MSF ACTIVITY REPORT 2007

MEDECINS SANS FRONTIERES

THE MÉDECINS SANS FRONTIÈRES CHARTER

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

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

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

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

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

The country texts in this report provide descriptive overviews of MSF work throughout the world between January and December 2007. Staffing figures represent the total of full-time equivalent positions per country in 2007. Reasons for Intervention classify the initial event(s) triggering an MSF medical-humanitarian response as documented in the 2007 International Typology study. Country summaries are representational and, owing to space considerations, may not be entirely comprehensive.

COVER PHOTO Nurse working with MSF treating baby with severe dehydration in Pieri, in Jonglei State (South Sudan)

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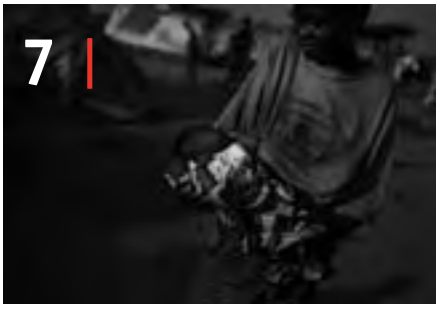
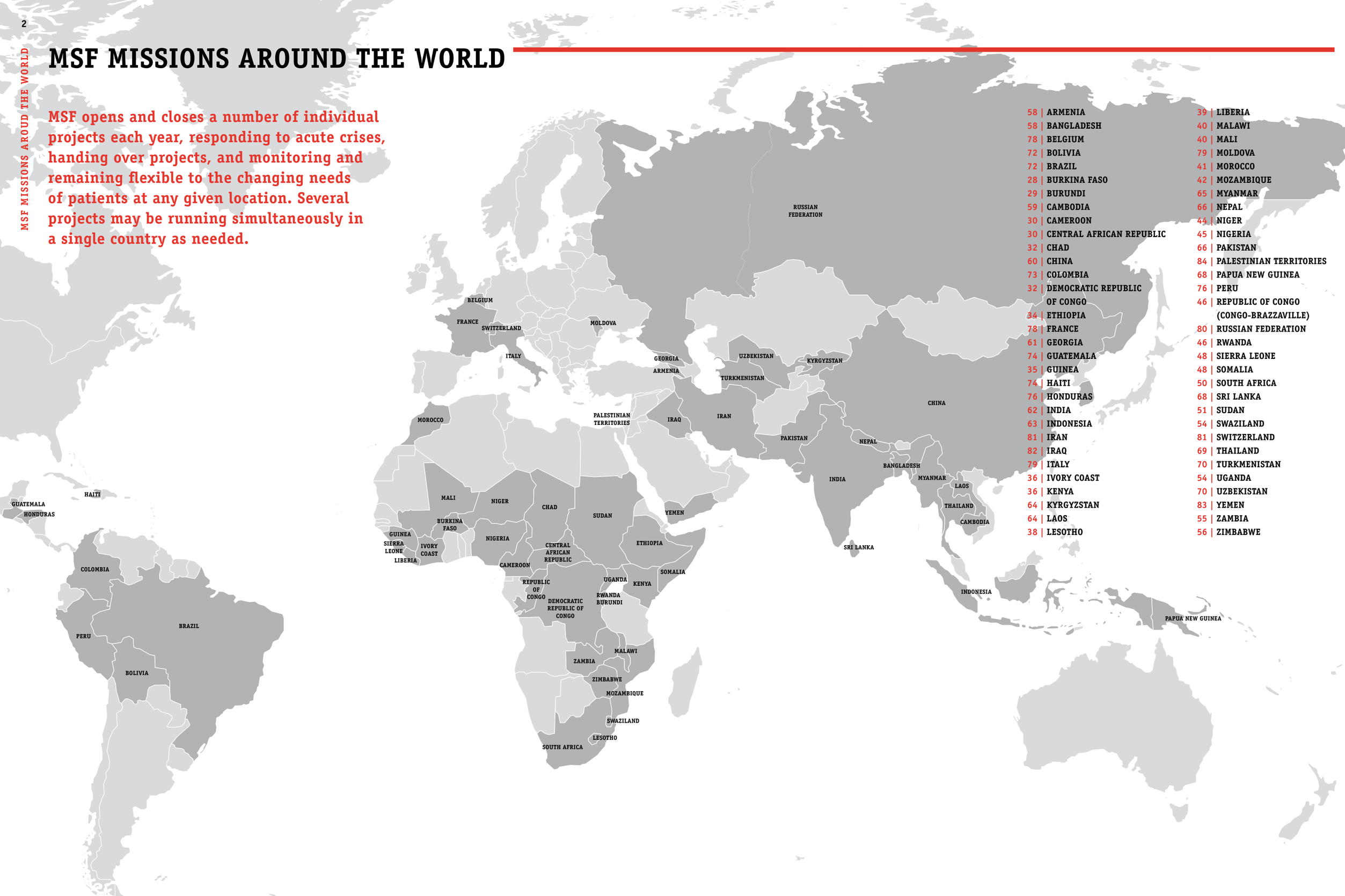


MSF MISSIONS AROUND THE WORLD

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.



The Year in Review

by Dr. Christophe Fournier, *President, MSF International Council*

Nyakabanda camp in Kisoro, Uganda
© Vanessa Vick

Once beyond the first days of life, children who die before their fifth birthday usually succumb to infectious pathologies such as pneumonia, diarrhoea, malaria, measles and AIDS.

If we were asked whom we treat the most often, we would reply: first young children, then young women. Amongst the displaced, refugees and populations caught up in fighting or whose health structures have collapsed, beside the directly wounded or those affected by specific epidemics, women and children occupy the majority of our consultations. This is the reason why we have to put a particular energy into improving the way we address some of the main pathologies responsible for the mortality and the morbidity of these two categories of population.

Overcoming childhood dangers

Once beyond the first days of life, children who die before their fifth birthday usually succumb to infectious pathologies such as pneumonia, diarrhoea, malaria, measles and AIDS, particularly as half of them suffer from malnutrition. The good news is that our weapons against the main diseases decimating young children are increasingly effective and may even, potentially, allow us to prevent a good number of them including:

- **Pneumococcus** is a class of bacteria responsible for a large number of lower respiratory infections. A particular vaccine that covers the prevalent strains in Africa exists and we are starting to use it.

- **Rotavirus** is responsible for more than a third of diarrhoea cases in children. We are looking forward to seeing the use of the existing vaccine against this virus being recommended for Africa and other contexts where we have to intervene.

- The **measles** vaccine has been around for a long time and its systematic use has increased. Unfortunately, the vaccination coverage is often too low, particularly in some regions of sub-Saharan Africa to prevent repeated epidemics.

- With the new conjugate vaccine for **meningitis**, we will be able to durably immunize populations exposed to recurrent epidemics particularly in the Sahel region of Africa. But this vaccine will only be available for use in 2009.

- We are still waiting for a **malaria** vaccine, but at least the Artemisinin based Combination Therapies give us a highly effective therapeutic weapon.

- There is no vaccine for **HIV** yet either, but an antiretroviral treatment protocol can considerably reduce the risk of mother-to-child transmission when administered correctly, and we can effectively treat infected children with improved paediatric forms of antiretroviral drugs.

- Finally, we now have ready-to-use therapeutic foods that allow us to treat far more children suffering from acute **malnutrition** more effectively and as out-patients in most cases. We also use them at increasingly early stages of malnutrition and are measuring their impact on morbidity and mortality of children in their first years of life.

Addressing maternal mortality

Maternal mortality represents a quarter of female mortality in the majority of the countries we work in. Half of the deaths are linked to the moment of delivery or the subsequent 24 hours. Another quarter happen during pregnancy.

This explains why we should put so much of our attention into **antenatal care and deliveries**. The more direct complications of delivery for the women (haemorrhage, eclampsia) are difficult to anticipate but if handled in time should not prove fatal. The medical technology required for treating these complications was standardised half a century ago in developed countries. It is well known and not difficult to use. Obviously it requires qualified personnel, appropriate drugs and adequate transfusion products, but it saves the lives of both mother and child. In 2007, we carried out over 500,000 antenatal care consultations and almost 100,000 deliveries. Yet, a dramatic impact on maternal mortality is difficult to achieve as the vast majority of pregnant women are not coming to any health structure for follow up and even less for delivery except when a complication occurs. Among the different post delivery chronic complications, vesico-vaginal fistulas are the most disabling and stigmatising and we are exploring the possibilities of further developing our surgical care to women affected.

Access to **family planning** is obviously a precondition for all women in being able to determine how many pregnancies they choose to have. This is one activity that we have to reinforce and extend systematically to post delivery care, nutrition programmes, HIV activities, so that all women can access these kinds of services.

The pre-requisites to progress

We have the sense that we should be at a turning point in the medical care we can offer to our patients. Yet, considerable steps and obstacles have to be overcome. This is in particular why we continue to fight to ensure that the Doha agreements, allowing the production of generic medicines, are not constantly called into question. In 2007, we were once again the instigators of a petition, this time against the laboratory Novartis for its law suit attacking the Indian Patent Act. We were reassured when the laboratory lost as this meant we could continue considering India as a source of good quality and affordable medicines for our patients. The current system for encouraging research is based on the market and the patent protection. Discussions are underway at World Health Organisation level for setting up a system encouraging research into essential health needs that have a disproportionate impact on poor countries. These discussions aim to set up new mechanisms that will not rely on the sale of medicines or vaccines for financing research but rather will put funds upfront for the research stages of well-defined products - like for example through the creation of prize fund to boost the development of tuberculosis diagnostics.

Our daily struggle to gain access

If we were asked what represents our major daily challenge, we would reply access to civilian populations in areas of war or conflict. Despite the Geneva conventions signed by States nearly 60 years ago, and some superficial posturing we are hardly ever welcomed by warring governments or factions into the field of their own action. This reality can carry a heavy price. Both international and national MSF staff have been kidnapped or killed during the last year. In Somalia, an MSF nurse and doctor were kidnapped and held captive for several days in December 2007 and three of our colleagues were deliberately murdered in February 2008. And in Central Africa a logistician was killed in June 2007.

The reality is that we face continuing difficulties intervening in numerous conflict areas in 2007:

- In **Darfur**, where we have a high presence, we struggle to reach some areas, our convoys are attacked and we are looted right down to our stocks of medicines.

- In **Ethiopia**, we tried in vain to intervene in Ogaden, where anti-governmental counter-insurrection operations were displacing local populations. This access was consistently refused.

- We increased the presence of our teams in **Somalia**, particularly in and around Mogadishu, where a third of the population has fled the latest wave of violence. Yet, despite our appeals, our work is at best not respected and at worst deliberately targeted. The recent murders of our colleagues forced us to withdraw our international teams, which has obviously reduced our capacity to meet the increasing needs of civilians fleeing or held hostage by the fighting. Somalia was one of the major crises of 2007 and the situation is only getting worse.

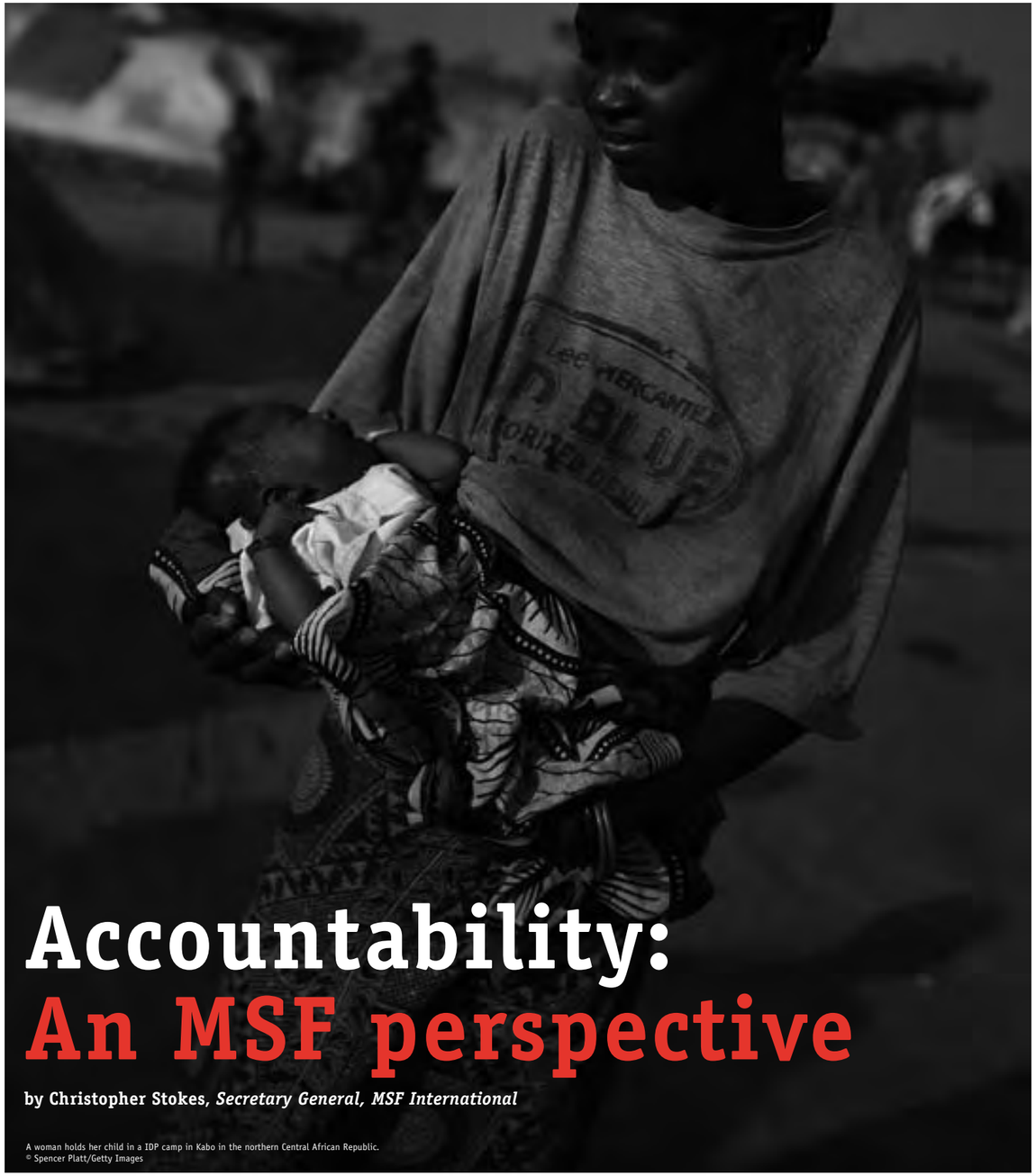
- We are not present in **Iraq**, except in the autonomous region of Kurdistan where we are based in two hospitals capable of handling large numbers of wounded from neighbouring towns. Yet, transferring these patients remains problematic. We are also trying to open a hospital in Iran to handle serious surgical cases that cannot be properly treated in Iraq. Our orthopaedic and reconstruction surgical programme in Amman continues for those seriously wounded patients we manage to transfer to Jordan and we provide essential supplies to a large number of hospitals where we cannot sustain a real presence.

- The ongoing deterioration of the conflict situation in **Afghanistan** drastically reduces the access to medical and humanitarian facilities for the civilian population in several provinces. Today, most humanitarian actors, apart from the ICRC, are mainly absent from the unstable areas where the coalition forces and the opposition groups are fighting. MSF left the country in 2004, following the murder of five colleagues in Badghis province on June 2, and to date there have been no concrete results from the judicial investigation. However, we remain very concerned about the potential medical needs of the most vulnerable. MSF has to consider an operational return to an environment where it will be a great challenge to be perceived as a neutral actor to the conflict.

We will persevere because this is the mandate we have given ourselves but the reality of our working environment means we will never assume that our action, the perception of it and its legitimacy are clearly and universally accepted.

It is access to victims in areas of war or conflict that remains the major challenge.

Displaced flee fighting in Karuba and Mushake as fighting rages in Karuba, Kivu Province, DRC.
© Marcus Bleasdale / VII



Accountability: An MSF perspective

by Christopher Stokes, *Secretary General, MSF International*

A woman holds her child in a IDP camp in Kabo in the northern Central African Republic.
© Spencer Platt/Getty Images

The general drive for accountability of humanitarian organisations is necessary and timely. Aid organisations have to both 'give account' and 'be answerable' for the choices they make. However, there are different ways of approaching accountability and each organisation has to find its own way based on its field of activity, mission and principles.

Since the early 1990s, the 'humanitarian sector' has embraced increasingly ambitious efforts to measure humanitarian assistance. There has been a significant increase in the number of initiatives trying to ensure degrees of accountability. These initiatives started by trying to define common principles of action (ie: The Red Cross Red Crescent Code of Conduct). They continued

to focus on promoting evaluation (ALNAP) and standardising methods for project planning (logical framework) and creating common standards (Sphere) and consistent methods for information gathering.

An important driver was the desire of governmental donor agencies to better account for their funds, and to bring order to a sector seen as largely unregulated (it effectively remains so). The drive for greater accountability was also shaped by a desire to exert greater governmental control over aid delivery to ensure that aid contributed to the greater goal of coherence in terms of humanitarian assistance to countries in need. This integrated approach requires that all sectors act in synergy to promote for example the peace-building priorities of the donor community in a given country. They consider humanitarianism more as a technical action rather than as a principles-based political challenge.

Being an aid organisation firmly attached to principles such as impartiality and independence MSF has been cautious in approaching the accountability issue as framed in the humanitarian sector. There is a need for appropriate, innovative and adaptable tools to monitor and evaluate the effectiveness of aid deployed, to avoid the development of bureaucratic mechanisms that will not improve our standards or relevance.

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The way we look at accountability in MSF, assessing the results of our action in order to improve our operations and the quality of medical assistance to patients, is our main objective.

For example, as an early protagonist of artesunate combination therapy to alleviate malaria and anti-retroviral therapy for people living with AIDS in resource-poor settings, MSF has developed careful programme monitoring tools to be able to publish the results of these interventions in order to effect wider change. Subsequent advocacy efforts led to some national health priorities and protocols being modified after the release of this data, to the benefit of previously neglected patients.

MSF has increasingly sought to give a strong scientific base to its field work; through initiatives such as its epidemiology centre, known as “Epicentre”, which carries out research and training in latest epidemiology practices. This initiative aims to increase the capacity to monitor and evaluate the effectiveness of interventions through mortality and morbidity surveys.

MSF’s approach to accountability is based on several principles.

MSF’s approach to accountability is based on several principles. We consider that we are accountable for what we set out to achieve and the means that we use to do this. In that respect, our action is primarily to be assessed in terms of its ***relevance***, meaning the extent to which our interventions reach and correspond to the actual needs of the most affected populations in a crisis, as well as to our scope and competence as a medical humanitarian organisation.

Our action should also be assessed in terms of its ***effectiveness***, meaning the extent to which our programmes achieve expected results based on their objectives.

Thirdly, our action should be assessed on its ***efficiency***, meaning the way in which inputs (human, material and financial resources) are used to achieve intended outputs.

Beyond these three key criteria, the intervention’s broader ***impact***, meaning its effects, both direct and indirect, intended and unintended, should also be considered.

Our approach to accountability aims to be realistic, taking into consideration the fact that the often highly volatile and insecure contexts in which we work offer ‘only bad choices’.

We seek to recognise the diversity of constituencies, at local, national and international levels, that have a stake in our medical humanitarian work and aim to address their particular needs and interests.

Finally, we view our assessments as an ongoing learning process. Mistakes will continue to be made and failures will occur, due to the fact that humanitarian aid is a real-time response to acute needs in exceptional circumstances that require risk-taking, innovative approaches and difficult judgment calls.

In conclusion, accountability for MSF could be defined as a proactive process of deeper “engagement” with those who we define as our stakeholders, reporting the reasons for our choices, the results of our actions and the limits, challenges and dilemmas inherent in our work, based on our responsibilities as a medical and humanitarian organisation in order to change and improve our response.

Accountability to beneficiaries is still in its infancy and it is the hardest to achieve. The example of Angola given here concerns the effectiveness and impact of MSF’s intervention during the massive 2006 cholera epidemic. The Angola report is part of a mutual accountability drive whereby critical reviews of interventions are conducted and debated within MSF.

Treating a child with cholera in a MSF cholera treatment center in Luanda, Angola.
© Paolo Pellegrin/Magnum Photos

Saving lives and learning lessons

In 2006, Angola’s worst-ever recorded outbreak of cholera affected 15 of the 18 provinces. The crisis emerged just as MSF was withdrawing from the country after 23 years, a fact that may have restricted the initial reaction and delayed intervention. Despite treating almost 40,000 people, MSF directors requested a full evaluation of the programme to determine MSF’s effectiveness and efficiency and, equally important, document any lessons learned.

Although cholera had previously been endemic in Angola, there had been no significant outbreaks in 10 years. However, the many years of civil war had seen massive population movements into towns without any significant expansion or improvements to sanitation systems.

Population density, poor sanitation and regular population movement combined with catastrophic effect in mid-February. Within six days of the first cases being detected in the capital Luana, an epidemic was declared. The disease quickly spread along the main transport routes to neighbouring provinces.

As MSF was preparing its withdrawal from Angola, there was an assumption that the outbreak would be handled by the Ministry of Health, without investigating its capacity to do so. Relying on official data on the epidemic that eventually proved anything but reliable meant MSF teams also underestimated the potential scale of the crisis and took longer than usual to become functional. Even then, continual surveillance systems were weak and data recording patchy.

These factors were exacerbated by the failure to appreciate the changed context of this emergency. Whereas previous cholera outbreaks had been restricted to the capital and coastal areas, the greater freedom of movement and accessible transport systems meant there was a significantly increased risk that transmission of the disease would spread inland.

At the same time, the dramatic growth of Luanda’s population rendered the classic urban strategy, which relies on the speedy movement of ambulances to ferry patients to a single treatment centre, unsuitable and ineffective. And MSF’s late reaction meant the usual balance of early prevention and curative activities became, by necessity, focused on curative activities only.

All these lessons to be learned were highlighted in the evaluation report. Yet, despite these oversights and obstacles, MSF teams still cared for nearly 80 per cent of all cases treated in the country during the crisis accounting for more than 40,000 people of which most survived (with a case fatality rate of only 2.3%). In addition MSF organised appropriate logistics, coordinated sufficient supplies to be brought into Angola, and acted when no one else did. MSF also raised awareness of this forgotten epidemic and called on other agencies to also intervene.

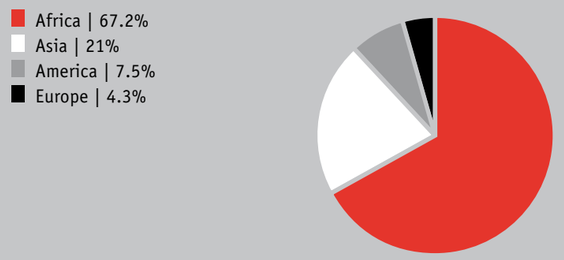
No intervention can ever be described as ‘perfect’. There will always be a system that might have been more effective, a process that might have been more efficient, a treatment that might have been more available. No organisation can ever become truly accountable unless it accepts this reality – because it means there is always room for improvement and it is always worth striving for more.

OVERVIEW OF MSF OPERATIONS

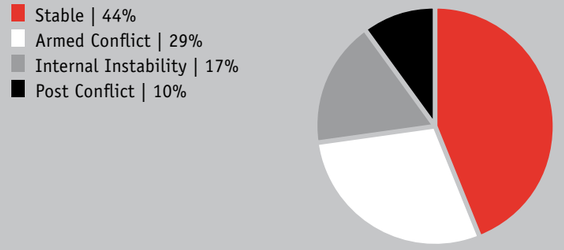
Largest Interventions Based on Project Expenditure

1 Democratic Republic of Congo
2 Chad
3 Somalia
4 Sudan South
5 Niger
6 Sudan North
7 Haiti
8 Kenya
9 Liberia
10 Myanmar

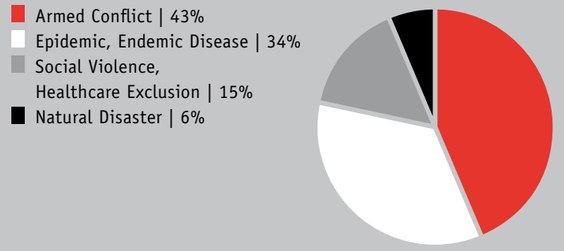
Project Locations



Context of Interventions



Event Triggering Intervention



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	8,447,106
Inpatient	Total number of admitted patients	340,689
Malaria	Total number of confirmed cases treated	1,201,358
TFC	Number of severe malnourished children admitted to inpatient or ambulatory therapeutic feeding centres	122,231
SFC	Number of moderately malnourished children admitted to supplementary feeding centres	64,980
Deliveries	Total number of women who delivered babies, including Caesarean sections	111,292
Sexual Violence	Total number of cases of sexual violence medically treated	12,791
Surgical - Interventions	Total number of major surgical interventions including obstetric surgery, under general or spinal anaesthesia	53,626
Violence Trauma	Total number of medical and surgical interventions in response to direct violence	33,441
HIV	Total number of HIV patients registered under care at end 2007	166,481
ARV first-line treatment	Total number of patients on first-line anti-retroviral treatment at end 2007	111,125
ARV second-line treatment	Total number of patients on second-line anti-retroviral treatment at end 2007. First-line treatment failure.	1,212
PMTCT - mother	Number of HIV-positive pregnant women who received prevention of mother-to-child transmission (PMTCT) treatment	11,463
PMTCT - baby	Number of eligible babies born in 2007 who received post-exposure treatment	9,254
TB	Total number of new admissions to tuberculosis first-line treatment in 2007	29,107
TB second-line - treatment	Total number of new admissions to tuberculosis treatment in 2007, second-line drugs	640
Mental Health - Individual	Total number of individual consultations	126,454
Mental Health - Group	Total number of counselling or support group sessions	34,768
Cholera	Total number of people admitted to cholera treatment centres or treated with oral rehydration solution	43,202
Measles - Vaccinations	Total number of people vaccinated for measles in response to an outbreak	429,996
Measles Treated	Total number of people treated for measles	22,181
Meningitis - Vaccinations	Total number of people vaccinated for meningitis in response to an outbreak	2,498,241
Meningitis - Treated	Total number of people treated for meningitis	10,829

Reasons for intervention

By Emmanuel Tronc, *Policy and Advocacy Coordinator, MSF International*

A woman walks in the rebel held town of Kaga Bandoro, Central African Republic. December 2008
© Spencer Platt/Getty Images

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. This triggers a medical humanitarian response, and if required, the obligation to speak out to ensure those in need are assisted. The four events are armed conflict, endemic/epidemic disease, social violence/healthcare exclusion and natural disasters.

However, in reality life is not this simple or clear so MSF uses its previous experience and judgment to decide whether its expertise is needed. MSF also recognises the inherent limits that exist in delivering aid and, therefore, MSF does not intervene in all conflicts or respond to all natural or man made catastrophes. Our actions reflect an analysis of the potential added value we can bring, and we question the pertinence of our presence or absence in any given situation on a regular basis.

Armed conflict

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

In an environment of such destruction and disruption of health-care systems, medical, surgical and psychological care is needed. Indirect effects of conflict and instability, including a collapse of general infrastructures and a ruined economy, also lead to suffering. As a result, people are excluded from essential medical care and services, and can be devastated by epidemics such as AIDS, TB, malaria, or lesser known diseases such as sleeping sickness.

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

Natural disasters

Populations affected by natural disasters require an immediate medical humanitarian response. They find themselves in desperate conditions, having suddenly lost their homes, material goods, family members and relatives. They are highly traumatised, in need of rapid and diverse medical care and 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 wide range of answers: medical support such as surgery, psychological and nutritional programmes, and preventative actions addressing potential epidemic risks. These are provided in existing hospitals

or through the erection of temporary buildings if needed. Provision of relief items such as blankets, tents and cooking oil may also be distributed. These operations are developed through extensive collaboration with national actors, taking into account the importance of local efforts and strategies, and the limitations of an international intervention with regards to time, quality and pertinence.

Populations affected by epidemic or endemic disease

Such populations arise in variable contexts of stability and conflict. Emergency capacity and innovative medical actions are imperative to ensure a viable response.

People who live in precarious regions, remote and/or underdeveloped areas, slums of capitals and cities, camps or shantytowns, often do not receive strong support from the local and international authorities. They are often minority groups, refugees or nomads. They are at increased risk in situations of economic and social dependency. Women and children are the most worrying categories. Exposed to infectious and communicable diseases, vulnerable during pregnancy, and traditionally less able to express their pains and concerns, women's realities go unnoticed in many countries. The dependency of infants and children further increases their vulnerability.

MSF works in existing medical structures and also establishes new structures if needed. It responds quickly to outbreaks of disease including cholera, measles and malaria. It targets the most vulnerable to infection. In addition, it raises awareness about the risks of an epidemic through training and prevention initiatives. Collaboration with local governments and authorities 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, is also crucial in identifying responsibilities, understanding political intentions and mounting effective responses.

Social violence and healthcare exclusion

Populations affected by social violence and healthcare exclusion often suffer because of who they are. They could be minority groups, ethnic groups, migrants, displaced people or refugees. They may be street kids or night commuters. They may be sex workers or simply a patient with HIV/AIDS or TB.

Living in environments where their conditions and rights are limited or non existent, they frequently do not receive adequate support from local authorities and also suffer the limits of international aid.

MSF becomes directly involved to alleviate such 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 healthcare, and raising the concerns and the realities of our patients to national and international actors.

Labuta, Delta area, Myanmar, May 2008
© Eyal Warshawski

Bongor, Chad, October 2007. An MSF volunteer giving advice to villagers how to prevent households from malaria infection by using mosquito nets. © Tim Dirven / Panos

Every year thousands of migrants are employed as seasonal farmer workers in the fields of Southern Italy. These workers remain "invisibles" despite their support to an entire economical sector. © Lorenzo Maccotta

IDP camp of Kilimani, near Masisi, North Kivu.
© Cedric Gerbehaye/Agence VU

Deciding when to leave

By Emmanuel Tronc, *Policy and Advocacy Coordinator, MSF International*

The decision to close or hand over a medical programme or leave a country for whatever reason is always based on an analysis of whether our presence and operations are still required and relevant.

Stable or unsafe situations

MSF will leave or close a programme when a previously violent situation is sufficiently stable and displaced populations have safely been able to resettle in their native areas. On the other hand, teams may leave if it becomes necessary to denounce the diversion of aid away from the most vulnerable civilians (refugee camps in Zaire 1995 and DPRK 1998). Equally, a conflict situation can deteriorate to the point when MSF and other humanitarian staff are threatened or murdered (Somalia 1997, Iraq and Afghanistan 2004). While infrequent, this does happen and often results in the temporary or permanent withdrawal of our teams for their own safety. However, if an authority or armed/political group deliberately obstructs MSF's access to operations in a specific area, MSF may use humanitarian positioning or public lobbying to try and reverse the situation.

Capacity and responsibility

Leaving will be considered when local or national authorities and local actors have the capacity and motivation to restore and develop a medical system able to meet the needs of the population. If there are other actors, humanitarian or otherwise, providing medical support, MSF teams will also assess whether their presence brings a risk of effort being duplicated.

A decrease in acute needs

MSF will leave when our presence interferes with local activities and capacities. MSF will end an intervention when a medical emergency, such as a meningitis or measles epidemic or natural disaster, ceases to exist. In these cases, relief operations are eventually replaced by longer-term development activities by other actors (which was seen eventually after the Asia tsunami). Teams will also move on when marginalised populations, such as prisoners and street children, are no longer excluded from healthcare.

Of course, the decision to stop, close, handover a programme or leave comes with no guarantee that MSF will not need to return in future (such as with Sri Lanka when MSF left in 2003 but had to return in 2006 when the conflict escalated again). There is no guarantee that a conflict will not resume, that medical and humanitarian needs will be correctly addressed or will not again reach a medical crisis-point or that the resources and strategies put in place will not be diverted and misused.

The decision to bring an end to assistance is, therefore, based on our experience, our perception of the situation and our concern that our short-term solution should not wrongly substitute more permanent solutions. It is an acknowledgement that our actions and presence are limited and replaceable. MSF does not represent a long-term response to the public health responsibilities of a State but contributes to strategic healthcare improvements by training national teams before leaving.

While it can appear a significant decision to make, ending activities reflects the will and identity of MSF to carry out its specific mandate as an emergency medical-humanitarian actor that exists to help the most vulnerable people at times of extreme crisis.

MSF COUNTRY PROGRAMME CLOSURES

ANGOLA

MSF started working in Angola in 1983 in response to conflict-related medical emergencies. It 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. In 2007, as the state was continuing to rehabilitate the healthcare system, MSF completed a two-year long handover process of its projects to government, local and international development NGOs.

MSF worked in Angola from 1983 to 2007.

BENIN

In Mono-Couffo department, a rural area of Benin with the highest prevalence of HIV, MSF established an HIV/AIDS programme including education, counselling, testing and treatment in 2002, and started providing anti-retroviral medicines two years later. In total, MSF treated 903 HIV-positive patients during the course of the project. At the end of June 2007, the project was transferred to local health authorities and partners, who are now providing free anti-retrovirals.

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 Benin Red Cross.

MSF worked in Benin from 2002 to 2007.

ECUADOR

MSF was the first NGO to treat HIV in Ecuador. In 2004 MSF began an HIV/AIDS project in three health areas of Guayaquil town, which had the highest prevalence of HIV in Ecuador. Until then, Guayaquil had only one reference hospital and one health unit. MSF opened an additional health and treatment unit in the hospital, and also started three maternity units and eight health centres, providing free access to counselling and testing, anti-retroviral treatment (ART), lab follow-up, and health education. By December 2007, MSF finalised the handover of this project to the Ministry of Health. Over the course of the project, MSF attended to approximately 1,770 patients and initiated 530 of them on ART.

MSF worked in Ecuador from 1996 to 2007.

JAPAN

Despite the existence of a welfare system that targets the socially disadvantaged in Japan, the 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 objective of providing medical care through a fixed clinic. However, this was not immediately possible so over the next 14 months, MSF used mobile clinics to conduct 1,351 medical consultations, offering treatment to 296 patients for conditions including hypertension, diabetes and joint pain. Despite several attempts to establish the fixed clinic, this never came to fruition due to opposition from the local community and authorities.

Therefore, after much deliberation, MSF decided to close the programme in early 2007 and referred patients to other health facilities.

MSF worked in Japan from 2004 to 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. These people often have no official status and face difficulties in accessing healthcare. In 2006, MSF opened three mobile clinics, working in close collaboration with local partners, carrying out 8,159 medical consultations.

The clinics offered primary healthcare, mental health consultations and referrals. MSF also organised community health education, psychosocial 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, in April 2007 MSF handed the project over to local partners, to continue the 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. A more permanent solution needs to be found that addresses the underlying causes for the lack of access to healthcare.

MSF worked in Malaysia from 2004 to 2007.

RWANDA

MSF has ended its activities in Rwanda after 16 years in the country. Over the years, MSF's work has included assistance to displaced persons, war surgery, programmes for unaccompanied children and street children, support to victims traumatised by the conflict, programmes to improve access to healthcare, responding to epidemics such as malaria, cholera and tuberculosis, and projects linked to maternal and reproductive health.

Rwanda has now begun a clear shift towards long-term development plans. The number of organisations in the country now covers the needs of the population. The AIDS epidemic appears contained due to the high level of investment by local authorities and the support of many international actors. As a result, MSF felt able to end its presence in the country at the end of 2007.

MSF worked in Rwanda from 1991 to 2007.

Most under-reported crises of 2007

Displaced fleeing war in Somalia face humanitarian crisis

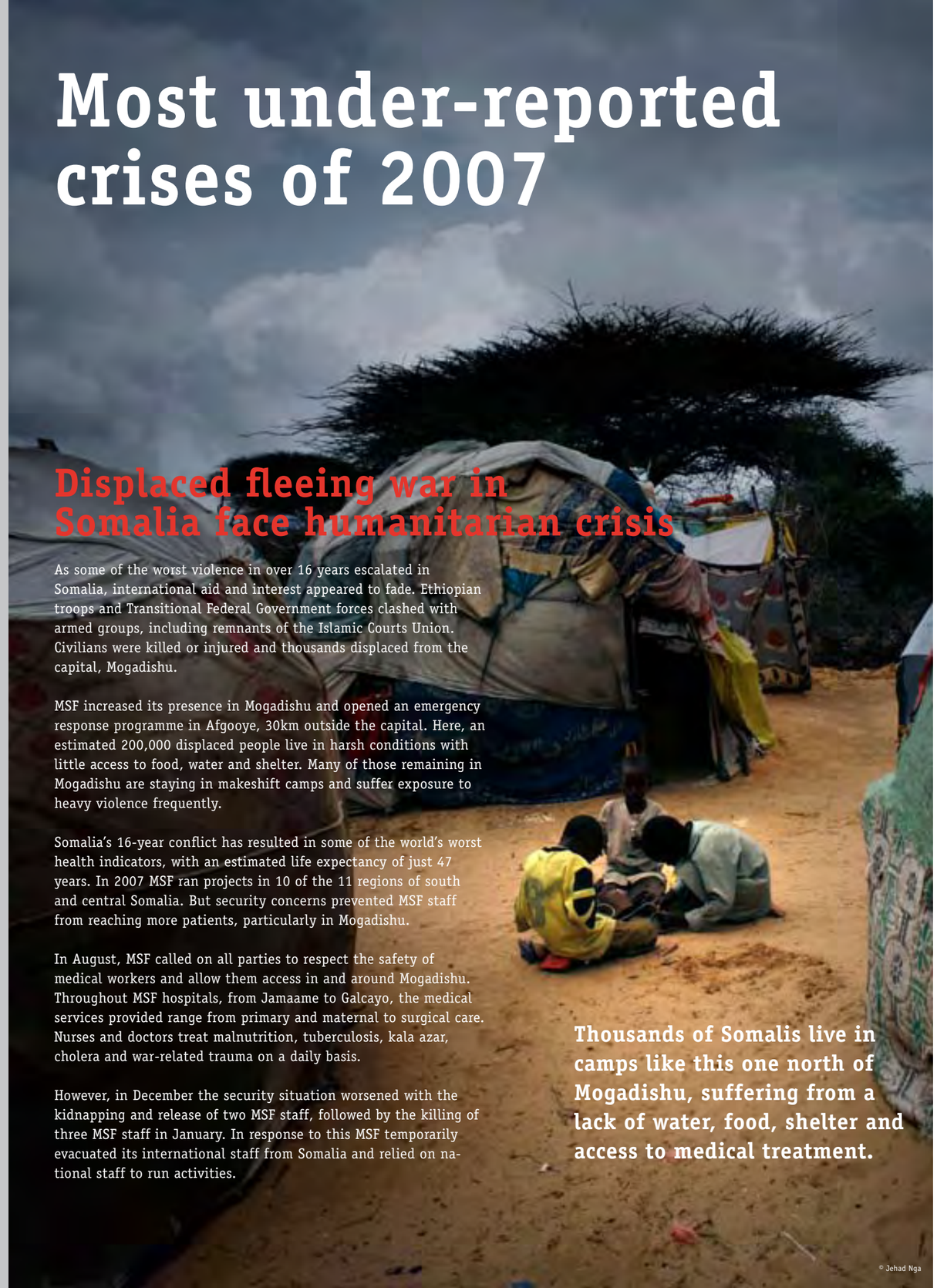
As some of the worst violence in over 16 years escalated in Somalia, international aid and interest appeared to fade. Ethiopian troops and Transitional Federal Government forces clashed with armed groups, including remnants of the Islamic Courts Union. Civilians were killed or injured and thousands displaced from the capital, Mogadishu.

MSF increased its presence in Mogadishu and opened an emergency response programme in Afgooye, 30km outside the capital. Here, an estimated 200,000 displaced people live in harsh conditions with little access to food, water and shelter. Many of those remaining in Mogadishu are staying in makeshift camps and suffer exposure to heavy violence frequently.

Somalia's 16-year conflict has resulted in some of the world's worst health indicators, with an estimated life expectancy of just 47 years. In 2007 MSF ran projects in 10 of the 11 regions of south and central Somalia. But security concerns prevented MSF staff from reaching more patients, particularly in Mogadishu.

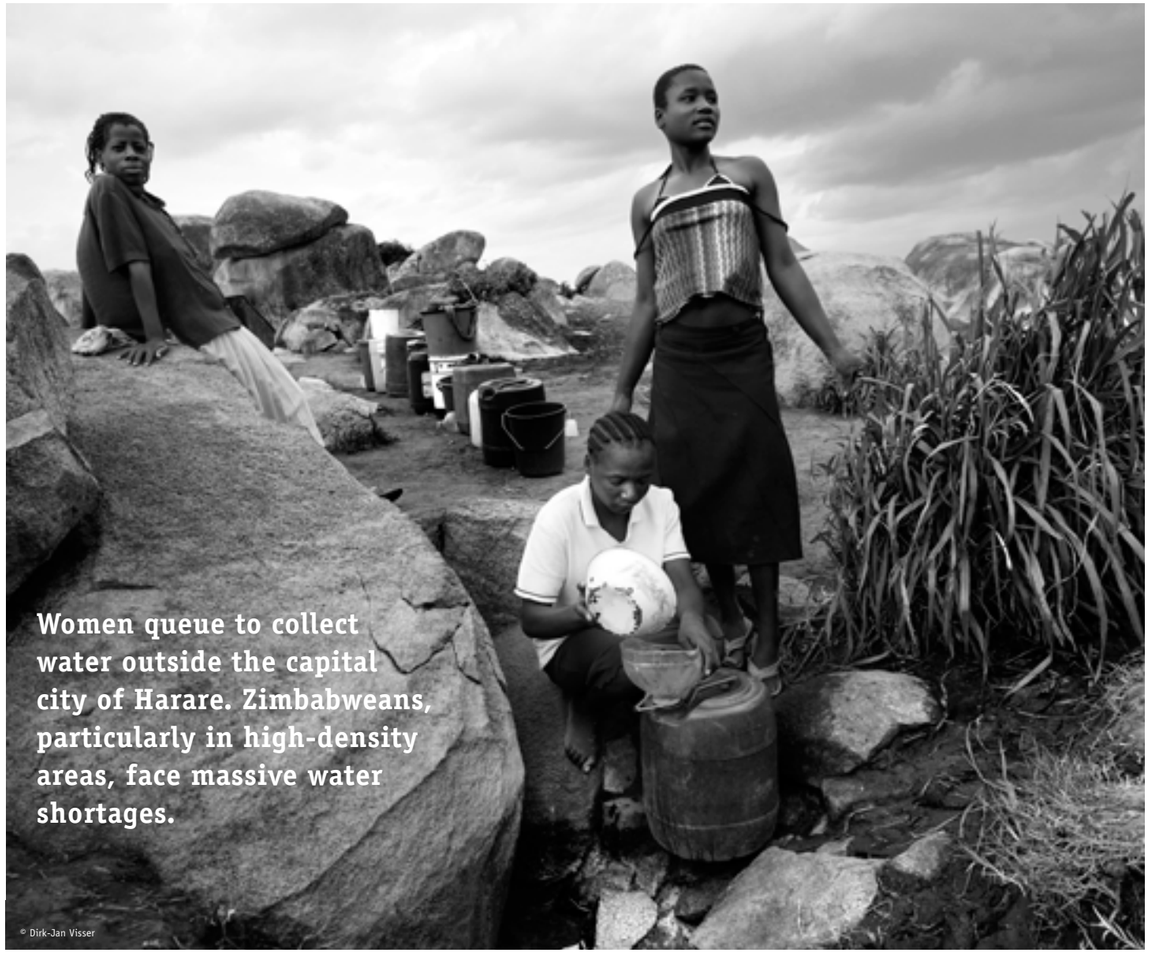
In August, MSF called on all parties to respect the safety of medical workers and allow them access in and around Mogadishu. Throughout MSF hospitals, from Jamaame to Galcayo, the medical services provided range from primary and maternal to surgical care. Nurses and doctors treat malnutrition, tuberculosis, kala azar, cholera and war-related trauma on a daily basis.

However, in December the security situation worsened with the kidnapping and release of two MSF staff, followed by the killing of three MSF staff in January. In response to this MSF temporarily evacuated its international staff from Somalia and relied on national staff to run activities.



Thousands of Somalis live in camps like this one north of Mogadishu, suffering from a lack of water, food, shelter and access to medical treatment.

© Jehad Nga



Women queue to collect water outside the capital city of Harare. Zimbabweans, particularly in high-density areas, face massive water shortages.

© Dirk-Jan Visser

Political and economic turmoil sparks healthcare crisis in Zimbabwe

Zimbabweans continue to suffer rampant unemployment, rocketing inflation, food shortages and political instability. According to the UN up to a quarter of the country's 12 million people are believed to have fled to neighbouring countries in recent years.

The healthcare system now threatens to collapse, with particularly serious consequences for the estimated 1.8 million people living with HIV/AIDS. Less than a quarter of those in urgent need of life-extending anti-retroviral (ARV) treatment receive it and some 3,000 die each week. Medical professionals are leaving the country, the government HIV/AIDS treatment programme is oversubscribed and the lack of ARV supplies has stifled further expansion. The high cost of fuel and transport often make travelling to hospitals or clinics difficult.

Through programmes in Bulawayo, Tshlotsho, Gweru, Epworth and Manicaland province, MSF provides free medical care to 35,000 people living with HIV/AIDS. Of these, 16,000 are receiving ARV treatment, nearly a tenth of all people on treatment. However, MSF's ability to care for more people is restricted by the lack of trained health workers, restrictions on who can prescribe ARV drugs and increasingly strict administrative requirements for international staff to work in the country.

Zimbabweans also face the health consequences of deteriorating or non-existent water and sanitation systems. Outbreaks of diarrhoea have affected the populations of Harare and Bulawayo. Nor is it easy to flee the country, as the numerous reports of refugees attacked along the South African border testify. Some of those who do make it live with little or no access to healthcare.

An MSF physician examines a tuberculosis patient in the Maela refugee camp near Maesot.

© Francesca Di Bonito

Drug-resistant tuberculosis spreads as new drugs go untested

Every year, an estimated nine million people develop tuberculosis (TB) and two million die. Yet there have been no advances in treatment since the 1960s and the most commonly used diagnostic test, sputum smear microscopy, developed in 1882, detects TB in only half of cases. Only $206 million of the estimated $900 million needed annually for TB research and development is invested worldwide.

Treatments and diagnostics are even less adapted for people living with HIV/AIDS, the easiest prey for the TB bacilli. For the more than 450,000 people a year who become infected with multi-drug-resistant TB (MDR-TB) or develop it following incomplete treatment, the prospects of survival are even bleaker. The few who access treatment have to endure up to 24 months taking a daily cocktail of highly toxic and expensive drugs that often trigger violent side effects.

Even under the best conditions in MSF programmes in Armenia, Abkhazia, Georgia, Cambodia, Kenya, Thailand, Uganda and Uzbekistan, only 55 per cent of MDR-TB patients completed the treatment. The rest of them either died, did not improve or could not cope with the side effects.

A further problem for medical staff on the TB pandemic's front line is the fact that not all new drugs are tested on those in greatest need: patients with MDR-TB. A recent article by international experts published in the medical journal PLoS Medicine called for new drugs to be tested on patients whose TB is resistant to standard treatment. This could make it easier to detect anti-TB activity of new drugs and ultimately accelerate drug development.

Expanded use of ready-to-use food to reduce child malnutrition

Child eating highly nutritious ready-to-use-food product in Niger which is used to treat malnutrition in children under five.

Acute malnutrition in early childhood is common in large areas of the Horn of Africa, the Sahel and South Asia, known as the world's 'malnutrition hotspots'. Every year, five million children under the age of five die.

Nutrient-dense ready-to-use foods (RUFs) have recently emerged as an effective response, capable of saving the lives of acutely malnourished children. RUFs are milk and peanut based pastes enriched with all the vitamins and nutrients needed for rapid recovery. They do not require refrigeration or preparation, so most malnourished children can be treated at home. Yet, only a tiny fraction of severely malnourished children are getting RUFs. Supplementing their daily diets with ready-to-use supplement foods can also prevent children from becoming acutely malnourished in the first place. Treatment and prevention should form part of all international food aid programmes targeting young children in areas of high prevalence.

In Niger in 2007, MSF launched a pilot programme using a modified RUF as a supplement to prevent some 62,000 children from becoming malnourished during seasonal food shortages. MSF is therefore urging international donors to support the systematic purchase and use of RUFs as a treatment and preventative measure worldwide.

A wounded woman and child receive treatment at MSF's surgical programme in Vavuniya, a town close to the front lines of the ongoing conflict between government and rebel forces.

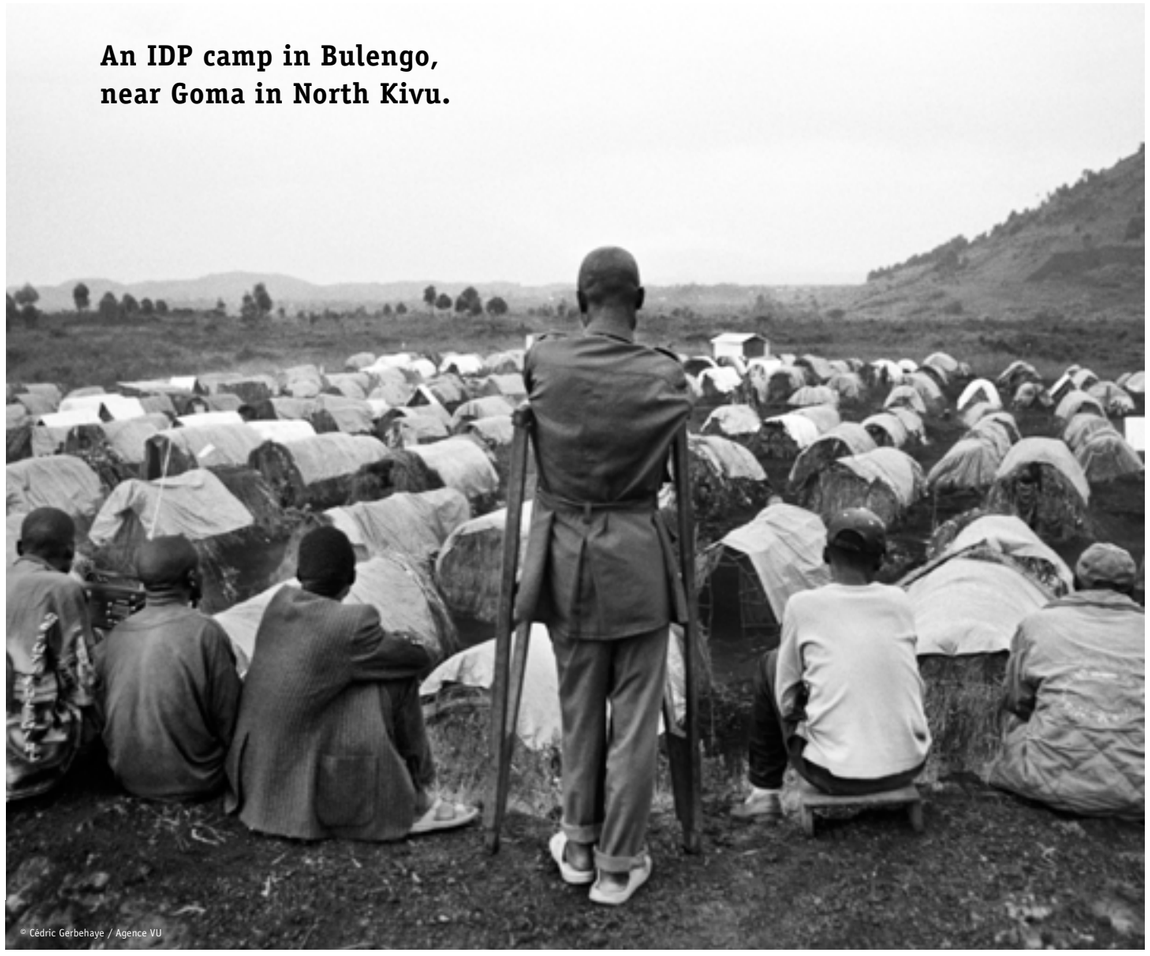
Civilians increasingly under fire in Sri Lankan conflict

Caught in the middle of fighting between government forces and the Liberation Tigers of Tamil Eelam, civilians in Sri Lanka's eastern and northern regions live in terror. Sri Lanka has been in the grips of this fighting on and off for nearly 25 years but the conflict, particularly the toll it has taken on civilians, has attracted minimal attention.

Targeted bombings, killings, mine attacks, suicide bombings, abductions, forced recruitment, extortion, restrictions on movement and arbitrary arrests make day-to-day life in Sri Lanka increasingly precarious. Hundreds of thousands of Sri Lankans in need of humanitarian assistance have been displaced since the resumption of major fighting in August 2006.

This dire situation is compounded by a general climate of hostility towards, and suspicion of, humanitarian aid organisations. Humanitarian aid is increasingly restricted and civilians suffer from lack of access to lifesaving emergency assistance. This comes at a time when areas near the front line of fighting have lost nearly all medical specialists and hospitals no longer have the human resources to treat the wounded.

After having to evacuate temporarily in late 2006, MSF is now providing medical, obstetrical and surgical care in Point Pedro, Vavuniya, Kilinochchi and Mannar.



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Escalating conflict causes destitution in Democratic Republic of Congo

More than a year after the first democratic elections in decades, fighting between armed groups has continued in the Democratic Republic of Congo (DRC) eastern province of North Kivu. Supported by MONUC, the UN force, the government is in open combat with the forces of rebel leader, Laurent Nkunda. Different groups such as the Mai Mai and the Rwandan Hutu rebels of the Democratic Forces for the Liberation of Rwanda are also involved.

Hundreds of thousands of people have fled their homes, often forced to hide in the forest, with little access to food or basic healthcare and under constant threat of attack. They are increasingly vulnerable to easily treatable diseases and conditions such as malnutrition, malaria and respiratory infections. Outbreaks of cholera have also struck.

MSF has reinforced its activities but the insecure environment makes it difficult to deliver comprehensive humanitarian assistance. Large areas are inaccessible and incidences of sexual violence are increasing alarmingly. In North Kivu, MSF cared for more than 3,000 victims of sexual violence in 2007.

In Ituri district, where different armed groups to those in North Kivu are in conflict, 150,000 displaced people are utterly destitute, vulnerable to exploitation and assaults. Through the Bon Marché hospital in Ituri's capital, MSF has treated 7,400 rape victims over the last four years, with more than a third admitted in the last 18 months.

MSF also responded to several disease outbreaks in other provinces, including an epidemic of Ebola hemorrhagic fever in southern West Kasai province.

© Espen Rasmussen / Panos

Living precariously in Colombia's conflict zones

As many as 3.8 million people have been driven from their homes by violence, according to UNHCR, ranking Colombia third in the world for the largest number of internally displaced people. As the conflict in Colombia enters its sixth decade and armed groups continue to target civilians, many Colombians do not remember a time when daily life was not ruled by guns and terror.

Armed groups have a stranglehold on roughly half of Colombia's rural areas. Impassable roads deprive civilians of access to healthcare, children are forcibly conscripted into militias and suspected armed forces collaborators are murdered. At the same time, anyone suspected of working with rebel groups face harsh reprisals by the armed forces.

Families flee their homes for urban slums with little more than the clothes they wear, only to find equally threatening conditions on arrival. They live in overcrowded shacks where living conditions can lead to respiratory infections and diarrhoeal disease but there is little access to healthcare. Very few have the option of returning safely to their homes.

MSF works in 13 of Colombia's 32 departments. Teams work in isolated rural areas through mobile and stationary clinics and in urban areas where displaced families have gathered. Teams provide medical care ranging from vaccinations to reproductive care and emergency services, as well as offering psychological care to victims of violence.

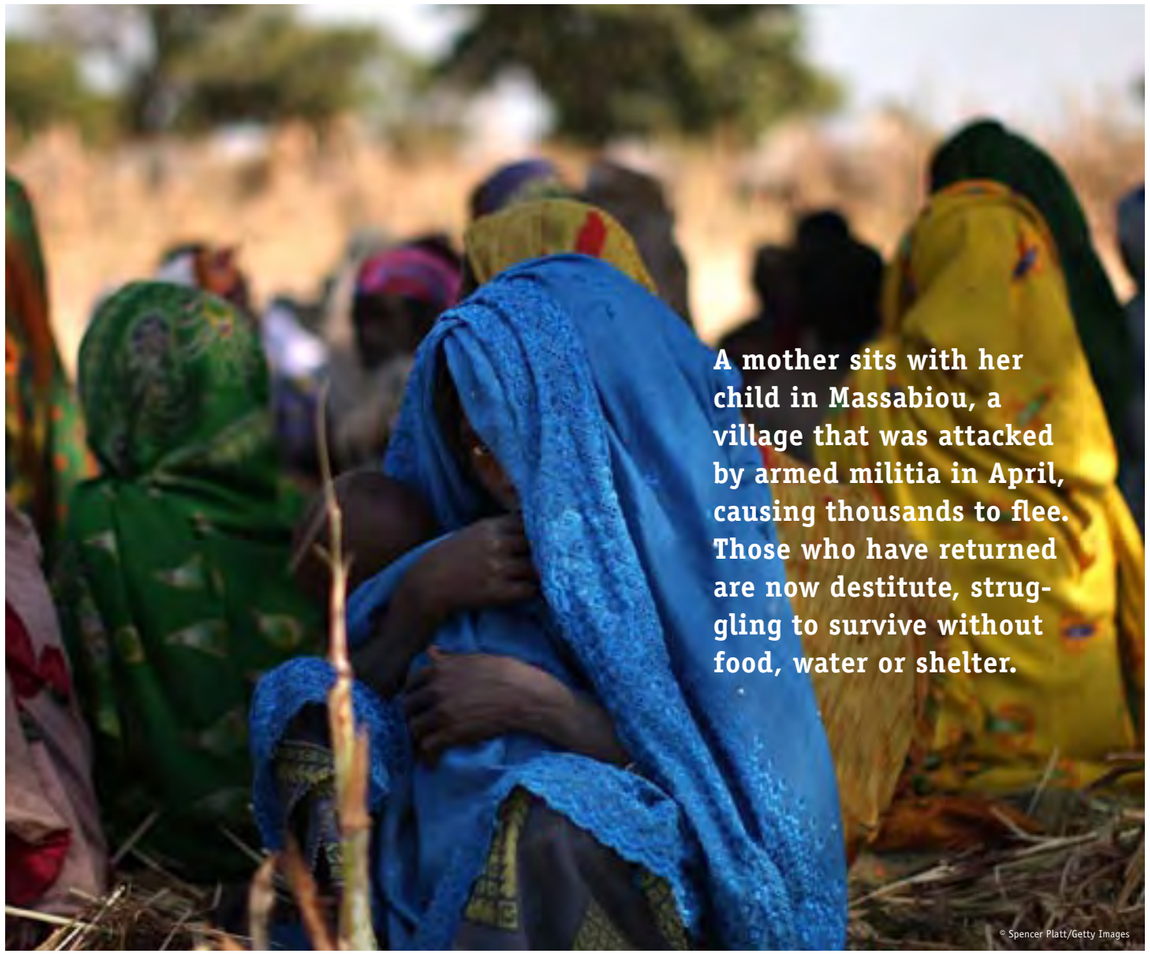
Humanitarian aid restricted in Myanmar

Isolated from the outside world since the military junta came to power in 1962, the people of Myanmar (formerly Burma) suffer repression and neglect. September's crackdown on monks marching for democracy attracted international attention but the reality of daily life for ordinary people remained hidden.

Few humanitarian aid groups work in Myanmar where the humanitarian space is limited. Donors are reluctant to fund programmes that could support the regime. Time-consuming administrative procedures can make responding to emergencies impossible and needs assessments challenging. In some regions, such as those gripped by armed conflict involving Karen and Mon rebels along the Thai border, government restrictions have thwarted aid efforts. Only 1.4 per cent of the regime's budget supports healthcare services.

Health services are particularly poor in the western Rakhine state, where MSF treated 210,000 people for malaria in 2006 and where Muslims, known as Rohingyas, are denied citizenship rights by the state and suffer numerous forms of abuse. MSF provides Rohingyas with basic medical care and HIV/AIDS treatment.

The slow response to the HIV/AIDS epidemic has fuelled the spread of the disease. MSF offers comprehensive HIV/AIDS programmes in Yangon, Rakhine, Kachin and Shan states but these meet only a fraction of the need. Only 10,000 of the UN-estimated 360,000 people living with HIV are believed to be receiving life-prolonging anti-retroviral treatment and 8,000 of them receive it from MSF. Few have access to care for opportunistic infections such as tuberculosis. The UN estimates that HIV/AIDS kills 20,000 people in Myanmar every year.



Civilians caught between armed groups in Central African Republic

Fighting between government forces and rebel groups in northern Central African Republic (CAR) since late 2005 has caused significant displacement of the population. Villages have been pillaged and burned, forcing people to flee into the forest, severely restricting their access to healthcare and leaving them prey to roadside bandits.

In 2007, MSF supported health structures and provided primary and secondary healthcare in and around Kabo, Batangafo, Paoua, Kaga Bandoro, Markounda and Boguila in the north-west, and Birao and Gordil in the north-east. In the first eight months, more than 100,000 consultations were carried out. Tens of thousands of people, including many children under five, were treated for malaria and other infectious diseases often associated with poor living conditions.

Harassment and general insecurity frequently forced MSF to stop its vital mobile clinics at short notice, sometimes for up to eight weeks. In June, MSF operations in north-western CAR were subject to a lengthy reduction after MSF aid worker, Elsa Serfass, was killed by rebel gunfire.

The violence has also forced nearly 30,000 people into neighbouring Cameroon, where they lack shelter, food and medical assistance. In 2007, MSF intervened when alarming rates of childhood malnutrition were discovered among this refugee population. Affected children were treated and supplementary food rations distributed. More than 45,000 CAR refugees also gathered in southern Chad, where MSF works in a district hospital and provides assistance to refugees in camps and local residents.

A paediatrician examines a child in Hospital No.5 in Grozny.

As the Chechen conflict recedes, medical needs remain.

It has been nearly four years since the most intense fighting subsided between Russian government and rebel forces in the republic of Chechnya. Tens of thousands of those who had fled to the neighbouring republics of Ingushetia and Dagestan have now returned home. The capital, Grozny, is being rebuilt and the republic's airport has reopened.

Yet the situation in the region remains highly volatile. Fighting outside Chechnya has increased and there is still a large military presence. Abductions, disappearances, assassinations and bombings continue. Inside Chechnya, the security situation for civilians is precarious. Dangers range from being caught in sporadic gunfire to getting into a car accident involving heavy military vehicles, an increasingly common cause of trauma.

Basic health services, particularly obstetrical and gynaecological care, are woefully lacking. Through clinics in and around Grozny, MSF and local Chechen doctors see a population with high levels of chronic illness, including lung, kidney and cardiovascular diseases. The teams also witness a widespread need for psychosocial care caused by years of violence and displacement. An MSF survey of people living in temporary centres in Ingushetia and Chechnya found that nearly all were suffering from anxiety, insomnia or depression.

Chechnya's wars also took their toll on the republic's tuberculosis (TB) control system. MSF, therefore, supports TB hospitals, serving a population of 350,000. Since 2006, MSF staff have also run a reconstructive surgery programme in Grozny to meet the needs of survivors with crippling injuries.

GLOSSARY OF DISEASES

CHAGAS DISEASE

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

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

Treatment must occur in early acute stages of the infection, and to date, drugs have only been 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 has been no effective treatment for chronic Chagas in adults.

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

MSF treated 685 people for Chagas in 2007.

CHOLERA

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

Although most people infected with cholera will have only a mild infection, the illness can also be very severe, causing profuse watery diarrhoea and vomiting, 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 over 43,000 people for cholera in 2007.

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 counselling; 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 166,000 people living with HIV/AIDS and anti-retroviral therapy for more than 112,000 people in 2007.

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 per cent 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. At this stage the disease is difficult to diagnose but relatively easy to treat. The second stage occurs once the parasite invades the central nervous system. The infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, or convulsions. 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 per cent of patients in some areas of Africa. It also kills up to five per cent 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 admitted over 1,700 patients for treatment for Human African Trypanosomiasis in 2007.

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 treated over 4,200 people for Leishmaniasis in 2007.

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 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 over 1.3 million people for malaria in 2007.

MENINGITIS

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

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

Meningitis occurs sporadically throughout the world, but 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 over 10,800 people and vaccinated 2.5 million people against meningitis in 2007.

TUBERCULOSIS

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

This contagious disease affects the lungs and is spread through the air when infectious people cough, sneeze or talk. Not everyone will become ill, but ten per cent 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 for uncomplicated TB takes six months. Poor treatment management and adherence has led to new strains of bacilla that are resistant to one or more anti-tuberculosis drug. Multi-drug-resistant TB (MDR-TB) is a most serious form of this, identified when patients are resistant to the two most powerful first-line antibiotics. MDR-TB is not impossible to treat, but the required regimen causes many side effects and takes up to two years. A newer strain, extensively drug resistant tuberculosis (XDR-TB), is identified when resistance to second-line drugs develops on top of MDR-TB. XDR-TB is at this time virtually untreatable.

MSF treated over 29,000 people for tuberculosis, including 640 for MDR-TB in 2007.

MSF PROJECTS AROUND THE WORLD

AFRICA

In Mali treatment for malaria is just 200 CFA through an MSF programme, making it affordable for local people.

BURKINA FASO

REASON FOR INTERVENTION • **Endemic/ Epidemic disease • Social Violence/ Healthcare exclusion**
FIELD STAFF **248**

In Burkina Faso high levels of infant malnutrition remains problematic in terms of detection and treatment. A more decentralised programme has now been developed to address this. MSF also tackled meningitis through a large scale inoculation programme, and continued to treat HIV/AIDS patients. Treatment was also provided to street girls and teenagers, vulnerable to disease and abuse.

The vast majority of Burkina Faso's population depends heavily on successful harvests for survival. In the semi-arid Sahel region, bordering Mali, one of the most densely populated areas, a poor harvest can quickly lead to extreme food shortages. As a result malnutrition is endemic, especially among children under five years old.

In September 2007, MSF launched a project to decentralised the treatment of malnutrition in the Yako and Titao districts by treating children close to their homes using mobile and local health clinics. Only acutely malnourished children suffering from complications are hospitalised, while all other children are screened and cared for through outpatient consultations in the local health clinics. By the end of December, 7,000 children under five years had been enrolled in the nutrition programme.


© Yasuhiro Kunimori

Malnutrition is endemic, especially among children under five years old.

Rapid response to meningitis

In mid-February, a meningitis epidemic broke out affecting over 25,000 people of which over 1,700 died. MSF rapidly intervened to support health authorities and treat meningitis patients. By the end of the emergency, MSF had treated 1,500 people in the capital, Ouagadougou.

In March, MSF ran a meningitis vaccination campaign in the Pissy health district, the most densely populated district of the capital. Approximately 470,000 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. In total, MSF vaccinated about 955,000 people.

Decentralising HIV/AIDS care

MSF continued to run an HIV/AIDS project in Pissy, now concentrating on improving patients' adherence to treatment through the decentralisation of care. This is done by bringing care closer to the patient through local health centres and increased community support which improves the autonomy of patients living with HIV/AIDS. More than 23,000 medical consultations were conducted. Since 2004, MSF has provided anti-retroviral treatment (ART) to people with HIV/AIDS, with over 4,000 patients receiving treatment so far.

Street girls in Ouagadougou

In Ouagadougou, MSF manages a project for street girls and teenagers aged nine to 20 years. Initially, the team was only referring and accompanying the girls to public health facilities but since the beginning of the year it has been more directly involved in providing medical services. Activities include providing treatment for sexually transmitted infections and HIV/AIDS, reproductive and obstetrical care, antenatal care and support for victims of sexual violence and improving their legal protection. Some 1,200 consultations and 29 deliveries were carried out. MSF also continues to reduce stigma by raising awareness with the authorities and civil society about the violence inflicted on these girls. In 2008, MSF will hand over this project to a local partner called Keogoo.

MSF has worked in Burkina Faso since 1995.

BURUNDI

REASON FOR INTERVENTION • **Endemic/Epidemic disease • Social Violence/ Healthcare exclusion**
FIELD STAFF **442**

As development agencies increase their activities in Burundi, MSF has been able to hand over some of its projects to the Ministry of Health and other humanitarian actors. However, the health situation in many parts of the country remains precarious, particularly in the area of women's health.

Handing over

In 2007, two years after Burundi held its first post-war democratic elections and four years after the end of the long-running civil war, MSF handed over programmes in Kinyinya, Kayanza and Karuzi.

MSF had been working in Kinyinya hospital, Ruyigi district, since 2003. As well as providing secondary care in the hospital, MSF staff also provided medical and material support to seven health centres around the district. However as development agencies increase their activities in Burundi, MSF has been able to hand over some of its projects to the Ministry of Health and other actors. In Musema, Kayanza Province where MSF has been working since 2004, four clinics and a hospital were handed over to the Baptist church in May. In Karuzi district, where MSF had worked since 1995, the European Community will start supporting a hospital and 12 health centres at the beginning of 2008.

Addressing the health needs of women

Women's health issues are often overlooked. Sexual violence is extensive and there is a clear need for quality free care. Medical teams at MSF's Seruka centre in Bujumbura cared for 1,430 victims of violence, 63 per cent of whom were under 19 years and 14 per cent were under five. The Seruka centre remains the only such centre in Burundi open seven days a week. After five years of activities, the centre is well established and well known by women in the area.

In the rural district of Bujumbura, MSF supports 12 maternity clinics with the management of obstetrical emergencies. Ambulances collect emergency cases and transfer them to private clinics in Bujumbura where they receive specialised care. However, the worsening security situation around the capital since August means that transfers are now only posible during the day as the roads are too dangerous at night.

MSF is currently building a specialised clinic in the Kabezi area. When finished, this will provide free quality emergency obstetric care so that women with complicated deliveries will not have to travel to the capital for medical care.

MSF has worked in Burundi since 1992.

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CAMEROON

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease**
FIELD STAFF **123**

Patients received innovative treatment for Buruli, a debilitating disease, the cause of which is unknown. Medical and psychological care continued with HIV/AIDS patients, and assistance was provided to refugees fleeing civil war in Central Africa.

Overcoming Buruli

Buruli is an emerging and neglected disease in several western and central African countries. How people contract Buruli is unknown but it appears to develop in populations living close to rivers. It causes ulceration of the skin, primarily the arms and legs, and destruction of underlying tissue and bone. Untreated, it can lead to permanent disability and limb amputation.

There have been cases of Buruli in several provinces of Cameroon, with the populations of Ayos, Akonolinga and Mbalmayo particularly affected. Local rumour attributes the 'mystical' disease to a curse, leading people to seek treatment from faith healers, often with catastrophic results. Advanced Buruli requires surgery and physiotherapy.

MSF's Buruli project in Akonolinga provides medical and surgical care for those living in the district. Since 2002, some 600 patients have been cared for, 40 to 50 per cent of them aged under 15 years. MSF has also tried to raise awareness amongst the population about the disease and availability of treatment, with the result that patients now seek medical help sooner and receive antibiotic treatment before the disease progresses. MSF also conducts active screening and is focusing on a progressive decentralisation of medical care to nurses in district health centres.

MSF is also undertaking innovative treatments in wound care that includes using a new range of dressings which should simplify the treatment and speed up the recovery process which, in turn, should reduce the chance of infection and complications.

Treating people with HIV/AIDS

In the Nylon district hospital at Douala, and through community facilities, MSF provides medical and psychosocial care to some 7,500 patients with HIV/AIDS, 3,100 of whom are following anti-retroviral treatment (ART). The Cameroon government now provides free treatment as part of a developing national programme, although patients must still pay for HIV testing, follow-up consultations and laboratory tests. MSF has worked to simplify protocols to enable the progressive transfer of the Nylon project to Cameroon authorities. Effort is also being put into the education of families and communities to follow the full treatment programme. At the D'joungoulo district hospital in Yaoundé, MSF also provides care for 800 patients with HIV, 525 of whom are following ART.

Feeding refugees from Central African Republic

By the end of 2007, a three-year-long civil war in neighbouring Central African Republic led to the exodus of over 200,000 people. More than 60,000 took refuge at 59 sites along Cameroon's eastern border, many without adequate food. MSF assisted refugees in the East and Adamaoua provinces, distributing 18 tonnes of supplementary food rations to 4,180 people. MSF also screened children for malnutrition and offered medical and nutritional care in collaboration with Cameroon's Ministry of Public Health for the most urgent cases.

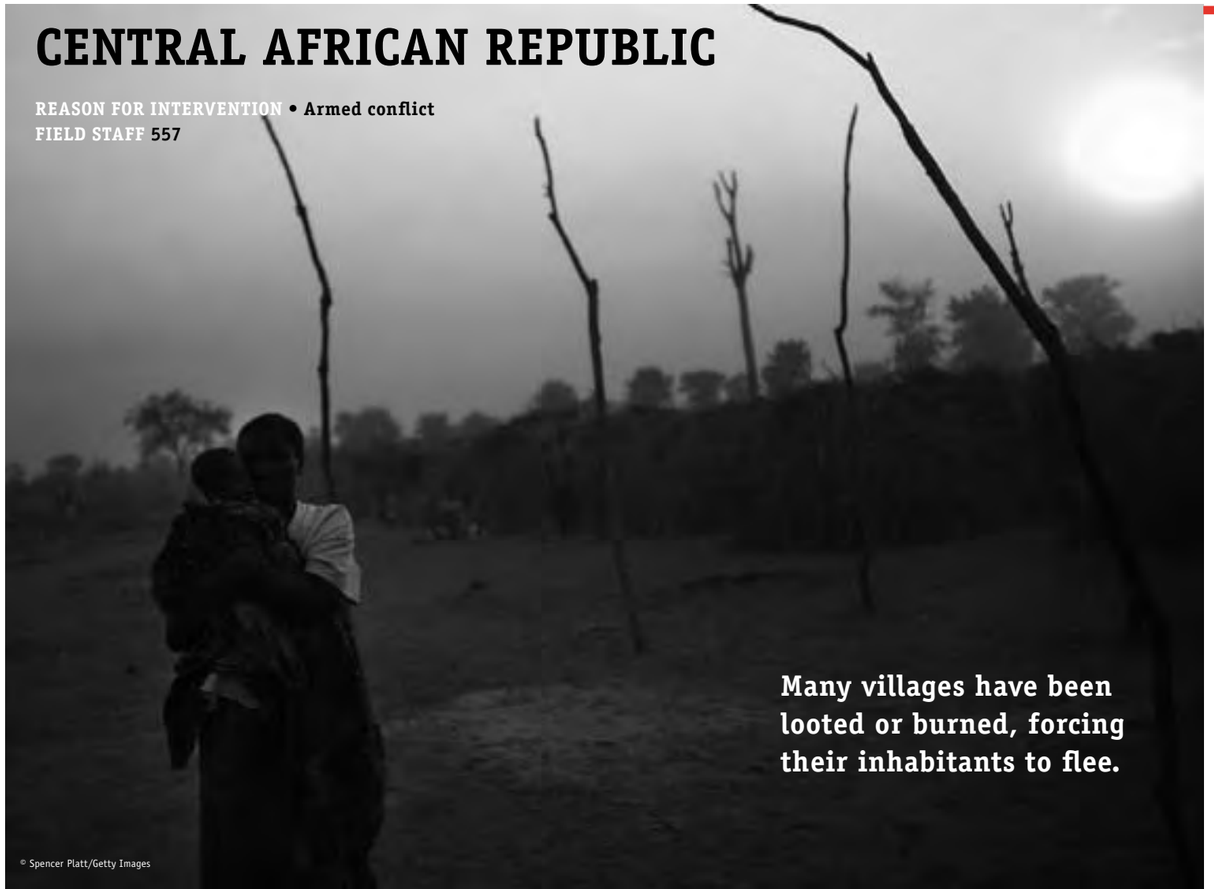
MSF has worked in Cameroon since 2000.

© Claude Mahoudeau

Local rumour attributes the 'mystical' disease to a curse, leading people to seek treatment from faith healers, often with catastrophic results.

CENTRAL AFRICAN REPUBLIC

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **557**



Many villages have been looted or burned, forcing their inhabitants to flee.

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On June 11 all activities came to an abrupt halt after the fatal shooting of 27-year-old MSF volunteer, Elsa Serfass. Elsa was struck by a bullet while travelling in a well marked MSF vehicle in the Ngaoundai region. The rebel group known as The Popular Army for the Restoration of Democracy was responsible for the shooting. MSF condemned the murder. Following discussions with all parties involved in the ongoing conflict and after a careful evaluation of the humanitarian space, a portion of activities resumed one month later.

The population of northern Central African Republic (CAR) continues to live in an environment of chronic violence where many needs are not being met through humanitarian assistance. Fighting between government forces and rebel groups abated slightly in the second half of 2007, becoming a low-intensity conflict with isolated but unpredictable clashes. At the same time, there was an increase in attacks by roadside bandits taking advantage of the general lawlessness that prevails in the region.

Since late 2005, fighting between the government and various rebel groups in the north-east and north-west of the country has caused massive displacement of the population. Many villages have been looted or burned, forcing their inhabitants to flee. Most have sought refuge in the bush, often a few kilometres away from their destroyed homes. Displaced people are mostly scattered in small groups rather than gathering in camps, apart from recently in Kabo. Some villagers have had to flee several times after continued attacks by different armed groups.

Despite an increase in international aid in 2007, many people who have fled continue to live in makeshift shelters exposed to the elements and in constant fear of a new attack. They have no blankets or mosquito nets, no access to healthcare and clean water, and struggle to find food. They are particularly vulnerable to malaria, respiratory infections and diarrhoeal diseases.

MSF focused on providing medical assistance to populations affected by the conflict through a network of mobile clinics, hospitals and health centres across the north-west in Kabo, Batangafo, Kaga Bandoro, Markounda, Paoua, Boguila, and in the north-eastern areas of Birao and Gordil. More than 270,000 outpatient consultations were conducted and more than 16,000 patients hospitalised. Treating patients for diseases such as tuberculosis, HIV/AIDS and sleeping sickness. Mental health services were also provided to communities living with the ongoing threat of displacement and violence.

The chronic insecurity severely affected the population's access to healthcare, preventing aid organisations from reaching people and stopping many people from venturing out and visiting the health facilities. As the second half of 2007 progressed, the growing presence of bandits and the lack of clear control in many areas made it extremely difficult for international organisations to work in such an environment.

MSF has worked in the Central African Republic since 1997.

CHAD

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion**
FIELD STAFF **1,437**

In recent years, eastern Chad has experienced a humanitarian crisis affecting the entire population, including residents, refugees and internally displaced people. Over 240,000 refugees from Darfur depend entirely on international aid, and the number of internally displaced people sharply increased in 2007, affecting in turn the host population of the sites where they gathered.

Violence increasingly affecting the Chadian population

In eastern Chad, increasing violence has led to massive population displacement, with over 180,000 internally displaced Chadians living in camps by the end of the year. These people live in critical conditions resulting in emergency sanitary and health crises, with high malnutrition rates and outbreaks of bloody diarrhoea in the first half of the year. Despite difficult security conditions, MSF managed to scale up its assistance to internally displaced people, providing primary and secondary healthcare, drinking water, food and relief items around Goz Beïda, Adé, Kerfi, Koukou, Arkoum, Am Timam, Am Dam and Dogdoré. In December, MSF had to suspend programme activities in Koukou after several serious security incidents.

MSF continued to provide complete healthcare to the resident population in Adré, Guereda, Birak, Djiré and Wilikouré, ranging from surgery to prenatal care and vaccination campaigns.

After a period of calm and a ceasefire agreement between the government and four rebel groups in October, fighting broke out again in late November, with an intensification of the clashes in the last weeks of the year. Anticipating an influx of wounded, MSF improved the surgical infrastructure in the hospital of Abéché and prepared stocks of emergency supplies.

Over 180,000 internally displaced Chadians are living in camps.

Assisting refugees

Since 2003, more than 240,000 refugees from Darfur have been living in camps in eastern Chad, entirely dependent on international aid. MSF continued to provide medical care, including paediatric and maternal care as well as psychosocial support, to some 90,000 people living in Iridimi, Touloum, Farchana and Bredjing refugee camps and to the surrounding Chadian population. The teams also treated the consequences of sexual violence and malnutrition, provided health education and treated communicable diseases. In Adré and Iriba hospitals, MSF surgical teams provided emergency surgery to refugees, residents and displaced Chadians.

Since June 2005, increased violence in neighbouring Central African Republic has prompted tens of thousands of villagers to flee, with some 50,000 seeking refuge in southern Chad. MSF provided assistance including water, sanitation and healthcare in the camps around Goré 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.

Decentralised care for malaria

Since 2003, MSF has been developing a programme to treat malaria in the southern district of Bongor, one of the most affected by the disease. To overcome the lack of health workers, the high resistance to the treatment and the difficult access to the area over long periods, MSF introduced a therapeutic strategy using Artemisinin-based combination therapy and introduced decentralised care by empowering the local population to care for those affected. In 2007, 110,000 people were treated through this programme.

MSF has worked in Chad since 1981.

DEMOCRATIC REPUBLIC OF CONGO

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **2,386**

Malnutrition, epidemics and surgical emergencies continue in DRC. Insecurity persists in many regions, particularly in North and South Kivu, where the population is subject to violent attacks and causing continual displacement. Many areas are totally isolated and deprived of any functioning health infrastructures, illustrated by catastrophic health indicators.

Assisting victims of violence

Intense fighting between different armed groups in the Kivu region has caused thousands of people to flee their homes since August. Some sought safety in camps for displaced people in the regional capital, Goma. MSF strengthened existing projects and opened new projects to try and meet the huge needs but in many places the fighting and insecurity forced the evacuation of staff and the temporary suspension of work.
In North Kivu, MSF opened a new project in Masisi, about 80 kilometres west of Goma, at the end of August. In response to ongoing violence and displacement, a team started working in the hospital and a health centre in Masisi town, focusing on emergency surgery and nutritional care. The hospital's capacity was increased from 72 to 170 beds. In October, admissions to Rutshuru hospital, where MSF has worked since 2005, increased by 50 per cent. The MSF team added tents to increase inpatient capacity, employed more staff and reinforced the pharmacy with additional supplies. In October, 330 surgical operations were performed, compared to a monthly average of 220 since January.

Repeated displacement, lack of transport and ongoing insecurity mean that mobile clinics are an essential part of MSF's work. When security permits, mobile teams visit numerous sites in Masisi and Rutshuru districts. In December, MSF carried out 3,299 consultations in Kitchanga, Kilolirwe, and Mweso health zones.

Responding to the needs of victims of sexual violence has long been a key component of MSF's work. Between January and September, MSF staff treated around 3,000 victims of sexual violence in North and South Kivu. Yet it is not only in active conflict zones where this medical care is so urgently needed. In Bunia, where MSF supports the Bon Marché hospital, teams continue to see around 150 victims of sexual violence every month. In 2007 MSF carried out more than 25,000 consultations in the hospital.

Since 2003, Angolan authorities have on various occasions expelled Congolese migrants working in the Angolan province of Lunda Norte. According to UN estimates at least 44,000 people were deported to DRC in 2007. In October MSF teams set up a health centre in Kamako, Western Kasai province, close to the Angolan border. Between November 2007 and January 2008, the centre provided medical and psychological care to Congolese migrants, many of whom were women who had been subjected to sexual abuse by Angolan forces. MSF treated about 200 victims of sexual violence and offered primary health care to more than 900 women and children in the Kamako centre and through mobile clinics. The teams also collected one 100 testimonies exposing collective rape and physical abuse perpetrated by the Angolan military.

Responding to disease outbreaks

The retreat of humanitarian agencies has left large areas of the country abandoned. Many areas are isolated and the capacity of the new government is often extremely limited. What few health structures exist either do not function fully or are not accessible to the majority of the population living below the poverty line.

In Ituri, MSF responded to a Shigella emergency in Pimbo in May and to a cholera epidemic in Laudjo in June. A new project for sleeping sickness was opened in May in the health zone of Doruma, where this neglected disease is endemic. Within three months, MSF had screened about 10,000 people and treated more than 450 patients.

In August, the influx of an additional 45,000 displaced people to crowded camps with limited sanitation just outside Goma led to a cholera epidemic. In September, MSF opened a cholera treatment centre (CTC) in a central location between four of the largest camps. Teams also supported a smaller CTC in Goma hospital, and CTCs in four health clinics: two in Goma itself and two in the neighbouring towns of Saké and Kiroche. By the end of November, over 1,500 people had been treated, with only six deaths reported. In the last two months of 2007, MSF responded to another outbreak of cholera in Rutshuru district, treating 1,600 people.

On 10 September, an outbreak of the deadly haemorrhagic fever Ebola was declared in Kampungu, Western Kasai province. Within days, an emergency team had arrived and was isolating and supporting infected people. Over two months, MSF teams admitted 46 people suspected of having the disease. Medical staff tried to trace anyone who had been in contact with the Ebola patients as well as searching for active cases.

© Vanessa Vick

Repeated displacement, lack of transport and ongoing insecurity mean that mobile clinics are an essential part of MSF's work.

Ongoing projects

As well as reinforcing and expanding medical activities in the Kivu region, long-running projects continue to provide HIV/AIDS care in Kinshasa and South Kivu, primary and secondary healthcare in Katanga and Maniema provinces and treatment for sexually transmitted infections in Kisangani. In some areas of Katanga, South Kivu and Dungu in Oriental province, the situation has stabilised to such an extent that MSF has been able to hand over activities to the Ministry of Health and other partner organisations.

MSF has worked in DRC since 1987.

ETHIOPIA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **729**

Conflict escalated in the Somali region of Ethiopia in 2007. As the violence intensified, MSF exploratory missions in the five conflict-affected zones of Somali region revealed an alarming humanitarian crisis in which civilians were subject to violence and displacement, their livelihoods threatened and access to healthcare severely limited. However, MSF was repeatedly blocked from accessing these areas following a team evacuation resulting from a security incident in July. In September, MSF spoke out about the humanitarian situation and the government's refusal to allow staff to return to the region. By the end of the year, MSF had still not gained adequate and independent access.

© Jean-Pierre Amigo

Almost 500 people infected with kala azar were cured in Humera hospital.

Delivering essential healthcare

Despite the disruptions, MSF's Ethiopian staff in Cherrati continued working with the Ministry of Health to provide primary healthcare and tuberculosis (TB) care in Cherrati's health centre. Construction of a special 'TB village' was completed during the year, providing a number of huts where patients can stay during their eight-month treatment. As well as medical care, patients receive food from MSF, which appears to increase the likelihood of them completing treatment. A total of 430 patients were treated in the TB village.

When MSF was able to return to Somali region in December, teams started supporting a Ministry of Health centre and mobile clinics in Fiiq zone. By the end of the year, MSF teams were seeing up to 50 patients a day, mainly for respiratory and urinary tract infections and diarrhoea. Support to a Ministry of Health centre in Wardher resumed at the end of the year. MSF also conducted an assessment in Degahbur and will start activities in 2008.

Assistance to vulnerable populations in Gambella region was not affected by the conflict in Somali region. Working in a health centre in Itang and mobile clinics in five areas, MSF staff provided integrated HIV and TB care, inpatient care and primary healthcare. Support to a health centre in Abdurafi, Amhara region, continued throughout the year, focusing on treating and caring for people suffering from kala azar, otherwise known as visceral Leishmaniasis. Almost 400 people were cured. Given the high number of migrant workers in the area and an estimated HIV prevalence of between 15 and 20 per cent, MSF started providing anti-retroviral treatment in Abdurafi health centre in April. During the course of the year, around 120 patients were started on treatment. MSF staff also travel by tractor to 12 sites in the region to run mobile clinics.

MSF implemented a primary healthcare project in Libo Kemkem, Amhara region, providing quality treatment to some 364 kala azar patients, treating patients with malaria and TB in health facilities and supporting a therapeutic feeding centre for people suffering from malnutrition.

Emergency response

Throughout 2007, MSF teams have responded to emergencies in Ethiopia. In June, an emergency programme was set up at resettlement sites in Awi zone and in Quara district, Amhara region, to deal with an outbreak of measles and prepare for the malaria season. Almost 6,000 children were vaccinated against measles in Awi zone and 5,000 in Quara district. MSF also provided nutritional screening and support in affected areas through mobile clinics. After the summer, MSF responded to a major cholera outbreak in Tigray and Amhara region, treating over 1,700 people. In October, teams in Gambella region distributed non-food items, such as jerry cans or cooking sets, to around 41,000 people affected by floods. In mid-November, MSF reacted to a nutritional crisis in Afar region by establishing a therapeutic feeding centre and organising mobile teams to visit the worst affected areas. During the intervention, 116 severely malnourished children received care. MSF staff continue to treat people infected with kala azar in Humera hospital and support 10 outreach sites around the region where rapid testing is undertaken. Almost 500 people infected with kala azar were cured.

Closing and handing over

In other parts of the country, MSF was able to hand over its projects to the Ministry of Health. In January, a primary healthcare project in Fogera was handed over to the national health authorities. As the national TB programme was being implemented in Galaha, Afar region, MSF closed its TB project in this area in February. In May, MSF transferred the HIV/AIDS component of its programme in Humera, Tigray region, to the Ministry of Health.

MSF has worked in Ethiopia since 1984.

GUINEA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease**
FIELD STAFF **272**

Rising commodity prices, falling living standards and pervasive corruption in Guinea triggered strikes and social unrest at the beginning of 2007, leaving an estimated 180 people dead and more than 1,000 injured. MSF provided care to the wounded during the violent turmoil and continued to treat HIV/AIDS patients in its projects while also responding to cholera outbreaks during the rainy season.

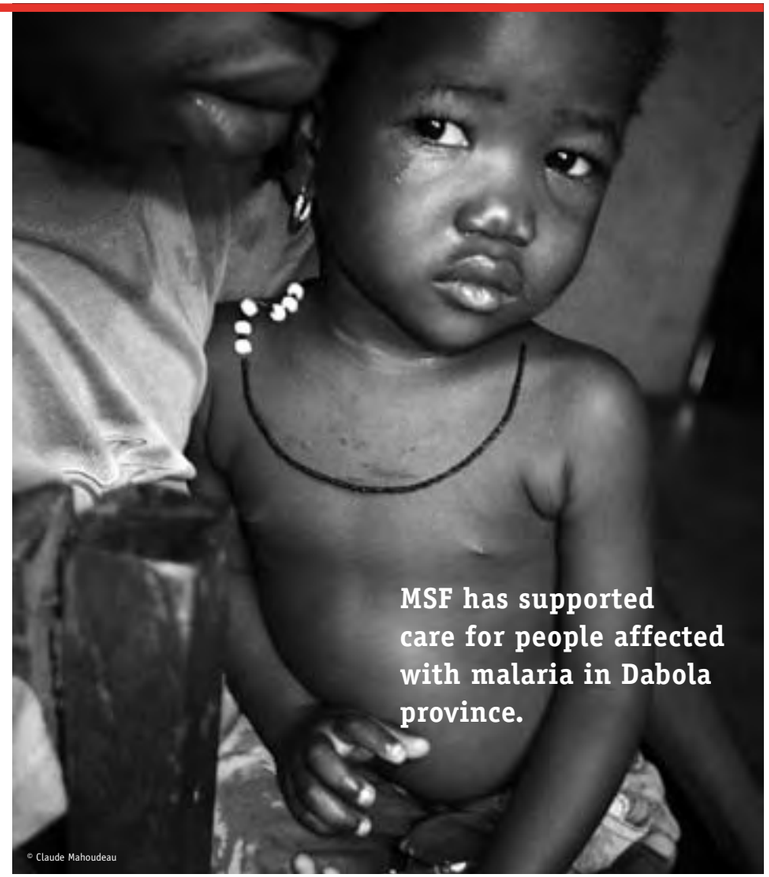
Caring for the wounded

Violence unfolded in the capital, Conakry, and in cities like Guéckédou at the Liberian border in February as a consequence of the country's worsening economic and political crisis. MSF provided emergency medical assistance to Conakry's Matam health centre and to Guéckédou hospital, transferring the most serious cases to Donka hospital in Conakry. MSF treated more than 150 injured people during this two-month emergency operation. With material and technical support from MSF, Donka hospital also cared for a further 800 wounded people.

Treating TB, malaria and HIV/AIDS

Economic stagnation combined with the shortcomings of the cost-recovery healthcare system has impeded the population's access to healthcare. MSF continued to address HIV/AIDS, malaria and tuberculosis (TB). Around 32,000 outpatient consultations were conducted for patients with HIV and TB, with about 700 diagnosed with TB and treated in Conakry and Guéckédou, including many who were co-infected with HIV/AIDS.

Existing actors and their capacities have been insufficient to meet the needs of HIV-infected patients. MSF has, therefore, run two HIV/AIDS programmes in Guéckédou and Conakry since 2003 and offered anti-retroviral treatment (ART) since 2004. In 2007, MSF scaled up its activities and initiated the decentralisation of care for HIV/AIDS patients from Matam centre to several other health centres in order to bring free healthcare closer to the patients. MSF followed the treatment of 3,900 people with HIV/AIDS and provided ART to some 2,400 patients, more than 50 per cent of all patients under ART in Guinea.


© Claude Mahoudeau

MSF has supported care for people affected with malaria in Dabola province.

Since 2005, MSF has supported care for people affected with malaria in Dabola province and lobbied for the use of Artemisinin-based combination therapy (ACT), a more efficient treatment to fight the disease. MSF has provided ACT and diagnostics tests to outpatient services and nine health centres in the region. Although the government agreed in 2005 to modify the national malaria treatment protocol to include the use of ACT, this life-saving treatment was still not available to a majority of Guineans by the end of 2007, mainly due to the cost. This may, however, be resolved in the near future as The Global Fund finally decided in October to grant funds to Guinea for ACT. MSF is planning to leave Dabola in 2008; in the meantime, MSF will document the use of ®Arthemeter to treat severe cases of malaria.

Responding to cholera outbreaks

Cholera is endemic in Guinea, where poor hygiene and sanitation provide a breading ground for epidemics. The cholera epidemic was particularly extreme, especially in Conakry, which accounted for half of all cases. More than 8,000 cases and about 300 deaths were registered. By November, MSF had opened two additional cholera centres in the areas of Ratoma and Matoto, in Conakry. MSF treated about 4,000 patients during this operation.

Project handovers

In August, MSF ended its project in the region of N'Zérékoré (in Guinée forestière), after the official closure of the Lainé refugee camp following the departure of most refugees. MSF had provided assistance in the camp for five years to people fleeing Liberia and Ivory Coast, offering basic, inpatient, outpatient and maternal care as well as treatment for women with HIV/AIDS and victims of violence. On departure, MSF gave the hospitals of Lola and N'Zérékoré a one-year supply of anti-retroviral drugs for HIV positive patients who had started their treatment with MSF.

MSF has worked in Guinea since 1984.

IVORY COAST

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **1,098**

2007 was a turning point for Ivory Coast. After four years of civil war and political deadlock, a peace agreement was signed in March, leading to a process of reunification between the government-controlled south and the north of the country, previously held by rebel forces. After a national union government was formed, the 'Zone de Confiance', a buffer zone separating the warring parties, was dismantled in April. Previously monitored by United Nations peacekeepers and French military forces, the zone is now secured by 'Brigades Mixtes', a police force integrating both sides. Administrative and health civil servants have now redeployed to the north and west, enabling MSF to hand over some projects to the authorities.


© Thierry Dricot

MSF also runs a primary health centre and mobile clinics, providing basic healthcare and treatment for malnutrition in the district.

Improving access to healthcare in former rebel areas

Despite political change, access to health services continues to be limited for most people in Ivory Coast who cannot afford healthcare under the current cost-recovery system. While continuing to support people living in former rebel-held areas, MSF has called for a reorientation of the government's health policy and free healthcare.
Insecurity remained high until April in the district of Bangolo, in the former Zone de Confiance, where MSF treated several people with gunshot wounds. This led MSF to denounce publicly the repeated attacks, robberies, assassinations and rapes perpetrated against civilians living in the area and to release a collection of testimonies. In June, MSF upgraded the Bangolo health centre to the level of district hospital. Here, MSF offers free quality secondary healthcare, including inpatient and emergency services, in the absence of adequate national health support. MSF also runs a primary health centre and mobile clinics, providing basic healthcare and treatment for malnutrition in the district. About 85,000 outpatient consultations were conducted during the year.

MSF continued to manage services at Danané hospital in the west of the country at the Liberian border. These included providing secondary healthcare in inpatient services, integrated care for tuberculosis and HIV/AIDS, treatment for malnutrition and paediatric and obstetric care.

Until October, MSF supported a local hospital in Bin Houyé as well as the district hospital in Zouan Hounien, in the south of the Zone de Confiance. These projects have now been handed over to district health authorities. MSF also managed mobile clinics and a mobile nutrition programme in Danané and Zouan Hounien districts. By the end of 2007, three mobile clinics and 13 ambulatory nutrition sites remained. MSF will continue to monitor malnutrition in the district until the planned withdrawal from Danané in 2008.

Project handovers

As public health structures started to function again, the Minister of Health expressed a willingness to take over healthcare. Where possible, MSF began to transfer projects to the authorities. This process will continue in 2008.

During an emergency in 2002, MSF had launched a project offering free healthcare in the hospital of Bouaké, a major city in the country. Following improvements in regional health capacities, MSF handed over its project to the Ministry of Health in April 2007. In the first four months of 2007, 1,243 patients were hospitalised and 6,360 consultations conducted. In June, MSF closed its project in the referral hospital of Man in the west, where it had provided free primary and secondary healthcare since 2003, including anti-retroviral treatment for HIV/AIDS patients and surgery for the wounded and women with obstetric fistulas. Between January and June, MSF carried out more than 1,200 surgical interventions and 28,000 outpatient consultations.

In September, MSF ended its activities in Guiglo in the west where it offered medical care in a primary health centre and treated severely acute malnourished children under the age of five. Until September, about 26,800 outpatients consultations were carried out and 611 children under five were included in the nutritional programme.

MSF has worked in Ivory Coast since 1990.

KENYA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **463**

Escalating violence has left many people unable to access healthcare in the Mount Elgon region. MSF has responded by using mobile clinics to reach those in need. Throughout the country HIV/AIDS and TB infection rates continued to rise. MSF is treating many co-infected patients using new technologies and facilities. Meanwhile MSF continues to campaign for access to drugs to treat the neglected disease, kala azar.

Responding to ongoing displacement

Since August 2006, ongoing violence and disputes over land in the Mount Elgon area of western Kenya have caused thousands of people to flee their homes and seek refuge in larger towns, higher parts of Mount Elgon, the forest or nearby villages. These people are often trapped between fighting groups and receive little assistance. In April, MSF began delivering humanitarian medical assistance to this population in the Mount Elgon district. MSF is mainly dealing with the health consequences of violence against civilians and repeated short-term displacement. Through a system of mobile clinics and support to primary healthcare structures in the area, MSF teams provide access to free quality medical care.

In Molo district, fighting, violence and intimidation displaced around 17,000 people by December. Many were living in small camps scattered around the district, so MSF started mobile clinics to assess needs and provide medical consultations and water sanitation services at different sites every week.

Ongoing HIV/AIDS care

Despite some positive progress in recent years, HIV/AIDS continues to have a devastating impact on every sector of Kenyan society. While around 5.9 per cent of adults are thought to be infected, this can be as high as 35 per cent in some rural areas where MSF works, such as Homa Bay. Working in two of Nairobi's slums, Kibera and Mathare, and two locations in the west of the country, Busia and Homa Bay, MSF provides comprehensive HIV/AIDS treatment and care to thousands of Kenyans. MSF's first HIV/AIDS project opened in 1996. By the end of 2007, MSF was caring for over 17,000 people living with HIV/AIDS and providing anti-retroviral treatment (ART) to 10,500.

Tackling tuberculosis

Treating HIV/AIDS without also addressing tuberculosis (TB) is ineffective. TB is the leading killer of people living with HIV/AIDS. Globally, around 11 million people are thought to be 'co-infected' and half of all deaths of HIV-positive people are due to TB. Throughout 2007, MSF expanded its efforts to treat people infected with TB in Kenya. By the end of the year, 1,445 people had been started on treatment in various projects around the country.

Diagnosing TB in patients who are HIV positive can be challenging as the sputum samples produced often do not show the presence of TB when analysed in standard laboratory tests. After months of building and preparation work, MSF opened a TB culture laboratory in Homa Bay hospital in November. One of only five in the country, this laboratory will enable much more effective and accurate diagnosis of TB, particularly in patients who are co-infected with HIV.

Growing resistance to first-line TB treatment is another challenge and MSF has been treating people with multi-drug resistant MDR-TB since May 2006. In addition social issues, including housing and food availability, are assessed because these are often the main reasons why people fail to complete treatment. MSF remains the only provider of free treatment for MDR-TB in Kenya.

Treating neglected diseases

MSF works in West Pokot district, Rift Valley Region, treating people infected with kala azar, otherwise known as visceral Leishmaniasis. This disease, spread by the sandfly, is fatal if left untreated and affects around two million people globally every year. In 2007, MSF teams screened over 1,678 people for the disease and successfully treated 850.

Until mid-2006, the only drug available in Kenya to treat kala azar was a patented drug called Pentostan. MSF has lobbied the Kenyan Government for the use of a cheaper generic drug called Sodium Stibogluconate (SSG). In 2007, SSG was registered in Kenya, although manufacturing problems indicate that it will not be available for supply any time soon. MSF continues to advocate for the inclusion of SSG into the Kenyan Ministry of Health guidelines for treating kala azar. Whereas Pentostan costs 150 USD per treatment course, SSG costs 30 USD, so it will be much more easily absorbed into the Kenyan health system. As kala azar can be difficult to diagnose, MSF is also advocating for the use of a rapid diagnostic test that is ideal for resource-poor settings and is encouraging the use of these tests in health centres around the district.


© Brendan Bannon

MSF is dealing with the health consequences of violence against civilians and repeated short-term displacement.

MSF has worked in Kenya since 1987.

LESOTHO

REASON FOR INTERVENTION
• Endemic/Epidemic disease
FIELD STAFF 24

© Alessandra Vilas Boas

MSF services a population of 220,000 including an estimated 35,000 people living with HIV/AIDS.

Lesotho, also known as the Mountain Kingdom, is a small landlocked country surrounded by South Africa. Of its 1.8 million inhabitants, an estimated 23,000, more than 1% of the entire population, die each year of HIV-related causes. By far the leading cause of death among HIV-positive people is tuberculosis (TB). More than 90 per cent of TB patients in areas where MSF works are also infected with HIV.

Over two years, more than 2,200 people have started anti-retroviral treatment (ART) in MSF-supported structures. The programme is based at Scott hospital in Morija, 40 kilometres south of the capital, Maseru, and supports 14 primary care clinics in remote rural areas. The health facilities supported by MSF serve a population of 220,000, including an estimated 35,000 people living with HIV/AIDS.

In addition to providing ART, MSF works with hospital management and staff to give comprehensive care, including HIV counselling and testing, prevention of mother-to-child transmission, early diagnosis of HIV in infants and management of opportunistic infections and co-infections, particularly TB.

By the end of 2007, over 21,000 people had been tested for HIV (34 per cent HIV-positive), vertical transmission from mother to child was reduced to six per cent when both the mother and the baby received an intervention and for whom an early test (DNA-PCR) result for the baby was available. TB and HIV services were integrated so that HIV-positive patients are systematically screened for TB and TB patients are routinely offered an HIV test. Co-infected patients can therefore benefit from a 'one-stop service'. Efforts were also made to improve diagnosis of TB, including smear-negative and drug-resistant TB.

The programme achieved these results within a short timeframe by training more nurses; ensuring weekly visits to each clinic by MSF mobile medical teams; recruiting and training 'HIV/TB lay counsellors' (mostly members of the community living with HIV/AIDS enrolled on the programme) to take on multiple tasks, including adherence support; strengthening laboratory and pharmacy capacity at the district hospital; and promoting treatment literacy, openness about HIV and community involvement in service delivery.

An acute shortage of healthcare workers threatens further scale-up of activities in Lesotho and hopes for long-term continuity of services all the more daunting. There are fewer than 100 doctors in the entire country, most from other African countries, who are working in Lesotho while awaiting their certification to work in South Africa, where they can get higher-paying jobs, so their stay in Lesotho is usually only temporary. Additionally, in June, at a time when the HIV-related workload was increasing sharply, over half the professional nursing posts in the 14 clinics supported by MSF and 30 per cent of professional nursing posts at the district hospital were vacant.

In May, the team in Lesotho, together with other projects in the Southern African region made the decision to launch a report on the healthcare worker crisis. This was reinforced by advocacy at national and international levels for measures to improve retention and recruitment of professional health staff and ensure 'task-shifting' of certain clinical tasks from doctors to nurses and non-clinical tasks from nurses to lay health workers. Without fundamental change, the prospects for expanding access to ART and improving quality of care in the long-term are bleak.

MSF has worked in Lesotho since 2006.

LIBERIA

REASON FOR INTERVENTION • Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion
FIELD STAFF 1,023

Improving the health of mothers and children is the main focus of MSF's work in Liberia. Although the situation has improved in recent years, many Liberians still live in crushing poverty. Women and children remain particularly vulnerable and in need of specialised health services.

Protecting mothers and their children

Each month, more than 1,300 children are treated at Island and Benson hospitals in the capital, Monrovia. Benson hospital also provides maternity care and obstetric surgery, as well as running a women's health centre. Two MSF-supported primary health clinics also handle 13,000 consultations a month. The majority of the patients are pregnant women, new mothers and children. To prevent expectant mothers with HIV transmitting the virus to their child, pregnant women attending MSF clinics are offered free HIV testing and those testing positive are enrolled in treatment.

In April, MSF began offering HIV testing at Island hospital for children showing symptoms associated with the virus. Fifty-four children who have tested positive are receiving anti-retroviral treatment (ART). A new outpatient section has been added to the hospital for HIV and tuberculosis patients who get treatment and medication but are able to live at home.

In Saclapea in Nimba County, MSF has built a comprehensive 42-bed health centre, replacing the original tent structure with permanent buildings. The hospital provides outpatient and inpatient services and has a clinic dedicated to women's health. The centre was completed in late 2007. MSF also offers ART for HIV patients at the health centre.

Providing recovery from, and raising awareness of, sexual violence

Since 2003, MSF has provided medical care for survivors of sexual violence in Monrovia and carried out activities to raise awareness of this serious problem. Each month, MSF teams in Monrovia treat approximately 140 survivors of sexual violence, more than a third of whom are under 12 years old. Awareness of the importance of seeking treatment within 72 hours of an attack is increasing, particularly among police and community organisations, and more patients now seek care earlier. However, despite positive changes to tackle the issue, MSF is still one of the very few organisations providing medical care to survivors of sexual violence in Monrovia.

Reducing activities

As Liberia moves towards stability and reconstruction, humanitarian organisations including MSF, which work mainly in emergency situations, are beginning to leave the country. MSF gradually stopped working in some of the health facilities in Nimba county and withdrew from Lofa county. Most were handed over to the Liberian health authorities or to other non-governmental organisations. MSF has also closed the medical facility at Mamba Point.

Prior to an international donor conference in Washington D.C. in February , MSF released a report stressing the need to find alternatives to humanitarian assistance and to build capacity in the Liberian health services to address the country's healthcare needs. The paper was used to brief major donors and States.

MSF has worked in Liberia since 1990.

© Sofie Stevens

Pregnant women attending MSF clinics are offered free HIV testing and those testing positive are enrolled in treatment.

MALAWI

REASON FOR INTERVENTION • **Endemic/ Epidemic disease**
FIELD STAFF **652**

HIV/AIDS is one of the most acute health concerns in Malawi. In this country of 13 million people, about one million are infected and 86,000 die each year. Despite intensive efforts by the authorities and international bodies, more than 170,000 people living with HIV in Malawi are still in urgent need of anti-retroviral treatment (ART).

MSF is supporting the implementation of a national HIV/AIDS plan. MSF is also closely involved in increasing the number and capacity of health centres to provide life-long care for HIV patients in the southern rural districts of Thyolo and Chiradzulu and in the central district of Dowa. In order to cope with an acute lack of doctors and other health professionals, the strategy has been to shift some functions to more junior staff such as health surveillance assistants. MSF has been focusing on increasing the skills of existing staff and lay people, including 'expert patients', to provide essential services.

Specially trained 'expert patients' and members of the community are now able to undertake testing and counselling as well as providing support to help people continue with their treatment. These tasks were traditionally undertaken by nurses but many became overwhelmed by the increasing number of HIV patients combined with a scarce workforce, so a complementary approach was needed.

Nurses can now focus purely on medical issues. MSF is providing HIV-related training for nurses, who are now able to prescribe ART, a responsibility previously performed only by clinical officers, medical assistants and doctors. The decentralisation of HIV services together with the task shifting and intense training for care providers has allowed better follow up through smaller, more local health structures and home visits. Now patients do not have to travel long distances to hospitals for routine consultations and medication.

This decentralised approach has allowed MSF teams in Chiradzulu, Thyolo and Dowa to start more than 27,000 people on treatment.

MSF also strongly focuses on detecting and treating tuberculosis (TB) and malnutrition in HIV patients. Both conditions jeopardise the efficiency of HIV treatment. Over 1,700 people, many of whom were HIV positive, were admitted for TB treatment.

By December, approximately 19,000 people were still on treatment in MSF-supported structures across Malawi and more than 700 people were starting treatment in an MSF structure every month.

After more than seven years of working in Dowa district hospital in central Malawi, MSF has handed over its HIV/AIDS project to the Ministry of Health. This project started in 2000 with a strong focus on the prevention and treatment of sexually transmitted infections. In December 2004, the first patients started on ART. By the end of the project in October 2007, more than 1,100 HIV patients were undergoing treatment in Eastern Dowa and more than 270 in Mponela. It is estimated that over 3,300 patients have enrolled in the programme over the last three years.

By December, approximately 19,000 people were still on treatment in MSF-supported structures across Malawi and more than 700 people were starting treatment in an MSF structure every month.

MSF has worked in Malawi since 1986.

MALI

REASON FOR INTERVENTION • **Endemic/ Epidemic disease**
FIELD STAFF **54**

These mobile 'malaria teams' mean children in isolated villages can now receive free treatment during the rainy season.

© Bruno De Cock

Malaria is endemic in Mali, where it is the main cause of mortality for children under five. Access to healthcare is limited in this country, where 72 per cent of the population still live below the poverty line. The cost-recovery system of care is a serious impediment and attendance at health centres is extremely low. MSF is working to offer quality care for malaria, especially to the most vulnerable and those excluded from the healthcare system during the rainy season.

Back in 2005, a medical investigation conducted by MSF in southern Mali produced alarming results. Significant mortality rates were found, together with poor access to care and high levels of resistance to the chloroquine-based treatments. In collaboration with national health authorities, MSF launched a project in Kangaba to help people with malaria by offering quality diagnostics and care using Artemisinin-based combination therapy (ACT), reducing the cost of treatment and addressing the geographical barrier to care.

MSF offers free treatment to all children under five, and free consultations and treatment for febrile diseases to pregnant women in seven health centres in Kangaba. A flat rate policy of only 200 FCFA (50 cents) is also implemented instead of the cost-recovery system to enable the rest of the population to access treatment for malaria and other febrile diseases.

Since the implementation of this combined system, the number of consultations has increased four-fold. In 2007, each health centre was seeing about 34 patients a day, compared to an average of eight in 2005. Pregnant women and children under five are the main beneficiaries.

Distance between villages and health centres has been identified as a main obstacle to access to care, particularly during the rainy season when roads are impassable. MSF has trained community groups and equipped them with rapid screening tests and ACT, enabling them to treat simple cases of malaria in children under the age of 10. These mobile 'malaria teams' mean children in isolated villages can now receive free treatment during the rainy season.

The number of children with access to quality healthcare at sites more than five kilometres from a health centre was five times higher in 2007 than in 2006 during high transmission periods. Malaria rates fell from eight per cent in 2006 to 1.7 per cent in 2007 following the implementation of this new model of care.

MSF has worked in Mali since 1992.

MOROCCO

REASON FOR INTERVENTION • **Social Violence/Healthcare exclusion**
FIELD STAFF **13**

Recent and increased barriers preventing the transit of migrants to Spain means Morocco has become a destination country. Longer-than-intended stays in the country have resulted in the recent urbanisation of migrant populations, notably in Rabat and Casablanca. Although living conditions are less precarious than in rural areas, the population faces a higher cost of living with reduced means of subsistence and limited access to healthcare. Migrants are exposed to increased exploitation and violence. Prostitution is common and infectious diseases such as tuberculosis (TB) and HIV/AIDS are emerging.

Migratory routes have also shifted, with many people now originating from southern countries such as Mauritania, Senegal and, to a lesser extent, regions of the Sahara. Many arrive only to realise that there is little hope of crossing to Spain so unexpectedly stay in Morocco.

MSF continued to work on preventive and curative healthcare for migrants. Healthcare projects have followed the migrants from rural to urban areas, responding to their increasing needs. A new project opened in October to address the medical and humanitarian needs of migrants in Rabat and Casablanca. In Rabat, the majority of consultations centred on digestive and respiratory infections exacerbated by precarious living conditions. MSF also treated migrants for more serious and chronic diseases, including TB and HIV/AIDS. In total, MSF conducted 2,584 medical consultations in 2007. MSF also worked to raise awareness of reproductive health issues.

A new phenomenon has been the increase in mental health problems due to the longer stay of migrants in the country and the resulting loss of hope.

2007 saw some improvement in the access to public healthcare for migrants in Tanger-Tétouan. As a result, the MSF project in Tanger was scaled down and closed by the end of the year. However MSF will continue to assist migrants in Rabat and Casablanca, and in parallel will advocate for more inclusive national healthcare provision.

MSF has worked in Morocco since 1997.

MOZAMBIQUE

REASON FOR INTERVENTION • **Endemic/ Epidemic disease • Natural disaster**
FIELD STAFF **565**

With more than 16 per cent of the population infected, HIV is one of the main health concerns in Mozambique. MSF runs various programmes to combat the spread of the epidemic as well as providing timely assistance to areas repeatedly affected by heavy rains and floods.

Decentralised HIV/AIDS care

MSF has established long-term projects to support the authorities' response to the HIV/AIDS epidemic. The programmes are based in the capital city of Maputo and the provinces of Tete in the north-west and Niassa in the north. In December, about 14,300 patients were receiving anti-retroviral treatment (ART) through MSF-supported facilities. Programmes include health education, counselling, testing and prevention of mother-to-child HIV transmission.

MSF continued to transfer care from hospitals to health centres closer to communities. This increases access to HIV care, including ART, and helps prevent hospital congestion and staff being overwhelmed by the number of patients.

The current human resources crisis in the health sector due to emigration and the effects of HIV on the workforce has been a major challenge. MSF is providing intensive training to local medical staff and continues to simplify treatments for patients with HIV and tuberculosis. MSF also lobbies the authorities to allow qualified paramedical staff, after professional training, to prescribe anti-retroviral drugs and to use 'lay counsellors' to reduce the workload of nurses. There is a strong belief that shifting tasks is the only way to provide HIV/AIDS treatment on the scale required.

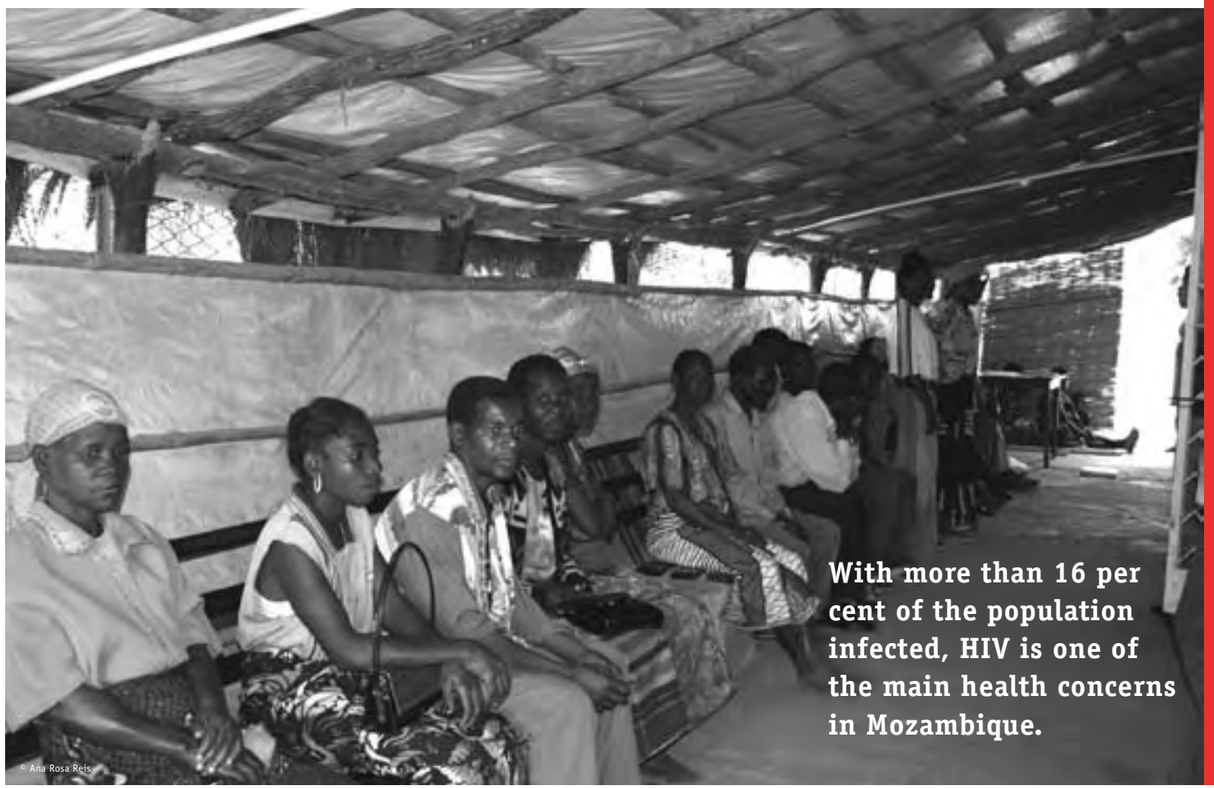
Seasonal floods and cyclone Favio

The year started with torrential rains flooding the Zambezi valley and forcing some 250,000 people to leave their homes. Although heavy rainfall is a seasonal phenomenon, these floods were the worst since 2001 and were exacerbated by the arrival of cyclone Favio.

In February, MSF launched a two-month emergency intervention to help people affected in Zambezia and Tete provinces. More than 50,000 people benefited. The main activities were distribution of clean and drinkable water, construction of latrines and distribution of plastic sheeting for temporary shelters.

MSF also supported the Mozambican health authorities by providing medical care in resettlement centres and helped implement a surveillance system to detect malnutrition and potential disease outbreaks such as measles, diarrhoea and cholera.

MSF has worked in Mozambique since 1984.



© Ana Rosa Reis

With more than 16 per cent of the population infected, HIV is one of the main health concerns in Mozambique.

Prevention of Mother-to-Child transmission of HIV

Prevention of mother-to-child transmission (PMTCT) of HIV in developing countries is far from optimal. In 2007, an estimated 420,000 children were newly infected with HIV, with almost 90 per cent of them living in Sub-Saharan Africa. In contrast, in developing countries the number of new paediatric infections has dramatically declined: in the United States, for example, only 250 infants are infected each year.

© Jean-Marc Giboux

In 2007, an estimated 420,000 children were newly infected with HIV, with almost 90 per cent of them living in Sub-Saharan Africa.

The vast majority of HIV-positive children are infected from their HIV-positive mother either during pregnancy, in delivery, or through breastfeeding. In the absence of any medical intervention, the risk of such transmission is between 15 and 30 per cent if a mother is not breastfeeding, and between 30 and 45 per cent if the mother is breastfeeding on a long-term basis. PMTCT is, therefore, a unique opportunity to stop the transmission of this virus and avoid a new generation being lost to HIV/AIDS.

Ironically, mother-to-child transmission is almost entirely preventable. Developed countries have been successful in reducing the risk of transmission to less than two per cent, by implementing medical interventions that include: antiretroviral (ARV) treatment to all HIV-positive women during pregnancy (irrespective of their need for ARV for their own health), and to the infant in the first weeks of life; obstetrical interventions including elective caesarean delivery; and complete avoidance of breastfeeding. Such interventions cannot be simply replicated in developing countries, mainly because it is often risky for the baby not to be breastfed, nor acceptable for mothers not to breastfeed.

There lies the greatest difference between developed and developing countries regarding the risk of transmission. In developed countries, formula feeding has totally replaced breastfeeding by HIV-positive mothers. In developing countries however, formula feeding is often not an option for cultural and financial reasons, but also because the lack of access to safe water (needed to create the formula) increases the risk of infant death due to diarrhoeal and other infectious diseases. The only intervention recommended by WHO and UNICEF so far to reduce HIV transmission through breastfeeding is that the mother exclusively breastfeeds her baby during six months (i.e. giving breast milk only, at the exclusion of any other liquid or food) and then weans the baby in a few days. Indeed, trials have shown that HIV transmission is reduced in exclusively breastfed infants, compared to those who received mixed feeding during their first months of life.

MSF follows the above WHO guidelines, established in 2006. These however are difficult to implement on a large scale, because they depend on the health status of the mother, but also because they rely on cultural changes about breastfeeding. This is particularly true in settings where little support can be given to the mother because prenatal and delivery services are not well established or of poor quality. While theoretically, implementation of these guidelines could reduce the risk of transmission to between eight to ten per cent, access to the full package of PMTCT interventions and treatment is limited in many developing countries. In South Africa, for instance, less than 11 per cent of women have access to services offering PMTCT interventions.

Today some clinical trials provide convincing evidence to support a regime of treating all HIV-positive mothers - even those who do need ARV for their own health as yet - with triple anti-retroviral therapy during pregnancy and delivery, as it is done in resource-rich settings, but also throughout the whole breastfeeding period. This could help reduce transmission of HIV in contexts where formula feeding is not possible.

Some questions, however, remain to be answered, and such a strategy still needs to be tested in routine programme conditions. MSF is planning to start such field tests with the objective of showing that, even in programme conditions, it is feasible, simpler, safer, and more effective than the currently recommended strategy. Results of such pilot projects could hopefully lead to the improvement of international recommendations.

NIGER

REASON FOR INTERVENTION • Endemic/Epidemic disease • Social Violence/Healthcare exclusion
FIELD STAFF 1,278

© Anthony Jacopucci

Acute child malnutrition is a serious medical issue that has not been adequately addressed in Niger despite increased national and international attention since the massive nutritional crisis of 2005. An annual 'hunger gap' exists between April and September, when family food stocks run out and hundreds of thousands of children have little access to food or the nutrients they need for healthy development. Malnutrition reduces immunity, stunts growth, affects brain development and can be fatal.

Child malnutrition is most severe in the regions of Diffa, Zinder and Maradi, where low weight and stunted growth affect 41 per cent of children living in poor households and just over 32 per cent of those in wealthier households.

Following a nutritional survey in Dakoro district, Maradi, MSF began a medical-nutritional programme in April, supporting seven integrated health centres to provide free care for children aged five and younger. MSF also supports the maternal health service, paediatric service, emergency obstetric surgery and maternity activities of the Dakoro district hospital. A total of 133,000 consultations were undertaken during the year.

In June, with high numbers of children from Aguie and Tessahoua arriving at existing health centres, a five-month emergency intervention was launched in Aguie. MSF provided support to the district hospital and ran the nutritional rehabilitation centre during the hunger gap, eventually handing over activities to Save the Children UK. In total, 1,102 children were admitted to the hospital, 925 for severe malnutrition.

In Tahoua district, MSF worked in two hospitals and six health centres, providing nutritional support and over 5,000 free monthly consultations for illnesses such as malaria, diarrhoea, respiratory and skin infections. Approximately 1,200 malnourished children were treated every month.

In Zinder, almost a million packets of RUFs were consumed and MSF treated 21,542 children. MSF is working in two intensive nutrition centres in Magaria and Zinder and in 13 mobile centres.

Using RUFs to prevent acute malnutrition

At the end of 2006, MSF research showed that more than half of children under the age of three developed an episode of acute malnutrition in two districts in Maradi. MSF therefore implemented a new approach aimed at preventing acute severe malnutrition and reducing the death toll linked to malnutrition. The new approach involved distribution of supplemental Ready-to-use foods (RUFs) to all children under three at risk in the area. Such RUFs does not replace regular meals but compensates for major deficiencies in diet by providing a child's daily nutrient needs. MSF distributed supplemental RUFs monthly to all 62,000 children aged from six months to three years in one district in Maradi during the seasonal hunger gap.

MSF has worked intermittently in Niger since 1985.

NIGERIA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease**
FIELD STAFF **319**

Improved treatment was provided to patients with trauma related injuries in the Niger Delta. The handover of HIV/AIDS treatment in Lagos was possible, and MSF responded to a meningitis outbreak in Jigawa.

In 2007, Nigeria was characterised by tensions surrounding the April presidential election and continuing strife in the Niger Delta, a volatile, densely populated area where various armed and political groups continue to struggle for power and control over natural resources. MSF's trauma centre was established in Teme hospital in Port Harcourt in 2005 to provide free emergency medical services and psychological care. The centre saw peaks of admissions in 2007, owing to several sporadic outbreaks of violence. In August, 70 casualties were received in a two-week period, many having sustained high velocity gunshot wounds. During the year, 6,300 patients were admitted to the emergency room and 2,000 surgeries and 800 psychological consultations were carried out. MSF also provides medical and psychological care to victims of sexual violence at the centre and is working to raise awareness of this service.

The Teme centre underwent technical improvements in 2007 to advance the quality of care, including the introduction of internal fixation (an operation that mechanically unites the ends of a fractured bone). This had a dramatic effect on the quality of the management of orthopaedic injuries and the average length of stay, which dropped from 23 to nine days and nearly tripled inpatient capacity. Physiotherapy for orthopaedic cases was also improved to reduce any loss of mobility.

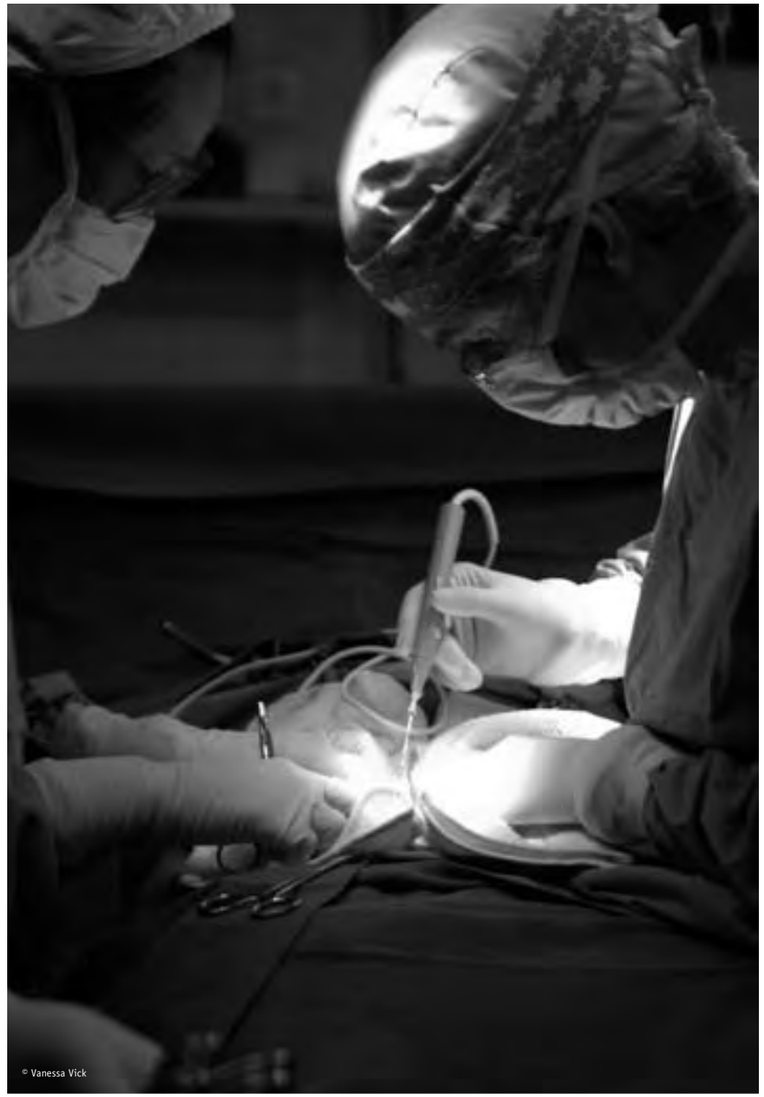
Improved HIV/AIDS care in Lagos

When MSF started providing free anti-retroviral treatment (ART) and comprehensive care for HIV/AIDS patients in 2003, there were no other agencies providing free ART in Nigeria. In 2006, a President's decree announced a national programme to offer free ART to all HIV/AIDS patients in the country. As a result 20 centres started offering counselling and treatment of HIV/AIDS in Lagos state in 2007. This national progress allowed MSF to begin the handover of its HIV/AIDS project, which provided ART to over 1,900 patients, to local partners and authorities.

Meningitis outbreak in Jigawa

MSF provided case management between March and May in response to a meningitis outbreak in Jigawa state, the most affected areas being Gwaram and Dutse. MSF provided support to health facilities, trained staff and donated drugs and diagnostic tests. A total of 583 people were treated.

MSF has worked in Nigeria since 1996.



© Vanessa Vick

Improved treatment was provided to patients with trauma related injuries in the Niger Delta.

REPUBLIC OF CONGO (CONGO-BRAZZAVILLE)

REASON FOR INTERVENTION • Armed conflict • Endemic/Epidemic disease
FIELD STAFF 190

MSF handed over the screening and treatment of sleeping sickness patients to the Ministry of Health.

After more than a decade of war and unrest, the Republic of Congo has now completed its fourth year of post-conflict negotiations. The formal cessation of armed hostilities has allowed the resumption of economic activities concentrated principally in the oil town of Pointe Noire and the capital, Brazzaville. The Ministry of Health has now taken responsibility for healthcare in the Pool region. The situation is no longer considered an emergency and MSF has therefore started handing over some activities.

However, medical needs are still numerous in Mindouli and Kindamba, in the Pool region, where malaria, respiratory infections, diarrhoea, HIV/AIDS and tuberculosis (TB) are prevalent. The country remains prone to outbreaks of infectious disease.

MSF provided integrated healthcare in the hospitals of Mindouli and Kindamba. Services ranged from outpatient care, maternal care and treatment of infectious diseases such as TB and HIV to voluntary-care treatment for HIV/AIDS, psychosocial counselling and emergency surgical care. Overall, MSF conducted over 78,000 consultations.

MSF handed over the screening and treatment of sleeping sickness patients to the Ministry of Health, though we will remain available to provide assistance if required. MSF also provided healthcare through its mobile clinics to communities surrounding the towns of Mindouli and Kindamba.

Responding to cholera outbreak

In late January, an outbreak of cholera was identified in the city of Pointe Noire and a few weeks later in Brazzaville. MSF supported the Ministry of Health by reinforcing an isolation area for patients and providing medicines, medical training and water and sanitation materials and expertise.

Project handover

In June, MSF announced that it would hand over its activities and leave the country by mid-2008. To ensure continuity of its medical services, MSF will strive to identify other partners, including local non-governmental organisations and the United Nations, to support the Ministry of Health in the Pool region. MSF will also support the Ministry of Health to address small pockets of high incidence of sleeping sickness identified during the final project evaluation of 2008.

MSF has worked in the Republic of Congo since 1997.

RWANDA

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
FIELD STAFF **71**

At the end of 2007, MSF ended its activities in Rwanda after 16 years in the country. Over the years, MSF's work has included assistance to displaced persons, war surgery, programmes for unaccompanied children and street children, support to victims traumatised by the conflict, programmes to improve access to healthcare, responding to epidemics such as malaria, cholera and tuberculosis, and projects linked to maternal and reproductive health.

In 2000, Rwanda faced a growing HIV/AIDS epidemic and a lack of available resources. MSF joined the fight against HIV/AIDS, focusing initially on prevention and awareness before quickly including medical treatment.

In the health centres of Kinyinya and Kimironko in Kigali, thousands of patients have been cared for by MSF. At the time of final handover to the health authorities in December, more than 6,200 patients were receiving medical care in these two health centres, with 2,700 benefiting from anti-retroviral treatment (ART). More than 10 per cent of these patients were children.

Caring for children with this life-long disease brings particular challenges. MSF medical teams, therefore, developed an innovative approach focusing on the specific needs of children living with HIV/AIDS in Rwanda. This included discussion of HIV testing of children in adult discussion groups, training specialised staff in psychosocial care and disclosure of the child's status to the child and their caregiver using adapted tools. A key part of MSF's approach was the creation of children-only support groups, which not only give children a voice but also allow them to play an active role in their treatment.

Rwanda has now begun a clear shift towards long-term development plans. The number of organisations in the country now covers the needs of the population. The AIDS epidemic appears contained due to the high level of investment by local authorities and the support of many international actors. As a result, MSF felt able to end its presence in the country at the end of 2007.

MSF has worked in Rwanda since 1991.

Leaving Rwanda

After 16 years in Rwanda, MSF closed down its activities at the end of 2007, handing over to the health authorities its last remaining programme (see opposite). The handover marks the culmination of an intervention that has spanned war, genocide, epidemics and reconstruction.

MSF first began work in Byumba and Ruhengeri districts in 1991, supporting those displaced by the civil war. It was to prove to be the start of one of the most deadly and horrifying periods in the region's and the country's history. Within a couple of years, MSF teams were providing health and nutritional care not only to many suffering from the internal unrest but also to refugees fleeing massacres in Burundi.

By 1994, MSF teams were witness to the brutal genocide unfolding in front of their eyes. Efforts to help survivors were dangerous. Patients and members of the MSF medical team were killed, and eventually, MSF had no choice but to evacuate.

However MSF medical teams managed to return after a few days, crossing the border with Uganda and Burundi. The scale of the suffering they found was such that the number of staff increased quickly, offering urgent medical care at hospitals in Kigali and Nyamata, and in Byumba and Gitare on the Ugandan border. A health centre was also opened in Kigali.

The capacity of local systems and the involvement of other external actors have allowed MSF's gradual handover and withdrawal.

But providing direct care to the victims was not enough. Shocked by the international community's refusal not only to recognise the slaughter as genocide but also to intervene to save lives, MSF went public. A high-profile witnessing campaign ran across Europe, culminating in the handing over of a report on the genocide to the United Nations. This collective lack of action remains one of the most shameful episodes of recent years.

In the months following the massacres, MSF gradually expanded its activities across the country, focusing particularly on displaced and unaccompanied children and supporting health structures that were close to collapse. Massive medical assistance was also provided to some two million refugees who had fled the killings and were now living in precarious camps in Congo (formerly Zaire) but also Burundi and Tanzania.

The need for MSF to bear witness impartially was unabated. Staff denounced intimidation and atrocities both in a camp and in Gitarama prison, leading to the expulsion of some MSF teams and the withdrawal of others. Essential work continued elsewhere in Rwanda and, particularly that along the borders, was to prove essential in 1996 when fighting in Congo sparked a massive return of hundreds of thousands of Rwandan refugees to the country.

As the 1990s drew to a close, the situation in Rwanda gradually moved from emergency intervention to reconstruction and development. MSF teams continued their work, addressing the new challenges of rebuilding the healthcare infrastructure, providing mental health support to traumatised survivors, helping the country cope with the surge of HIV/AIDS cases, working to improve maternal and reproductive health and responding to epidemics and other emergencies. Over the years, the capacity of local systems and the involvement of other external actors have allowed MSF's gradual handover and withdrawal.

SIERRA LEONE

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
FIELD STAFF **492**

Malaria is the main killer of children under the age of five in Sierra Leone. In Bo and Pujehun districts in southern Sierra Leone, where MSF is working, malaria is the most common disease. During 2007, staff in the MSF-supported health centres treated more than 100,000 cases of malaria.

MSF is fighting malaria through diagnosis and treatment using effective tools and drugs. Pinprick blood tests, so-called rapid diagnostic tests, are easy to interpret and suitable to use in areas where microscopy is not available. As in all MSF projects, malaria patients are treated with Artemisinin-based combination therapy (ACT), drugs that are more effective than earlier medicines, to which the malaria parasite has developed a high resistance. MSF's experience has also shown that to improve access to effective treatment of malaria, both healthcare and medicines have to be free. Sierra Leone is one of the poorest countries in the world and even low patient fees deter people from seeking treatment.

To make malaria treatment more accessible to people in remote areas far from the nearest clinic, MSF began to support 30 smaller health posts in rural areas. In November, a pilot programme started to train community malaria workers to test for malaria using rapid diagnostic testing and to offer free treatment for uncomplicated malaria with ACT in their villages. Information and education on how to prevent and recognise malaria and to encourage people to seek care quickly are also important components in combating malaria. To prevent people from contracting the disease, more than 64,000 bed nets were distributed in 2006 and 2007.

Gondama referral centre

MSF runs the Gondama referral centre, a hospital outside Bo town that offers paediatric and maternity care and therapeutic feeding. Each month, the centre admits around 500 paediatric patients, 100 malnourished children and 50 pregnant women. In 2007, a new operating theatre opened where caesareans and other obstetric-related surgery are performed.

In March, an ambulatory therapeutic feeding programme started making it possible to treat a greater number of children. The children come to the health centre once a week for a medical check up and to receive their weekly supply of therapeutic food, an enriched peanut paste.

The risks of pregnancy

Women in Sierra Leone face one of the highest risks of dying from pregnancy and childbirth in the world. The five MSF-supported clinics include a special consultation area for women, where all medical staff are female. These provide ante- and post-natal care, family planning, treatment of sexually transmitted disease and medical and psychological care for victims of sexual violence. Normal deliveries also take place in the clinics while complicated cases are sent to the referral centre.

MSF has worked in Sierra Leone since 1986.

SOMALIA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion**
FIELD STAFF **1,061**

2007 saw an escalation of violence in Somalia as fighting intensified between the Transitional Federal Government, groups linked to the Union of Islamic Courts and various other armed factions, particularly in the capital, Mogadishu. As a result thousands of people fled Mogadishu, increasing the medical needs in the country with a weakened health system.

Alleviating the suffering

Thousands of those who fled Mogadishu found themselves living without shelter, food, water or medical care. In April, MSF launched an emergency response in Afgooye, a town some 30 kilometres west of Mogadishu where many had sought refuge. MSF teams focused on meeting immediate needs, supplying medicines to the few existing health structures, such as the Hawa Abdi clinic, and distributing non-food items, such as plastic sheeting and jerry cans. With cholera cases reported in several locations, MSF staff also focused on providing clean drinking water through water trucking distributions.

Throughout the year, people continued to arrive from Mogadishu and needs increased every day. In Afgooye and Hawa Abdi, a large majority of the 1,700 weekly medical consultations carried out by MSF teams were linked to precarious living conditions: severe malnutrition, diarrhoea and acute respiratory tract infections. MSF teams doubled the capacity in Afgooye and set up a paediatric ward in Hawa Abdi. The nutritional care centre in Hawa Abdi also increased its capacity by the end of the year.

Despite the insecurity, MSF also opened new projects in Mogadishu itself. A cholera treatment centre was opened in MSF's primary healthcare clinic in Yaqshid in March. By May, the centre had admitted over 1,000 patients, more than double the number treated in previous cholera outbreaks in the capital. Over the course of the year, three new outpatient clinics for children under 12 were opened in Balcad, Karaan and Lido. In December, the Lido clinic was reinforced with an inpatient ward.

A paediatric clinic opened in the Hawladag area of the capital in May had to be closed and relocated in November due to insecurity. The MSF team now carries out mobile clinics in displaced person's camps around the city and continues to run an inpatient and outpatient clinic for children and an ante-natal care clinic in the K4 area of the city, reaching some 250 people a day. In late September, MSF started providing emergency surgical care in a hospital in the Dayniile area, receiving 705 patients in the emergency room and performing 140 surgical interventions in the first three months.

Expanding activities

Victims of violence and displaced people were not the only ones needing medical assistance. The absence of public health services, coupled with chronic malnutrition, droughts, floods and regular outbreaks of cholera and other epidemics, have left the general population extremely vulnerable.

MSF has increased its operational presence in Somalia.

MSF expanded its activities, opening new projects in Hiraan region, Lower Juba region and Puntland. In Belet Weyne, Hiraan region, MSF opened a hospital programme in February focusing on surgical care. Once the surgical capacity of the hospital was functioning well, MSF also started a paediatric ward providing maternity care. In Jamaame, Lower Juba region, MSF set up a 30-bed hospital with a large nutritional programme and outreach activities in March. Since then, 950 patients have received nutritional treatment and MSF teams have carried out 1,400 consultations a month. Every day, four mobile medical teams screened between 300 and 1,000 children and pregnant women for malnutrition. The major health problems presented were malnutrition, pneumonia, and diarrhoea.

In Kismayo, also in Lower Juba region, MSF began an emergency surgical project in September. In Bossaso, Puntland, a nutritional emergency intervention was launched in late August in camps where thousands of internally displaced people and refugees, both Somalis and Ethiopians, gather before trying to cross the Gulf of Aden to reach Yemen. Between August and December over 1,000 patients were treated for malnutrition.

Healthcare in a hazardous environment

With 14 projects in 11 regions, MSF was one of the biggest healthcare providers in Somalia in 2007. MSF's medical teams performed more than 2,500 surgical operations, 520,000 outpatient consultations and admitted around 23,000 patients to hospital. Yet the challenges of working in such an insecure environment were evident. MSF was occasionally forced to remove its international staff because of violence, or threats of violence, against staff and patients, although MSF activities continued to be run by dedicated Somali staff.
At the end of the year, two international staff members were kidnapped in Bossaso and held captive for a week before being released without being harmed.

MSF has worked in Somalia since 1991.

SOUTH AFRICA

REASON FOR INTERVENTION
• Endemic/Epidemic disease
• Social Violence/Healthcare exclusion
FIELD STAFF 56

In South Africa it is estimated by the UN that over 5.5 million people are HIV-positive and about a million are in urgent need of anti-retroviral treatment (ART), half of whom are still waiting. Tuberculosis (TB), including drug-resistant TB, is the leading cause of illness and death among those living with HIV. At the same time, South Africa has become the leading destination in the region for migrants fleeing economic and political chaos in neighbouring countries in search of jobs and safety. An estimated 2,000 - 6,000 people cross the border every day. Despite a constitution that guarantees healthcare for all, access to services for this group is far from assured.

Providing HIV/TB treatment in a township

Since May 2001, MSF has been providing primary care level HIV/AIDS treatment in the township of Khayelitsha, on the outskirts of Cape Town, in partnership with the Western Cape Province Department of Health. MSF has progressively handed elements of the programme over to provincial and local health authorities but continues to support TB and HIV services.

The Khayelitsha programme has the oldest group of patients on AIDS treatment in the public sector on the continent. A special priority has, therefore, been set together with partners, particularly the University of Cape Town, to monitor and evaluate treatment results. As of December 2007, nearly 9,000 people had been started on ART in clinics supported by MSF, including almost 3,000 who have been on treatment for more than two years.

More than 200 new patients were started on ART monthly but this rate was threatened by complete saturation of existing sites and severe shortages of health workers. To cope with the ever increasing number of patients and with the goal of reaching 15,000 people by 2010, MSF focused on delivering HIV services in new decentralised health centres using a nurse-based model of care, improving clinic organisation and triage of patients, re-defining staff roles and training. MSF also launched new strategies to address the challenges of long-term adherence to ART, including creating 'adherence clubs' for stable patients on ART for at least 18 months with no complications.

Given the extremely high incidence of TB in the township and because 70% of TB patients are also HIV-positive, MSF introduced an integrated TB/HIV clinic in the country in 2003. Since then Ubuntu has become one of the busiest primary care clinics in the province. Efforts were made to improve diagnosis of drug resistant TB in Khayelitsha, strengthen TB infection control and develop a decentralised community-based model of care. MSF continues to coordinate the township's Simelela Centre for Survivors of Sexual Violence, which provides medical care, psychosocial support, forensic examination and police assistance to rape victims in one setting open 24 hours a day, seven days a week. In 2007, nearly 1,000 survivors of sexual violence attended Simelela.

Improving access to care for migrants

In late 2007 and in response to an increasingly dire situation, MSF carried out an assessment and started providing essential healthcare to migrants, primarily from Zimbabwe. In the border town of Musina, Limpopo Province, MSF provides primary healthcare through mobile medical teams on farms and in townships. In Johannesburg, MSF opened a small clinic next to the Central Methodist Church where 1,500 migrants seek refuge every night. MSF provides basic care and enables access to public health services and more specialised care through a referral network.

MSF has worked in South Africa since 1999.

SUDAN

REASON FOR INTERVENTION • Armed conflict • Endemic/Epidemic disease
• Social Violence/Healthcare exclusion • Natural disaster
FIELD STAFF 3,174

More than three years after the signing of the Comprehensive Peace Agreement, medical needs in south Sudan remain critical. In many areas, MSF is struggling to maintain primary healthcare services, while reinforcing secondary care and emergency outbreak response services.

Emergency response

In a country devastated by over 20 years of war, with little or no health infrastructure, where deadly diseases are common and outbreaks of meningitis and cholera frequent, the ability of MSF teams to respond quickly and efficiently to emergencies remains crucial.

When meningitis swept through southern Sudan in early 2007, MSF emergency teams responded immediately. Between January and April, the Ministry of Health reported 11,447 suspected cases of meningitis, including 632 deaths, in nine out of 10 states. MSF teams set up a surveillance system to monitor cases, supplied health structures with medicines, treated people and launched mass vaccination campaigns in all nine affected states. Around 2,000 people were treated, including 255 severe cases, and more than 630,000 people were vaccinated.

MSF teams responded to several cholera outbreaks throughout the year by setting up isolation and treatment centres and reinforcing teams with additional staff. Some 2,400 people were treated for cholera. In July, MSF supported the health authorities in Wau, in Bahr-el-Ghazal state, after an increase in diarrhoea cases. MSF teams also ran measles vaccination campaigns throughout 2007, vaccinating 47,500 children. After flooding in September, MSF staff distributed essential survival items, such as cooking sets, to 3,000 families in Ayod, Jonglei State.

A country devastated by over 20 years of war, with little or no health infrastructure

The struggle to meet substantial needs

An absence of healthcare staff and health structures, roads and transport, other actors and investment means that MSF is the only medical organisation present in many areas of south Sudan and struggling to meet the substantial needs. MSF teams worked in five states, providing medical care ranging from primary healthcare to surgery and treatment of malnutrition and sleeping sickness. Staff in MSF's health centres and hospitals in Jonglei, Upper Nile and Unity State performed over 350,000 outpatient consultations and more than 2,000 surgeries. In Unity State, around 150 patients operated on had to be airlifted in from remote sites. As well as working in fixed structures, mobile clinics and outreach teams are an essential part of MSF's work, ensuring that people living in extremely remote areas without roads or transport facilities can receive medical care.

The security situation remains precarious. Outbreaks of fighting are frequent and the number of patients in MSF wards suffering from violent trauma is high, representing four out of 10 patients undergoing surgery in Bor Civil hospital (Jonglei State). In November, MSF was forced to withdraw staff temporarily from Bor when clashes between different tribes led to the death of four people within the MSF compound.

In some areas, MSF has been able to hand over or end its activities. In March MSF withdrew from a hospital in Akuem, Bahr El Ghazal State, which was established in 2000 during the civil war, when people were unable to reach any other health facilities. Services included in- and out-patient care, antenatal care, deliveries, treatment for TB and emergency interventions for meningitis, cholera, malaria and malnutrition. In the seven years MSF worked in the hospital, teams provided over 320,000 outpatient consultations and treated 1,187 people with TB.

In October, MSF handed over responsibility for Marial Lou rural hospital, in Warap State, to a partner organisation and as a new hospital was opened in Bentiu, Unity State, MSF also decided to end its assistance in this area as well. Activities there had focused on kala azar, tuberculosis and HIV co-infections.

MSF has worked in Sudan since 1979.

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Darfur

MSF has provided medical humanitarian aid in the Sudanese region of Darfur since 2003, when government forces and allied militia began fighting rebel groups seeking greater autonomy for the arid and impoverished region. In 2007, the political environment became increasingly complex, with continued fragmentation of armed groups leading to outbreaks of violence and heightened insecurity. Aid organisations including MSF were the target of numerous attacks and robberies. Harassment from members of armed forces, increased banditry and clashes between nomadic tribes led to new population displacements. By the end of 2007, the number of displaced people in Darfur had reached close to 2.5 million.

West Darfur

Access to medical care and emergency support is a constant problem for populations faced with ongoing violence in west Darfur, complicated by refugee arrivals from neighbouring Chad. In June, MSF started working in Foro Boranga on the Chadian border, caring for 20,000 people living in difficult conditions whose basic needs included food and clean drinking water. Mobile clinics were started to provide general consultations, nutritional assistance, vaccinations and referrals for the seriously ill. Mosquito nets were also distributed. Following a serious security incident, MSF had to shut down its activities in Fora Boranga in November.

In Habilah, another border camp with over 22,000 displaced, MSF's health centre began providing mental health services in May. The health centre is being handed over to Save the Children, as their presence together with the increased involvement of the Ministry of Health in the area are sufficient to meet the needs of the population. MSF also continued to provide medical and technical support in projects at the Aradamata and Dorti displacement camps from a base in El Geneina.

Seleia, in the north of the province, has witnessed significant fighting. MSF supports a hospital in the town, providing reproductive healthcare and medical services for victims of sexual violence and surgical care. At the end of the year, MSF evacuated its international staff after an increase in fighting between the JEM rebel group and the Sudanese armed forces.

In Zalingei, home to 100,000 displaced people, MSF opened two outpatient feeding centres and handed over some of its activities in the hospital, where there is an increased presence of Ministry of Health doctors.

In the mountainous rebel-controlled Jebel Mara, MSF provides healthcare in Niertiti, where 23,000 of the 33,000 population are internally displaced. On average, 5,500 consultations and 278 hospitalisations take place each month. MSF also travels to nearby Thur twice a week, consulting 200 patients a day.

In Kutrum, MSF staff perform around 1,900 consultations a month and refer emergency cases to Zalingei hospital. A polio and measles vaccination campaign reached nearly 10,000 children.

South Darfur

With a population of 100,000, Kalma is one of the Darfur's largest camps for displaced people. Here, MSF runs an outpatient health centre providing 3,000 consultations a month. The project includes a special component for women's health and a comprehensive mental health service providing counselling, workshops, support groups and community outreach. In July, the MSF clinic was set on fire by arsonists. Tensions in the camp in October forced up to 15,000 residents to flee and find refuge around the capital with little access to aid. MSF responded by providing medical care to these displaced people using mobile clinics.

MSF provides medical care to approximately 70,000 people in the southern town of Muhajariya. Services include inpatient and outpatient care, surgery and treatment for victims of sexual violence. Mobile and inpatient feeding are integrated into the basic healthcare programme to respond to the high number of malnourished children. In October, an intensive attack on the town casued the death of two Sudanese MSF staff. Following this tragic incident MSF evacuated part of its team from Muhajariya.

MSF opened a new project to assist the residents and displaced in and around Feina, providing basic healthcare, ante-natal care and a home-based feeding programme. About 130 patients were seen daily and the feeding programme averaged 60 new admissions a month. MSF also started running mobile clinics to access a population that remains scattered across a broad area.

In early 2007, newly displaced families began arriving in the Bulbul area from west and south Darfur in search of security. Approximately 25,000 people were in need of relief. MSF provided clean water and distributed essential survival items such as soap and blankets.

North Darfur

In April, MSF was able to resume medical activities in the dispensary in Kaguro, which had been on stand-by since a deterioration in security in mid-2006. Care is provided to almost 85,000 people completely cut off from assistance since 2003, when the whole area was attacked and most villages burned. Many people were killed and most survivors fled to the surrounding mountains. Activities were extended to five additional health posts at the end of 2007 and a network of community health workers was established. Transport and access remain a challenge and many of these health posts are reachable only by donkey.

An international team returned to the medical facility in Serif Umra in July. This has been run entirely by Sudanese staff since an evacuation of international staff in 2006. There are 7,000 outpatient consultations each month. Patients needing secondary healthcare are transferred to hospitals in Zalingei or El Geneina.

In August, MSF started working in Tawila, where approximately 35,000 internally displaced people had gathered in three camps. They had been without health services since April, when the last relief organisation in the area had to leave due to security problems. MSF started mobile clinics and established a small inpatient ward in Tawila town. The team suffered several security incidents and had to be provisionally evacuated in mid-September. Activities resumed in November. All services are in place and an average of 3,000 consultations take place each month.

In Shangil Tobaya, MSF cares for 28,000 displaced people in the Shangil and Shadat camps and residents of Shangil Tobaya village. Services include inpatient and outpatient departments, a therapeutic feeding programme, reproductive health services and treatment for victims of sexual violence. Malnutrition rose in 2007 because continued insecurity meant people still could not cultivate or grow crops.


© Yuri Kozyrev / Noor

Many people were killed and most survivors fled to the surrounding mountains.

MSF runs three health centres in Kebkabiya, assisting some 75,000 people, many of whom sought refuge in the city at the beginning of the conflict in 2003. Some 12,000 consultations take place each month. MSF also supports the Kebkabiya public hospital, mainly in the obstetric ward.

Project closures

MSF closed its clinics in Killin and Gorni in the Jebel Mara. This area had been stable for many months and had a number of other health facilities. MSF also withdrew from the Mornay camp in west Darfur, handing over activities to the government and other organisations.
In Um Dukhun, bordering Chad and CAR, MSF offered primary, secondary and surgical healthcare for refugees and displaced communities until the middle of 2007.

Until April 2007, MSF teams worked in Shariya, south Darfur, a government enclave where 27,000 people had regrouped before being systematically dispersed by attacks. MSF was compelled to scale down the programme after repeated robberies from its mobile teams. MSF also ended outpatient services and a feeding programme for displaced people who had fled Muhajariya in 2006 and had been living in Seleah and Yassin.

MSF has worked in Darfur since 2003.

SWAZILAND

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

Despite a relatively stable political situation and what appears to be a reasonable resource base, about 69 per cent of the population of Swaziland still lives below the poverty line. The health situation, which had improved in the 1980s and 1990s, has entered a downward trend as a consequence of the HIV/AIDS and tuberculosis (TB) epidemics.

In November, MSF launched a project to support the national authorities in providing decentralised care to people affected by HIV and TB.

Both diseases have already had a devastating effect on the population and the economy. Life expectancy at birth is only 32.5 years, the lowest in the world. The country has the world's highest HIV prevalence rate and one of the highest levels of HIV-TB co-infection. Twenty-six per cent of young adults are infected with HIV and may die in the coming years if not given adequate treatment. With the escalation of the HIV and TB epidemics, health infrastructures risk being overwhelmed.

In November, MSF opened a project in the region of Shiselweni, populated by some 202,000 inhabitants. MSF works in the hospital of Hlatikulu, in two healthcare centres in Nhlangano and Matsanjeni and in 19 rural health clinics throughout the region. This project aims to reduce mortality from HIV/AIDS and TB and to improve access to anti-retroviral treatment (ART) and TB treatment for those who urgently need it.

In collaboration with the health authorities, MSF is focusing on decentralising integrated care for HIV/AIDS and TB to the level of the health clinics, the closest health facilities to the population. The strategy relies on wide community involvement to enable prevention, testing and adherence to treatment.
This is achieved through the contribution of health workers and people living with HIV/AIDS, known as 'expert patients', who provide peer support and guidance. Special emphasis is put on the improvement of prevention and diagnostics, notably through carrying out complete tests for HIV/AIDS and TB. MSF also provides comprehensive care for complex cases of HIV/AIDS and TB, including patients with multi-drug resistant TB.

In 2008, MSF aims to start 3,000 new patients on ART in the Shiselweni region.

MSF has worked in Swaziland since 2007.

UGANDA

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion**
FIELD STAFF **858**

An improved security situation and ongoing peace negotiations between the Lord's Resistance Army rebel group and the government of Uganda have resulted in the cautious return home of thousands of internally displaced people who have been living in camps in northern Uganda for several years. As the Ministry of Health takes on more responsibility in many areas, MSF has been able to hand over some projects and focus on providing secondary care, HIV/AIDS and tuberculosis (TB) care. However, the health situation remains fragile. During 2007, regular disease outbreaks and emergencies demonstrated the need for MSF's continued presence in the country.

Refocusing activities

As some of the camps in the north empty, with people either returning home or moving to satellite camps, MSF has handed over a number of projects in Pader, Kitgum, Lira and Gulu districts to other organisations or the Ministry of Health. Yet many health needs, such as hospital care and treatment for people living with HIV/AIDS, remain unmet. In May, MSF opened a new project in Madi Opei camp in Kitgum district. Working in a Ministry of Health clinic, MSF staff provided HIV/AIDS and TB care and secondary and reproductive healthcare to around 70,000 people, most still living in camps. In Arua district, MSF's long-running HIV/AIDS and TB project continues to grow. By the end of December, 11,618 people had been enrolled in the programme, with 4,090 receiving anti-retroviral treatment.

Responding to emergencies

On 29 November, an outbreak of Ebola was declared in Bundibugyo district, western Uganda. This highly contagious hemorrhagic fever has no known cure and is often fatal, so MSF teams had to move quickly to contain the outbreak and isolate and support those infected. The MSF intervention started in December and lasted approximately six weeks, during which 149 patients were treated. Throughout the year, MSF also responded to outbreaks of cholera, meningitis, marburg and Hepatitis E.

In February, an MSF emergency team of more than 75 staff supervised the meningitis vaccination of 291,000 people in Arua and Koboko districts and assisted the Ministry of Health in the vaccination of another 333,000 people by supplying vaccines and medical materials.

MSF teams also provided assistance to refugees who had fled violence in neighbouring countries. When approximately 12,000 Congolese refugees crossed the border in October, MSF staff set up a health centre in Nyakabande transit camp. MSF also built shelter for the refugees and provided clean water and sanitation facilities.


© Michael Goldfarb

In February, an assessment by the World Food Programme in the Karamoja district of north-eastern Uganda revealed that 20 per cent of those surveyed were suffering acute malnutrition. MSF teams opened a mobile therapeutic and supplementary feeding programme for children under five in the district, with eight locations for food distribution and treatment and a stabilisation centre at the district hospital. Between July and December, 159 severely malnourished and 2,698 moderately malnourished children were treated, with 284 hospitalised at the stabilisation centre. An MSF assessment in Karamoja district in November indicated that the situation was improving, with a global acute malnutrition rate of 15.3 per cent.

MSF has worked in Uganda since 1980.

ZAMBIA


© Juan Carlos Tomasi

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
FIELD STAFF **157**

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 the number of medical consultations rapidly increased, 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 such as HIV/AIDS.

MSF has focused on helping people with HIV through a project in the remote 'transit area' of Kapiri M'Poshi, a fast-growing town and the site of main railway transfers. The national figures estimate that 20 per cent of people in Kapiri M'Poshi have HIV. Access to healthcare in general and HIV care in particular is limited for the 250,000 people living in the rural Kapiri district, where there are few roads or means of transportation.

The hospital in Kapiri was recently upgraded to a district hospital but still lacks essential health facilities such as x-ray and surgery. MSF runs a clinic in the hospital and works in 12 rural health centres, implementing a decentralised model of HIV care so people can access medical services closer to home. By the end of 2007, MSF had enrolled 7,000 patients in the project, with 3,500 receiving anti-retroviral treatment (ART). Teams conducted over 3,000 consultations a month.

In 2001, MSF established an HIV/AIDS project in the rural district of Nchelenge, another transit area in northern Zambia. MSF worked at integrating care into regular health services and provided ART to 700 patients. A total of 4,195 HIV patients are followed up in the project. Patients are also screened for tuberculosis (TB) and MSF worked with health authorities to ensure that treatment for people co-infected with HIV and TB was integrated into primary care. MSF also involved the community in prevention, treatment and support of people with HIV/AIDS. This project was transferred to the Ministry of Health at the end of 2007.

MSF worked at integrating care into regular health services and provided ART to 700 patients.

MSF has worked in Zambia since 1999.

ZIMBABWE

© Dirk-Jan Visser

According to the UN three million economic refugees are estimated to have fled Zimbabwe, a country characterised by 80 per cent unemployment, rampant inflation, foreign currency shortages, food insecurity and a crumbling health-care infrastructure. In addition to the HIV/AIDS crisis, MSF has seen the rise of epidemic diseases such as cholera and tuberculosis.

Since 2002, MSF has implemented projects in Zimbabwe to prevent and treat HIV/AIDS. Despite the efforts of the Ministry of Health and other donors, the prevalence of HIV/AIDS among pregnant women in some areas of Zimbabwe is above 30 per cent and the general prevalence is 15.6 per cent, still one of the highest in the world.

MSF has supported the Ministry of Health in decentralising healthcare delivery to rural and city clinics in Bulawayo, Tsholotsho, Gweru, Epworth and Buhera. Increased proximity has resulted in more patients accessing the treatment and care they need. By the end of 2007, MSF was providing care to 35,000 patients with HIV/AIDS, approximately 16,000 of whom were receiving anti-retroviral treatment (ART).

The comprehensive approach to the prevention and treatment of HIV/AIDS includes voluntary counselling and testing, treatment for HIV and opportunistic infections, prevention of mother-to-child transmission, nutritional supplements, medical care to victims of violence and general psychological support. MSF also carries out HIV/AIDS educational programmes and trains health workers to manage the different components of the HIV/AIDS programmes and ART.

The effects of price policies, hyperinflation, food shortages, recurrent droughts and poor harvests in recent years, combined with a high prevalence of HIV and TB, have resulted in worrying trends in malnutrition. MSF supports a therapeutic feeding centre in Tsholotsho district hospital and, at the end of 2007, set up a day feeding centre in Epworth to respond to the increasing numbers of malnourished children seen during the year.

MSF also provided emergency clinical support for diarrhoeal outbreaks in the rural district of Gokwe, the town of Kadoma, the Harare suburb of Mabvuku-Tafara and in the city of Bulawayo.

MSF has worked in Zimbabwe since 2000.

MSF has seen the rise of epidemic diseases such as cholera and tuberculosis.

ASIA AND THE CAUCASUS

In Sri Lanka, Vavuniya, MSF opened three surgical programs in Point Pedro, Vavuniya and Mannar, all in conflict-affected areas.
© Henk Braam / HH

ARMENIA

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

Poor adherence to treatment programmes and late diagnosis of tuberculosis (TB) are critical problems in Armenia. The treatment success rate is low and the lack of control over the spread of TB is one of multiple problems facing the crippled healthcare system.

Armenia remains largely impoverished. The complexity and high cost of TB treatment has led to MSF being the only medical agency dealing with drug resistant tuberculosis (DR-TB) in Armenia. When uncontrolled, this disease has serious consequences. Particularly alarming is the emergence of extensive drug resistant (XDR) TB, when a patient is resistant to the main second-line drugs.


© Clement Saccomani

Since the programme started in Abovian, more than 100 patients have been admitted.

Treatment for drug resistant TB takes up to 24 months and involves a daily intake of dozens of medicines that can cause unpleasant side effects. Despite this, by the end of 2007, a few patients had completed the MSF treatment programme in Abovian, near the capital, Yerevan.

When the programme started in 2005, it covered a population of about 300,000 in two Yerevan city districts and occupied a small ward at the Republican TB Hospital. In early 2007, MSF started to treat patients in the renovated 36-bed facility in Abovian dedicated to drug resistant TB treatment. Inpatient treatment is offered, including to those with severe cases of extreme drug resistant TB. Once the period of hospitalisation is over, patients are followed up through mobile clinics or home-based care until the treatment cycle is completed.

Since the start of the programme, more than 100 patients have been enrolled. In collaboration with the National TB Programme, the objective is to expand the treatment to other districts of Yerevan.

MSF has worked in Armenia since 1988.

BANGLADESH

REASON FOR INTERVENTION • **Endemic/ Epidemic disease • Social Violence/ Healthcare exclusion • Natural disaster**
FIELD STAFF **165**

In November a severe cyclone killed and injured many. MSF responded to this emergency providing essential medical care. Parallel to this, work continued to help the stateless people of Rohingya who have little access to healthcare.

Cyclone Sidr destruction

Cyclone Sidr killed more than 3,000 people and made hundreds of thousands homeless. MSF provided assistance to victims in some of the remote areas using mobile clinics. By December, MSF had provided medical care to over 7,600 patients, most of whom had diarrhoea and skin infections. In addition MSF distributed 4,000 household kits.

Severe floods increased diarrhoea risk

Cases of diarrhoea increased following the early severe flooding in July and August. MSF initiated a severe watery diarrhoea intervention supporting the existing facilities in Dhaka. In September and October, MSF treated over 1,800 diarrhoea cases, about 30 per cent of which were cholera.

Rohingya find little support

Stateless Rohingya people have been crossing the border between Myanmar (Burma) and Bangladesh for decades. They are a Muslim minority in Myanmar, a country that does not recognise them as citizens. They are subject to forced labour, land confiscation and restrictions on movement and marriage but receive little support when they get to Bangladesh.

MSF has worked with the Rohingya in Bangladesh for many years. After opening a project in the Teknaf region at the border with Myanmar in 2006, MSF in 2007 focused on improving access to healthcare, particularly for the 9,000 people living in the makeshift 'Tal camp'. MSF has also advocated on the plight of the Rohingya to encourage other international actors to recognise their vulnerable situation and take action to help.

Throughout the year, MSF carried out medical activities through an outpatient clinic, undertaking some 1,200 consultations a week, and a feeding centre (over 2,100 admissions in 2007) near Tal camp. Respiratory and skin infections were the most common conditions. Due to a lack of access to health care of refugees in the official camps of Kutupalong and Nayapara, MSF opened two 20-bed inpatient units in the camps. By the end of the year, these facilities had admitted 3,800 patients.


© Eddy Van Wessel

Cyclone Sidr killed more than 3,000 people and made hundreds of thousands homeless.

At the beginning of May, MSF closed its project in the Chittagong Hill Tracts after eight years. It was partially handed over to the Bangladeshi regional health authorities. When MSF first intervened, the area was emerging from a 20-year armed conflict between the central government and the indigenous people. Today, access to healthcare is improving. A better infrastructure allows people to reach existing health structures and more assistance is coming into the region.

With the government now offering better accommodation to the people living in Tal Camp, MSF plans to hand over its project there to another organisation. MSF is intending to leave the country by the end of 2008.

MSF has worked in Bangladesh since 1985.

CAMBODIA


© Dieter Telemans

MSF increasingly focused on developing treatment for patients affected by TB.

REASON FOR INTERVENTION • **Endemic/ Epidemic disease**
FIELD STAFF **245**

Improved health facilities and a government commitment to fight HIV/AIDS has ensured critical progress in the scale-up of anti-retroviral treatment (ART) programmes in Cambodia. Because of this improved situation MSF has begun handing over some of its HIV/AIDS projects. MSF is currently offering HIV/AIDS care in four locations and has 8,000 patients on ART, 30 percent of all those on treatment nationwide.

In its HIV/AIDS programmes in Siem Reap, Phnom Penh, Takeo and Kompong Cham, MSF provides ART including second line treatment for those who do not respond well to standard (first line) treatment. Counselling, treatment of opportunistic infections and information on HIV/AIDS are also provided. A total of 360 patients are on second line treatment.

In Phnom Penh, MSF is working in the Khmer Soviet Friendship Hospital, one of the largest public hospitals in the city. Alongside its HIV/AIDS care, which began in 1997, MSF has been providing HIV/AIDS care to 42 inmates from three of the city's main prisons since 2006 and hospital-based and ambulatory medical follow-up for HIV patients co-infected with drug-resistant tuberculosis (TB).

Kompong Cham, west of Phnom Penh, is one of the most populated provinces in Cambodia. MSF has been working here since 2003, offering comprehensive HIV/AIDS care. During 2008, MSF will transfer HIV care to the national programme and focus on treating patients co-infected with HIV and TB, including building a new TB ward. Seventy per cent of current HIV patients in the hospital ward in Kompong Cham also suffer from TB.

In Takeo, Siem Reap and Phnom Penh, MSF increasingly focused on developing treatment for patients affected by TB, including multi-drug resistant TB, independent of their HIV status.

In Takeo and Siem Reap, MSF uses an innovative approach, treating HIV/AIDS as a chronic disease alongside diabetes and hypertension, which also have high prevalence rates. By December 2007 over 6,200 patients had been treated for diabetes and hypertension since the beginning of the project in 2002.

In Siem Reap, MSF works closely with local non-governmental organisations to increase access to treatment and testing for HIV and other sexually transmitted infections. MSF provides medicines, supports the transport of sex workers to health centres and referrals to appropriate services for specific care such as abortion, post-abortion care and cervical cancer.

MSF's paediatric HIV/AIDS programmes throughout the country have seen dramatic improvements in children's immune system, growth, development and quality of life. Some 890 children were on treatment by the end of 2007.

MSF continues to support the local health authorities' response to seasonal epidemics such as dengue fever. The 2007 dengue outbreak was particularly severe, with 35,000 cases and 190 deaths reported nationwide. MSF provided assistance to Cambodian medical staff in Takeo and Kompong Cham.

MSF has worked in Cambodia since 1979.

CHINA

REASON FOR INTERVENTION • **Endemic/Epidemic disease**
FIELD STAFF **63**

MSF is providing free HIV/AIDS treatment to complement the national government programme, which still has significant gaps. In addition, cases of drug resistant TB are on the increase, and this trend needs to be addressed using affordable, accessible drugs.

Addressing gaps in HIV/AIDS treatment

Official figures indicate that some 700,000 people in China were infected with HIV/AIDS at the end of 2007. Of the 85,000 needing anti-retroviral treatment (ART), fewer than half, including 600 children, are actually receiving the drugs they need. Through a national programme, the government has provided free testing and medication, including ART drugs, to people living with HIV/AIDS and schooling for children infected with or affected by HIV/AIDS.

Nevertheless, HIV/AIDS treatment and care are not integrated. ART drugs are delivered at the Chinese Centre for Disease Control, whereas treatment for opportunistic infections is provided at a designated county hospital. Tuberculosis (TB) treatment is provided in another structure. Some patients also face high treatment costs, including the HIV confirmation test, medical consultations, laboratory tests, drugs to prevent and treat opportunistic infections, hospitalisation and transportation. Many do not seek or receive comprehensive care due to the stigma associated with their situation.

The free HIV/AIDS comprehensive care and treatment provided by MSF aims to address some of these problems. After five years, the project in Xiangfan, Hubei Province in Central China, will be handed over to local health authorities in March 2008. Another project in Nanning, Guangxi Zhuang Autonomous Region will continue. By the end of 2007, almost 1,500 HIV/AIDS patients were registered in the Nanning and Xiangfan MSF projects and over half received ART drugs and other services.

As tuberculosis numbers grow, MSF implements programmes

According to the recent World Health Organisation Global Tuberculosis report, China had 4.5 million cases of tuberculosis in 2006, with an estimated 1.3 million new cases each year. The spread of drug resistant TB is of even greater concern, with over 130,000 new patients estimated each year. At least half of drug resistant patients in China have never taken TB drugs before, a population equal to 10 per cent of the global burden.

Due to the growing epidemic and the lack of access to affordable treatment, MSF plans to launch TB treatment programmes in collaboration with the provincial and central authorities. In Inner Mongolia Autonomous Region and Jilin province, two northern provinces where government statistics indicate the situation to be more severe, MSF has engaged in in-depth negotiations to establish a drug resistant TB prevention and management programme.

MSF has worked in China since 1988.

This photo was taken in 2008 in the post-earthquake intervention in Sichuan, China.

© Joanne Wong

China had 4.5 million cases of tuberculosis (TB) in 2006, with an estimated 1.3 million new cases each year.

GEORGIA

REASON FOR INTERVENTION • **Endemic/Epidemic disease • Social Violence/Healthcare exclusion**
FIELD STAFF **202**

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In Sukhumi (Abkhazia) and Zugdidi (West Georgia), MSF treats multi-drug resistant (MDR) tuberculosis (TB). The estimated prevalence is over 10 per cent of new TB cases and 57 per cent of re-treatment cases. The daily intake of dozens of medicines and the extremely prolonged treatment are difficult to endure and patients' adherence to the treatment course is generally poor.

Patients find it hard to stay isolated in hospital for several months. Many are from poor families and cannot afford to stay too long in hospital when their dependants are relying on them for financial support. MSF has tackled this problem by reducing the period in hospital from between six and eight months to an average of just two. In this pilot project, as soon as the sputum smear test shows a patient negative for active TB bacilli, he or she can leave hospital and be cared for through a mobile service that provides follow-up treatment and support.

MSF also helps to improve patients' homes, which often do not provide good enough infection control or comfort. Mental health support is another integral part of the programme, as is the additional resources provided to families to help fill the economic gap caused by the patient's incapacity.

In 2007, 78 MDR-TB patients were enrolled on the programme in Zugdidi. Since the start of the programme in November 2006, no patient has dropped out of the treatment. MSF renovated the TB facility and provides a constant supply of drugs and medical materials. MSF has also been working closely with the Georgian national TB control services providing technical assistance and training in the management of MDR-TB. The Zugdidi project is expected to be used as a model for the Georgian national TB programme.

Patients find it hard to stay isolated in hospital for several months.

In Abkhazia, MSF has supported the local TB control service since 1999. MSF rehabilitated a TB hospital near Sukhumi and supplies it with drugs, materials and laboratory equipment. Since 2001, the programme has focused on drug-resistant tuberculosis and by end of 2007, 166 drug resistant TB patients had been started on treatment. MSF also introduced the life-prolonging anti-retroviral treatment for TB/HIV co-infected patients.

In early 2007, MSF handed over its regular TB programme to the health authorities of Abkhazia but continued to support TB activities in Dranda. The health access programme for vulnerable people has also been considerably downsized, although MSF mobile teams in Sokhumi and Tkwarchili continue to provide care to a group of vulnerable elderly patients who have no means or access to basic healthcare.

MSF has worked in Georgia since 1993.

INDIA

© Jean-Marc Giboux

By the end of 2007, MSF had treated 675 patients with kala azar in Bihar.

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **446**

In 2007, MSF worked in the states of Kashmir, Manipur, Assam, Chhattisgarh and Bihar, providing basic healthcare to communities in conflict-ridden areas.

In Kashmir, MSF continues to provide community-based psychosocial support and basic healthcare to those affected by years of violence, including over 12,000 consultations.

In Manipur, MSF runs integrated basic healthcare clinics with an emphasis on the diagnosis and treatment of HIV/AIDS. MSF is also studying the extent of mental health needs arising out of the low-intensity conflict and continuing violence and has appointed a mental health officer. In total over 61,000 consultations were conducted.

In October, MSF closed a basic healthcare project in Assam, as the Ministry of Health was able to cover the needs. A key focus had been to optimise management of falciparum malaria with Artemisinin-based combination therapy (ACT). A total of 58,971 consultations were conducted.

In the heart of India, clashes between Naxalites, the local Maoists rebels, and the Indian government have displaced tens of thousands of people. Caught in the fighting, an estimated 56,000 people have been forced to move to government-run camps in Chhattisgarh. Thousands of others are hiding in the dense forest of southern Chhattisgarh in Naxalite-controlled areas or have taken refuge in settlements for the displaced around villages across the border in Andhra Pradesh.

MSF tries to reach all those who have been isolated by the conflict, providing medical assistance including primary healthcare and a mobile therapeutic feeding programme for moderate and severely malnourished children. MSF works in three camps and has mobile clinics in Chhattisgarh and Andhra Pradesh. Services provided include ante- and post-natal care. A total of 22,700 consultations were conducted.

MSF began an HIV project in Mumbai in 2006, with a specific focus on treating HIV/tuberculosis (TB) co-infected patients and other people excluded from the national healthcare programme. The project offers counselling, treatment for opportunistic infections and anti-retroviral treatment (ART) to the transgender community and commercial sex workers. By early 2008, over 530 patients were registered at the clinic, with 259 patients on ART and 23 on second-line treatment. MSF has also started treating multiple drug resistant MDR-TB and currently has 19 MDR-TB patients.

In Bihar, MSF opened a project at the Hajipur referral hospital to tackle the growing problem of visceral Leishmaniasis or kala azar, of which India has 80 per cent of the world's cases. Ninety per cent of cases are in Bihar. In July, MSF began treating this neglected disease with a simpler, shorter and more effective treatment than the one to which patients had grown resistant. By the end of 2007, MSF had treated 675 patients with kala azar.

During the rainy season, MSF mobile clinics also provided medical and humanitarian assistance to some 30,000 people affected by the floods in three isolated districts of Bihar.

MSF has worked in India since 1999.

INDONESIA

REASON FOR INTERVENTION • **Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **174**

Located on the 'Ring of Fire', Indonesia is prone to natural disasters such as earthquakes, volcanic eruptions, floods and landslides. MSF began working in the country in October 1995. After the 2004 Tsunami, MSF set up a clinic in Aceh and ran projects in eight affected districts providing medical care including surgery, vaccinations and psychological support. MSF continues to assist victims of natural disasters through its emergency programmes and provides healthcare in remote areas.

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MSF teams ran mental health activities providing psychological support to 29,000 people.

Responding to emergencies

MSF responded to a measles outbreak in Mamuju District, West Sulawesi, and worked with the local health authority to set up a mass vaccination campaign reaching over 7,000 children.

MSF treated 1,132 cases of malaria in South Halmahera and distributed 3,701 bed nets in Buano Island of Maluku Province. MSF also provided healthcare to 1,291 miners in Mimika in Papua after a high number of cases of meningitis was reported.

MSF intervened after floods in Jakarta and a series of earthquakes that jolted West Sumatra, in Bengkulu, Muko Muko and Mentawai Island. The teams ran mental health activities providing psychological support to 29,000 people.

After the March earthquake in West Sumatra, MSF set up four hospital tents to support Padang Panjang hospital and Puskesmas Lunang Silaut and donated medical supplies to the local health authority. The teams conducted 5,110 medical consultations and distributed 43,600 blankets, 24,600 plastic sheets, 1,400 cooking sets and 22,000 hygiene kits.

Providing healthcare in remote areas

Following a measles vaccination campaign on the remote island of Papua in May 2006, MSF launched a primary healthcare programme in Asmat, southern Papua, in partnership with the Ministry of Health. The programme aimed to improve mother and child healthcare and access to basic and emergency medical care for these isolated communities. In 2007, over 5,500 consultations were conducted, 269 babies were delivered in the supported health facilities and an obstetric referral system was set up in case of emergency. Other activities in Asmat included the rehabilitation of the surgery room, the donation of surgery and medical materials and water and sanitation activities.

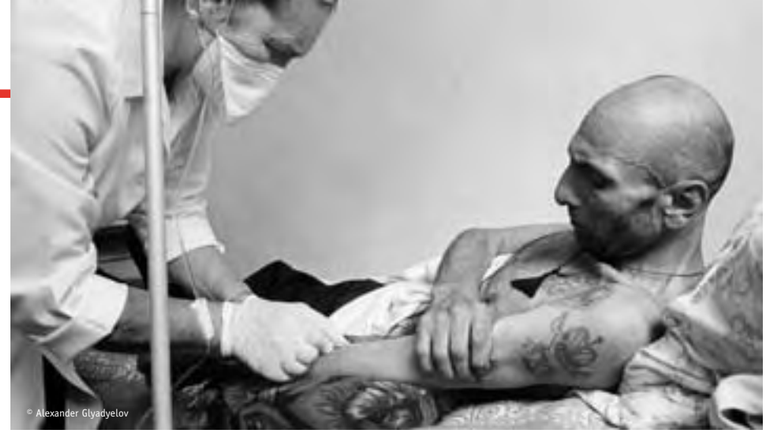
In June, MSF handed over its tuberculosis activities in Ambon, in the Moluccan islands, to the local health authorities. This pilot project focused on a patient-centred approach and provided fixed drug combinations. It improved patients' adherence to treatment and strengthened the counselling skills of local health staff.

MSF has worked in Indonesia since 1995.

KYRGYZSTAN

REASON FOR INTERVENTION • **Endemic/ Epidemic disease**
FIELD STAFF **46**

Since 2005, MSF has worked to address tuberculosis (TB) in two of Kyrgyzstan's prisons, where incidence rates were estimated to be 25 times higher than in civil society. MSF supports TB detection and administers TB treatment in the prisons. Together with national institutions and other international organisations, such as the International Committee of the Red Cross, MSF is also trying to respond to the alarming rate of drug resistant TB.


© Alexander Glyadyelov

The Ministry of Justice has initiated a penal reform process but the prisons remain among the most overcrowded in the former Soviet states. Despite high TB prevalence, cumbersome bureaucracy makes it extremely difficult to set up mechanisms of TB control. Continuity of treatment when a patient is transferred or released is questionable and those leaving prison often face stigma and discrimination.

Many prisoners get sick in prison, while others learn they have TB only when they arrive. Prisoners used to be kept in crowded cells, with poor ventilation and scarce light. To change this MSF has implemented early detection of TB in the pre-trial detention centres and has rehabilitated medical rooms and the cells of TB patients. MSF also undertakes infection control and the separation of sick inmates.

MSF refurbished and maintained the laboratory and rehabilitated the hospital in one of the prisons. The new facility ensures the isolation of highly infectious and drug-resistant patients and the separation of patients with different resistance patterns from recovering patients. MSF provides TB care for 550 patients a year and nutritious food to support recovery.

To help alleviate the stigma, MSF organised a photography exhibition depicting the lives and treatment of TB patients 'behind bars'. It was the first such event to unveil this hidden world to the wider public. MSF is also lobbying respective authorities to take responsibility for solving the problem of TB in prisons, particularly by providing sufficient human resources.

MSF has worked in Kyrgyzstan since 2005.

LAOS

REASON FOR INTERVENTION • **Endemic/ Epidemic disease**
FIELD STAFF **36**

The gradual introduction of a decentralised cost-recovery system over the past 10 years means there is no universal access to quality healthcare in Laos. Access to treatment for people with HIV/AIDS has been particularly lacking.


© Bruno Stevens / Cosmos

By the end of the year over 600 patients were receiving care with 490 on ART in Savannakhet.

When MSF opened its HIV/AIDS project in Savannakhet in 2001, there was little recognition of this disease in Laos. The medical centre became the first and only in the country to offer care for people with HIV. Along with providing urgently needed treatment, the project aimed to sensitise the general public and the authorities to the existence of HIV/AIDS and the need for specialised care.

MSF's project offers a free service for patients, who until recently travelled from all provinces. In Savannakhet, southern Laos, MSF provides prophylaxis and treatment for opportunistic infections and anti-retroviral treatment (ART). By 2007, HIV testing and counselling services had been handed over to the hospital. By the end of the year, 608 patients were receiving care, with 490 on ART. In August 2006, about 100 patients originally from the north of the country were progressively transferred from Savannakhet to the hospital at Setthathirat in the country's capital, Vientiane. In 2007, this HIV unit began receiving new patients and by December, 300 patients were being cared for.

MSF is progressively working towards a handover of all HIV activities to the Lao authorities. Most medications are supplied by the Global Fund and other non-governmental organisations (NGOs) are becoming involved in treatment and there have been positive developments within the government. This represents a major improvement compared to previously, when HIV/AIDS was not even officially recognised. However, technical capacity and training infrastructure remain inadequate, making further external assistance from donors and development NGOs still necessary. Gaps in costs of laboratory testing and certain medications still exist and will need to be covered if access to treatment is to be assured.

MSF has worked in Laos since 1989.

MYANMAR

REASON FOR INTERVENTION • **Armed conflict • Endemic/Epidemic disease • Social Violence/Healthcare exclusion**
FIELD STAFF **1,200**

The population endures widespread and often hidden suffering. Controlled by a military regime since 1962 and largely cut off from the outside world, the health and welfare of people in Myanmar is affected by repression and low intensity conflict. Ethnic minorities, many of whom are displaced and live in border regions, are particularly vulnerable. Provisions for healthcare are inadequate, with 80 per cent of people living in malaria risk areas and thousands going without treatment for conditions such as tuberculosis (TB) and HIV/AIDS.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In 2007, MSF continued its medical aid projects in areas where it had secured humanitarian access: Rakhine, Kachin, Shan and Kayah states, as well as Yangon and Thanintharyi divisions.

In Rakhine state, MSF provides basic healthcare with a focus on malaria, TB and sexually transmitted infections. Almost half a million patients were tested for malaria and 210,000 were treated.

In Yangon, Kachin and Shan, MSF provided medical care for 16,000 HIV/AIDS patients, half of whom were receiving anti-retroviral treatment by the end of the year. Focusing on high-risk groups including sex workers, intravenous drug users and migrant workers, MSF also provided health education, distributed over 3.5 million condoms and provided needle exchanges.

In Myeik, south of Dawei, MSF has run a malarial control and treatment project since 2002, including surveillance and emergency response for epidemic diseases. Four mobile clinics provide care in three townships of Thanintharyi. At the end of 2007, the project was handed over to another international non-governmental organisation (Aide Médicale Internationale).

In Kayah state, a pocket of ongoing civil strife previously off-limits to international aid, MSF

MSF also provided health education, distributed over 3.5 million condoms and provided needle exchanges.

In Thanintharyi division, southern Myanmar, MSF runs a project aimed at controlling and treating malaria. The goal was to ensure adequate infrastructure for the screening and treatment of malaria. There are now seven fixed structures integrated into public clinics, a private clinic and several mobile clinics.

In Dawei, Thanintharyi division, MSF has developed a more integrated approach to the treatment of TB, malaria and sexually transmitted infections including HIV, illnesses previously addressed through separate projects. Care is provided through two fixed clinics and an additional health centre focusing specifically on HIV/AIDS and TB. In total, 914 patients were receiving HIV/AIDS treatment and 586 people were treated for TB.

provides primary healthcare and TB treatment for people trapped in poverty, low-level conflict and inadequate healthcare. A total of 22,350 consultations were provided through three clinics in the north of the state, one in the south and a new clinic that opened in mid-2007 to care for those living in the eastern part of Kayah.

During the year, MSF advocated for its patients nationally and internationally, raising awareness of the situation faced by Rakhine Muslims, Kayan and Karen minorities, as well as the vulnerability of HIV/AIDS patients in Myanmar. One of few international NGOs in the country, MSF has urged and helped other actors to become more engaged with the humanitarian crisis in Myanmar.

MSF has worked in Myanmar since 1992.

Child malnutrition

To maintain health and growth, young children need 40 essential nutrients. Those who do not get them become malnourished, a condition that contributes to more than five million deaths in children under five each year. The World Health Organisation estimates there are 178 million malnourished children worldwide, all of whom are less able to fend off disease and 20 million of whom are at risk of death. In an international campaign launched in October 2007, MSF advocates for crucial change in the response to childhood malnutrition.

The critical age is between six and 24 months. At six months, mothers usually start supplementing breast milk with other foods. Yet, in 'malnutrition hotspots', such as Africa's Horn and Sahel regions and South Asia, adequate food is either too expensive or simply not available. Ensuring a complete balanced diet for children is a significant challenge that requires an urgent response.

MSF and several other NGOs working in resource-limited settings have seen excellent results over the past five years through treating malnourished children with ready-to-use foods (RUFs). These deliver all the nutrients a child needs in an energy-dense paste made with milk powder. They are easy to eat and require neither refrigeration nor preparation. A mother can effectively treat the child herself so only the most severe cases need to be hospitalised. It is therefore easier to reach many more children, most of whom recover remarkably quickly. Despite all this, only five per cent of the 20 million children at risk of death receive RUFs.

There is less certainty about how best to approach less severe forms of malnutrition and different strategies will work in different contexts. Yet the success of RUFs is undeniable and MSF would like to see a dramatic expansion of this response.

A mother can effectively treat the child herself so only the most severe cases need to be hospitalised.

Wealthy countries must do more to prevent childhood malnutrition and stop donating foods that are inadequate for small children. Food aid must include specific products that meet the nutritional needs of children below two years of age. Equally, governments of affected countries must prioritise malnutrition and ensure acutely malnourished children receive RUFs or other effective supplements. RUFs have to be more affordable, available from more producers and in a wider range of products that meet local needs and address different levels of malnutrition.

Most important, however, is the will to challenge the status quo so that children in developing countries have equal access to nutritional food. This is a crucial step towards dramatically reversing the number of children dying from malnutrition.

NEPAL

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **125**

People living in the mountainous regions of Nepal suffer a wide range of preventable illnesses associated with poor living conditions including respiratory infections, skin ailments and diarrhoeal diseases. Health structures are poor and dilapidated, with blocked and unusable sanitary facilities, no healthcare waste management, inadequate staffing levels and a lack of medical supplies.

MSF initially began working in Nepal to care for those isolated by the Maoist conflict. However, projects are increasingly focusing on upgrading basic healthcare and establishing services for women. Often excluded from the healthcare system by social discrimination, women have little access to routine reproductive care or emergency obstetrical surgery.

In May, MSF organised and supervised a women's 'surgical camp' in partnership with the Nepalese Ministry of Health and the Public Health Concern Trust. The project provided surgery for women suffering from uterine-vaginal prolapse, often caused by obstetrical trauma during labour and delivery. The condition results in a variety of debilitating and difficult symptoms including pain, discharge and bladder infections. Successful surgery was provided to over 80 women.

MSF also expanded its Kalikot project, which focuses on women's health as well as offering general primary and secondary care. Almost 20,000 patients were seen. The infrastructure and operating procedures of the hospital were improved and MSF opened a day centre providing therapeutic feeding for over 100 malnourished children. The team also responded to numerous cholera outbreaks. Despite the conflict between Maoists and the government being officially over since November 2006, sporadic fighting has continued to threaten the fragile peace. MSF opened a new project in the Central Terai, Rauthahat district, where the local population lives amid fighting between Madheshi armed groups and government forces. The violence has resulted in severe restrictions on movement, limiting people's ability to reach healthcare services. By mid-year, marked improvements in the security situation of certain areas allowed MSF to hand over three projects. Health authorities took over the work in Khotang, while activities in Rukumkot and Arviskot were transferred to local non-governmental organisations.

MSF has worked in Nepal since 2002.


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PAKISTAN

REASON FOR INTERVENTION • **Armed conflict • Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **413**

Life in Pakistan is slowly returning to normal after the devastating earthquake of 2005. However in June, this progress was hampered by cyclone Yemyin that caused widespread damage in the South. MSF responded to this crisis, and continued to provide other health services in the country, particularly around maternal health.

The aftermath of Cyclone Yemyin

Heavy monsoon rains exacerbated by cyclone Yemyin, which swept through the southern part of the country in June, caused flooding and displaced thousands of people in the western province of Balochistan. MSF responded to the emergency, complementing the activities of the Ministry of Health.

MSF treated over 1,000 patients for diarrhoea, malaria and skin infections in the first weeks of the floods and set up two cholera treatment centres 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 and medical supplies in Jaffarabad, Jhal Magsi, Nasiribad and Turbat. Doctors and nurses were sent to provide additional support and ran mobile clinics to target isolated communities.

Improving maternal health

In October 2006, MSF started a project in Malakand district, North West Frontier Province. The project aimed to support Agra hospital and a series of health centres in delivering primary healthcare, with a particular emphasis on maternal health. By December 2007, MSF had conducted some 6,300 consultations at the hospital, assisted over 60 deliveries and admitted 100 patients, many with respiratory infections, trauma and chronic diseases.

Delivering care in the federally administered tribal areas since March 2006, MSF has provided up to 1,000 paediatric consultations a month 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 Alizai and Sadda hospitals.

Sectarian violence

MSF teams also provided emergency medical support and surgical supplies during sectarian violence in March and distributed relief supplies to displaced families.

In December, fighting in Swat district, north of Malakand, left many people injured and many more were forced to flee. MSF donated drugs and materials to the emergency room of Mingora hospital and began a mobile clinic in partnership with a local ambulance service during curfew hours. Working together with local non-governmental organisations, MSF also distributed food, hygiene and shelter materials to displaced people. However, the security situation prevented the full deployment of MSF emergency operations.

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 every month, including mental health support. Health services in the border town of Chaman are over-stretched, providing for the local population, refugees and patients coming from neighbouring Afghanistan. In May, MSF, therefore, started supporting Chaman hospital in Balochistan through a reproductive health project that includes emergency obstetric surgery and neo-natal services.


© MSF

MSF treated over 1,000 patients for diarrhoea, malaria and skin infections.

Earthquake project transfer

In October 2007, MSF transferred the only remaining project related to the 2005 earthquake, a 60-bed temporary hospital in Bagh, to local authorities.

MSF has worked in Pakistan since 2000.

PAPUA NEW GUINEA

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **163**

Papua New Guinea's circumstances are fairly unique. The island country has only been independent for 30 years and is comprised of hundreds of tribes (speaking more than a total of 860 languages).

The inhabitants are still unfamiliar with the idea of being one nation with a central government and much of the country is struggling to adjust. The country's population of approximately six million people predominantly lives in rural and often very remote areas of the island.

Significant health issues

Papua New Guinea has some of the worst health statistics in the Pacific region. Maternal and infant mortality rates are high, and treatable diseases such as malaria, pneumonia and tuberculosis (TB) remain common. With an overall estimated HIV prevalence of two per cent among adults and pockets of much higher prevalence in some communities, AIDS has become a significant health issue. Violence occurring at all levels of society causes an enormous amount of harm, with physical and sexual violence against women and children (particularly girls) being extreme. Currently, the country's health services cannot handle the tremendous need for care.

Assessment

In mid-2007, a second assessment confirmed that women and children continued to suffer from massive levels of domestic and social violence and that appropriate medical and psychosocial assistance for its survivors was almost entirely absent in most parts of the country. Based on these findings, MSF began supporting the Women and Children's Support Centre in the city of Lae. The clinic, founded by Soroptomists International, was handed over to MSF by the signing of an agreement with the Morobe province Angau Memorial Hospital. This programme aims to establish quality healthcare services and provide a model of care for others. An additional new facility was also built and the staff started seeing patients in December 2007. The team provided comprehensive outpatient medical and psychosocial care to survivors of gender-based violence, including rape. The MSF team also worked closely with staff from the Ministry of Health in Lae Hospital, in an effort to improve hospital services for victims of violence, particularly those services offered in the emergency department.

New project sites

In 2008, MSF plans to further develop and expand the existing clinic's services while also looking for potential, new project sites in the country. When appropriate, MSF will carry out advocacy work to help establish national protocols and service guidelines to better meet the needs of those harmed by gender-based violence.

MSF has worked in Papua New Guinea since 2007.

SRI LANKA

REASON FOR INTERVENTION
• **Armed conflict**
FIELD STAFF **163**

Whilst a cease-fire agreement was signed between the warring factions in 2002, conflict erupted again in 2006.

In 2007, war escalated in the northern and eastern parts of the island. Daily life is dominated by the conflict, with fighting at the frontlines, aerial bombings (sometimes on civilian settlements), roadside mines, restrictions on movements, suicide bombings, abductions, judicial executions, disappearances and arbitrary arrests.

Insecurity seriously hampers access to people affected by the conflict but so do the government restrictions on humanitarian assistance. Few humanitarian organisations are in a position to address needs and people are left without access to healthcare. Although MSF returned to the country in 2006, it was not until January 2007 that the Minister of Health authorised the teams to start providing care. MSF offers surgical, obstetric/gynaecological and paediatric care in government-controlled and LTTE-held zones in the northern part of the island.


© Henk Braam / HH

Daily life is dominated by the conflict.

The conflict and resulting insecurity have led many health workers to flee and there is now a serious shortage of health specialists in conflict areas. In government hospitals, MSF nurses and doctors are filling health staff gaps to assist victims of the conflict.

MSF has started three programmes in Point Pedro (east of Jaffna Peninsula), Vavuniya and Mannar, all government-controlled areas close to the frontline of conflict where the population is particularly at risk. Working with local staff, MSF offers quality general and emergency surgery and obstetrics assistance. MSF performed more than 6,000 surgical procedures.

MSF was also able to extend activities in conflict and LTTE-controlled areas. MSF holds a surgical outpatient clinic in Point Pedro and supports the Vavuniya district hospital, which also serves as the referral hospital for people living in the LTTE-controlled area. In May, MSF launched a project in Kilinochchi, in the heart of the LTTE-held region. However, due to the fighting in Mannar district, MSF was unable to start supporting Adampan hospital, also situated in a LTTE-held region.

MSF established a project in Batticaloa to assist 12,000 internally displaced people by conducting mobile clinics and providing relief supplies. However, as the situation improved, by the end of the year MSF handed over the project.

MSF has worked in Sri Lanka since 2007.

THAILAND

REASON FOR INTERVENTION • **Endemic/Epidemic disease • Social Violence/ Healthcare exclusion**
FIELD STAFF **225**


© Espen Rasmussen / Panos

In Mae Sot, there were over 5,000 consultations involving over 500 patients, 70 per cent of whom successfully completed treatment.

MSF provides medical care, including HIV/AIDS treatment and prevention, for vulnerable groups, ethnic minorities and migrants.

Establishing non-discriminatory care for HIV/AIDS

MSF began its first anti-retroviral treatment (ART) programme in Thailand in 2000 and has since worked closely with the health authorities and local partners to support people living with HIV/AIDS and improve treatment and care. Currently, 100,000 patients receive free first-line ART through the national health security scheme. Second-line treatments are also available free.

In Kalasin province, north-east Thailand, MSF is working in partnership with Kuchinarai district hospital and support groups to strengthen and maintain first-line ART through viral load monitoring and community activities. Currently, 220 patients receive first-line treatment and five patients are on second-line treatment.

MSF began screening and treating patients for retinitis CMV, a dangerous opportunistic infection that can lead to blindness and death. Twenty-eight patients have received treatment.

In Chiang Saen and Mai Sai hospital, in Chang Rai province on the Thai-Lao 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 and Lao patients can now be referred and treated in their country.

Providing healthcare to migrants and minorities

In Petchabun, northern Thailand, MSF has been ensuring adequate medical care, water supply and sanitation in the Lao Hmong refugee camp since 2005. In late June, 7,900 refugees were relocated to a bigger holding camp. MSF continued its medical and water and sanitation services in the new camp and began food distribution. Mental health activities began in November, with the main diagnoses including anxiety, depression and post-traumatic stress disorders.

Thailand has announced the repatriation of Hmong refugees and is screening the population without involving an independent party. MSF has urged Thailand not to repatriate refugees without proper guarantees of their well being on return to Laos. MSF is also asking for an independent third party, such as UNHCR, to monitor the situation.

In Mae Sot, on the Thai-Burmese border, MSF began treating tuberculosis (TB) among unregistered migrant workers from Burma and refugees in Mae Lae camp in 1999. The project also offers counselling and health education. In 2007, there were 5,234 consultations involving 581 TB patients, 70 per cent of whom successfully completed treatment. Twenty-one patients have drug-resistant TB. MSF also offers ART for those co-infected with TB and HIV and had 115 patients under ART at the end of the year.

In Phang Nga, thousands of undocumented migrant workers from Burma are still crossing the border to seek jobs in Thailand. As they have no official access to heathcare, MSF provides mobile clinics, health centres and Burmese-speaking medical staff. The primary healthcare services include mother-child healthcare and treatment of communicable diseases including HIV/AIDS. MSF carried out over 4,500 consultations and some 200 women were assisted to give birth safely in hospital.

Providing healthcare to excluded populations

Drug users are among the highest risk groups for HIV infection. MSF provides health education and trains peer workers in one of Bangkok's drop-in centres.

MSF is progressively handing over its project in two prisons in Bangkok to the Department of Correction. The project, which began in 2003, offered HIV prevention information and treatment to prisoners. MSF also trained prison medical staff and covered laboratory costs. MSF is working with the Department of Correction to develop a training curriculum, which will be used to extend these services to all Thai prisons.

MSF has worked in Thailand since 1983.

TURKMENISTAN


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REASON FOR INTERVENTION
• Social Violence/
Healthcare exclusion
FIELD STAFF 68

High mortality rates among newborns, infants and young children is a serious issue.

MSF is working to advance the quality of healthcare for children and pregnant women in Magdanly – an impoverished area on the Eastern frontier of Turkmenistan, predominantly populated by ethnic Uzbek communities. Despite some bureaucratic problems improvements in paediatric care have been made.

Overcoming bureaucratic obstacles

High mortality rates among newborns, infants and young children is a serious issue and the prevalence of communicable diseases such as tuberculosis (TB) and sexually transmitted infections are also of grave concern. The lack of accountability on illness and death caused by disease has led to a downward spiral in the quality of healthcare.

MSF started working in the eastern Magdanly district in 2004 and supports the general paediatrics, infectious disease, intensive care and maternity wards of the Magdanly Town hospital. The project has set up an intensive baby care room and child screening facilities and makes regular outreach visits to primary healthcare posts around Magdanly. MSF also built and equipped a TB laboratory to help tackle the rising number of cases.

While MSF is attempting to improve paediatric care in the city, its ability to provide meaningful care has been hampered by the fact that all healthcare services in this district face bureaucratic obstacles and a lack of political commitment. Despite these frustrations, MSF's programme managed to support more than 4,000 hospital-based consultations, about 15,000 outpatient visits and over 1,000 deliveries.

MSF's ability to work closely with patients, local healthcare workers and healthcare managers, enabled the team to gain an understanding of the country's most acute healthcare needs.

In 2008, MSF plans to expand its activities to other regions and will remain on standby for any health-related emergencies.

MSF has worked in Turkmenistan since 1999.

UZBEKISTAN

REASON FOR INTERVENTION • Endemic/
Epidemic disease
FIELD STAFF 81

The ex-Soviet republic of Uzbekistan has a high tuberculosis (TB) incidence rate and one of the world's highest levels of multi-drug resistant (MDR) TB, a strain that is resistant to the most powerful anti-TB drugs. MDR-TB rate accounts for 13 per cent of all new TB cases and 40 per cent of re-treatment cases.

MSF has been treating TB in Uzbekistan since 1998, initially using the directly observed treatment short course (DOTS) and more recently DOTS-Plus for treating MDR-TB in the autonomous region of Karakalpakstan.

Inappropriate and inadequate treatment of common sensitive TB increases drug resistance. MSF has seen many alarming practices in the local healthcare system that fuel this epidemic, from poor infection control in TB facilities and inappropriate use of first and second-line drugs, to self-treatment with anti-TB medicines easily available on the market. MSF is now seeing a number of cases of extensive drug resistant (XDR) TB.

In a joint MSF and Ministry of Health programme, MSF has set up a reference laboratory in Nukus where MDR-TB is diagnosed by testing sputum for sensitivity to certain drugs.

Patients from Nukus and Chimbay region receive DOTS-Plus treatment in a renovated MDR-TB hospital. The treatment is complex and lengthy. Some patients suffer unpleasant side effects. After six months in hospital, patients need to continue on medication for another 18 months supported by a mobile DOTS-Plus clinic or home visits from an MSF nurse. In 2007, MSF enrolled 265 patients, compared to 150 in 2006. Since the start of the programme in late 2003, MSF has enrolled over 617 patients.

At the end of the year, MSF signed a memorandum of understanding with the Ministry of Health of Karakalpakstan on the gradual handover of the MDR-TB treatment programme over the next three years. MSF still has major concerns about the sustainability and future of the project and plans to address these by investing in local capacity-building and advocacy.

MSF has worked in Uzbekistan since 1997.

THE AMERICAS

An MSF psycho-social team works with children and adults to help them recover from the August earthquake that rocked the Peruvian coast.
© Jodi Hilton / Corbis

BOLIVIA

REASON FOR INTERVENTION • **Endemic/ Epidemic disease**
FIELD STAFF **35**

The Chagas parasitic infection affects some 18 million people in Latin America, with the highest prevalence in Bolivia. Transmitted by blood-sucking insects commonly found in impoverished areas and rural dwellings, Chagas can debilitate the heart and intestinal systems, shortening life expectancy by about 10 years.


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Initially, the chagas projects treated children only but a new project has opened in Cochamba for adults also.

Chagas has attracted little investment in terms of diagnostics and drug development. The only treatment is based on two older-class drugs that risk many side effects and make patient monitoring and follow-up essential. The main target for medical interventions has always been children as treatment for adults has never proved completely successful.

MSF has undertaken several projects to prevent and treat Chagas in Bolivia. Initially, the projects treated children only but a new project opened in Cochamba in August also treats adults and is integrated into six urban health centres. The need to work with and train health workers meant a slow start but Chagas is now a step closer to being treated like any other disease at the primary care level. While the Chagas National Programme started diagnosing and treating patients under 15 years old in various municipalities in the country in 2006, access remains unavailable for the majority and MSF has been increasing its advocacy within the country to improve this. Research has also been a key part of the Chagas projects in Bolivia, and further research into new diagnostic tools and treatments is planned for the coming year.

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

MSF has worked in Bolivia since 1986.

BRAZIL

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **42**

Complexo de Alemão is a deprived and violent neighbourhood of Rio de Janeiro. The area is well known for regular clashes between local armed groups and with the Rio de Janeiro police forces. The local population, estimated to be around 150,000, lives trapped in the violence.


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Since October, MSF has been providing emergency and mental health services to those living in Complexo do Alemão. MSF runs an emergency room in Fazendinha, at the heart of the neighbourhood, offering emergency care, mental health services, MSF ambulatory referrals and an advisory service. Techniques such as advanced trauma life support are practiced by medical staff, establishing an efficient triage system for the quick diagnosis of patient needs. By December, MSF had treated around 2,000 patients, mainly for violent and accidental injuries, respiratory tract infections and suspected dengue fever. Across Brazil, MSF offers training to municipalities, mainly on security risk management in violent settings. Over 600 staff from the family health programme in Rio, Belo Horizonte and other municipalities followed this training programme during the year.

In partnership with the Oswaldo Cruz Foundation, MSF has a Chagas diagnosis project in the Amazon region. The project aims to train health professionals to identify the parasite that causes the disease while screening for malaria. The project, implemented in 12 health centres so far, has identified some 200 cases of Chagas. The project will expand in 2008, to include more health centres.

MSF has worked in Brazil since 1991.

COLOMBIA

REASON FOR INTERVENTION • **Armed conflict • Social Violence/Healthcare exclusion • Natural disaster**
FIELD STAFF **312**


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Hundreds of thousands of Colombians are displaced, trapped, isolated and impoverished by the conflict that has ravaged their country for the past 45 years. Guerrilla groups, government forces and paramilitary groups continue to fight in many areas. The violence has caused widespread physical and psychological distress, yet many victims continue to be overlooked by their government and the international community. Healthcare access is difficult and dangerous for those in rural conflict zones and those forced to seek refuge in urban slums.

Delivering healthcare in conflict stricken areas

MSF has a wide range of healthcare projects across the country particularly in areas affected by violence and conflict. Mobile clinics provide primary care, sexual and reproductive healthcare and mental health care to patients in the rural areas of Norte de Santander , Sucre/Bolívar, Chocó, Córdoba, Nariño, Cauca, Putumayo, Arauca and Caquetá.

In July, MSF began to provide medical healthcare using mobile teams to assist the populations in the rural areas of Cartagena del Charia and San Vicente de Caguán. Inhabitants in southern Colombia are also suffering the effects of the conflict, with Cauca and Putumayo witness to frequent fighting. In March MSF began working in the area, supporting health facilities and providing healthcare through mobile teams.

MSF also gained access to the Montes de Maria region following a three-year blockade of all international organisations.

In Buenaventura (Valle del Cauca), one of the most violent cities in Colombia, where access to healthcare is limited by the dangers of travelling in the city, MSF has established mobile clinics to provide urgent medical care. MSF has also opened a centre to assist patients who cannot access other health facilities for financial or security reasons.

Supporting IDPs

MSF also supported the internally displaced populations (IDPs), seeing over 9,000 patients in the urban clinic in Sincelejo, Sucre. On the outskirts of Bogotá, Colombia's capital, MSF works with the displaced in Soacha, conducting medical consultations and providing mental health support for those excluded from the public health system. The team also tells families about their right to national healthcare and provides information on gaining access to the government-run health system. Some 2,700 patients were seen in 2007, many suffering from skin diseases, respiratory infections and psychological distress.

In August, MSF began a new project for IDPs on the Venezuelan border, in Tame, Arauca department, where nearly 1,500 consultations were carried out in the first two months. Delays in receiving government social benefits leave IDPs with gaps in healthcare coverage, which MSF covers by providing medical care to all recent IDPs. Mental health consultations are also complemented with training and support for local mental health institutions. Efforts to address mental health are made in Caquetá department through mental health centres in Florencia and adjacent municipalities. During 2007, 9,540 people were seen.

Prioritising maternity needs

In Quibdó, Chocó, MSF focuses on the maternity needs of women and babies by providing direct support to the maternity ward. MSF also provides sexual, reproductive and mental healthcare using mobile clinics in the IDP areas of the city. Over 17,600 consultations were carried out, with particular attention paid to the medical and psychological needs of victims of sexual and domestic violence.

Projects closed in Tolima and Huila

After seven years, MSF has begun closing projects that provided primary and mental healthcare in rural Tolima and Huila and to displaced people in Ibagué as there is now a lesser need for mental health consultations as the displaced population has decreased.

MSF has worked in Colombia since 1985.

GUATEMALA

REASON FOR INTERVENTION • **Endemic/Epidemic disease • Social Violence/ Healthcare exclusion**
FIELD STAFF **44**

Poverty in Guatemala is widespread in the countryside and amongst indigenous communities. Child mortality and malnutrition rates are the highest in the region, and life expectancy is the lowest. The country is plagued by organised crime and violent street gangs.

Not enough medical attention has been paid to victims of sexual violence in Guatemala. A protocol for addressing these patients in health structures approved by the Ministry of Health in 2005 has yet to be implemented.

MSF started a project to treat survivors of sexual violence in zone 18 of Guatemala City. This is one of the 'barrios' most affected by violence and organised drug crime. MSF activities included reproductive healthcare and psychological services in a Ministry of Health primary care clinic and maternity clinic.

Healthcare is also provided by MSF through a mobile unit working with several non-governmental organisations (NGOs) throughout Guatemala City. The project also aims to raise awareness of the violence and the importance and availability of specialised care.

Handover of HIV/AIDS treatment projects

Increased support from international donors and gradual improvements in healthcare services, funded and delivered through Guatemalan government structures, led MSF to transfer its remaining HIV/AIDS projects in Coatepeque, Puerto Barrios and Guatemala City to health authorities.

MSF started a project to treat survivors of sexual violence in zone 18 of Guatemala City.

The national health service has taken over responsibility for HIV/AIDS care at the hospital in Coatepeque, where 900 patients were treated, and treatment for most of the 750 patients in the Guatemala City programme will now be provided by a local medical NGO called Fundación Marco Antonio.

However, issues of scale-up and continuity of care remain major challenges in Guatemala. MSF supplied anti-retroviral drugs to treatment centres experiencing drug shortages.

Such shortages were mainly due to low treatment targets that did not reflect the actual number of people in need, budgetary issues, inadequate coordination between the national HIV/AIDS programme and the Global Fund's implementing partner and the late procurement of drugs. MSF raised these concerns publicly, including to representatives of the Ministry of Health.

In September, MSF also highlighted gaps in support for the HIV/AIDS department in Coatepeque hospital and the risks associated with anti-retroviral drug shortages. MSF believes the Global Fund should work with its implementing partner to set realistic treatment targets and use its financial leverage to lower drug prices. MSF also advocated for 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.


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HAITI


© Cristina De Middel

REASON FOR INTERVENTION
• **Armed conflict**
• **Social Violence/Healthcare exclusion**
FIELD STAFF **794**

Large sections of Haiti's population, particularly in the capital, Port-au-Prince, live in precarious conditions due to poverty, neglect, urban violence and lack of access to basic healthcare. Violence continues, especially in Martissant, where MSF treated over 200 gunshot injuries. An MSF survey between January 2006 to July 2007 showed that nearly one in four deaths in Martissant was related to violence.

Violence and conflict

Since December 2006, MSF has operated an emergency health centre in Martissant, a neighbourhood characterised by daily violence and a lack of medical facilities. Every day, patients are referred from the emergency health centre to the other hospitals where MSF works. MSF established a number of mobile clinics in the heart of the Martissant neighbourhoods, with medical teams offering primary healthcare to some 400 patients a day.

At the end of 2007, MSF handed over its project in the slum of Cité Soleil, where the security situation has improved, to the Ministry of Health. The project started in July 2005 to guarantee access to care for victims of the violence. The ongoing presence of MSF teams, even during the most intense fighting, resulted in 72,000 consultations at the primary health centre of Chapi and 32,000 at Choscal hospital, where more than 13,000 patients were hospitalised. However, since April the situation has got better, with no patient with a bullet wound seen at the Choscal hospital and people in the neighbourhood no longer living in fear and isolation.

MSF continued to provide medical and surgical care at its Trinite trauma centre in Port-au-Prince, admitting more than 14,000 patients compared with 11,000 in 2006. The number of admissions for gunshot wounds fell from 1,300 in 2006 to 500 in 2007, although the number of victims of stab wounds, rape and beatings continued to rise. In total, 2,847 patients were admitted for violence-related trauma.

Throughout the year, MSF medical teams focused on improving quality of care, working to perfect the recently introduced surgical technique of orthopaedic internal fixation. A total of 205 patients benefited from this technique, which sharply reduced their length of stay in hospital.

MSF also operates a physical rehabilitation centre where patients needing specialised post-operative treatment can receive physiotherapy and psychological care.

In June, MSF increased its capacity to treat victims of sexual violence in the capital, offering comprehensive psychological and medical treatment. The programme treated 242 victims between July 2006 and June 2007. Awareness campaigns emphasising confidentiality and the need to seek treatment within 72 hours resumed in July in the shantytowns and city centre.

MSF mobile teams offer primary healthcare to some 400 patients a day in Martissant.

Maternal health needs

Maternal mortality rates in Haiti are the highest in the western hemisphere (approximately 630 women die for 100,000 births), mainly due to eclampsia. The insecure urban slum environment where many women live limits their access to healthcare as physical and sexual violence, extortion and common crime are serious threats.

In 2006, the emergency maternal Jude Ann hospital was opened in Port-au-Prince, the only hospital in Haiti to offer free emergency obstetric care. By the end of 2007, over 13,000 women had given birth here. MSF also started providing services in fixed clinics in selected slum communities, with ante- and post-natal care and a referral service in the three slums of La Saline, Pelé Simon and Solino. Mental health services will be added in 2008.

MSF has worked in Haiti since 1991.

HONDURAS

REASON FOR INTERVENTION • Social Violence/Healthcare exclusion
FIELD STAFF 41

Urban violence in the capital, Tegucigalpa, often affects street children who are already marginalised. Many have drug addiction problems, precarious employment, and poor access to healthcare facilities.

MSF runs a day centre for young people on the street in Comayaguela, one of the poorest neighbourhoods of Tegucigalpa. The project provides medical and psychological help to children and adolescents up to the age of 24 who live on the streets. Awareness campaigns aim to make sure the young people know about the centre and its services. They are also informed of their rights and accompanied to health facilities in emergency situations.

The emphasis is on addressing the damage caused by drugs, particularly the common addiction of glue sniffing. Further medical activities focus on sexual and reproductive health, as young girls are often involved in commercial sex activities or become victims of sexual violence. An estimated 400 young people were seen at the day centre in 2007.

MSF advocates on behalf of these children, highlighting their plight among governmental and non-governmental agencies and the public in an effort to improve their situation. In one example, MSF documented the experiences of young people living on the street in a book distributed to the local authorities, partner organisations and the general public.

At the end of the year, MSF began to assist other vulnerable and stigmitised groups who also have limited access to health and social services.

MSF has worked in Honduras since 1998.


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PERU

REASON FOR INTERVENTION
• Endemic/Epidemic disease
• Social Violence/Healthcare exclusion
• Natural disaster
FIELD STAFF 73

Psychologists provided support group sessions called 'Charlas'.

When a powerful earthquake hit Peru in August, MSF provided emergency medical relief to remote communities. Parallel to this, MSF continued to help vulnerable groups affected by HIV/AIDS.

Helping the remote and the traumatised

On 15 August, an earthquake measuring 7.9 on the Richter scale shook the coast of Peru, killing 600 people, wounding 2,000 and making tens of thousands homeless. The towns most affected were Chincha, Pisco and Ica, around 200 kilometres south of Lima. The first MSF team arrived within 24 hours to assess the needs and launch emergency relief activities.

MSF focused its efforts in the most remote areas to the east and Guadalupe, a town in the south-east. A centre for post-traumatic and post-operative care was set up in the centre of Pisco. Mobile clinics were established in many towns, supported by 30 healthcare facilities providing medicines and epidemiological monitoring. Psychologists provided support group sessions called 'Charlas', and individual sessions to help people cope with the psychological effects of the disaster. When relief activities ended in December, psychosocial assistance had been provided to 8,000 people. In addition, 12,000 people benefited from the provision of medicines, water and sanitation activities and distribution of relief goods.

MSF transfers HIV/AIDS projects

MSF's recent work in Peru focused on providing comprehensive care to people living with HIV/AIDS. The prevalence of HIV in the country is relatively low, although highly concentrated in marginalised groups such as commercial sex workers, drug users and prisoners.

In 2004, a project was started in Villa El Salvador, the second biggest slum in Lima and home to half a million people. This aimed to decentralise HIV/AIDS care and reduce stigma and discrimination by promoting free access to care with free single-dose medication.

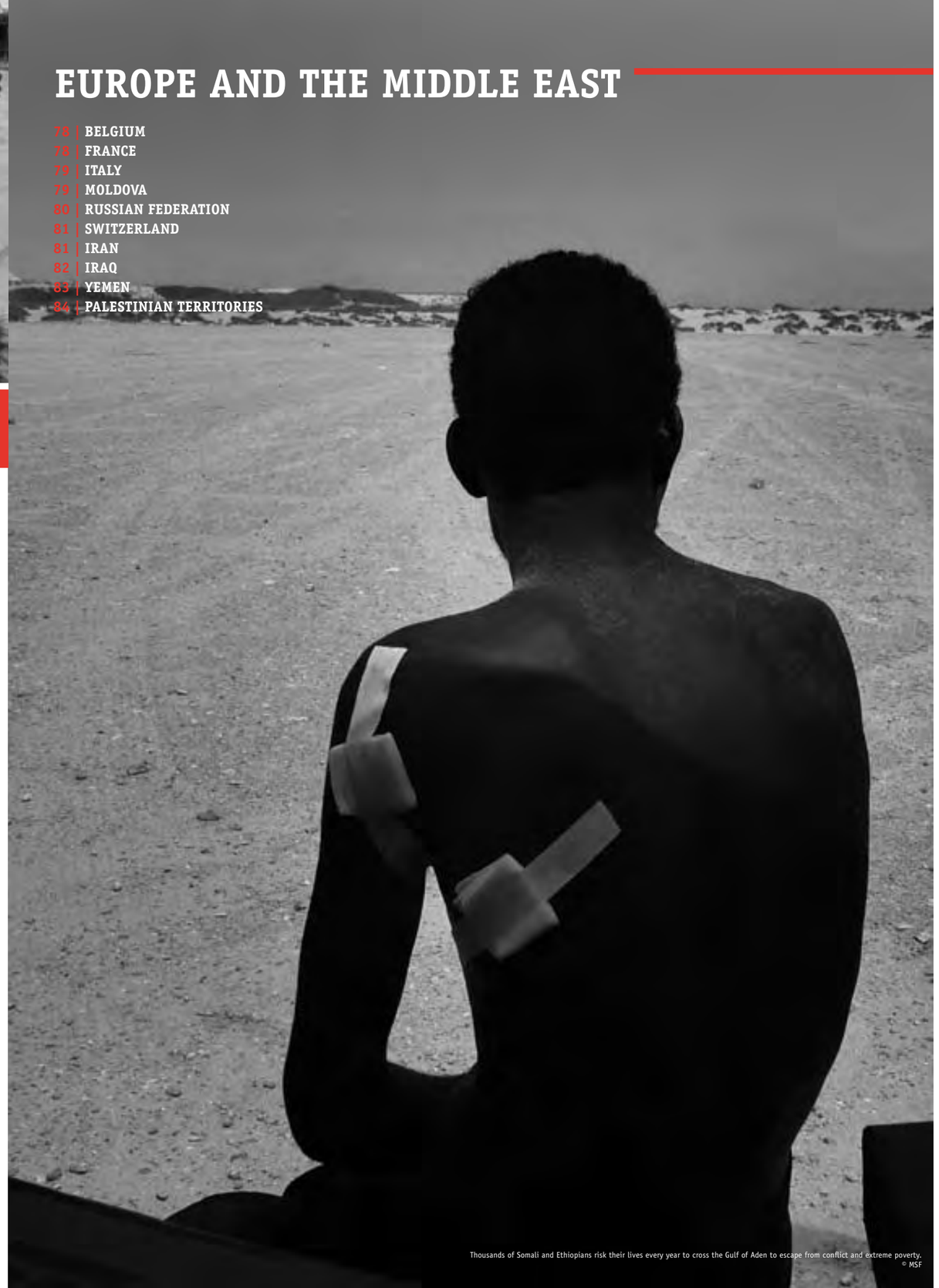
MSF also implemented the manual CD4 count in five Peruvian provinces. MSF has trained health providers from the Ministry of Health on this technique, which is crucial to establishing immunity levels and determining when an HIV-positive person should start anti-retroviral treatment (ART).

Since 2006, MSF has gradually handed over this project to the Ministry of Health. By the end of the project, MSF had trained over 2,000 health staff and implemented voluntary counselling and testing in more than 30 health centres. A total of 482 patients affected by HIV were enrolled in the programme, with 342 started on ART.

MSF also completed the closure of a project for sexually transmitted infections and HIV/AIDS in the state prison of Lurigancho, the largest prison in Peru. The project was replicated in Chorillos Common, Chincha and Huaral prisons.

MSF has worked in Peru since 1985.

EUROPE AND THE MIDDLE EAST


Thousands of Somali and Ethiopians risk their lives every year to cross the Gulf of Aden to escape from conflict and extreme poverty.
© MSF

BELGIUM

MSF continues to provide medical and psychosocial consultations in Brussels and Antwerp.

Everyone in Belgium is entitled to healthcare. This includes undocumented migrants and asylum seekers, although in practice their access to health services is restricted by numerous administrative obstacles. MSF assists migrants in Belgium by providing medical care and advocating for government services to face up to their responsibilities.

MSF continues to provide medical and psychosocial consultations in Brussels and Antwerp to people who cannot access these through normal channels. More than 5,000 consultations were conducted in 2007, with the majority of patients being undocumented migrants and asylum seekers. Rather than creating a parallel system, the aim is to direct people towards the official system, which is supposed to provide the service.

When necessary, MSF advocates for patients both with the social services and within political spheres that has led to improvements in access to national health services. As a result, MSF will hand over its activities to another organisation in April 2008 because although the situation has improved, there remains a need for a focal point to help migrants and asylum seekers find their way through the complex health system.

Until the end of May, MSF also provided psychological and medical consultations in the five detention centres in Vottem, Melsbroek, Steenokkerzeel, Merksplas and Brugge where illegal migrants are kept before their expulsion. Most of the 206 people seen since May 2006 were suffering from stress-related psychosomatic problems. MSF published a report highlighting the negative impact of the detention centres on health and more particularly on mental health.

MSF has also witnessed the human cost of detention for critically ill patients, including women with complicated pregnancies, people living with HIV, diabetics and acute psychiatric cases, many of whom remain in detention centres for several months. MSF has called for a major review and changes to the detention policies for undocumented migrants in Belgium.

MSF 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 been launched making the information 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 **5**

2007 has seen an increase in the number of illegal immigrants deported from France and new attempts to reform asylum policies. In addition, access to the French and European territory is becoming more difficult and administrative procedures for those seeking refuge are increasingly complex. Psychological assistance for homeless and non french speaking refugees in France remains extremely limited.

In March, MSF opened a centre in Paris targeting particularly those without valid immigration papers who have sought refuge after fleeing conflict, violence or persecutions in their home countries. These people are likely to be suffering psychological distress. Their precarious living conditions only increase their anxiety. Psychological care is essential to avoid deterioration leading to suicide attempts. Most do not speak French and, without valid papers, have little access to healthcare.

At its centre, MSF provides refugees with psychological and medical care and advises them on the social and legal aspects of their situation. The multidisciplinary team of doctors, psychologists and social workers conducted some 2,700 consultations, including 1,300 for psychological distress.

MSF has worked in France since 1987.

ITALY

REASON FOR INTERVENTION • **Social Violence/Healthcare exclusion**
FIELD STAFF **32**

The plight of migrants arriving and living Italy continues to be worrying. MSF provides medical care, but for many the reality of life in Italy is more precarious than expected.

Every year, thousands of migrants arrive in Italy having made the precarious boat journey across the Mediterranean sea to Europe. Many lives are lost. Survivors arrive exhausted and dehydrated, suffering from respiratory infections and skin complaints, caused by over-exposure to salt and water and burns from fuel accidents. MSF has established a base at one of the most used landing points on the Island of Lampedusa, providing medical help to more than 12,000 migrants in 2007.

MSF continues to work in the Campania region, in Caserta and Naples provinces, running various clinics for undocumented migrants. The area is one of the most deprived in Italy and home to a large number of illegal migrants who live in extremely difficult conditions. The MSF project focuses specifically on women migrants employed as sex workers. It includes outreach activities and medical care for sexually transmitted infections and HIV/AIDS prevention. More than 7,000 consultations were performed in the MSF clinics in 2007.

Many thousands of migrants move around southern Italy to work as seasonal farm workers in the fields. Most are young men from Africa with no permit to stay in Italy. Between July and November 2007, at the same time as providing medical services, an MSF team interviewed over 600 seasonal workers. A full report of the results will be issued in 2008 but the initial picture is one of poor living, working and health conditions.

After five years of carrying out programmes in Sicily, MSF handed over all clinics for undocumented migrants to the Ministry of Health.

MSF has worked in Italy since 1999.

MSF provides medical care, but for many the reality of life in Italy is more precarious than expected.

MOLDOVA

REASON FOR INTERVENTION • **Social Violence/Healthcare exclusion**
FIELD STAFF **28**

HIV patients in Transnistria, the breakaway republic of Moldova, have limited access to quality healthcare. MSF is providing life-prolonging anti-retroviral treatment (ART) for HIV-positive patients as well as supporting local health authorities in introducing HIV/AIDS care into the primary healthcare system.

MSF is one of few agencies providing direct assistance to people living with HIV/AIDS in this isolated region. According to official statistics, the prevalence of HIV/AIDS in Transnistria is four times higher than in the rest of Moldova. The region is not recognised by the international community and little international aid has reached here despite the enormous amount of assistance given to Moldova by international institutions to tackle the HIV/AIDS epidemic.

In May, MSF started HIV-positive patients on ART. In August, after rehabilitation and in close collaboration with the local health authorities, MSF opened an outpatient department in the main hospital of the capital, Tiraspol, and trained Ministry of Health medical staff to enable the integration of HIV/AIDS treatment into the primary healthcare system. In September, the programme was extended into the prison system, where HIV/AIDS prevalence is significantly higher than average. The rate of co-infection is also much higher, with TB being the main cause.

The MSF team also visits Bender TB hospital every week to treat co-infected patients and Slobozia, the region's only inpatient HIV/AIDS facility. In December, the programme expanded its activities to Ribnitza in the north of the country and began operating a weekly clinic in the city's hospital.

By the end of 2007, in partnership with the Ministry of Health, MSF had enrolled over 360 patients on the programme and 65 had started ART. MSF is now working to make the programme sustainable so that it can be handed over to the local authorities by the end of 2008.

MSF has worked in Moldova since 2007.

RUSSIAN FEDERATION

REASON FOR INTERVENTION • **Armed conflict • Social Violence/Healthcare exclusion**
FIELD STAFF **74**

MSF's focus is on the post conflict North Caucasus region, treating trauma-related injuries, providing mental health support, healthcare for women and children and tuberculosis (TB) care.

Healthcare in Chechnya has been crippled by more than a decade of war. The majority of doctors have fled and the security situation for hundreds of thousands of civilians and internally displaced persons (IDPs) remains precarious. MSF has responded by providing basic primary healthcare, surgery and mental health services, as well as supporting Chechnya's TB programme. For security reasons, there are few international staff on site. Instead, programmes are run by national Chechen staff, supported by the international team based in Moscow.

In the Chechen capital, Grozny, MSF provides primary healthcare to the most vulnerable communities with limited or no access to medical services. Mobile medical teams consisting of a therapist, gynaecologist, paediatrician and psychologist served six temporary accommodation centres for Chechen IDPs who returned from Ingushetia to find their homes in ruins. In an attempt to solve the IDP problem, the local authorities attempted to close these centres but with no alternative housing available, they remain and are now called 'communal hostels'. The MSF mobile team conducted around 38,000 medical consultations in 2007.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In the Chechen capital, Grozny, MSF provides primary healthcare to the most vulnerable communities.

MSF rehabilitated two clinics in Grozny where it runs free pharmacies. MSF doctors also provided women's health and paediatric medical care in four clinics and reproductive health, family planning consultations and medical equipment to the capital's maternity hospital. Outside Grozny, MSF supports district hospitals in the mountainous villages of Shatoy, Sharoy and Itum-Kale, and has set up a primary health clinic in remote Shelkovskoy district.

MSF runs a medical centre in Nazran, the capital city of neighbouring Ingushetia, providing medical and mental health consultations. Some 17,000 IDPs from the conflict in Chechnya and 18,000 from the Ossetian conflict of the early 1990s still live in Ingushetia. They lead difficult lives with little support and largely without access to health services. MSF conducts up to 1,200 consultations a month for IDPs and the few locals who also use MSF's clinic.

As Chechnya's TB services were largely destroyed during the war, MSF supports the implementation of a directly observed treatment short course (DOTS) programme in four TB hospitals serving around 350,000 people. Since the beginning of the programme in 2004, more than 1,500 patients have received treatment. The programme enrolled 455 patients in 2007. The success rate of over 80 per cent is made possible by the work of MSF health educators and counsellors who help patients adhere to the lengthy treatment. The programme plans to double by extending to the main TB hospital in Grozny.

MSF continued to perform violence-related reconstructive surgery in Grozny's hospital No.9, the main republican trauma hospital. MSF has also been supporting the neuro-surgical and trauma wards, which performed around 600 emergency surgeries throughout the year.

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

SWITZERLAND

REASON FOR INTERVENTION • **Social Violence/Healthcare exclusion**
FIELD STAFF **7**

In January 2006, MSF launched the 'Meditrina' project in Zurich. Free consultations are provided to anyone who has no access to the public health services because they have no medical insurance or the means to pay for medical consultations and treatment.

The centre has focused primarily on undocumented foreign nationals living in unstable circumstances and unable to access medical care through the Swiss healthcare system. Homeless people and asylum seekers have also used the service. Gynaecological and dental problems, as well as diseases of the skeletal system, are the most common complaints. By December, some 70 consultations a month were being provided.

Nine community 'mediators' of various nationalities have been integrated into the community of migrants living and working in Zurich. These mediators have taken on the role of raising awareness of this free service.

Free consultations are provided to anyone who has no access to the public health services.

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

MSF has worked in Switzerland since 2003.

IRAN

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **78**


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In 2007, an economic crisis in Iran led to increased resentment towards refugees.

Since 2001, MSF has been assisting Afghan refugees in Zahedan, capital of the Iranian province of Sistan-Baluchistan, where they have been crossing the border for the last 30 years. In 2002, despite a deterioration of conditions in Afghanistan, the Iranian government adopted a policy of forced repatriation. Many are reluctant to return to Afghanistan, some even returning to Iran after deportation.

In 2007, an economic crisis in Iran led to increased resentment towards refugees. Some 150,000 Afghan refugees were expelled between May and August but over half a million remain in Sistan-Baluchistan and an average of 34 new families arrive at Zahedan every week. With Iranian restrictions on work, educational opportunities and health services, living conditions for refugees are difficult but remain better than in Afghanistan. Iranian authorities estimate that the majority of Afghans are economic migrants and, therefore, not entitled to legal status or access to free healthcare.

In response, MSF provides primary and secondary healthcare to this population. MSF runs three medical clinics in Shirabad, Karimabad and Besat, offering free medical consultations and nutritional support for children. MSF also refers patients to secondary health facilities and covers costs for specialist consultations, treatments and hospitalisation. A team of social workers identify those in need of medical care and ensure they get access to consultations. A total of 18,000 people were assisted through this programme.

New project in Mehran

Given the extreme difficulties in accessing patients and providing healthcare inside Iraq, a project started at the end of 2007 in Mehran, close to the Iraqi border, to provide surgical care for victims of violence coming from Iraq. This project plans to receive between 30 and 50 patients each month.

MSF has worked in Iran since 1996.

IRAQ

REASON FOR INTERVENTION • **Armed conflict**
FIELD STAFF **249**

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Four years into the conflict, the gap between emergency medical needs and the capacity of Iraq's medical infrastructure persists. Bombings and lesser reported sectarian violence result in devastating injuries requiring immediate and intensive medical attention, yet skills and supplies in many areas are limited. The economy has collapsed and approximately 50 per cent of Iraqi doctors have fled the country. The high-level insecurity and ongoing violence reduces direct access to civilian victims.

Movements are dangerous and people cannot access medical care or may receive limited and insufficient care leading to life-threatening complications. Unable to run direct medical programmes with a permanent presence of staff in violence-affected areas, MSF has sought viable ways to provide assistance to Iraqis within and outside the country.

In the Kurdistan area, programmes have been established in three hospitals in Dohuk, Erbil and Sulemaniyah to deliver surgical assistance and psychological support. One of the most common medical problems is skin burns caused by domestic accidents, failed suicide attempts or explosions. In Erbil, over a hundred operations a month were carried out, about half of which were war-related. In July, MSF opened a programme in Sulemaniyah to care for burn patients and provide orthopaedic surgery. By December, 738 patients had been treated, many for severe burns.

The adjacent provinces of Tameem and Ninevah experienced an upsurge of violence in 2007. MSF supports healthcare structures in these provinces with materials and drugs and enables referrals of severely injured war victims to hospitals in Kurdistan. MSF is also evaluating the situation of displaced people and providing basic humanitarian assistance particularly in the governate of Dohuk, where some 1,000 families received support during the harsh winter.

Operations in Jordan and Iran in support of Iraqi population

An MSF team based in Amman, Jordan, began offering limited support to five Iraqi hospitals in zones severely affected by the violence. This involved providing essential medical supplies including anaesthetics, analgesics and surgical equipment. Some Iraqi staff also visit Amman regularly for training on life support protocols and mental healthcare in emergencies.

In Amman, MSF runs a surgical programme in partnership with the Red Crescent, staffed mainly by Iraqi surgeons performing maxillo-facial, plastic and orthopaedic surgery. Patients have complicated bone and wound infections and six or seven operations are often required to restore functionality and a minimum quality of life. The project treated 281 patients but its potential capacity is limited by administrative obstacles and impositions on bringing patients to Jordan from Iraq.

At the end of the year, MSF launched a reconstructive surgery project in Mehran, Iran. The objective is to care for patients from the eastern provinces and south of Baghdad.

Confusing political and humanitarian objectives

Security issues make Iraq an exceedingly difficult context for independent humanitarian interventions. The US-led coalition and UN system blurring roles demand a reaffirmation of MSF's strictly impartial and humanitarian character and an insistence on the need to preserve, defend and protect the integrity of humanitarian action from political and military objectives. MSF struggles to reassert and gain recognition for its identity as an independent humanitarian organisation, separate from any political, commercial, religious or personal interests. In November, MSF reinforced dialogue with all key stakeholders and warring factions to secure safe space in which to carry out its work.

MSF has worked in the current Iraqi conflict since 2006.

YEMEN

REASON FOR INTERVENTION • **Armed conflict • Healthcare exclusion**
FIELD STAFF **44**

Since the reunification of its northern and southern parts in 1990, the Republic of Yemen has been exposed to political and social tensions and sporadic waves of violence. The Saada province in the north-west has been particularly affected by tensions between governmental and rebel forces since 2004. MSF began working in Yemen in September 2007, supporting health structures in the Saada province and assisting migrants and refugees in the Abyan and Shabwah governorates.

Supporting health infrastructures

In the first half of 2007, some 56,000 people fled their homes temporarily when violence once again erupted in Saada province. In September, following the signing of a ceasefire agreement, MSF began working in Haydan hospital to improve access to healthcare.
It is the first time since the beginning of the fighting that an international relief organisation other than the International Committee of the Red Cross has been authorised to work in the region. The team supports inpatient and outpatient services, antenatal and maternity units, and the emergency room of the hospital. On several occasions in November, MSF had to temporarily evacuate Haydan as fighting resumed, although activities were sustained by national staff. In 2008, activities at the hospital will be expanded to cover surgery.

During the fighting of 2007, the hospital of Razeh, west of Haydan, which serves a population of 75,000, was looted and partially destroyed. MSF repaired it and in December resumed medical activities in the emergency room and in the inpatient, maternity, antenatal and family planning services.

The volatile security situation makes movement difficult in some areas so an MSF team goes six days a week to the town of Dhayan, home to 25,000 people in the rebel zone. On average, 120 consultations are carried out each day, mainly focused on children and women's healthcare. MSF is also contributing to the rehabilitation of the hospital of Al Talh, close to Dhayan, which will reopen in April 2008 after seven years of closure.

Providing assistance to migrants and refugees

Every year, thousands of people risk their lives to cross the Gulf of Aden, the dangerous stretch of water between Yemen and Somalia. This treacherous journey is taken by Somalis fleeing fighting in their country and Ethiopians who cannot find employment back home for political reasons or due to the conflict in the Ogaden region. In 2007, although 28,000 people reached the southern coast of Yemen, some 650 died and the same number went missing. The death toll is probably much higher. Since September, MSF has been assisting refugees who have survived this risky voyage, providing medical and humanitarian assistance to over 3,000 refugees and migrants. The MSF mobile team offers survivors emergency medical treatment, food, water and relief items on arrival. MSF also provides counselling, as many migrants arrive exhausted and emotionally shattered. In 2008, MSF will continue to provide medical assistance to this population, notably at a new reception centre opened recently by UNHCR in Ahwar.

MSF has worked in Yemen since 2007.


© MSF

MSF supports health structures in the Saada province and assists migrants and refugees in the Abyan and Shabwah governorates.

PALESTINIAN TERRITORIES

REASON FOR INTERVENTION • Armed conflict
FIELD STAFF 91

© Valerie Babize

Poverty, restricted movement and increasing violence in the Palestinian Territories have inflicted a tremendous toll on mental health, yet there are few trained psychologists. MSF focuses on supplying psychological support to victims of violence in the Israeli-Palestinian and intra-Palestinian conflict. MSF also provides medical assistance to people without access to health services. Teams work in the West Bank and Gaza.

Patients live in exposed and insecure conditions such as refugee camps or areas where they are subject to frequent incursions, often close to checkpoints and Israeli settlements. People suffer from depression, anxiety, post-traumatic disorder and psychosomatic troubles. They are burdened with symptoms such as disrupted sleep, flashbacks and nightmares.

MSF supplies psychologists to provide individual and group therapy for children, adolescents and adults. This clinical care is aimed at reducing symptoms and helping people develop coping mechanisms. Teams comprise a psychologist, medical doctor and social worker. The programme has remained flexible and reactive in order to meet patient needs while operating in a volatile and unpredictable context. Travel is difficult due to closures and restrictions, so consultations and therapy are often provided through home visits. A total of 4,617 consultations (1,284 in Hebron, 1,851 in Nablus and 1,482 in Gaza) were provided in 2007. Almost half (42 per cent) of patients were under 12 years old.

Emergency post-operative programme

Following violent clashes with the Fatah in May and June, Hamas took control of the Gaza Strip. The violence left more than 1,200 people injured and several needing specialised care. By July, MSF had established a post-operative care programme to help people recover from their injuries and gain maximum mobility. The service included follow-up consultations, pain management, antibiotic supply and physiotherapy for several hundred people. As well as meeting medical criteria, patients were admitted to the programme as a result of financial, security or mobility problems.

Supplying drugs and medical material

The 2006 embargo by western states has led to a general deterioration in the health system and numerous strikes by health workers. The Ministry of Health is completely dependent on donations from the international community. Although a mechanism is now in place to alleviate financial pressures and supply medical materials, health workers still do not receive full salaries and recurrent strikes in the public sector have disrupted healthcare access, particularly in the West Bank. MSF made periodic drug donations in Hebron to help cover critical shortages, as well as donations of drugs and emergency medical material to hospitals in Gaza.

MSF has worked in the Palestinian Territories since 1988.

Gaza strip

As with the whole of the Occupied Palestinian Territories, the Gaza strip had been subject to an international embargo since early 2006. The already difficult situation deteriorated significantly in mid-2007 when Hamas took control after weeks of bitter internal fighting. With an array of security services and militia allied along factional lines, the bloody takeover was the culmination of an increasingly intense Hamas-Fatah rivalry. The remainder of 2007 saw violent repression of anti-Hamas demonstrations and an emerging insurgency by disgruntled members of the former security establishment.

While Israel and international donors quickly recognised and engaged the new Palestinian government in the West Bank, the Gaza strip effectively remained under Hamas control and subject to tougher sanctions. Israel limits passage into Gaza to basic food and medicine and the number of medical referrals abroad is decreasing. Fuel and electricity supplies have been reduced in an attempt to pressure the Hamas regime, which the Israeli cabinet officially labelled a 'hostile entity' in September.

Alongside the political and economic isolation of the Gaza strip, the Israel-Palestinian conflict fluctuates. Hamas and smaller groups continue to target neighbouring Israeli communities and military bases with rocket and mortar-fire. Targeted air strikes and limited incursions from the Israeli side ostensibly aim to limit the rocket fire but inevitably lead to civilian casualties.

During the peak of internal Palestinian clashes in May and June, at least 200 people were killed and some 1,200 injured. However, the subsequent split in the Palestinian Authority has had the most far-reaching consequences. The already fragile health sector has become highly politicised, with the two opposing parties often issuing contradictory instructions. Disputes result in political appointments, strikes and a demoralised staff.
With the embargo making the re-supply of hospitals with drugs and equipment highly problematic and a general economic collapse, access to healthcare has been significantly reduced. MSF has, therefore, expanded its activities beyond the mental health sphere to include post-operative care in addition to rehabilitation and paediatrics.

The increased need for external medical assistance is a result not only of the violence and reduced capacity of secondary medical structures but also of the political climate. As the positions of the main antagonists become increasingly polarised, individuals with specific or perceived affiliations have correspondingly limited access to health services.

The parallel Ministries of Health and many local organisations are seen as directly influenced by Hamas or Fatah while some international non-governmental organisations, particularly those funded by key institutional donors, are believed to have wider political motives. Therefore, being financially independent as a medical relief organisation is not just relevant but also necessary in order to operate in Gaza. MSF repeatedly explains and highlights this independence to the recognised Palestinian authorities in the West Bank, the Israelis and, of course, local actors on the ground, in an effort to gain as much access as possible to the communities in need.

Disputes continue however, and healthcare becomes simply another political tool through which pressure can be applied. As positions remain entrenched, health services are likely to deteriorate further, making independent humanitarian action increasingly relevant and important.

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AUDITED FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, medical humanitarian organisation that is also private and not-for-profit. It is comprised of 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 with 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-Logistique, MSF-Supply, SCI MSF, SCI Sabin, and Wali-Nawaz. 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. The 2007 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 2007 financial report may be obtained from the International Office upon request. In addition, each national office of MSF publishes annual, audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

The figures presented here are for the 2007 calendar year. All amounts are in millions of euros.

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

Programme expenses by country/region

Countries/Regions	in M€
Africa	
Sudan	40.9
Democratic Republic of the Congo	39.9
Chad	25.3
Somalia	21.9
Niger	15.8
Kenya	13.1
Liberia	10.1
Uganda	9.8
Ivory Coast	9.0
Zimbabwe	9.0
Malawi	8.6
Mozambique	8.3
Central African Republic	8.1
Ethiopia	7.3
Sierra Leone	5.3
Burundi	5.3
Nigeria	4.9
Burkina Faso	4.7
Guinea	3.5
Republic of the Congo	3.0
South Africa	3.0
Zambia	2.9
Angola	2.4
Cameroon	2.4
Rwanda	1.2
Mali	1.2
Other countries*	1.7
Total	268.7

Countries/Regions	in M€
Asia/Middle East	
Iraq	10.0
Myanmar	8.9
India	5.9
Cambodia	4.9
Thailand	4.2
Pakistan	3.9
Sri Lanka	2.9
Indonesia	2.8
Palestinian territories	2.4
Georgia	2.3
Bangladesh	2.1
Uzbekistan	2.1
Yemen	1.7
Armenia	1.6
Nepal	1.5
China	1.5
Iran	1.3
Other countries*	3.0
Total	62.9
Americas	
Haiti	12.6
Colombia	7.5
Peru	1.7
Guatemala	1.5
Other countries*	2.4
Total	25.8
Europe	
Chechnya / Ingushetia /	6.3
Russia	2.0
Italy	1.1
Kyrgyzstan	1.1
Belgium	1.0
Other countries*	1.1
Total	12.7

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

Where did the money go?

Program expenses* by nature

- National Staff | 28%
- International Staff | 25%
- Medical & nutrition | 20%
- Transport, freight, storage | 13%
- Logistics & sanitation | 6%
- Operational running costs | 5%
- Training & local support | 1%
- Other expenses | 1%

Program expenses* by continent

- Africa | 72%
- Asia | 17%
- Americas | 7%
- Europe | 3%
- Non-allocated | 1%

**project and coordination team expenses in the countries*

Income

	2007 In M€	2007 In %	2006 In M€	2006 In %
Private Income	518.7	87.6%	488.4	85.9%
Public Institutional	54.2	9.1%	61.8	10.8%
Other Income	19.8	3.3%	18.5	3.2%
Total Income	592.7	100.0%	568.7	100.0%

How was the money spent?

*Operations**	*439.1*	*76.1%*	*431.2*	*77.0%*
Témoignage	*19.4*	*3.4%*	*18.0*	*3.2%*
Other humanitarian activities	*9.1*	*1.6%*	*7.9*	*1.4%*
Total Social Mission	467.6	81.0%	457.1	81.6%
Fundraising	76.9	13.3%	71.8	12.8%
Management, general & administration	32.9	5.7%	30.9	5.5%
Total Expenditure	577.4	100.0%	559.9	100.0%
Net exchange gains & losses (realised and unrealised)	-3.2		-4.5	
Surplus/(deficit)	12.1		4.3	

* Programs & HQ program support costs

Balance sheet

(year-end financial position):	In M€	In M€
Non-current assets	37.1	35.8
Current assets	61.0	66.2
Cash & equivalents	350.2	347.5
Total assets	448.4	449.5
Permanently restricted funds	*2.5*	*2.5*
Unrestricted funds	*402.2*	*389.4*
Other retained earnings	*-14.6*	*-7.1*
Total retained earnings and equities	390.1	384.7
Non-current liabilities	3.4	3.7
Current liabilities	52.5	55.5
Unspent donor-restricted funds	2.3	5.6
Total liabilities and retained earnings	448.4	449.5

HR Statistics

International departures (full year):	4,134	100%	4,623	100%
Medical pool	1,117	27%	1,292	28%
Nurses & other paramedical pool	1,303	32%	1,500	32%
Non-medical pool	1,714	41%	1,831	40%
First time departures (full year): (*) in % of total international departures	1,152	(*) 28%	1,332	(*) 29%
Field positions:	24,348	100%	26,981	100%
International staff	1,994	8%	2,022	7%
National staff	22,354	92%	24,959	93%

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 2007, 90.9 per cent of MSF's income came from private sources. More than 3.8 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 program-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 either 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 to further 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 2007, their available part (the unrestricted funds decreased by the conversion difference) represented eight 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 programs (e.g. ARV treatment programs), 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).

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

Today MSF is an international medical humanitarian movement with national sections in 19 countries. In 2007 over 26,000 doctors, nurses, and other medical professionals, logistical experts, water and sanitation engineers and administrators provided medical aid in over 60 countries.

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