reduce the workload of nurses.

MSF has worked in Mozambique since 1984.

The main priority was to provide clean and drinkable water, build latrines and distribute plastic sheeting for temporary shelters



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NIGER

REASON FOR INTERVENTION • Endemic/Epidemic Disease • Social Violence/
Healthcare Exclusion

FIELD STAFF 1,546

The extreme nutritional crisis in Niger in 2005 provoked an international response, but malnutrition here is both recurrent and life threatening. Even though some regions of the country produce a surplus of cereals, a “hunger gap” exists between May and October when family millet stocks become depleted and the country’s free market economic system renders food unaffordable for the poorest families. Mortality rates for children under five years old are very high, similar to those in countries at war.

In 2006, MSF continued to use a relatively new nutritional rehabilitation product to treat malnourished children, ready to use therapeutic food (RUTF). A vacuum packaged, nutrient dense peanut-milk paste, this portable product has allowed MSF to increase its capacity to treat malnutrition 10-fold, as children without medical complications can now be cared for as outpatients. This strategy is much easier for mothers, who can provide this food to their children at home. MSF also showed that this rehabilitation strategy was highly effective for treating moderately malnourished children, who can be cured with RUTF in less than a month, on average. The only obstacle is price and MSF is lobbying both for price reductions and for the government and other NGOs to implement wider use of RUTF.

By the end of 2006, MSF had cared for over 73,000 children suffering from acute malnutrition - both severe and moderate - in two districts (Guidan Roumdji and Madarounfa) of Maradi province alone, most under the age of three and with a cure rate of over 90 percent. Over 17,000 children were treated in Zinder. MSF also ran nutritional projects in Dakoro and Aguié, Maradi district; and Madoua and Bouza in Tahoua district. In total MSF ran or supported over 30 feeding centres in Niger during the hunger gap and treated approximately 100,000 children for malnutrition.

Nutritional deficiencies are also associated with immune system impairment and increased risk of illnesses. MSF provides free healthcare for children in many project facilities. In coordination with the Ministry of Health in Guidan Roumdji and Madarounfa districts, MSF provided almost 130,000 medical consultations for ill children under age five and 4,500 children with severe illness were hospitalised in paediatric units in Maradi, Dan Issa and Tibiri. Between August and December, approximately 7,260 new cases per month were



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MSF is increasingly integrating nutrition into paediatric healthcare by monitoring, screening and treating malnutrition within the framework of regular healthcare

attended in health facilities supported by MSF in Tahoua. MSF also provided support to the paediatric department in Tahoua’s district hospital in 2006, treating 400 patients, and provided free healthcare for 9,600 patients through four health centres in Aguié district, Maradi province.

In March 2007, MSF began to support five health clinics in Dakoro as well as the Dakoro hospital. MSF is increasingly integrating nutrition into paediatric healthcare by monitoring, screening and treating malnutrition within the framework of regular healthcare. This allows

the malnourished children to be identified early and allows for year-round monitoring.

MSF also responded to a number of disease outbreaks in Niger over 2006/2007. In September 2006, several cholera treatment centres were established in Maradi following an outbreak in several regions of the country. In 2007, MSF also assisted the MOH with vaccination campaigns in response to a meningitis epidemic in February, and a measles outbreak in March in Tahoua.

MSF has worked in Niger intermittently since 1985.

Treating children at an earlier stage of malnutrition

When children suffer from acute malnutrition, their immune systems are so impaired that risks of death are greatly increased. A banal children's disease such as a respiratory infection or gastroenteritis can very quickly lead to complications and eventually death. UNICEF estimates that malnutrition is currently associated with half the deaths of children under five, representing five million children each year.

Severe acute malnutrition is defined by a very low weight for height, visible wasting, or the presence of nutritional oedema (excessive accumulation of fluid in the body tissues). In children aged six to 59 months, an arm circumference of less than 110mm is indicative of severe acute malnutrition.

In 2005, ready-to-use-therapeutic food (RUTF) proved that thousands of severely malnourished children could be treated with very good results. With this strategy it was possible to consider giving better nutritional care to all children who were at risk of death, not just the most severe cases.

In 2006, in Maradi, Niger, children suffering from "moderate malnutrition" (also a medical emergency) got access to these therapeutic products in two districts in Maradi region and over 95 percent of the moderately malnourished children were cured. The mortality rate for those admitted to the programme with moderate malnutrition was 0.4 percent. These results are significantly better than those ob-

It was possible to consider giving better nutritional care to all children who were at risk of death, not just the most severe cases

tained in classic supplementary feeding programmes directed to the moderately malnourished using fortified blended foods. The treatment of acute malnutrition at an earlier stage reduced admissions for severe acute malnutrition and lowered the usual rise in severe cases during the "hunger gap" between May and October. In one district, up to half the children under age three received treatment. Others suffer from different forms of malnutrition: they have a low weight or a low height for their age because of poor alimentation. In such a context, giving a nutritional product to all children at risk may be more efficient than addressing moderately malnourished children individually.

The vast majority of the children suffering from acute malnutrition are aged between six months and two years, an age group that corresponds to weaning, the critical transition in children's lives that starts when they begin to eat something other than their mother's milk. Children remain fragile until the age of five, when they complete a rapid growth period. In Gouidan-Roundji department, Niger, MSF in 2007 is implementing a preventive strategy involving the



distribution of a new product adapted to the needs of these children. Once a month during the hunger gap, MSF is distributing an enriched peanut-milk paste mothers can feed their children. This is a food supplement, complementing the usual food intake. Three spoonfuls daily provide children with essential nutrients they cannot get from available family food. Distributions will continue until harvest time, for approximately 63,000 children.

By August 2007, results looked promising with a drop in admissions to the nutrition centres among children living where the supplement was distributed. These children also had fewer medical complications requiring referral to an inpatient centre.

Effective complementation for all children at risk and nutritional treatment for the acutely malnourished using ready-to-use food could have a major impact on the mortality of young children amongst the poorest populations of the world. In October 2007, MSF is launching a campaign advocating for the use of RUTF in nutrition programmes globally. MSF is also highlighting the need for increased research and development into a range of nutrient-dense therapeutic products including ones without milk, which accounts for the largest proportion of RUTF costs.

Definitions

Moderately acute malnourished when the ratio between the weight and height of a child is between 70 and 80 percent of normal

Severely acute malnourished when the ratio between the weight and height of a child is less than 70 percent of normal

NIGERIA

REASON FOR INTERVENTION • **Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion**
FIELD STAFF 291

Increased outbreaks of armed violence among political and criminal groups in the Niger Delta have caused activities to expand significantly at MSF's Port Harcourt trauma centre. In 2006, bed capacity increased from 17 to 70 and MSF responded to a total of 3,058 medical emergencies, 188 of these people suffering from gunshot wounds.

The centre, located in Port Harcourt's Teme hospital, opened in 2005 to provide emergency medical services free of charge to the population of Port Harcourt and surrounding areas. Most patients arriving at the hospital have sustained life-threatening trauma. Up to 200 surgical procedures are performed here each month.

In July 2006, MSF began providing medical and psychological care to victims of sexual violence and increased efforts to generate awareness of this programme. Psychological support was also extended to all trauma victims in need at the hospital.

New surgical technique

In December 2006, MSF introduced an orthopaedic surgical technique known as "internal fixation" in the Teme trauma centre. Used to repair fractures, this surgical method helps patients by reducing the average length of stay required in hospital and allows them to resume normal function more quickly than with

"external fixation" methods. MSF has also integrated a physical rehabilitation programme to help patients regain maximum mobility following surgery. A total of 1,064 surgeries were conducted at Port Harcourt in 2006, more than 40 percent of these were orthopaedic interventions.

Responding to cholera and floods

MSF responded to a cholera outbreak in Borno State in the last quarter of 2006 and supported the state Ministry of Health in setting up isolation camps with water and sanitation, training and a donation of medical materials. Following flooding in Zamfara, MSF also set up and organised direct distributions of water and sanitation equipment and drug supplies for 1,000 people.

Lagos HIV/AIDS project

In its HIV/AIDS project in Lagos, MSF had 1,335 patients registered for treatment at Lagos General Hospital (LGH) at the end of 2006. MSF is negotiating with the LGH and the Global HIV/AIDS Initiative Nigeria to hand over patients with uncomplicated cases of HIV who are following firstline (standard) drug regimens.

In addition to giving medical aid, MSF works with various civil groups advocating for free government provision of HIV/AIDS treatment. In 2006, this campaign helped lead to a presidential decree announcing free anti-retroviral treatment for all Nigerians. The decree has improved local investment in patient care and expanded local capacity to treat patients following both firstline and secondline drug regimens.

MSF has worked in Nigeria since 1996.



RWANDA

REASON FOR INTERVENTION • **Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion**
FIELD STAFF 109



Since 2002, MSF's work in Rwanda has focused on helping people with HIV/AIDS. The MSF programme treats patients in Kimironko and Kinyinya health centres, both located in the capital city, Kigali. The projects include voluntary counseling and testing, medical care to prevent the development of AIDS, treatment of opportunistic infections and prevention of mother-to-child transmission. By June 2007, 6,200 patients were enrolled in the programme, with 2,723 on anti-retroviral (ARV) medicines. MSF helps implement the national AIDS protocol and promotes access to generic ARVs, the less expensive alternatives to patented brands.

Handover of project in Northern Province

For four years, MSF also ran a reproductive health programme in Northern Province, based in the maternity ward of the provincial hospital and six health centres in the Burera district. By the end of 2006, the capacity of the maternity ward of the hospital had increased to 104 beds and approximately 450 women were admitted monthly in the maternity ward. In Burera district, activities included medical

SIERRA LEONE

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 505



Six years of peacekeeping and rebuilding have led to a relatively politically stable Sierra Leone. Whilst mobile phones have largely replaced the Kalashnikovs and machine guns commonly used during the decade-long civil war, the post-conflict situation still represents a struggle for survival – now one predominantly against malnutrition, malaria infections and women's health issues.

MSF continues to provide free and quality healthcare in the southern town of Bo. The Gondama Referral Centre on the periphery of Bo hosts an intensive care unit, a paediatric unit and a Therapeutic Feeding Centre (TFC) for malnourished children. MSF admits approximately 600 patients every month in the centre and approximately 150 children in the TFC. MSF also supports five public health clinics in the neighbouring area – where approximately 26,000 curative consultations take place monthly.

Implementing prevention and treatment for malaria

Malaria is hyperendemic in Sierra Leone and is the number one killer. Children below the age of five and pregnant women are the most vulnerable. In the Gondama Referral Centre, children under five represent 75 percent of the total admissions, 92 percent of these children arriving because of malaria or the consequences of malaria. Every month an average of 7,000 confirmed cases are treated with an increase up to 10,000 during the peak malaria season. MSF has worked closely with the Ministry of Health (MoH) to change the malaria protocol to artemisinin-based combination therapy

(ACT). Implementation has been slow and three years on, many people affected by malaria do not have access to efficient treatment. It is a challenge to ensure that ACT is continuously supplied to all clinics throughout the country.

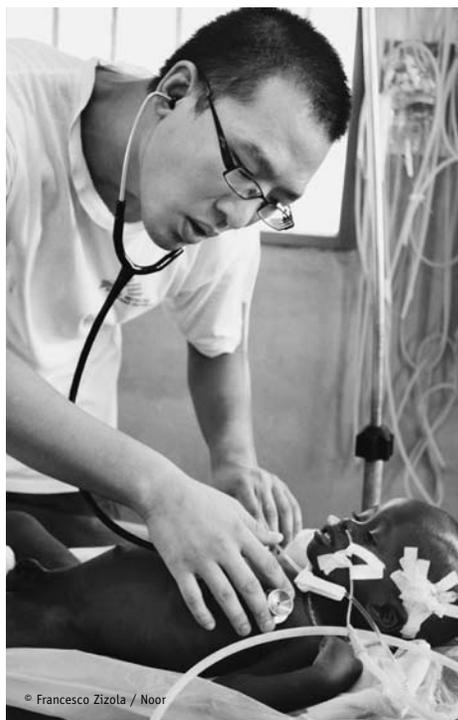
In an effort to prevent an overwhelming amount of child mortality, MSF decided to bring medical care closer to where people live. Before MSF mobile clinics were set up, people had to walk long distances to reach a health structure. This often meant that patients would die or reach a critical state before obtaining treatment. MSF created a community health-related programme addressing nutrition, malaria and maternity through information, bed net distribution (to prevent mosquito bites) and medical treatment. Between June 2006 and April 2007, MSF outreach teams tested 17,000 persons with Paracheck – a rapid malaria test – and handed out nearly 40,000 bed nets. Severe cases of malaria are referred to Gondama.

Developing women's clinics

Sierra Leone has one of the highest maternal mortality rates in the world. In the MSF Gondama women's clinic all women are welcome for free treatment.

The clinics offer a complete primary health-care package, with a separate small structure dedicated in each clinic to reproductive health, known as the women's clinic. This concept has been developed successfully in Sierra Leone and may serve as a model that can be implemented elsewhere. In each clinic, ante-natal, post-natal and basic obstetric care, family planning, treatment for sexually transmitted infections and care for survivors of sexual violence are offered.

MSF has also been working in Kambia and Tonkolili districts, supporting local hospitals and several clinics, with a focus on maternal health and children under five years old. By July 2007, MSF was able to transfer these activities to the Ministry of Health.



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care for the general population. Close to 179,000 consultations took place in 2006 in the different health centres supported by MSF, and over 1,700 referrals to the hospital were transported by MSF ambulances.

Activities involving members of the local health community, such as traditional birth attendants, have contributed to an increase in quality healthcare. The number of women giving birth within health structures increased throughout 2006, as did ante-natal consultations and family planning. By December, over 4,000 babies had been delivered. The project was transferred to the Ministry of Health (MoH) in December.

The number of organisations now present in the country ensures sufficient capacity to react to major epidemics and natural disasters. The AIDS epidemic appears well contained because of a high level of investment made by local authorities and the support of many international actors.

MSF will cease its activities in the country at the end of 2007 and transfer its HIV/AIDS project to the MoH and its new partner organisation.

MSF has worked in Rwanda since 1991.

MSF has worked in Sierra Leone since 1986.

SOMALIA

REASON FOR INTERVENTION • **Armed Conflict • Endemic/Epidemic Disease • Natural Disaster**
FIELD STAFF 654

The political climate in Somalia in 2006/2007 was highly turbulent, with massive insecurity caused by fighting between the Union of Islamic Courts and the Transitional Federal Government and the presence of Ethiopian troops.

Conflict once again worsened the situation in a country where needs are vast, yet little medical-humanitarian assistance is delivered on the ground. Since 1991, the Somali people have been without either a functioning central government or public health services. There was a need for MSF to repeatedly speak out on the deteriorating humanitarian situation in Somalia.

Coupled with famines, droughts, floods, and repeated conflict between armed factions and foreign armies, the absence of public health services has resulted in enormous unmet basic health needs for a large majority of the estimated population of over 11.5 million. Women and children under five are particularly vulnerable. One in ten women die during childbirth and more than one in five children die before their fifth birthday.

What little medical aid exists is privately owned and costly – out of reach for most Somalis. Many suffer from easily treatable diseases that can be fatal with no healthcare, such as diarrhoea and respiratory tract infections. Somalia also has one of the world's highest prevalence rates of tuberculosis (TB). The neglected tropical disease kala azar claims the lives of thousands and there are regular outbreaks of measles, cholera and other epidemics.

MSF has provided medical care in Somalia since 1991, comprising basic and secondary health services, treatment for neglected diseases, and emergency surgery. Activities were increased and expanded over 2006/2007, with new projects opening in Jamaame, Galgadud and Belet Weyne. In the first two months of operations in Belet Weyne hospital, which opened in early 2007, MSF staff carried out 95 major surgical interventions and 33 minor surgical procedures. The volume of activities



also increased dramatically in extant projects. In Huddur, for example, a large health centre in the Bakool region, consultations for kala azar patients rose by 530 percent between 2004 and 2006 and outpatient consultations increased by 58 percent.

Civilians displaced from Mogadishu

Insecurity overshadows all of MSF's work in Somalia. In early 2007, fighting in Mogadishu caused the displacement of over 300,000 people. Whilst many were taken in by family or friends, in some towns close to Mogadishu, MSF found thousands of people living out in the open with no food, water or medical care.

MSF launched an emergency response in Afgooye, a town approximately 30 kilometres west of Mogadishu, and in Balad, a town approximately two hours from Jowhar on the road to Mogadishu. In Afgooye, a team of MSF Somali staff supplied medicines to existing health structures and items such as plastic sheeting to more than 3,500 families. With the threat of a cholera outbreak looming, the provision of clean water was a priority. MSF provided 72,000 litres of clean water daily to the displaced people through water trucking distributions. In Balad, MSF distributed food and vaccinated 1,300 children against measles. A temporary outpatient clinic was set up, providing approximately 80 consultations

daily. MSF also conducted a vaccination campaign in Al Ma'an, a small port location north of Mogadishu.

Although some of those who fled to Afgooye returned to Mogadishu, lack of resources and theft or destruction of homes made return impossible for many others. Throughout the fighting, MSF's Somali staff continued to run a primary health clinic in the Yaqshid area of Mogadishu, in an environment of insecurity. The fighting destroyed

With continued insecurity, it is very difficult for people in Mogadishu to get to clinics

many public buildings and the few functioning public hospitals were closed. Cholera was particularly worrying in the capital. In March, MSF set up a cholera treatment centre (CTC) in Forlanini, south Yaqshid, which treated over 1,300 patients.

In early May, MSF was able to open another, smaller CTC in Mogadishu. As the number of patients with the disease seemed to be declin-

SOUTH AFRICA

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 50

An estimated 19 percent of the South African population, or approximately 5.5 million people, are infected with HIV. Yet only a quarter of the approximately one million people requiring treatment are receiving it. Since 1999, MSF has been providing HIV care in poor areas of the country with a high prevalence of HIV infection. The major challenges are an increase in tuberculosis-HIV co-infection and the lack of health workers to cope with the increasing number of patients.

At the end of 2006, MSF started providing comprehensive HIV care - including anti-retroviral (ARV) treatment - in two additional clinics in Khayelitsha, the largest township near Cape Town. MSF has handed over most elements of the programme to provincial and local authorities, but continues facilitating the decentralisation of care, addressing the challenges of long-term adherence to ARVs and facilitating integration of HIV and TB services. Since May 2001, MSF in partnership with the Western Cape Department of Health has been providing AIDS treatment at the primary care level.

Decentralisation is a response to the high demand for services that has saturated existing clinics, and to the projected 15,000 people who will need to start treatment by 2010. Today, the Khayelitsha programme provides ARV therapy to over 6,000 people. Whilst more than 200 patients are started on ARVs monthly, this rate is threatened by the lack of health staff. To cope with the increasing number of patients, intense efforts toward clinic organisation, patient triage, re-definition of staff roles, and training are being implemented.

Integrating tuberculosis and HIV care

Given an extremely high incidence of tuberculosis (TB) in the township; a high level of TB-HIV co-infection (approximately 70 percent); and the different manifestations of TB in HIV positive patients; an integrated response to the TB-HIV epidemic has been in place since 2003. Ubuntu Clinic in Khayelitsha is the first in the country that provides integrated TB and HIV care. It has become the busiest primary care clinic in the province, indicating a good acceptance of the model by patients.

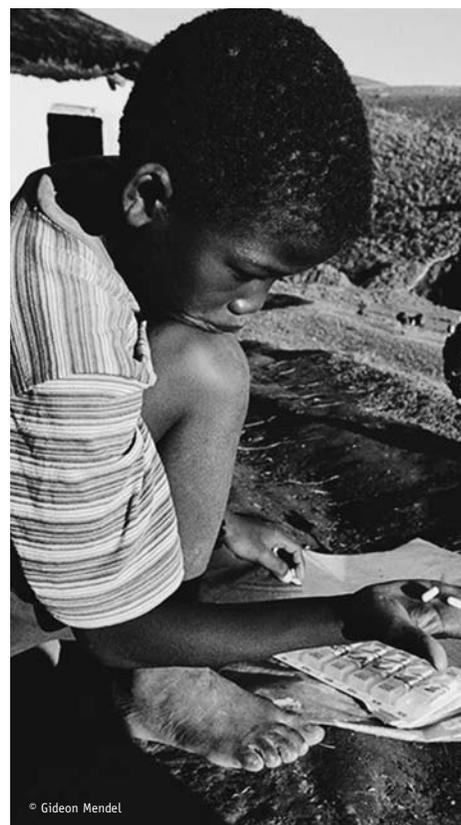
In October 2006, after four years of collaboration, MSF handed over all the components of an HIV programme in Lusikisiki to the Provincial Government of the Eastern Cape. Since early 2003, MSF and its partner, the Nelson Mandela Foundation, were implementing a decentralised model for HIV care, includ-

ing ARV therapy, in one of the most under-resourced rural areas in the country. Because of intense efforts to promote voluntary counseling and testing for HIV and the implementation of medical services, over 40 percent of the adult population in Lusikisiki now know their HIV status. At handover, more than 80 percent of the people requiring ARVs were receiving the treatment they need.

Complete care for rape victims

MSF also continues to manage the Simelela rape survivors centre in Khayelitsha, a response to the high degree of sexual violence against women and children in the slum. Simelela provides medical care, psychosocial support, forensic examination, and police assistance to rape victims in a one-stop service.

MSF has worked in South Africa since 1999.



© Gideon Mendel

ing, this centre has now been converted into an outpatient clinic for children under five years of age, with approximately 90 patients treated daily. With continued insecurity, it remains very difficult for people in Mogadishu to get to clinics.

Continuing to work amidst insecurity

Insecurity in the capital is not the exception. Unfortunately, MSF is sometimes forced to suspend its medical activities because of violence or threats of violence against staff and patients. International staff must be evacuated at times and the projects continue to run under the management of Somali staff, the core providers of MSF's work in Somalia.

Following fighting in late 2006, at least 250 wounded were treated in various medical facilities in Dinsor. On 27 December 2006, representatives of military forces entered an MSF medical facility, pressured the Somali medical staff employed by MSF and confiscated all inpatient confidential medical files. MSF publicly expressed its grave concern for the safety of staff and patients following this serious incident.

MSF has worked in Somalia since 1991.



SUDAN

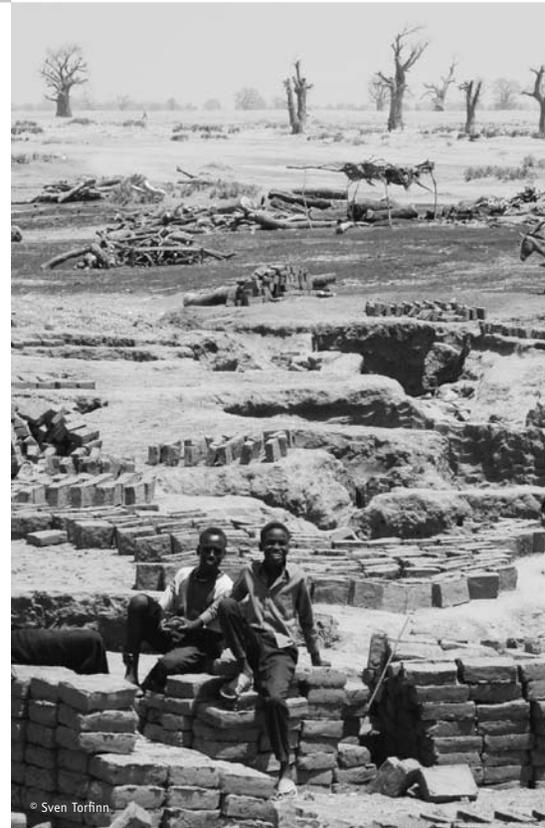
REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease
 • Social Exclusion
 FIELD STAFF: 4,590

In January 2005, the signing of the Comprehensive Peace Agreement between north and south Sudan ended decades of civil war. The Darfur Peace Agreement was signed in May, 2006. And in the east of the country, a simmering conflict was brought to an end by a peace agreement in October 2006. Yet insecurity and displacement continue in Darfur and many people throughout the country lack access to the most basic healthcare.

All across the south, the health system has to be almost completely rebuilt and the Ministry of Health (MoH) lacks the capacity to deal with the major epidemics that frequently ravage this part of the country. MSF has responded to numerous outbreaks of cholera, measles and meningitis. In March and April 2007, MSF vaccinated approximately 700,000 children against meningitis.

In the Upper Nile State of southern Sudan, MSF maintains a number of projects focusing on primary healthcare. Because of a desperate shortage of infrastructure, reaching much of the region, especially in the rainy season, is particularly onerous and few NGOs are present on the ground. In the western Upper Nile, a former frontline area with increasingly significant oil exploitation, MSF runs a hospital in Ler town, offering in- and outpatient services, tuberculosis (TB) treatment, ante-natal care, surgery and feeding programmes. Since

December 2006, MSF has also provided anti-retroviral treatment (ART) for HIV/AIDS. In the Upper Sobat, MSF runs a hospital in the former garrison town of Nasir and four outreach clinics in the northern Upper Nile area, accessible only by boat or air. In Jonglei and Eastern Upper Nile, remote rural areas without road access, MSF has clinics in the towns of Lankien and Pieri. In both places MSF provides basic healthcare with in- and outpatient services, TB and kala azar treatment and ante-natal care. Institutional and home-based feeding programmes are also in place. Outreach teams cover four health clinics in the surrounding area. In Jonglei State, MSF conducts an average of 4,500 consultations monthly in the referral civil hospital in Bor, a "secondary level" care facility, including surgery, inpatient, outpatient and maternity services, whilst in Pibor, MSF runs one county referral health centre and two outreach clinics.



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In Yambio, in the province of Western Equatoria, a new sleeping sickness project was opened in October 2006, focusing on community awareness and screening. A ward for the sleeping sickness treatment was set up in Yambio County Hospital. Since opening, a total of 2,500 patients have been screened and 78 treated.

Project handovers

In Bentiu, located in the oil-rich Unity State, MSF teams are treating patients co-infected with HIV/AIDS, TB, and the potentially fatal parasitic disease, kala azar. The number of patients has decreased in 2007 and MSF is preparing the handover of its activities by the end of the year.

In the east of the country, MSF continues to support Port Sudan hospital, whilst in the capital, Khartoum, MSF was able to close the Mygoma orphanage in December 2006. In Bahr El Ghazal, MSF withdrew in March 2007 from a hospital in Akuem, established seven years ago during the civil war, when people were unable to reach any other health facilities. The project had established primary and secondary healthcare, a nutritional centre and treatment for TB. In 2006, nearly 60,000 people received medical consultations and 345 people were admitted for standard treatment for TB alone. A second project in Marial Lou was also closed in mid 2007.



© Sven Torfinn

MSF has responded to numerous outbreaks of cholera, measles and meningitis



Darfur

The situation in Darfur has shown little or no improvement over 2006/2007. Four years into the conflict, over two million people remain in camps for the displaced, violence continues and swaths of the region are still largely inaccessible for aid workers. Over a year after the signing of the May 2006 Darfur peace agreements, various armed factions - both rebels and pro-government - have splintered. Increasing insecurity has caused MSF to temporarily reduce some of its work and repeatedly suspend clinics because of attacks on compounds or danger on the roads. Teams are sometimes forced to evacuate and MSF relies completely on air transportation through many areas. MSF has more than 2,000 staff working in the region.

The mountainous rebel-controlled Jebel Marra area of Darfur has been a particular area of concern. Violence against NGOs and a lack of security has made this area extremely problematic to reach with humanitarian assistance. MSF provides an average of 4,500 consultations and 200 hospitalisations per month in Niertiti, a town in the foothills of the Jebel Marra. Emergency cases are referred to the Zalingei hospital. MSF supplies technical support to this reference structure, which has an average of 600 hospitalisations monthly. In Kutrum, MSF runs a health centre, one of the only medical facilities serving the entire

western part of the Jebel Marra, carrying out approximately 1,400 consultations per month. MSF also runs projects in Kaguro, Killin and Gorni in the same region, although temporary evacuations of international staff are common. Seleia was a site of ongoing fighting in 2006/2007. In early 2007, a four-person team set up a surgical facility to treat the wounded and assist in emergency obstetric cases. The team also provides support to the health centre, and a mobile clinic is planned.

In El Geneina, the capital of West Darfur, MSF supports the emergency and surgery ward of the general hospital by providing medicines, medical materials and technical support. Fighting to the north of El Geneina led to the displacement of several thousand people in December 2006, 5,000 of whom arrived in the nearby Aradamata and Dorti camps. In Aradamata camp, on the outskirts of town, MSF set up a medical mobile unit to screen new arrivals, and more than 500 people were treated in less than a week. In 2006, MSF performed surgery on 574 people with violent injuries in the town of Muhajariya. When fighting erupted towards the end of 2006, causing the displacement of approximately 50,000 people, some 20,000 sought refuge in Saleah, where an MSF team provided food and outpatient services. Whilst MSF was able to close its projects in Shariya in April 2007, a new South Darfur project was opened to provide healthcare for

the thousands of displaced in Feina. In Sherif Al Umra, North Darfur, despite numerous evacuations, MSF continues to provide healthcare to 40,000 displaced persons. MSF also continues to work in large camps for the displaced. In Habilah, a camp near the border with Chad, MSF runs a medical clinic with a 30-bed inpatient ward. The clinic provides therapeutic feeding for severely malnourished children and ante-natal care and assistance with deliveries. On average 35 babies are delivered each month in the health centre. Outreach workers assist with health education and referrals. In 2006, 25,000 consultations were conducted in the outpatient department and 750 patients were hospitalised. Following a wave of insecurity in Chad in early 2007, thousands of people fled to the Foro Baranga area, to the south of Habilah. MSF set up a system of mobile clinics providing basic healthcare in five locations, targeting an estimated 35,000 people.

In Um Dukhum, also bordering Chad in West Darfur, MSF handed over its hospital, which was providing surgery for the conflict-affected population. In 2006 MSF carried out distributions of plastic sheeting and blankets for newly displaced arriving in the area. In the camp of Mornay, where 68,000 displaced people are still living, MSF handed over its medical activities in June 2007 after three years of emergency assistance. The Ministry of Health and other organisations already working in the camp were able to take over. In 2007, teams started working in the 75,000 strong Kass camp, located between Zalingei and Nyala. In North Darfur, MSF is the only humanitarian agency providing healthcare services for 25,000 displaced people living in Shangil and Shadat camps, and for the inhabitants of Shangil Tobaya village. MSF provides in- and outpatient services, runs women's health and therapeutic feeding programmes and assists victims of violence. The outpatient department carries out approximately 200 consultations daily.

With a population of over 90,000 people, Kalma remains one of the largest camps for displaced people in the world. MSF continues to provide medical assistance with a focus on mother and child care through a dedicated women's clinic, where approximately 120 women deliver babies each month. A mental health programme has also been established to help people cope with the psychological stress of violence and displacement.

MSF has worked in Sudan since 1979.

UGANDA

REASON FOR INTERVENTION • **Armed Conflict • Endemic/Epidemic Disease**
FIELD STAFF 1,159

In August 2006, a fragile truce was signed between the Ugandan government and the Lord's Resistance Army (LRA) and the 1.6 million people who have been virtual prisoners in the approximately 200 camps for the displaced began drifting toward home.

In 2007, as peace talks continue and LRA fighters leave northern Uganda, people continue to return to their villages or to half-way decongestion camps. The return, however, is not uniform. In Lira, it was estimated that in mid-2007, only 11 percent of people remained in their original camps, whilst in Kitgum, that figure was as high as 79 percent.

At the height of the LRA's presence, MSF provided water, sanitation and healthcare in over 20 of the squalid camps for the displaced, but activities have been reduced as people leave the camps. In Kitgum, where MSF has worked since August 2004, the situation remains precarious, yet improvements in security and a decrease in health needs has allowed MSF to hand over four health centres, with the objective of pulling out from two more, Orom and Lukung, by the end of 2007.

The reduction in activities has provided MSF the capacity and flexibility to begin work in other areas of northern Uganda where there are people with unmet medical needs for HIV, tuberculosis (TB), malnutrition and surgery. In Lalogi camp in Gulu, where MSF had previously focused on basic care, emergency obstetric care and treatment for HIV/AIDS have now been introduced. By June 2007, 405 HIV patients had been identified, of whom 75 were under treatment with anti-retroviral drugs. In May 2007, MSF began a second new HIV/TB project in Madi Opei, Kitgum.

In Arua, in northwest Uganda, a more established AIDS programme continues to expand. Over 10,000 people have been included since it opened in 2003, and by the end of April 2007, 3,323 people were receiving firstline treatment and 75 who had failed firstline (standard) treatment were following a secondline drug regimen. The programme includes 634 children. At the beginning of 2006, a pilot project began for TB/HIV co-infection, and an average of



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90 new patients begin TB treatment every month, around 50 percent of whom are co-infected.

MSF also supports ten health centres in surrounding areas as part of a decentralisation and referral plan aiming to bring HIV/AIDS treatment closer to people's homes and providing them with easier access to care.

In 2006/2007, MSF worked closely with the Ugandan Ministry of Health and the World Health Organization in response to an outbreak of bacterial meningitis. MSF completed a vaccination campaign in two districts of the West Nile region, supervising the inoculation of

291,000 people and assisting with 333,000 more. Meanwhile, as the truce in the north began to take effect, the Ugandan government stepped up its attempts at disarmament in the impoverished and often lawless Karamoja province to the east. Following the results of a World Food Programme nutritional survey conducted in Kaabong District, MSF launched a response in June 2007, setting up four ambulatory feeding centres and one centre for severely malnourished children. By mid-July, 2,000 children had been screened and 445 children were being treated.

MSF has worked in Uganda since 1980.

ZAMBIA

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 165

In July 2005, the Zambian government started providing HIV/AIDS care free of charge and in 2006 abolished the national cost-sharing system of healthcare. Although medical consultations, now free, increased in number, no viable substitute system of healthcare was implemented. The drug supply was not adjusted, resulting in occasional stock ruptures and patients sometimes being asked to pay for drugs, placing an extra burden on those with chronic and debilitating illnesses.



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MSF has had HIV/AIDS projects in Zambia for several years, and particularly in remote and “transit areas,” such as Kapiri M’Poshi, a fast-growing town and the site of main railway transfers. Here it is estimated that one in five persons has HIV. Access to healthcare in general and HIV care in particular is very limited for people in the rural Kapiri district, where there are few roads or means of transportation. Although the Kapiri hospital has been recently upgraded to a district hospital, it lacks essential health facilities such as X-ray and surgery. In Kapiri, MSF runs a clinic within the hospital and is also working in a total of 12 rural health centres. By the end of July 2007, a total of 6,500 patients were en-

rolled in HIV care, with 3,008 on anti-retroviral treatment (ART). Teams conduct over 3,000 consultations per month.

In the rural district of Nchelenge, another transit area in northern Zambia, MSF established an HIV/AIDS project in 2001. MSF has worked at integrating care into regular health services and ART has been provided to 786 patients. A total of 4,195 HIV patients are followed up in the programme. Patients are also screened for tuberculosis (TB) and MSF has worked with health authorities to ensure treatment for people co-infected with HIV/TB; worked to integrate this into primary care, and involved the community in prevention,

treatment and support of people with HIV/AIDS. This project will be handed over to the Ministry of Health (MoH) at the end of 2007.

Frequent outbreaks of cholera

Cholera is also endemic and mainly seasonal in Zambia, with epidemic outbreaks occurring in the rainy season from November to April. In response to a cholera outbreak in March 2007 in Lusaka, MSF set up a cholera treatment centre in Matero, in the northwest part of

Lusaka, and treated 1,227 people. A further 800 patients were treated from January to April in Nchelenge District, where MSF set up treatment centres and units in response to an outbreak. Logistical support and medical material was given in the Chiengwe District to respond to a cholera outbreak.

In January and February of 2007, floods affected 1.4 million people in 41 districts of Zambia. MSF assessed the medical situation in Northwestern province and assisted by supplying drugs.

MSF has worked in Zambia since 1999.

ZIMBABWE

REASON FOR INTERVENTION • Endemic/Epidemic Disease • Social Violence/
Healthcare Exclusion
FIELD STAFF 267

With hyperinflation, political turmoil and a deteriorating economy as evidenced by widespread food shortages, an estimated three million people had fled Zimbabwe by July, 2007. Access to healthcare in this context is increasingly difficult, whilst health threats are on the rise.



MSF provides free medical care to 33,000 HIV-positive patients in Zimbabwe, 11,000 of whom are receiving anti-retroviral therapy

There is a continuing crisis in the country related to HIV/AIDS: one in five adults is HIV positive, and less than one fourth of the people in urgent need of life-prolonging anti-retroviral treatment (ART) receive it. Whilst treatment access had slightly improved, a collapsing healthcare system is jeopardising gains. Trained medical staff are leaving the country and the government programme for HIV/AIDS treatment is over-subscribed and experiences ruptures in drug stocks.

The cost of fuel exacerbates transport problems, resulting in the failure of most people in

the countryside to reach treatment sites to receive the care they need. Zimbabwe's dismal reputation on the international stage has led many international donors to refuse to support programmes in the country. The government's project to implement a comprehensive multi-sectoral response to HIV/AIDS has fallen short, whilst approximately 3,500 people die of AIDS-related illnesses weekly.

MSF provides free medical care to 33,000 HIV-positive patients in Zimbabwe, 11,000 of whom are receiving anti-retroviral therapy. This accounts for over one fifth of all ART

provision in the country. Care is provided through a decentralised system implemented in Bulawayo, Tshlotshlo, Gweru, Epworth and various locations in Manicaland province.

MSF's ability to care for more patients in need could be hindered, as only doctors and clinical officers are allowed to make the decision to prescribe anti-retroviral drugs. "Task shifting" the responsibility of drug provision to nurses and other trained staff has proven to be an effective way to scale-up treatment in other settings.

MSF has worked in Zimbabwe since 2000.

Asia and the Caucasus



ASIA AND THE CAUCASUS

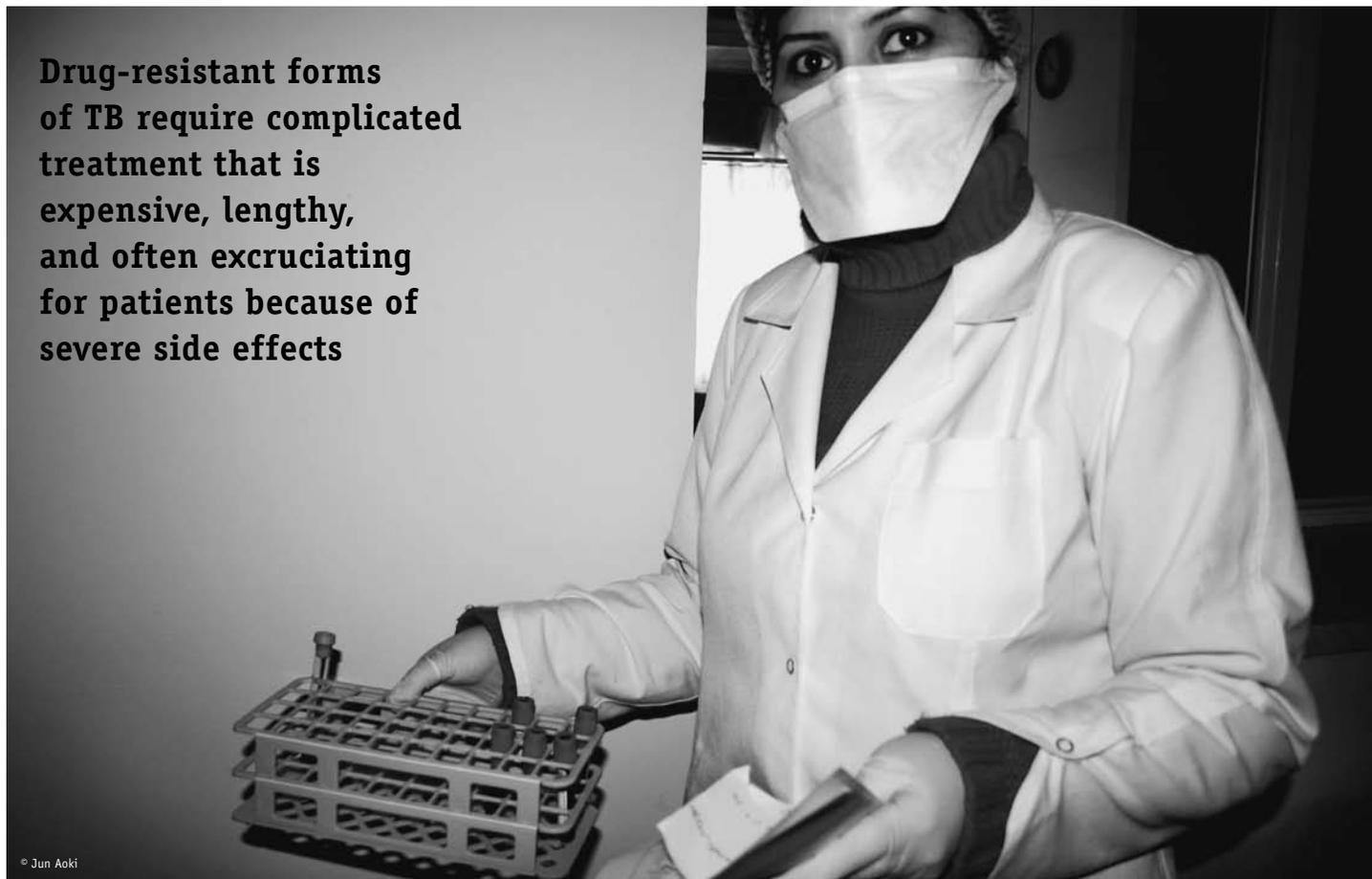


ARMENIA

REASON FOR INTERVENTION • Endemic/Epidemic Disease • Social Violence/
Healthcare Exclusion
FIELD STAFF 134

People living in impoverished, landlocked Armenia in the South Caucasus, once part of the former Soviet Union, suffer the effects of a chronically under-funded healthcare system. Tuberculosis is one disease that is spreading, yet appropriate treatment is not widely available and an accurate infection rate is unknown.

Drug-resistant forms of TB require complicated treatment that is expensive, lengthy, and often excruciating for patients because of severe side effects



© Jun Aoki

Working in collaboration with the Ministry of Health (MoH) and the Yerevan City Mayor Hall in the TB programme in Yerevan, the country's capital, MSF teams see drug-resistant TB in some of its patients. Together with the MoH, MSF offers the only drug-resistant TB care available in the country in Abovian, near Yerevan, where MSF has renovated a 36-bed inpatient unit at the Republican TB hospital.

The drug-resistant forms of TB require complicated treatment that is expensive, lengthy, and often excruciating for patients because of severe side effects. By June 2007, MSF had enrolled a total of 70 patients for drug-resistant TB treatment. These patients have to take up to 25 medicines daily during several months of hospitalisation in Abovian, followed by outpatient treatment, often lasting 18-21

months, in clinics in two districts of Yerevan. To ease this cumbersome treatment, MSF has adapted a patient-centered approach and provides individually tailored adherence and social support. MSF is also exploring the treatment coverage for drug-resistant TB in the two districts in Yerevan to further develop the programme.

Handover of mental health, primary healthcare and STI treatment programmes

The past year was marked for MSF in Armenia with the reduction of its projects. MSF has provided assistance to the Armenian population for many years and a number of long-supported projects have now been handed over. At the end of 2006, MSF entrusted its project working with mentally ill outpatients

in Gegharkunik Marz (northeastern Armenia) to the MoH and a local NGO "Mission Armenia". Combating the stigma traditionally associated with mental illness, MSF was developing a system of alternative care for this highly vulnerable group of people, aiming to decrease unnecessary hospitalisation. In January 2007, the MoH took over another MSF project in the same district, which included primary healthcare provision for the most needy. In northern Shirak district, MSF had established anonymous, free of charge services for diagnosing and treating sexually transmitted infections (STI) including HIV/AIDS. The project also increased knowledge and raised awareness about STI prevention, and has continued under local healthcare structures since March 2007.

MSF has worked in Armenia since 1988.

BANGLADESH

REASON FOR INTERVENTION • Social Violence/Healthcare Exclusion
FIELD STAFF 229

Stateless Rohingya people have been crossing the border between Myanmar and Bangladesh for decades. They are a Muslim minority in Myanmar, a country that does not recognise them as citizens. They face poor access to healthcare and little protection when they get into Bangladesh.

MSF has worked with the Rohingya in Bangladesh for many years, providing medical care, advocating for their needs to the authorities, and raising awareness of their living conditions through public communications.

In the spring of 2006, MSF re-opened a project in Teknaf, following an assessment in the Tal makeshift refugee camp that found appallingly overcrowded living conditions, lack of access to food and potable water and very limited access to healthcare. In the following months MSF focused on improving access to



MSF started a weekly mobile clinic at Shamlapur beach, providing healthcare

Eddy Van Wessel

healthcare, particularly for the 7,500 people living in Tal camp, by opening a clinic and a therapeutic feeding centre near the camp.

MSF also started a weekly mobile clinic at Shamlapur beach, providing healthcare to the Rohingya refugees living there. Respiratory

and skin infections are the most common ailments.

In April 2007, MSF also opened two 20-bed inpatient units in the Kutupalong and Nayapara camps, the only two official camps that remain from the Rohingya's 1992 exodus

CAMBODIA

REASON FOR INTERVENTION • Endemic/ Epidemic Disease
FIELD STAFF 361

MSF's work in Cambodia began in 1979, providing medical aid to people in the refugee camps along the Thai-Cambodian border. A decade later, as refugees were repatriated, MSF moved inland and played a role in helping rebuild the country's health structure, which had collapsed after decades of war. MSF's presence in Cambodia is decreasing as the capacity of the health system improves, but the country remains the site of MSF's largest AIDS programme in Asia, with 7,900 patients on anti-retroviral treatment (ART) as of April 2007.

MSF in Cambodia has focused on an innovative approach, treating HIV/AIDS as a chronic disease alongside diabetes and hypertension, which also have high prevalence rates. The programmes are being progressively handed over to the Ministry of Health (MoH), but 44 percent of patients on ART nationwide still

receive their drugs through MSF-supported clinics.

In Siem Reap, Phnom Penh, Takeo, Kompong Cham, and more recently Otdar Mean Chay, MSF provides ART including secondline treatment for those who do not respond well to standard (firstline) treatment, as well as counseling, treatment of opportunistic infections and information on HIV/AIDS. MSF offers technical assistance to the government to help facilitate the national plan to put more people on ART. MSF also operates a paediatric HIV/AIDS project, which has been successful with approximately 750 children started on treatment by July 2007 with dramatic improvements in immune system functioning, growth, development and quality of life.

Particular attention has been given to neglected populations and MSF also provides treatment and care to HIV-positive inmates in two of Phnom Penh's main prisons.

During 2007 in Takeo, Siem Reap and Phnom Penh, MSF increasingly focused on developing treatment for patients affected by tuberculosis (including multi drug-resistant TB), independent of their HIV status. These activities included training national health staff on TB

management and renovating TB wards in Takeo. Further renovation is planned in Siem Reap and in Kompong Cham to provide better isolation for patients.

MSF also supports the local health authorities' response to seasonal epidemics. In the summer



from Myanmar. Over their first two months of operation, these facilities admitted 650 patients.

At the beginning of May 2007, MSF closed its project in the Chittagong Hill Tracts (CHT) after eight years in the region. It was partially handed over to the Bangladeshi regional health authorities. When MSF started to intervene, the area was emerging from a twenty-year long armed conflict between the central government and the indigenous people, who were facing discrimination and marginalisation. MSF began providing basic healthcare to the population of both tribal and Bangladeshi settlers in remote villages, where healthcare was almost nonexistent. A particular focus was given to treating malaria, which is endemic in the region.

Today, the humanitarian situation has improved: whilst access to tests and drugs still remains difficult in certain areas of the CHT, a better road infrastructure is in place and more aid actors are present in the region.

MSF has worked in Bangladesh since 1985.

of 2007 MSF offered medical supplies and human resources to control the outbreak of dengue fever, a disease transmitted through bites of infected mosquitoes, which is endemic in the region.

MSF has worked in Cambodia since 1979.



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CHINA

REASON FOR INTERVENTION • **Endemic/
Epidemic Disease**

FIELD STAFF 53

Only 31,000 AIDS patients, including 600 children, have received life-prolonging anti-retroviral therapy from the national free programme in China, despite efforts since 2002 and the probable growth of the epidemic in the absence of updated figures.

By July 2007, MSF had 1,300 HIV patients registered in its projects in Nanning, Guangxi Zhuang Autonomous Region and Xiangfan, Hubei Province, and was providing anti-retroviral drugs (ARVs) to patients requiring treatment – nearly half this cohort. Comprehensive care is provided at these locations alongside voluntary confidential HIV testing, treatment of opportunistic infections and psychosocial counseling. All MSF services are provided free of charge, a factor particularly important for HIV/AIDS patients who can face high treatment costs and stigmatisation, heavy barriers that may prevent them from seeking medical care. The Chinese government's "Four Frees, One Care" policy only provides free counseling, testing, ARVs and schooling for children orphaned by AIDS.

At the national level, MSF has advocated to the Chinese government for quality and affordable generic medicines, in view of the rapidly growing need for secondline drugs (necessary for those patients who do not respond to standard or "firstline" drugs prescribed) and the lack of fixed-dose combination pills (FDCs). These FDCs, a recommended protocol by the World Health Organization, simplify treatment and make it easier for patients to adhere to their life-sustaining drug regimens. They are not yet available in China.

Apart from HIV, multi drug-resistant tuberculosis (MDR-TB) also warrants an urgent medical-humanitarian response in China. It is estimated there are 150,000 drug-resistant TB patients in the country. In July 2007, MSF was waiting to receive permission from the central health authorities to commence an MDR-TB programme in Yanji, Jilin Province, with a target of 100 patients under treatment in the first year.

Project handovers

MSF in November 2006 initiated the handover

process of the Xiangfan HIV/AIDS project to local health authorities, in preparation for the completion of this five-year programme in March 2008.

MSF continues to provide financial support to a programme for street children in Baoji, Shan'xi Province. In 2006, the management of this crisis centre and shelter, started in 2000, was handed over to a local NGO.

MSF has worked in China since 1988.

MSF has advocated to the Chinese government for quality and affordable generic medicines



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GEORGIA

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion
FIELD STAFF 351

Simmering separatist conflicts in Abkhazia have created doubts about the feasibility for the Georgian Ministry of Health to manage treatment for drug-resistant tuberculosis in this region. In the early 1990s MSF helped victims of the violent secessionist conflict in Abkhazia and was one of few international NGOs to continue working there, having witnessed a major lack of access to healthcare in this *de facto* independent but unrecognized republic. Abkhazia does not receive international support.

MSF's tuberculosis (TB) programme in the Gulripsh hospital near Sukhumi, the capital of Abkhazia, now mainly concentrates on treating drug-resistant TB patients. Drug resistance to the main TB medicines (rifampicin and isoniazid), means a patient needs to take a daily handful of highly toxic medicines. Arduous side effects make it extremely hard to complete a course of treatment, which can last up to 24 months. MSF also provides psychological support for patients, and is trying to find solutions for reducing the hospitalisation period and developing outpatient and home care. The project includes eight ambulatory points located in seven districts throughout Abkhazia where patients receive continuation phase treatment. By mid-2007 MSF had diagnosed 195 TB patients with multi drug-resistance, and enrolled 126 patients into treatment. 29 percent of them have successfully completed their drug regimens, 7.9 percent died, 22.2 percent absconded, and 34 percent are still undergoing therapy. MSF runs a similar project in Zugdidi, Samegrelo region in central Georgia.

In a separate programme in Abkhazia, MSF is working to provide free access to quality healthcare for people excluded from the system, particularly isolated elderly people. MSF doctors, nurses and social workers make house calls to visit these patients, many of whom are confined to home.

MSF has worked in Georgia since 1993.

INDIA

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion
FIELD STAFF 350

Although India continues to experience phenomenal economic growth, hundreds of thousands of people in many parts of the country continue to have their health compromised by factors including poverty, conflict and neglected tropical disease.

In the state of Chhattisgarh, MSF brings assistance to the victims of ongoing conflict between Maoist rebels and the government-backed paramilitaries. The conflict has resulted in the displacement of approximately 30,000 people, some living in government-run camps in Andhra Pradesh or in dire conditions within the state. In Chhattisgarh, MSF in July 2007 provided medical assistance including primary healthcare and an ambulatory therapeutic feeding programme for moderate and severely malnourished children in three camps for internally displaced people. MSF's mobile clinics also offer primary healthcare in Khammam district of Andhra Pradesh.

Treating HIV, kala azar and malaria

In conflict-affected Manipur, MSF has started treating people with HIV, offering anti-retroviral treatment (ART) in its five basic health centres. By December 2006, medical care had been provided to 800 people living with HIV/AIDS and 344 patients had started ART. The total number of consultations in 2006 was 32,139. MSF aims to work in closer cooperation with the health authorities in Manipur and hand over some of its activities to India's National AIDS Control Programme.

MSF in 2006 also set up an HIV project in Mumbai, with a specific focus on treating HIV/TB co-infected patients and marginalised people excluded from the national healthcare programme. The project offers counseling, treatment for opportunistic infections and ART to the transgendered and commercial sex workers. In July 2007, over 400 patients were registered at the clinic, half of whom receive ART.

In the state of Bihar, MSF recently started a kala azar project in partnership with the Indian Ministry of Health (MoH). India is the site of 80 percent of the world's cases of kala



azar; in turn, 90 percent of India's cases are in Bihar. MSF helped rehabilitate the Kala Azar Ward at the Laboratory of the Rajendra Memorial Institute of Research (RMRI) in Patna, a public institute for treating people with complicated kala azar. Diagnosis and treatment of patients will begin in 2007.

In Assam, northeast India, MSF has continued a primary healthcare project for people displaced by ethnic violence. Malaria remains a serious health threat, and MSF in 2006 distributed 33,500 bed nets, treated 55,259 patients for malaria and lobbied for the widespread introduction of artemisinin-based combination therapy (ACT), proven to be the most effective malaria treatment. In the southern part of Assam, MSF conducted a total of 177,392 basic healthcare consultations. Violence in Assam subsided in 2006 and MSF plans to hand its activities to the authorities in 2007.

Tending to mental health

After the 2005 earthquake, MSF opened a project in Jammu and Kashmir, a region long-disputed by India and Pakistan. Mental healthcare is offered to victims of violence in Srinagar and Kupwara, and teams had counseled 7,900 patients by July 2007. MSF has also urged the Indian government to set up centres for mental healthcare in Kashmir. Mental health and basic healthcare is offered by MSF

INDONESIA

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion • Natural Disaster

FIELD STAFF 396

An MSF mobile emergency team based in Jakarta provides medical assistance to Indonesians affected by epidemics, earthquakes and floods across the archipelago. At the beginning of 2007, mobile clinics assisted victims of the floods in Jakarta by supplying plastic sheeting, blankets and hygiene kits and conducting 1,310 medical consultations. MSF also offered relief supplies and psychological support to communities affected by the earthquake in West Sumatra in March 2007, reaching 11,726 people.

In North Mamuju, capital of West Sulawesi, MSF responded to a measles outbreak in February, 2007, working in partnership with the District Health Office (DHO). In south Halmahera and in Buano Island, West Seram of Maluku, the team launched two malaria interventions, supporting the DHO by conducting medical consultations, donating anti-malarial drugs and medical supplies and distributing mosquito nets.

Particular attention was given to mental health needs through counseling and education sessions. Over time, MSF progressively refocused its intervention on inland communities whose access to healthcare, including mental health, had been restricted by years of civil war. When the medical situation in the region improved, activities were scaled down and transferred to the local health authorities in December 2006.



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to people in villages close to the Line of Control between Indian and Pakistani forces, where 12,281 consultations had been conducted by the summer of 2007.

In June 2007, the last MSF project for tsunami survivors was closed in Tamil Nadu. The Indian NGO Centre for Social Reconstruction has taken over the mental health programme dealing with tsunami survivors.

Pharmacy of the developing world

In 2007, the pharmaceutical company Novartis took the Indian government to court over its 2005 Patents Act because it wanted a more extensive granting of patent production for its products than offered by the law. Novartis claimed the Act did not meet rules set down by the World Trade Organization and was in violation of the Indian constitution. Novartis' claim was rejected by the High Court in Chennai on August 6, 2007.

A ruling in Novartis' favour would have drastically restricted production of affordable medicines in India that are crucial for the treatment of diseases throughout the developing world. In early 2007, MSF's Campaign for Access to Essential Medicines requested that Novartis drop the case and launched a petition signed by over 420,000 people worldwide.

MSF has worked in India since 1999.



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MSF refocused on inland communities whose access to healthcare was restricted by years of civil war

Launching primary healthcare in Papua

MSF in 2006 also launched a primary healthcare programme in Asmat, southern Papua, in partnership with the Ministry of Health. The programme focuses mainly on mother and child healthcare and access to basic and emergency medical care for these isolated communities.

Projects handed to local authorities

Following the December 2004 tsunami, MSF worked in Aceh's regional capital, Banda Aceh.

In June 2007, MSF also withdrew from tuberculosis treatment activities in Ambon, Molucca. This pilot project focused on a patient-centered approach and provided treatment through fixed combinations of drugs, which improves patient adherence. The project also strengthened the counseling skills of the local health staff. The TB programme has now been handed over to local authorities.

MSF has worked in Indonesia since 1995.

KYRGYZSTAN

REASON FOR INTERVENTION • Endemic/
Epidemic Disease

FIELD STAFF 30

Tuberculosis is a burden for the crippled healthcare system of Kyrgyzstan, a small landlocked republic in Central Asia. The country has one of the world's largest prison population rates and MSF has found the prevalence of tuberculosis in the country's rickety penal system to be 25 times higher than in the civilian sector. The rapidly growing number of people with drug-resistant tuberculosis (TB), which is very difficult and expensive to treat, is cause for alarm.

The penitentiary system cannot provide quick, reliable diagnosis or proper separation of infectious patients with TB. Overcrowded cells, lack of light and fresh air, and poor rations have created a breeding ground for TB. In cooperation with local authorities, MSF is

working in one colony for TB-infected prisoners and in two pre-trial detention centres (one for males, one for females) near the capital Bishkek, where the organisation has rehabilitated laboratories, medical rooms, and the cells of infectious TB patients undergoing intensive treatment. By June 2007, over 800 patients had been enrolled in the MSF's DOTS (Directly Observed Treatment Short Course) programme. This programme includes an important health information and education component. MSF also gives patients high-energy milk for better recovery, and a livestock project supplies eggs and meat.

MSF is focusing on the early detection of TB in all 35 penal institutions of the country: the earlier patients can be referred for TB treatment, the better are the outcomes, with less opportunity to spread infection. As there are no sufficient follow-up services for TB-infected ex-prisoners, MSF, together with other NGOs, works also to ensure that released patients can continue their treatment in the civilian health system.



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MSF has started to diagnose the multi drug-resistant (MDR) and polydrug-resistant (PDR) TB patients. Treatment for PDR-TB and MDR-TB will begin before the end of 2007.

MSF has worked in Kyrgyzstan since 2005.

LAOS

REASON FOR INTERVENTION • Endemic/
Epidemic Disease

FIELD STAFF 25

As little as six years ago, some authorities denied there were any people in Laos who had HIV/AIDS and those suffering from the disease had no way of accessing anti-retroviral treatment. In an effort to address the unmet need for HIV/AIDS care, MSF started a project in Savannakhet, southern Laos, in 2001.

Although anti-retroviral treatment (ART) in Laos is now available, it remains limited to services opened by MSF in two public hospitals: in Savannakhet and at Setthathirat Hospital in the country's capital, Vientiane. By May 2007, 800 patients were being monitored at these health structures, with 540 of them receiving ART.

Raising the awareness of the authorities and partners to the existence of these patients who require urgent care has been a key element in recognising the reality of HIV/AIDS in Laos. The inclusion of access to ART in the national strategy for addressing the disease was finally

achieved in 2006. In view of this and increased donor support, MSF's departure is planned for the end of 2008 and the process of handing over to national actors has already begun.

The emphasis has now shifted to helping improve the management capabilities of health service partners and their ability to track orders and supplies of medicines. Partnership with the representatives of organi-

sations for persons living with HIV/AIDS is another area of work inherent to this hand-over process. MSF is sharing lessons learned from its projects in the country and emphasises the importance of patients undertaking a monitoring role, ready to identify any problems with the system that may prevent them from receiving proper treatment.

MSF has worked in Laos since 1989.



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MYANMAR

REASON FOR INTERVENTION • Armed Conflict • Endemic/Epidemic Disease • Social Violence/Healthcare Exclusion

FIELD STAFF 1,083

The distress experienced by millions of people in Myanmar continues largely unnoticed. Controlled by a military regime since 1962 and subject to international sanctions, the country has been cut off from the outside world for decades. People lack access to healthcare and cannot afford these services even when they are available.

With malaria, malnutrition, tuberculosis (TB) and sexually transmitted infections (STIs) causing a huge amount of illness and death, MSF conducts ongoing negotiations to access patients in this difficult environment and performed over one million medical consultations in 2006. Projects in 2006/2007 were running in Yangon, Thaninthary division and in Kayah, Kachin, Shan and Rakhine states.

MSF has several projects focusing on prevention and treatment of STIs and HIV/AIDS in areas with a high presence of sex workers, drug users and migrants. In total, MSF had over 9,500 people registered for HIV/AIDS care in 2006.

People lack access to healthcare and cannot afford these services even when they are available

As HIV/AIDS patients are often co-infected with TB, MSF is devoting greater attention to the identification and treatment of people co-infected with HIV and TB at its clinics. In the HIV/AIDS project in Yangon, over 11,422 people were screened for TB and 4,397 admitted for treatment in 2006. The project also provides care to sex workers and other people with STIs. MSF also has an HIV/AIDS project with a TB component at Dawei, Thaninthary division, where 884 patients were treated for TB in 2006. Similar projects are running in Kachin, Shan and Rakhine states.

Malaria is widespread throughout the country. In Myeik, MSF has three clinics and a surveillance system that utilises a boat to reach people in the most remote areas of the archipelago, providing treatment to 17,462 people in 2006. Patients also received malaria treatment in Kayah, a particularly neglected state



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because of its difficult geography and worsening civil conflict. Here MSF has established a primary healthcare project to respond to the health needs of direct and indirect victims of conflict through mobile and fixed clinics.

Over 450,000 patients were tested and 210,000 treated for malaria in Rakhine state in 2006. This is MSF's largest malaria programme, supporting 30 clinics and running seven mobile clinics that focus primarily on diagnosis and treatment of the disease.

In Rakhine, MSF has responded to discrimination of the Rohingya - a minority Muslim group whose citizenship is disputed - by

offering free access to healthcare and treating approximately 50,000 patients yearly. In 2006, MSF also continued a feeding programme, helping over 3,000 malnourished children. MSF continues to advocate to the government for greater healthcare access for the Rohingya and raises awareness of the difficulties faced by this population through public communications.

MSF has worked in Myanmar since 1992.

NEPAL

REASON FOR INTERVENTION • **Armed Conflict**

FIELD STAFF 333

MSF established healthcare projects in Nepal during the violent conflict between Maoist insurgents and the royal government army that affected the country for over a decade.

In November of 2006, a peace agreement was reached and the Maoists became part of a transitional government formed in early 2007. Although this conflict is officially over, access to healthcare is still a concern and the state of women's health is particularly worrying. In the towns of Kalikot and Khotang, projects with an emphasis on women's health and reproductive care continue. Free healthcare and medicine are provided to all patients seen inside the hospitals as well as the outpatient departments. A total of 26,094 consultations were carried out in these locations in 2006.



In May 2007, MSF organised and supervised a six-day project to operate on 83 women with uterine-vaginal prolapse (UVP) in Khotang. UVP is a physical condition created when tissues supporting the uterus in the pelvic cavity are weakened, allowing the uterus to descend into the vaginal canal. This condition is usually caused by obstetrical trauma during labour and delivery. A variety of debilitating and difficult symptoms including pain, discharge and bladder infections greatly decrease quality of life and sometimes result in women being abandoned by their husbands.

The Nepalese Ministry of Health did initial screening of women and Public Health Concern Trust Nepal, a Nepalese surgical NGO, provided medical materials and supplied surgeons. MSF spent two months organising and overseeing the project, made extra shelters and temporary structures to facilitate the volume of operations, supplied accommodation for patients and their caretakers and provided follow-up care. All operations were performed successfully.

Project Handovers

MSF has worked in partnership with the Nepalese Ministry of Health in the reference hospital de Salle, in Rukum district. MSF in 2006 undertook 27,300 outpatient consultations, mostly for people with respiratory infections and diarrhoea; performed 1,728 gynaecological-obstetric consultations; followed 79 patients on treatment for tuberculosis; managed the pharmacy and assured proper hygiene and waste disposal. MSF has now withdrawn from this project.

In 2006/2007 MSF continued to manage two hospitals, located in what were previously "Maoist zones" at Rukumkot and Arviskot. In these two structures 37,500 consultations were carried out in 2006. The signing of the peace accord between the Nepalese government and Maoist rebels has permitted safer movement of people in these regions, allowing them to reach healthcare structures and decreasing the need for medical intervention by MSF. These projects were handed over to local NGOs in June 2007.

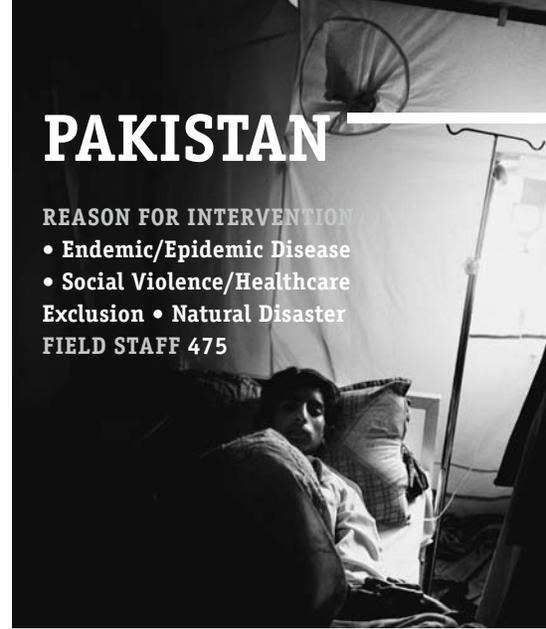
MSF has worked in Nepal since 2002.

PAKISTAN

REASON FOR INTERVENTION

• **Endemic/Epidemic Disease**
• **Social Violence/Healthcare Exclusion** • **Natural Disaster**

FIELD STAFF 475



Heavy monsoon rains in Pakistan, topped by Cyclone Yemyin, which swept through the southern part of the country in June 2007, caused flooding and displaced thousands of people in the western province of Balochistan. MSF responded with an emergency intervention, complementing the activities of the Ministry of Health.

MSF treated over 1,000 patients for basic diseases such as diarrhoea and skin infections in the first weeks of the floods and set up two treatment centres for people with diarrhoea in Turbat and Jhal Magsi. A water treatment unit in Ormara and a chlorination unit in Pasni were established to provide safe drinking water. MSF also provided relief items and medical supplies in Jaffarabad, Jhal Magsi, Nasirabad and Turbat, sent in doctors and nurses for extra support, and ran mobile clinics to target isolated communities.

New project in North West Frontier Province

In October 2006, MSF started a project in Malakand Agency, North West Frontier Province. The goal is to support Agra Hospital and a series of health centres in primary healthcare delivery, with a particular emphasis on maternal health. By July 2007, MSF had conducted approximately 2,000 consultations at Agra Hospital and admitted 104 patients, many with respiratory infections, trauma and chronic diseases.

Providing care in the Federally Administered Tribal Areas

Since March 2006, MSF has provided approximately 1,000 paediatric consultations monthly in the Alizai hospital in Kurram Agency. The project has been extended to cover reproductive health including emergency obstetric surgery and neo-natal services in both Alizai



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and Sudda Hospitals. MSF teams also provided support during the sectarian violence that erupted in the Agency in March 2007, providing emergency medical support and surgical supplies and distributing relief items such as food and blankets to displaced families.

Assisting Afghans in Balochistan Province

MSF provides care in a rural health centre and supports maternal and child care in Kuchlak, a largely Afghan refugee settlement just north of Quetta, Balochistan. Over 5,000 medical consultations are conducted monthly. In May 2007, MSF started assisting the Chaman Hospital, Balochistan, with a reproductive health project including emergency obstetric surgery and neonatal services. Government medical services in Chaman, a border town, are stretched to provide for city inhabitants, the rural population, Afghan refugees and patients coming from neighbouring Afghanistan. MSF began offering community-based feeding for malnourished children in the districts of Nasirabad and Jaffarabad in May 2007. By July, over 150 children were receiving therapeutic or supplementary feeding.

Ending earthquake assistance

In October 2005, an earthquake struck about 100 kilometres north of the Pakistani capital Islamabad causing massive destruction, with an estimated 73,000 people killed, almost 128,000 people wounded and over three million people rendered homeless. MSF expanded its activities in the region to include water and sanitation activities, primary healthcare and mental health support. Most programmes had closed by the end of 2006 and transfer to local authorities of the only remaining earthquake-related project, a temporary hospital built by MSF in Bagh, is planned for the end of 2007.

MSF has worked in Pakistan since 2000.

SRI LANKA

REASON FOR INTERVENTION • **Armed Conflict**
FIELD STAFF 30

After 20 years of civil war in which more than 60,000 people died, the Sri Lankan Government and the Tamil Tigers rebels (LTTE) finally concluded a ceasefire in 2002 and civilian life reestablished a certain sense of normalcy. The country, however, remained the site of many violent incidents throughout this period. At the end of 2005, clashes resumed on a larger scale and rapidly led to the *de facto* collapse of the ceasefire, with dramatic consequences for the civilian population.

More than 300,000 people have been displaced because of fighting in the north and the east and another 10,000 have sought refuge in neighbouring India. According to official figures, more than 3,000 persons died in 2006. People in conflict-affected areas live in fear and are victims of fighting, murder and kidnapping. Aid organisations have been affected by the violence as well, the worst incident taking place in August 2006, when 17 national staff of Action Contre la Faim/Action Against Hunger (ACF) were killed in Muttur.

As a result of the conflict, large parts of the civilian population are isolated. Movements are limited, roads are cut-off and the supply of essential goods is extremely difficult. This isolation has a serious economic impact, with a dramatic increase in prices and restriction of fishing and trade. Health services have also been severely affected: many medical specialists have fled, leaving the population largely without access to needed medical care.

MSF had worked in Sri Lanka since 1986, throughout the years of war, and with all programmes closing gradually after the 2002 ceasefire agreement. In May 2006, with the resumption of hostilities, MSF decided to return to assist the population in conflict-affected areas. Despite the Ministry of Health's (MoH) requests for assistance, bureaucratic obstacles prevented teams from continuing work that had started during the summer of 2006 in Point Pedro Hospital, on the Jaffna Peninsula.

All necessary authorisations and permits were not granted until January 2007, when activities resumed. MSF opened three surgical programs in Point Pedro, Vavuniya and Mannar, all in conflict-affected areas controlled by the government. The proximity to the frontline and restriction of movement make the inhabitants of these regions extremely vulnerable. MSF provides surgical support to the public hospitals, which mainly



© Henk Braam

lack specialised staff. Since the beginning of 2007, teams have been performing an average of 450 surgeries per month.

Once the first three projects were running, further expansion of medical programmes in conflict and LTTE-controlled areas was possible. Health facilities there suffer major shortages of staff and supplies and the population often remains stuck because of fighting. In May, MSF started a new programme in Batticaloa district in the east, where thousands of people have been displaced. The team organised mobile clinics offering primary healthcare to displaced people living in camps and supplies them with relief items and water. Gynaecological support is also provided to the Valachenai hospital. Another programme started in the LTTE-held town of Killinochchi, supporting paediatric and emergency obstetrics care in the general hospital.

In July 2007, MSF awaits government authorisation to open a project in Adampan, an LTTE-controlled area of Mannar district.

MSF has worked in Sri Lanka since 2007.

THAILAND

REASON FOR INTERVENTION • Endemic/Epidemic Disease • Social Violence/
Healthcare Exclusion
FIELD STAFF 161

MSF began its first-ever HIV anti-retroviral treatment programme in 2000 in Thailand, using generic anti-retroviral drugs. Since then, MSF has worked closely with health authorities and local partners to provide support to people living with HIV/AIDS and improve their treatment and care. By July 2007, 100,000 patients were receiving free firstline anti-retrovirals (ARVs) through the national health system and mainly generated through local generic production. Yet vulnerable groups remain excluded whilst the growing need for secondline medicines - drugs for those who do not respond to treatment on firstline regimens - raises new challenges. MSF's Campaign for Access to Essential Medicines continues to advocate for large-scale generic production of ARVs and supports the Ministry of Health's (MoH) use of compulsory licensing to increase access to generic AIDS medicines.



The Thai government is now deporting Hmong refugees upon entry to the country

In Kalasin province, northeast Thailand, MSF works in partnership with Kuchinarai district hospital and community groups to strengthen and maintain firstline anti-retroviral therapy (ART) through viral load monitoring and community activities. By July 2007, 180 patients were receiving firstline ARVs and five patients were on secondline ARVs. This pilot project is the only one to offer secondline ARV treatment at the district level.

Providing healthcare to migrants and minorities

In Thailand, health insurance is available only to registered Thai nationals and marginalised

groups have limited access to healthcare. MSF has publicised its health concerns for these neglected populations and lobbies the Thai authorities to address their needs.

In Huay Nam Khao camp in Petchabun, northern Thailand, MSF has assisted the Lao Hmong since 2005, ensuring adequate medical care, water supply and sanitation in the camp. In 2006 over 24,000 consultations were conducted, mainly for respiratory infections and diarrhoea. MSF liaised with camp leaders and public health authorities to raise awareness about the risk of epidemic outbreaks in this overcrowded camp. In late June 2007, the 7,900

refugees began to be relocated to a bigger holding camp. MSF helped with medical care and food distribution whilst ensuring families were not separated.

The Thai government is now deporting Hmong refugees upon entry to the country. MSF has called on the Thai government to stop the deportation and ensure the safety of the Hmong. MSF has also urged the international community to take a clear stance on the Hmong refugees.

In Mae Sot, on the Thai-Myanmar border, MSF began a tuberculosis (TB) project in 1999 with unregistered migrant workers from Myanmar. In 2006, the MoH gave permission to import treatment for multi drug-resistant TB. Between 2005 and 2006, the number of TB patients in care doubled, reaching a total of 799 people, 70 percent of whom successfully completed their regimen.

In mid-2007, MSF opened a malaria project providing early diagnosis and treatment in New Mon State, an autonomous state inside Myanmar. Based in Sangklaburi, Kanchanaburi province, MSF teams support the health facilities in Mon State, situated in the ceasefire zone along the Thai-Myanmar Border, by providing drugs, lab materials and training.

In Chiang Saen and Mai Sai hospital, in Chang Rai province on the Thai-Laos border, MSF offers cross-border HIV/AIDS treatment and care to unregistered minorities from Myanmar and Laos. MSF has also strengthened the capacity of three Lao hospitals so that Lao patients can be referred and treated in their own country.

In Phang Nga, thousands of undocumented migrant workers from Myanmar are still crossing the border in large numbers, seeking work in Thailand. The language barrier, fear of arrest, and lack of information prevent them from getting the medical attention they need. Through mobile clinics, health centres and the provision of Burmese speaking medical staff, MSF is assisting them with primary healthcare such as mother-child health and treatment of communicable diseases including HIV/AIDS. In 2006, 3,600 outpatient consultations were conducted at Phang Nga.

MSF activities with the Muslim community in the south of Thailand are limited by ongoing violence and the general feeling of suspicion from the government and local Muslim communities towards outsiders. MSF is maintaining a presence in the area with HIV/AIDS education activities to increase AIDS awareness.

Tuberculosis outpacing drugs and diagnostics

In 2006, the outbreak of an extremely lethal form of tuberculosis (TB) in South Africa sparked alarm around the world. The University of KwaZulu-Natal's investigation of patients not responding to treatment for multi-drug resistant tuberculosis treatment revealed that 52 out of 53 patients had died from extensively drug-resistant TB (XDR-TB), thrusting into the spotlight a spiraling health crisis that MSF has struggled to address for over seven years.

Although MSF has treated patients with simple tuberculosis for many years, the ability to treat patients has taken on a critical dimension with the emergence of resistant forms of the disease and the rapid spread of TB among people living with HIV/AIDS.

The current tools used to tackle tuberculosis - diagnostics, vaccines, drugs - are inadequate: an MSF survey showed that out of a group of 168 patients prescribed multi drug-resistant treatment in MSF projects around the world, only 55 percent completed the course successfully. Drugs to treat MDR do not work efficiently and cause serious side effects. Just over a fifth of the patients defaulted during the 18 to 24 month treatment period and 13 percent died despite optimal treatments. Some of the patients went on to develop the even more deadly form of the disease, XDR-TB.

The limitations of the current medical tools are revealed in southern Africa, the heart of the AIDS pandemic. TB is present in much of the HIV infected population, as their immune systems are particularly vulnerable to TB contagion: in an MSF project in Lesotho, 92 percent of patients who had begun TB treatment were also HIV positive. Diagnosing TB in HIV patients is especially difficult in remote settings, requiring sophisticated equipment not available in rural areas.

The limitations of the current medical tools are revealed in southern Africa, the heart of the AIDS pandemic. TB is present in much of the HIV infected population

Despite the urgency of the situation, there are no good drugs to treat drug-resistant TB and patients co-infected with HIV, and no adequate tests to diagnose the disease. Without these tools, it is unlikely the disease will be contained.

In its effort to galvanise and accelerate development of new drugs and diagnostics, MSF's Campaign for Access to Essential Medicines (CAME) has critically analysed the research pipeline for new drugs and diagnostics, identifying many gaps. After 40 years of inertia, new drugs are in development yet there is no sign of a major breakthrough that will significantly impact TB treatment or diagnostics.

In January 2007, an international symposium in New York organised by MSF with drug developers, clinical researchers, health professionals, policy makers, donors and activists created new momentum, generating a raft of proposals for boosting the development of better TB treatments and tests. Among them is the call to carry out clinical trials with all new drugs in development for MDR-TB. Currently, there is only one pharmaceutical company that is actually testing its drugs for use to treat MDR TB and MSF is calling on other drug developers to do the same.



Offering care to intravenous drug users and prisoners

Intravenous drug users (IDU) in Thailand are among the highest risk groups for HIV infection. Many of these people suffer from discrimination that prevents them from obtaining proper medical care. MSF runs a weekly clinic in two IDU centres offering general healthcare and treatment of infectious diseases such as HIV/AIDS. This involves accompanying IDUs through hospital procedures and monitoring them closely for treatment adherence and further complications.

MSF also provides HIV prevention and treatment in two prisons in Bangkok in partnership with the Thai government. Thai prisons have high HIV infection rates and suffer from lack of health staff and severe budget constraints. MSF has enrolled 67 patients on ARV treatment since the programme's inception in 2003. MSF's activities involve treatment of opportunistic infections, training the prison medical staff and covering lab costs. MSF is developing a training curriculum in collaboration with the Department of Corrections that will be used in the future to extend these services to all Thai prisons.

MSF has worked in Thailand since 1983.

TURKMENISTAN

REASON FOR INTERVENTION • **Social Violence/Healthcare Exclusion**
FIELD STAFF 73

MSF is working to improve the quality of healthcare for children and pregnant women in Magdanly – a predominantly ethnic Uzbek populated, impoverished area on the eastern frontier of Turkmenistan, remote from the capital. Despite state gas revenues, many Turkmen provinces are destitute in this ex-Soviet Central Asian state. The country is one where MSF struggles with a healthcare system that continues to risk stalemating progress of its programmes, whilst at the same time forming the basis for MSF's presence in Turkmenistan.

MSF works in the general paediatrics, infectious disease, intensive care, and maternity wards of the Magdanly Town Hospital, providing equipment, drugs and medical materials and supporting laboratory services. The project has set up an intensive baby care room in the hospital, a child screening room in the clinic, and makes regular outreach visits to primary healthcare posts around Magdanly. MSF addresses medical complications seen in babies, and focuses heavily on lifesaving support for premature births. MSF also undertakes extensive local staff training and community health education. In 2006, within MSF projects, 40,000 outpatient and 3,000 inpatient consultations in the hospital were directly supported by MSF medical staff, along with 1,000 deliveries.

No success introducing TB treatment

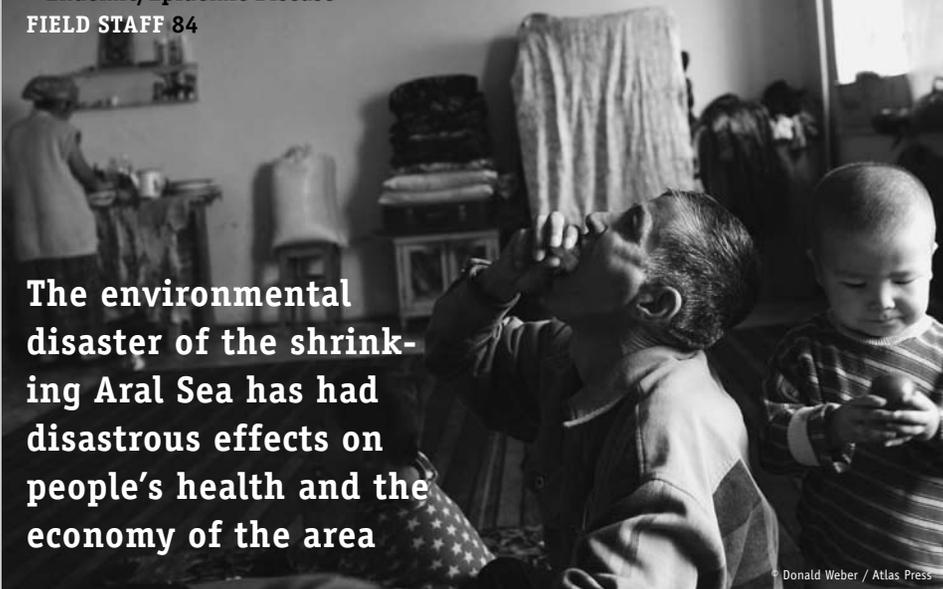
Throughout 2006, MSF continued to push forward a project of TB-DOTS (Directly Observed Treatment Short course) services, for inclusion in the district public healthcare. After months of lobbying, in summer 2006 MSF received positive feedback from the Ministry of Health on its proposal, but preparations to integrate patient screening and treatment have been on hold since September 2006, because of objections to the concept of integrated TB services. Although Turkmenistan has adopted a national programme of TB treatment along the World Health Organization's DOTS strategies, many TB patients continue to face a lack of access to quality care.

MSF has worked in Turkmenistan since 1999.

UZBEKISTAN

REASON FOR INTERVENTION
• **Endemic/Epidemic Disease**
FIELD STAFF 84

The environmental disaster of the shrinking Aral Sea has had disastrous effects on people's health and the economy of the area



Donald Weber / Atlas Press

Uzbekistan has one of the world's highest rates of multi drug-resistant tuberculosis, defined as resistance to the main anti-tubercular drugs, isoniazid and rifampicin. Rates of multi drug-resistant tuberculosis (MDR-TB) are 13 percent among newly diagnosed TB patients and 40 percent in re-treated TB cases. MSF has also witnessed people with extremely drug-resistant TB (XDR-TB), which has even less chance of being cured.

With lack of adequate healthcare and unfavourable socioeconomic factors, the situation looks particularly grim for patients in the Karakalpakstan autonomous region, where the environmental disaster of the shrinking Aral Sea has had long-lasting and disastrous effects on people's health and the economy of the area, which was highly reliant on its fishing industry.

MDR-TB requires a lengthy treatment of up to 24 months, with a daily cocktail of highly toxic and expensive secondline TB drugs. By June 2007, 468 patients in Karakalpakstan had been enrolled, with 260 on treatment, in the first "DOTS-Plus" programme for TB treatment in Uzbekistan, run by MSF in cooperation with the Ministry of Health (MoH). This project followed the first regional DOTS programme (Directly Observed Treatment Short course for uncomplicated TB), which MSF opened in 1998. MSF has rehabilitated a 75-bed hospital and a mycobacteriology laboratory in Nukus, the regional capital. Forty additional beds for MDR-TB have also been provided by MSF in the main MoH tuberculosis hospital.

Despite best efforts to include more patients, there is a growing waiting list of detected TB

patients, reflecting the high unmet needs in the region. Patients start taking treatment in the TB hospital until they stop spreading the infection, which can take two to four months, then continue their treatment through ambulatory care at DOTS-Plus corners located in smaller health centres in Nukus and the adjacent Chimbai district. Besides quality clinical care, the multidisciplinary MSF team provides prevention measures as well as health education and psychosocial support for patients, their families, and the community. The project does cutting edge operational research that will enhance understanding of MDR-TB.

The four-year long DOTS-Plus Pilot Project of MSF has been advocating with the MoH, the UN's Green Light Committee and the Global Fund to expand the availability of DOTS-Plus in the region, which will allow MSF to hand over this intervention to the MoH in the near future.

MSF has worked in Uzbekistan since 1997.

The Americas



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BOLIVIA

REASON FOR INTERVENTION • **Endemic/
Epidemic Disease**
FIELD STAFF 76

Little-known outside of the Americas, Chagas is a parasitic infection that currently affects approximately eight million people in Latin America, and the prevalence of the disease has been higher in Bolivia than any other country.

Transmitted by blood-sucking insects that are commonly found in impoverished areas and rural dwellings, Chagas can kill people by debilitating the heart and/or intestinal system. There are only two, older-class drugs available to treat Chagas that risk many side effects, and monitoring and follow-up of patients is essential. To date, treatment for adults has not been curative and children have been the main target for medical interventions.

MSF has undertaken numerous projects to address prevention and treatment of Chagas in Bolivia, and currently tests and treats youth under age 18 in the city of Sucre, Chuquisaca department. As the Chagas National Programme started diagnosing and treating patients under 15 in various municipalities in the country in 2006, MSF has been decreasing the volume of its activities. At the end of the year, MSF closed a project focusing on children under 15 in Tarija, O'Connor province. Over five years, the project focused on raising awareness and screening in a very complex rural setting, covering up to 95 percent of the targeted population and treating 1,400 children. In the second half of 2007, MSF will be implementing a new project treating adults in the urban area Cochabamba.

MSF also works with national and international organisations to raise awareness of Chagas and pushes for more research and development into effective diagnostics and drugs. MSF has been a partner of the Pan American Health Organization and participates in the newly formed Global Network for Chagas Elimination, launched at the World Health Organization in July 2007.

MSF has worked in Bolivia since 1986.

COLOMBIA

REASON FOR INTERVENTION • **Armed
Conflict • Social Violence/Healthcare
Exclusion**
FIELD STAFF 267

Active conflict has afflicted parts of Colombia for over 40 years, with guerrilla groups fighting against government forces, police and government-backed paramilitary. In 2007, it was estimated that 3.8 million people had been internally displaced as a result of violent events including massacres, assassinations and intimidation. The psychosocial consequences of living in this climate of fear can be debilitating and has a lasting impact on the lives of many Colombians. Psychological distress is widespread and mental health support is a key component of most MSF projects throughout the country.

In 2007, MSF began a new project in Tame, Arauca department. Lags in administration to receive government social benefits leave internally displaced people (IDPs) with gaps in healthcare coverage, and MSF provides medical care to all recent IDPs. Mental health consultations are complemented with training and support for local institutions providing mental health services. MSF is trying to create a support network for IDPs, involving all institutions that provide medical, psychological, economic and family tracing services. MSF also provides medical and psychological care in rural areas of Arauca.

In the rural departments of Tolima and Huila, MSF provided 11,074 medical and 4,700 individual and group consultations in 2006. Psychological assistance is available in Algeciras, Casa Blanca, also affected by conflict. In Ibagué, the capital of Tolima, MSF offers primary healthcare to people waiting for their certificate of displacement, which normally grants them access to government healthcare.

Near Bogotá, MSF assists the newly displaced in Soacha district, conducting medical consultations and providing mental health support for displaced persons and people excluded from the public health system. The team informs displaced families about their right to healthcare and provides information on gaining access to the complicated government-run

health system. Psychosocial care is also provided for people living in Florencia, Caquetá. Approximately 700 patients are seen monthly, most for depression and post-traumatic stress.

In addition to providing healthcare via mobile teams, MSF supports health facilities in the Barbacoas region of Nariño province, by training health staff, providing support to rehabilitate rural health structures and implementing water-sanitation and waste management systems.

In Uraba, Antioquia, basic healthcare services are provided in a fixed clinic including treatment for commonly found illnesses such as tuberculosis (TB), malaria and leishmaniasis. Mobile teams provide basic healthcare services including vaccination and dental care; water, sanitation and waste management; mosquito net distribution and mental healthcare. There is also a comprehensive reproductive clinic including services for HIV/AIDS and for victims of sexual violence. A similar project operates in the northeastern province of Norte de Santander through a clinic in Tibu.

Many displaced people are found in Sincelejo, an urban slum in the northwestern province of Sucre. Here MSF provides basic healthcare services and mental healthcare. Treatment is provided for people with HIV/AIDS, TB, sexually transmitted infections and those who have experienced sexual violence. Water and waste management projects improve the sanitation of IDP barrios.

Sexual and reproductive healthcare are provided in Riosucio and Quibdo town, Choco department including medical and psychological care for survivors of sexual violence. MSF also trains staff and local institutions on the use of a post-exposure prophylaxis kit, which can be used to reduce risk of infection after an incidental HIV exposure.

In the rural areas of Istmina and Río San Juan, also in Choco, mobile health brigades provide primary healthcare and sexual and reproductive healthcare. Communities in Río San Juan are provided with basic medical services and MSF provides technical support to health posts along the river. MSF runs a health centre in Andagoya/Istmina focusing on the health needs of women and provides housing in Andagoya for women in later stages of pregnancy who normally live in remote riverside areas.

MSF has worked in Colombia since 1985.

ECUADOR

REASON FOR INTERVENTION • Endemic/
Epidemic Disease • Natural Disaster
FIELD STAFF 28

Ecuador's Tungurahua volcano, located near the tourist town of Banos, erupted in mid-July and again in August 2006, prompting the evacuation of people in its vicinity. On both occasions, MSF provided support to the displaced population through area health structures. Medical and material aid, including shelters and hygienic kits, were provided for more than 3,000 people. Although the Tungur was active intermittently throughout 2006 and 2007, medical staff was sufficient and MSF was not needed to provide any human resources. Medical material to support rehabilitation of the hospital and health centres in the area was supplied.

MSF in 2004 began a project of integral attention to HIV/AIDS in three health areas of Guayaquil town

Guayaquil HIV/AIDS project

MSF in 2004 began a project of integral attention to HIV/AIDS in three health areas of Guayaquil town, which has the highest prevalence of HIV in Ecuador. Guayaquil has only one reference hospital and one "health attention unit." MSF opened a new attention and treatment unit in the hospital, and also three maternity and eight health centres, providing free access to counseling and testing, anti-retroviral treatment (ART) lab follow-up, and health education. By June 2007, MSF had attended to 1,770 patients and initiated 530 of them on ART.

MSF is finalising the handover process of the Guayaquil project to the Ministry of Health, and the official closure of the project is planned for December 2007.

MSF has worked in Ecuador since 1996.

GUATEMALA

REASON FOR INTERVENTION • Endemic/Epidemic Disease
• Social Violence/Healthcare Exclusion
FIELD STAFF 111

MSF is witnessing an increase of violence in Guatemala, and aiming to better understand the nature and extent of urban violence in order to provide an effective response. In 2007, a team began setting up medical and psychological services to answer to the needs of victims of social and domestic violence in Guatemala City.

Handing over numerous projects

Increased support from international donors and gradual improvements in healthcare funded and delivered through Guatemalan government structures led MSF to transfer a number of projects throughout 2006/2007.

and expanded treatment by Ministry of Health clinics enabled MSF to hand over two HIV/AIDS treatment programmes, one in Coatepeque in December 2006, and one at the Yaloc Clinic in Guatemala City in August 2007, together treating over 1,500 patients at time of handover.



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In Guatemala City a project for street children at the Tzité clinic was handed over in 2006 to a local NGO after running for six years. MSF conducted 2,393 external consultations, 206 pre-natal consultations, provided psychological assistance for 125 patients and had contact with 1,243 street children whilst running the programme.

In Olopa municipality, where MSF teams have worked to improve access to healthcare and treatment for people affected by Chagas disease, activities were handed to local authorities in December 2006. Comprehensive assistance provided to people living with HIV/AIDS in Puerto Barrios and Livingstone was also handed to local health authorities in July 2007. Since 2005, increased international investment

Supplying HIV/AIDS drugs during stock-outs

In 2006 and 2007, MSF teams supplied anti-retroviral drugs (ARVs) to several treatment centres that experienced repeated drug shortages. HIV/AIDS patients risk a deterioration in immune system functioning and life-threatening opportunistic infections without a steady supply of ARVs.

MSF has advocated for these patients by urging the Global Fund to use its financial leverage to lower drug prices, and the Guatemalan government to take advantage of World Trade Organization mechanisms to purchase the most effective medicines at the best prices.

MSF has worked in Guatemala since 1984.

HAITI

REASON FOR INTERVENTION • Armed Conflict • Social Violence/Healthcare Exclusion

FIELD STAFF 627

Violence and insecurity were pervasive in Port-au-Prince, the Haitian capital, during 2006/2007. Even with a newly elected government in place, there were confrontations involving various armed groups and the Haitian National Police and UN Stabilization Mission in Haiti (MINUSTAH), as well as extensive kidnapping and sexual violence.

In July 2006 alone, MSF treated more than 200 gunshot victims at its three medical facilities in Port-au-Prince: St. Joseph's Trauma Centre, St. Catherine Hospital in Cité Soleil, and Jude Anne Hospital.

In December 2006, MSF opened a new project in Martissant, a slum of Port-au-Prince without healthcare and where armed groups fight frequently. Approximately 5,000 patients were treated in the MSF emergency room during the first six months of activities. Patients in need of further care are transferred to other MSF facilities in the city.

MSF also works in Cité Soleil, another deprived area in Port-au-Prince, where an estimated 200,000 people live in poverty and amid violence. MSF has treated 15,900 patients in St. Catherine Hospital, 20 percent of these victims of violence, since the project began in 2005.

In the 55-bed Jude Anne hospital, MSF has provided emergency obstetrical care since March 2006. Activity has increased significantly, reaching a peak of 1,300 deliveries in September 2006, an estimated 20 percent of births in Port-au-Prince. Over 12,000 infants had been born at this hospital by June 2007. In May 2007, MSF also started mobile ante-natal care clinics in three Port-au-Prince slums.

Improving care for victims of violence

In November 2006, MSF moved its trauma centre from St. Joseph's Hospital to La Trinité hospital. In this larger health structure, MSF was able to improve the quality of care it provides to victims of violence by increasing emergency room capacity and introducing better orthopaedic surgical care. Since its opening in December 2004, MSF has treated 6,400 victims of violence, including nearly 3,000 people



© Pep Bonet / Noor

Violence and insecurity were pervasive in Port-au-Prince, the Haitian capital, during 2006/2007

suffering gunshot wounds, approximately 1,600 who had been stabbed, 700 beaten, 500 raped and 500 victims of domestic violence.

In June 2007, MSF increased its capacity to treat victims of sexual violence in the capital, offering comprehensive psychological and medical treatment. The programme had already treated 220 victims of sexual violence between July 2006 and June 2007. MSF also operates a physical rehabilitation centre where patients needing specialised post-operative

treatment can receive physiotherapy and psychological care.

Project closure

At the end of June 2007, a MSF project in Petite Rivière de l'Artibonite was handed over to the Ministry of Health, supported by a local organisation, Zanmi Lasante. The project was focused on maternal and child health.

MSF has worked in Haiti since 1991.

HONDURAS

REASON FOR INTERVENTION • Social Violence/Healthcare Exclusion
FIELD STAFF 37

Tegucigalpa, the capital of Honduras, is home to approximately one million people. In this urban setting, street youth are among those who suffer the most from repeated exposure to violence. MSF estimates there are minimum 400 children and adolescents living in very precarious circumstances, attempting to survive in the streets. The most common reason these youths flee their homes is to escape the consequences of family break-ups or violence. Drug addiction – most commonly to glue – increases the youths' marginalisation and sense of rejection.

Daily life for these young people is characterised by a struggle to survive. The repeated violence they experience is both physical and psychological, inflicted by a large range of perpetrators, including their peers, institutions, shopkeepers, the militia and the police.

MSF opened a therapeutic day centre to provide care for these street youth in 2005 in Comayaguera, a market area with some of the highest crime rates among districts most affected by urban violence. Services include medical care, mental healthcare and social and educational activities, the aims of which are to introduce an element of normality into daily lives affected by ongoing stress and addiction.

A special emphasis is put on sexual and reproductive healthcare, as these youth are exposed to the risks of multiple pregnancies, the consequences of commercial sex exploitation, sexual violence and sexually transmitted infections.

The centre provides a series of multi-disciplinary services that are backed up with street work, aiming to bring youths to the centre and/or other structures. In 2006, over 800 mental health and 1,200 medical consultations were conducted through this programme.

MSF has worked in Honduras since 1998

PERU

REASON FOR INTERVENTION • Endemic/Epidemic Disease
FIELD STAFF 56

In Peru, MSF has focused on developing projects to address sexually transmitted infections, and particularly HIV/AIDS. In 2006/2007, MSF implemented a new methodology (Dynabeads) for taking a manual CD4 count, an index of immune system functioning used to monitor patients with the disease. This technology is utilised in five Peruvian provinces and MSF is training Ministry of Health workers on its use.



MSF has focused on developing projects to address sexually transmitted infections, and particularly HIV/AIDS

MSF has continued a project offering HIV/AIDS care in the Lima slum of Villa El Salvador. This is a pilot project offering decentralised care via numerous sites at the health district level, rather than through a single health structure. One goal was to develop a viable model that could possibly be reproduced at the national level. As of June 2007, MSF had 289 patients following anti-retroviral treatment (ART) through the Villa El Salvador project and was providing voluntary counseling and HIV testing to approximately 1,100 people per month.

Closure of prison project

In June 2007, MSF completed the closure of a project for sexually transmitted infections (STIs) and HIV/AIDS in the state prison of Lurigancho, the largest prison in Peru, located in Lima. Lurigancho houses approximately 8,500 inmates in a space designed for 1,500,

and the risk of contracting HIV there is five to seven times higher than outside the prison.

A multidisciplinary approach to care involved doctors, a psychologist and social workers and was started in 2000. The Lurigancho programme demonstrated that it is possible to offer timely and adequate care for STIs and HIV/AIDS in a complex environment. Following an invitation from the penitentiary authorities, the project was successfully replicated in three other Peruvian prisons – Chorillos Common, Chincha and Huaral. MSF also shared the experience gained with this programme by publishing *Lessons Learned: a multidisciplinary work experience in STI and HIV/AIDS in Lurigancho prison in Lima, Peru*, in 2006.

MSF has worked in Peru since 1985 and will close all activities by the end of 2007.

Europe and the Middle East



EUROPE AND THE MIDDLE EAST



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BELGIUM

REASON FOR INTERVENTION • Social Violence/Healthcare Exclusion
FIELD STAFF 16

Belgian law grants undocumented migrants and asylum seekers the right to healthcare, but in practice many administrative obstacles impede their access to health services. MSF assists migrants in Belgium by providing medical care and advocates for government social services to face up to their responsibilities. In 2006/2007, teams also placed a specific emphasis on helping migrants in detention centres.



MSF has witnessed the human cost of keeping critically ill patients in detention centres

MSF provides regular psychological and medical consultations in the five detention centers in Vottem, Melsbroek, Steenokkerzeel, Merksplas and Brugge, where illegal migrants and asylum seekers are kept before being expelled. Out of the 206 consultations conducted since May 2006, most people suffered stress-related psychosomatic troubles including headaches, sleep problems and lack of appetite.

MSF has also witnessed the human cost of critically ill patients including women with complicated pregnancies, persons living with HIV, diabetics and acute psychiatric cases. These people often remain in detention centres for several months. In May 2007, MSF issued a report with data gathered by regular visits to those centres in the preceding year. The report showed that detainees with mental health problems do not get the care they need and critically ill patients and psychiatric cases are kept locked in. MSF has called for a major

review and changes to the detention policies for undocumented migrants in Belgium.

Providing care to those excluded from the system

MSF continues to provide medical and psychosocial consultations in Brussels and Antwerp to people who cannot obtain those services in the regular system. The majority of patients are undocumented migrants and asylum seekers. In 2006, more than 8,000 consultations were conducted.

MSF also provides information to people who face expulsion and who will not have access to the treatment they need in their country of origin. A website, www.ithaca-eu.org has now been launched so that the information is easily accessible to lawyers and other organisations trying to contest expulsion on medical grounds.

MSF has worked in Belgium since 1987.

FRANCE

REASON FOR INTERVENTION • Social Violence/Healthcare Exclusion
FIELD STAFF 17

In March 2007, MSF opened a project in Paris to address the psychological and medical health of refugees suffering from psychological distress, and more particularly those living without proper documentation.

Having worked with this population for two years in its socio-medical clinics in Paris and Marseille, MSF teams had observed that this group of people, even those with health coverage, lacked access to psychologists and psychiatrists. The difficulties associated with their conditions and within the context of their fragile social environment found them worsening without care.

The Paris programme has been designed to attend to patients experiencing psychological distress and also any other life-threatening problems and medical conditions associated with their precarious living situations. Patients presenting with social service needs or severe and chronic health conditions are referred to other structures for assistance as necessary. 2000 psychological and 1000 medical consultations are expected per year.

Closure of health clinics

MSF closed its two health clinics in Paris and Marseille in 2006. Expansion of the Permanence d'Accès aux Soins de Santé (PASS) will ensure healthcare access for people without social benefits. In 2006, more than 13,000 medical consultations were conducted by the team in Paris and 1,800 in Marseille before MSF discontinued these projects.

MSF has worked in France since 1987.



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IRAN

REASON FOR INTERVENTION • **Social Violence/Healthcare Exclusion**
FIELD STAFF 106

Since the end of the war in Afghanistan in 2002, a tripartite agreement between the United Nations High Commissioner for Refugees (UNHCR) and the governments of Iran and Afghanistan have encouraged Afghan refugees to return to their home country. This "voluntary repatriation" process, however, organised by UNHCR, stopped in 2006. In April 2007, deportation of illegal Afghans by Iranian authorities resumed and 150,000 Afghans have been expelled from the country.

There are officially 1.2 million documented Afghans in Iran and approximately the same amount without proper documentation. Iranian authorities estimate that the majority of Afghans are economic migrants, and therefore not entitled to legal status or access to free healthcare. Many people are reluctant to go back and prefer to remain in Iran. Even after deportation, some Afghans decide to return to Iran. With Iranian restrictions on work, educational opportunities and health services, living conditions for refugees are difficult, but remain better than in Afghanistan.

At Zahedan, capital of Seistan-Baluchistan province, close to the borders of Afghanistan and Pakistan, MSF runs a programme providing medical assistance to Afghan refugees. Primary and secondary healthcare are provided to this population, which has little or no access to the Iranian healthcare system. Three medical clinics offer consultations as well as nutritional support for children. In 2006, 55,520 consultations were conducted in Zahedan. MSF doctors refer patients to other structures for tests or to specialists when necessary and in 2006 3,522 patients were referred.

A team of social workers is also in place in the refugee community to identify people in need of medical care and ensure they get access to consultations. They also distribute material goods such as blankets and heaters as needed.

Mashhad project closes

MSF closed a similar programme assisting Afghan refugees in Mashhad, Khorasan province at the end of 2006, as an epidemiological survey showed that many of these people had access to jobs and healthcare. MSF has also urged the government and local NGOs to devote greater attention to this population. 25,000 consultations were performed here in 2006.

New project in Mehran

Given the extreme difficulties in accessing patients and providing healthcare inside Iraq, in late 2007, a project will start in Mehran, close to the Iraqi border, to provide surgical care for victims of violence coming from Iraq.

MSF has worked in Iran since 1995.

There are officially 1.2 million documented Afghans in Iran and approximately the same amount without proper documentation



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IRAQ

REASON FOR INTERVENTION
• **Armed Conflict**
FIELD STAFF 28

The situation in Iraq continues to deteriorate, with severe humanitarian consequences for the civilian population: as of June 2007 it was estimated that over two million people were displaced inside the country and another two million had sought refuge in neighbouring countries. There continues to be a massive number of civilian casualties and poor access to healthcare.

Medical structures are confronted with difficulties in caring for the high number of wounded people in terms of bed capacity and staff. Medical doctors and paramedical staff have fled the country because of insecurity and also because of targeted killings. Hospitals regularly report shortages of basic medical supplies and drugs.

MSF was operational in Iraq from April 2003 until November 2004, when a decision was made to close the projects and withdraw the staff because it was increasingly dangerous for international humanitarian organisations inside the country. Seeking ways to provide assistance for Iraqis, MSF in mid-2006 partnered with the Red Crescent hospital in Amman, Jordan and began a project offering reconstructive maxillofacial, plastic and orthopaedic surgery for Iraqis. Many patients have suffered war wounds from bombs or bullets, not properly treated at time of injury and requiring multiple operations to rectify and/or restore functionality and a minimum quality of life. As of August 2007, MSF had treated 236 patients in Amman, the majority (57 percent) presenting with trauma to one or more limbs, 25 percent in need of plastic surgery and 17 percent in need of facial reconstruction. The project has the capacity to treat more patients; however, complicated administrative procedures and refusals by the security force in Jordan make it difficult for patients to cross the border and





© Michael Goldfarb

obtain treatment. In August 2007, more than 100 patients were waiting to get to Amman for surgery. In late 2006, MSF also began providing emergency medical supplies to a number of hospitals in Iraq and organising 'training for trainers' courses for paramedical staff, also managed from Amman. The team provides anaesthetics, analgesics and surgical equipment to the casualty departments of hospitals in Baghdad and Anbar provinces where the worst fighting occurs. The first hospital to join the programme reported 2,882 surgical procedures over three months, of which 1,871 were emergency surgeries and 1,482 were violence related.

In early 2007, MSF decided to work in northern Iraq (Iraqi Kurdistan), to provide emergency medical and surgical assistance to Iraqi populations living in areas accessible from the north. The objective is to offer care for civilian victims of the conflict who have sustained war wounds such as severe burns and orthopaedic injuries. A direct intervention by surgical teams is conducted in three hospitals, situated in Dohuk, Erbil and Suleymania. These teams are specialised in the treatment of severe burns and orthopaedic trauma. MSF is also implementing, from war zones (Ninewa, Tameem, and Dyala provinces), a referral system for war wounded to reach these hospitals.

A mental healthcare programme is ongoing in four of the supported hospitals. MSF is also assessing the situation of displaced population and returnees in the northern part of Iraq in order to respond to their medical needs. Between January and June 2007, MSF treated 75 war-wounded people monthly in Erbil and 30 in Dohuk. The number of surgical interventions reached 690 and there were 242 admissions in the burn unit at Erbil hospital. In Dohuk hospital, 2,767 surgical interventions were registered.

MSF has worked in Iraq since 2006.

ITALY

REASON FOR INTERVENTION • **Social Violence/Healthcare Exclusion**
FIELD STAFF 31

Thousands of migrants continue to arrive in Italy, crossing the Mediterranean Sea by boat and risking their lives to reach Europe. During 2006 and 2007 there were several "tragic landings" reported, with an unknown number of deaths. Many people arrive with medical conditions related to their difficult journey, such as dehydration, skin infections caused by overexposure to the sun and salt, burns from petrol used as fuel for rubber dinghies, and respiratory infections.



© Sebastian Bolesch

Thousands of migrants continue to arrive in Italy and risk their lives to reach Europe

Immediate medical assistance is required and MSF has established a project at landings for one of the main entry doors to Europe, the island of Lampedusa. In 2006, MSF assisted more than 18,000 migrants arriving in Lampedusa, the majority originating from Africa, and some from as far away as Asia.

Although migration has become a structural phenomenon in Italy, reception conditions for these people have not markedly improved and the living conditions for undocumented migrants are usually extremely difficult. Even though high numbers of boat arrivals are foreseen, access to care for illegal migrants

still remains a mirage in various parts of the country. In June 2007, MSF was compelled to notify the press that it was hindered by Lampedusan authorities in accessing a boat with 43 migrants, at least two of whom were in need of immediate healthcare.

MSF also provides medical care for migrants through clinics in Puglia, Campania, Calabria and Agrigento, where ill health is frequently related to poor working and living conditions. Many people are seen for dermatological, respiratory and gastrointestinal infections.

In 2006, MSF expanded its presence in Campania, opening new clinics in Caserta province targeting the growing slum areas inhabited mainly by migrants. A specific focus for women migrants employed as commercial sex workers was also added. The component

includes outreach activities and medical care with a special focus on sexually transmitted infections (STIs) and HIV/AIDS prevention. MSF also continued to provide medical care in Calabria, where thousands of migrants find employment as seasonal farm workers. As the project had been fully developed, it was handed over to the Ministry of Health (MoH) in March 2007.

In 2006, MSF provided consultations for more than 13,000 migrants in all its clinics located in southern Italy.

MSF has worked in Italy since 1999.

MOLDOVA

REASON FOR INTERVENTION • **Endemic/
Epidemic Disease**
FIELD STAFF 33

In May 2007, MSF enrolled its first five HIV-positive patients into life-prolonging anti-retroviral treatment in Transdnistria, a breakaway republic of Moldova. The plan is to put 150 patients on anti-retroviral treatment (ART) by the end of 2007.

MSF is the first international NGO to establish an operational base in Transdnistria, a country unrecognized by the international community and thus excluded from the assistance normally provided by inter-governmental and international organisations. Moldova is the recipient of substantial assistance from the global monetary institutions assigned to tackle the HIV/AIDS epidemic, but the bulk of those resources, particularly for HIV/AIDS care and treatment, fails to reach Transdnistria. According to official statistics, HIV/AIDS prevalence here is four times higher than in the rest of the country.

Since a short violent war in the early 90s, when Transdnistria claimed its independence from Moldova, this predominantly Russian-speaking region is in a “political limbo.” The healthcare system is crippled and access to quality healthcare for HIV-infected patients is hampered by an almost complete lack of services or poor funding of the existing ones. Stigma around HIV/AIDS is enormous, and there have been issues concerning the confidentiality of patients’ test results.

In June 2007, after a major rehabilitation project, MSF opened the first outpatient department in the main hospital of the capital, Tiraspol, where treatment of HIV-positive patients is to be integrated into the primary healthcare system. To facilitate this, MSF has conducted training with local medical staff, the majority of whom knew little about HIV and its impact. As MSF continues to enrol patients into its programme, it plans to advocate nationally and internationally for people with HIV/AIDS in Transdnistria to have the same access to quality care as their Moldovan counterparts.

MSF began working in Moldova in 2007.

PALESTINIAN TERRITORIES

REASON FOR INTERVENTION
• **Armed Conflict**
FIELD STAFF 68

The lives of people in the Palestinian Territories continue to be permeated by violent events including inter-Palestinian clashes, incursions and destruction of homes by the Israeli Defence Forces (IDF), and targeted assassinations of known or suspected armed group leaders. Pressure on the population caused by the ongoing occupation of the West Bank continues to be maintained through increased checkpoints, settlements, and permit requirements that severely limit movement.

A financial embargo imposed by international donors in response to the January 2006 election of Hamas worsened an already precarious situation for Palestinians. In Gaza, this has come to include restrictions on all goods of a non-humanitarian nature. Despite direct donations made by a number of agencies, critical shortages of drugs and medical

materials resulted from the stoppage of international funds and increasing disorganisation of Palestinian health services. Budget issues also led to civil strikes of unpaid health workers, in the West Bank in particular, during the last trimester of 2006. MSF teams monitored the situation and made periodic donations to hospitals in the Gaza Strip and in Hebron.

In July 2006, MSF set up an emergency medical project in Hebron on a temporary basis, providing monthly donations to Alia District Hospital and starting a clinic in Hebron City for patients suffering from severe chronic illnesses. Approximately 2,750 medical consultations were conducted here in 2006. A strike of Ministry of Health staff began just after the Hebron clinic opened, and MSF expanded services by opening a second clinic in Yatta as well as mobile clinics to offer ante-natal care services. Both clinics functioned until the beginning of 2007.

Ongoing needs for mental health support

MSF continues a programme in Hebron,

RUSSIAN FEDERATION

REASON FOR INTERVENTION • **Armed Conflict • Social Violence/Healthcare Exclusion**
FIELD STAFF 331

Following its claim for independence from Russia 12 years ago, two successive wars have brought the Chechen Republic not only physical destruction, but also deep mental trauma amongst its people. Psychosocial counseling is an important component of most of MSF’s activities here.





Nablus and Gaza providing comprehensive medical, psychological and social support to Palestinians. The core of the programme is psychotherapy, with an integral approach that involves a social worker and medical doctor to help people with medical and social needs and no access to services. These projects direct care primarily toward the psychological needs of people living in a climate of violence and

extremely stressful living conditions. Psychologists work with patients suffering from anxiety, depression, post-traumatic stress disorder and other psychological syndromes, providing short-term therapy for individuals, families and groups. Approximately 100 to 150 people are seen per month specifically for psychological complaints. In Gaza alone, over 2,000 individual mental health consultations

Despite formal restoration of power and official reports about the stabilisation of the situation, security is precarious. Violent upsurges occur in Chechnya and the neighbouring republics of the Russian North Caucasus, and MSF has seen that many needs of the population remain unmet, including medical care. In Grozny, the Chechen capital, MSF mobile medical teams provide basic healthcare for the residents of six temporary accommodation centres (TAC) – the “homes” of refugees who returned from Ingushetia only to find their houses ruined and with little means to create a livelihood. MSF has also rehabilitated two clinics and runs free pharmacies in Grozny. Medicines are prescribed and distributed under the supervision of an MSF doctor. With a specific focus on mother and child health, Chechen MSF doctors provide paediatric and gynaecological care, reproductive health and family planning consultations, undertaking approximately 3,000 consultations per month in total. In the remote, economically depressed Shelkovskoy district, MSF runs a primary health clinic, conducting approximately 1,000 consultations monthly, and supports district hospitals in Shatoy, Sharoy and Itum-Kale.

MSF is developing its tuberculosis DOTS (Directly Observed Treatment, Short-course) treatment programme in four supported tuberculosis (TB) dispensaries serving a population of 300,000. The Chechen healthcare system lacks a general plan and funding to care for people with TB and there are only five functioning dispensaries in the Republic in total. MSF implements the DOTS strategy of TB treatment and provides patients with supplementary high-energy nutrition for better recovery. The rates of the treatment success in the program are high, and this is reinforced by the work of the MSF TB educators’ team, who ensure that patients adhere to the difficult and lengthy treatment course.

In July 2006, MSF opened a reconstructive surgery project in Grozny hospital No. 9, to care for people with crippling war-related injuries that were not properly treated, such as badly set limbs. Over 200 surgical interventions had taken place by May 2007. In the same facility, the main Republican trauma hospital, MSF supports the neurosurgical and trauma wards, where lifesaving surgery for violence-related injuries are performed.

were conducted in 2006. Teams saw increasing numbers of people seeking help in 2007.

Insecurity causes staff evacuation

Insecurity caused MSF to experience multiple and short interruptions in its programmes in Nablus, located on the West Bank, and in Gaza in 2006/2007. In May 2007 international staff were evacuated from the Gaza strip because of factional clashes and the subsequent armed takeover of the area by Hamas in June. MSF continued to function intermittently through a flexible programme, whereby consultations by national staff were conducted at homes or in fixed locations and the essential medicines were donated to secondary health structures. In July, psychotherapy activities are gradually returning to normal. MSF in July also launched a three-month post-operative care / physiotherapy project for the hundreds of wounded people, victims of violence during the fighting. Attempts are also being made to transfer severely injured Palestinians for specialised surgery to the MSF project in Amman, Jordan.

MSF has worked in the Palestinian Territories since 1988.

Reduction and closure of programmes

In early 2007, MSF closed most of its projects in Ingushetia, bordering Chechnya (paediatric, pre- and ante-natal consultations, and primary healthcare mobile clinics) because of the massive return of the Chechen refugees, the target population of the programmes. The MSF clinic in the capital city Nazran continues to serve remaining residents of spontaneous internally displaced settlements and MSF psychosocial consultants continue working in Ingushetia. In March 2007, MSF handed over the street children and teenagers project in Moscow to another NGO. MSF developed a working model of re-socialization for these children, which combined daily outreach work and the follow-up work of doctors, psychologists, educational and social workers in the day centre. A report entitled *Building a Bridge Between the Street and Society: MSF's Experience and Analysis of Assistance to Street Children in Moscow (2003-2006)* was published in 2007.

MSF has worked in the Russian Federation since 1988 and North Caucasus since 1999.

SWITZERLAND

REASON FOR INTERVENTION • Social Violence/Healthcare Exclusion
FIELD STAFF 2

In January 2006, MSF launched the “Meditrina” project for people living in Zurich. Free consultations are provided for all people of Swiss or other origin who are neither medically insured nor in possession of the necessary financial means to pay for medical consultations and treatment. By July 2007, approximately 60 consultations were being provided monthly. Many of the people who come to the centre are foreign nationals living in unstable circumstances and unable to obtain medical care through the Swiss healthcare system.



© Susanna Simoes

Many of the patients are foreign nationals unable to obtain medical care

The rise in patient attendance is attributed to the integration of six community “mediators” of various nationalities into the social fabric of migrants living and working in Zurich. These mediators have taken on the role of informing the different communities of the existence of this free service.

The Meditrina service now offers HIV counseling and voluntary screening. As with the detection of other medical conditions requiring more specialised treatment, patients may be directed toward other local medical facilities after their initial examination. Meditrina works with a network of national doctors, chemists, hospitals and laboratories to facilitate such referrals.

MSF has worked in Switzerland since 2003.

MSF COUNTRY PROGRAMME CLOSURES

Benin

In Mono-Couffo department, a rural area of Benin with the highest prevalence of HIV, MSF established an HIV/AIDS programme including education, counseling, testing and treatment in 2002, and started providing anti-retroviral medicines two years later. At the end of 2006, the project was transferred to local health authorities and partners, who are now providing free anti-retrovirals. In total, MSF treated 968 HIV-positive patients during the course of the project.

Since June 2005, MSF had also been providing medical care to people in a refugee camp of Togolese at Agamé, in the south of Benin. At the end of 2006, MSF handed over responsibility for medical activities in this camp of 8,000 people, to the national Red Cross.

Japan

Despite the existence of a welfare system that targets the socially disadvantaged in Japan, this system imposes a multitude of restrictions and complex procedures, leaving the majority of homeless people without access to proper medical care. To tackle this socio-medical problem, MSF launched a programme in Osaka in 2004, site of Japan's largest homeless population, with the objectives of providing medical care through a fixed clinic whilst enhancing understanding of the mechanism of social exclusion. Over 14 months, MSF mobile clinics conducted 1,351 medical consultations, offering treatment to 296 patients with conditions such as hypertension, diabetes and joint pain. MSF also made several attempts to establish a fixed clinic, but was faced with discrimination and opposition from the local community and authorities. After devising strategies and questioning the appropriateness and significance of this project in the socio-political context of Osaka, MSF decided to close the programme and referred patients to other health facilities in early 2007.

Malaysia

MSF started working in Malaysia in 2004 to improve access to medical and mental health services for refugee and asylum seeker communities in and around Kuala Lumpur, as these people often have no official status and face great difficulties if they need healthcare. In 2006, MSF opened three mobile clinics, working in close collaboration with local partners. The clinics offered primary healthcare, mental health consultations and referrals. MSF also organised community health education, psychosocial education and mental health training for NGOs, community groups and volunteers from refugee and asylum seeker communities.

After building up the capacity of local partners through training and direct support of clinical services, MSF in April 2007 handed the project to local partners, who will continue to carry out medical and mental health work. The health services provided by NGOs, although vitally important, are seen as temporary measures to alleviate some of the health problems faced by refugees and asylum seekers. In 2006 alone, MSF provided 8,159 medical consultations. A more permanent solution needs to be found that addresses the underlying causes for the lack of access to healthcare.

Poland

When asylum seekers cross the borders of the EU via Poland, they are registered and sent to one of 16 transit camps where they wait to receive refugee status. Having worked extensively within the Caucasus and recognising that approximately 40 percent of people ending up in these camps experienced psychological distress and post-traumatic symptoms such as recurring memories, nightmares, and sleep problems, MSF began a psychological care programme for Chechen asylum seekers in August 2005. Polish authorities now recognise the benefits of the psychological care in the asylum seekers' centres and decided their staff would take over these activities by integrating psychological care into their medical response. MSF withdrew from the project in 2006 after carrying out 2,507 individual consultations for 638 patients.

Tanzania

In 2004, following an MSF presence in the country to assist refugee communities, MSF began an HIV/AIDS project in Makete, Iringa Region. Makete is a rural and isolated district that has been highly affected by AIDS. The project involved support of HIV/AIDS treatment in the district hospital and two private hospitals. The main activities included provision of anti-retroviral treatment, house medical attention, training and preventive activities. The project was handed over to local health authorities and MSF withdrew in January 2007.

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 branches in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom, the United States, and an international office in Geneva.

The search for efficiency has led MSF to create specialised organisations – called satellites - in charge of specific activities such as humanitarian relief supplies, epidemiological and medical research studies, and research on humanitarian and social action. They include:

Epicentre, Etat d'Urgence Production, Fondation MSF, MSF Assistance, MSF Enterprises Limited, Médecins Sans Frontières - Etablissement d'Utilité Publique, MSF Foundation Kikin, MSF-Logistique, SCI MSF, SCI Sabin and MSF Supply. As these organisations are controlled by MSF, they are included in the scope of the financial statements presented here.

The figures presented here describe MSF's finances on a combined international level. These 2006 combined international figures have been set up in accordance with MSF international accounting standards, which comply with most International Financial Reporting Standards (IFRS). 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 2006 financial report may be obtained from the International Office upon request. In addition, each branch office of MSF publishes annual, audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

The figures presented here are for the 2006 calendar year. The Activity Report itself covers the period mid-2006 to mid-2007. All amounts are in millions of euros.

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

Where did the money go?

Programme expenses* by nature

- National Staff | 28.0%
- International Staff | 24.5%
- Medical & nutrition | 19.5%
- Transport, freight, storage | 13.7%
- Logistics & sanitation | 6.5%
- Operational running costs | 5.5%
- Other expenses | 1.2%
- Training & local support | 1.0%



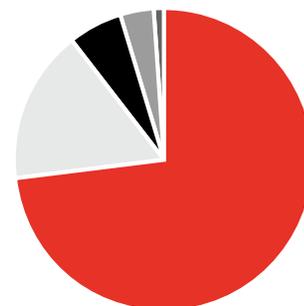
Programme expenses by country/region

| Countries/Regions | in M€ | Countries/Regions | in M€ |
|----------------------------------|--------------|----------------------------------|-------------|
| Africa | | Asia/Middle East | |
| Sudan | 49.3 | Pakistan | 9.3 |
| Democratic Republic of the Congo | 41.4 | Myanmar | 7.3 |
| Niger | 16.2 | Indonesia | 7.2 |
| Angola | 14.8 | Cambodia | 4.8 |
| Liberia | 14.7 | India | 4.5 |
| Chad | 14.0 | Lebanon | 4.0 |
| Kenya | 13.5 | Armenia | 3.0 |
| Somalia | 12.7 | Thailand | 3.0 |
| Ivory Coast | 10.2 | Georgia | 2.0 |
| Ethiopia | 9.4 | Nepal | 2.0 |
| Uganda | 9.1 | China | 1.8 |
| Zimbabwe | 7.5 | Iran | 1.8 |
| Malawi | 7.4 | Iraq | 1.8 |
| Burundi | 7.1 | Palestinian Territories | 1.8 |
| Central African Republic | 6.7 | Uzbekistan | 1.7 |
| Mozambique | 6.7 | Bangladesh | 1.6 |
| Sierra Leone | 5.8 | Other countries* | 3.3 |
| Nigeria | 5.3 | Total | 60.9 |
| Zambia | 4.3 | Americas | |
| Guinea | 3.3 | Haiti | 9.7 |
| Republic of the Congo | 2.7 | Colombia | 5.8 |
| Rwanda | 2.7 | Guatemala | 3.2 |
| South Africa | 2.7 | Peru | 1.2 |
| Burkina Faso | 2.6 | Other countries* | 2.4 |
| Cameroon | 1.6 | Total | 22.3 |
| Mali | 1.3 | Europe | |
| Other countries* | 2.2 | Chechnya / Ingushetia / Dagestan | 6.7 |
| Total | 275.2 | Russia | 2.5 |
| | | Italy | 1.2 |
| | | Belgium | 1.1 |
| | | Other countries* | 2.3 |
| | | Total | 13.8 |

* "other countries" combines all of the countries for which program expenses were below 1 million euros.

Programme expenses* by continent

- Africa | 73.3%
- Asia | 16.2%
- Americas | 5.9%
- Europe | 3.7%
- Non-allocated | 0.9%



*project and coordination team expenses in the countries

2006 2005

Income

| | In M€ | In % | In M€ | In % |
|---|--------------|---------------|--------------|---------------|
| Private Income | 488.4 | 85.9% | 543.0 | 83.7% |
| Public Institutional ECHO*, EU & DFID** | 20.2 | 3.6% | 44.8 | 6.9% |
| Public Institutional Other | 41.6 | 7.3% | 45.5 | 7.0% |
| Other Income | 18.5 | 3.2% | 15.7 | 2.4% |
| Total Income | 568.7 | 100.0% | 649.0 | 100.0% |

* European Community Humanitarian Office ** UK Department for International Development

How was the money spent?

| | | | | |
|--|--------------|---------------|--------------|---------------|
| Operations | 431.2 | 77.0% | 397.4 | 78.0% |
| Témoignage | 18.0 | 3.2% | 15.9 | 3.1% |
| Other humanitarian activities | 7.9 | 1.4% | 8.0 | 1.6% |
| Total Social Mission | 457.1 | 81.6% | 421.3 | 82.7% |
| Fundraising | 71.8 | 12.8% | 59.8 | 11.8% |
| Management, general & administration | 30.9 | 5.5% | 28.2 | 5.5% |
| Total Expenditure | 559.9 | 100.0% | 509.3 | 100.0% |
| Net exchange gains & losses (realised and unrealised) | -4.5 | | 4.1 | |
| Surplus/(deficit) | 4.3 | | 143.7 | |

Balance sheet

(year-end financial position):

| | In M€ | In M€ |
|--|--------------|--------------|
| Non-current assets | 35.8 | 35.5 |
| Current assets | 66.2 | 66.6 |
| Cash & equivalents | 347.5 | 352.1 |
| Total assets | 449.5 | 454.2 |
| Permanently restricted funds | 2.5 | 2.8 |
| Unrestricted funds | 389.4 | 384.6 |
| Other retained earnings | -7.1 | 1.5 |
| Total retained earnings and equities | 384.7 | 388.9 |
| Non-current liabilities | 3.7 | 5.0 |
| Current liabilities | 55.5 | 53.5 |
| Unspent temporarily restricted funds | 5.6 | 6.8 |
| Total liabilities and retained earnings | 449.5 | 454.2 |

HR Statistics

| | | | | |
|--|-----------------|-------------|---------------|----------------|
| International departures (full year): | 4,623 | 100% | 4,768 | 100% |
| Medical pool | 1,292 | 28% | 1,276 | 27% |
| Nurses & other paramedical pool | 1,500 | 32% | 1,558 | 33% |
| Non-medical pool | 1,831 | 40% | 1,934 | 40% |
| First time departures (full year): | 1,332(*) | 29% | 1,466 | (*) 31% |
| (*) in % of the international departures | | | | |
| Field positions: | 26,981 | 100% | 28,083 | 100% |
| International staff | 2,022 | 7% | 2,227 | 8% |
| National staff | 24,959 | 93% | 25,855 | 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 2006, 89.1% of MSF's income came from private sources. More than 3.3 million individual donors and private funders worldwide made this possible. Public institutional agencies providing funding to MSF include among others, ECHO, the governments of Belgium, Canada, Denmark, Ireland, Luxembourg, The Netherlands, Norway, Spain, Sweden, Switzerland 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 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 2006, their available part (the unrestricted funds decreased by the conversion difference) represented 8.2 months of activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, and/or a sudden drop of private and/or public institutional funding, and the sustainability of long-term programmes (e.g. ARV treatment programmes), as well as the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

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

Additional disclosures: Tsunami disaster

The Asian tsunami at the end of 2004 led to an enormous response from the general public worldwide. A total of € 111 million was received in 2004 and 2005. € 24.5 million was spent on the tsunami crisis in 2004-5. During 2006 the remaining restricted tsunami funds (€ 2.3 million) were spent. The increase in our other programmes activities during 2005 (€ 50m) and 2006 (€ 45m) absorbed the remaining funds that were collected and subsequently 'derestricted' with the consent of the donors

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