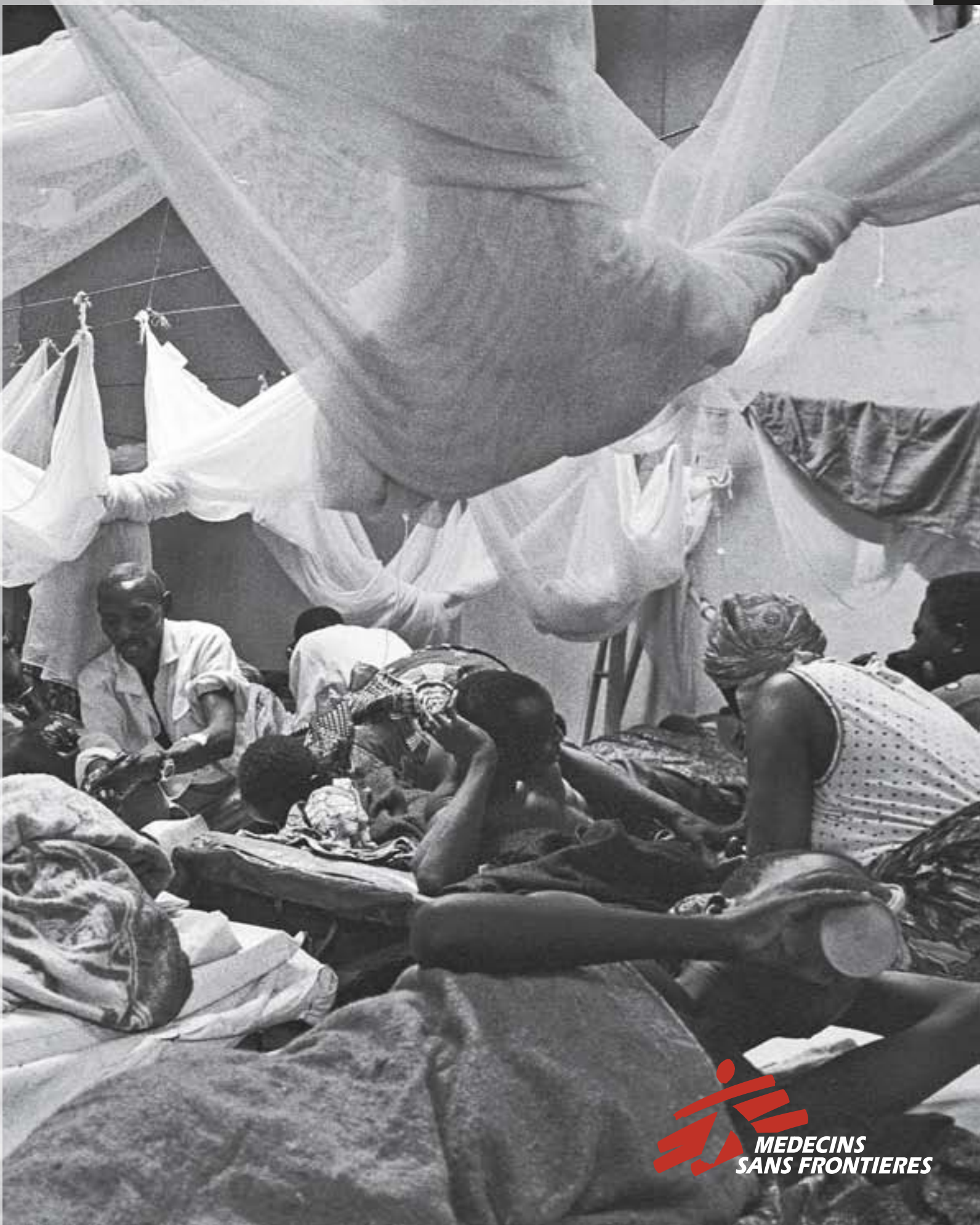


MSF Activity Report



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 honor 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.

COVER PHOTO

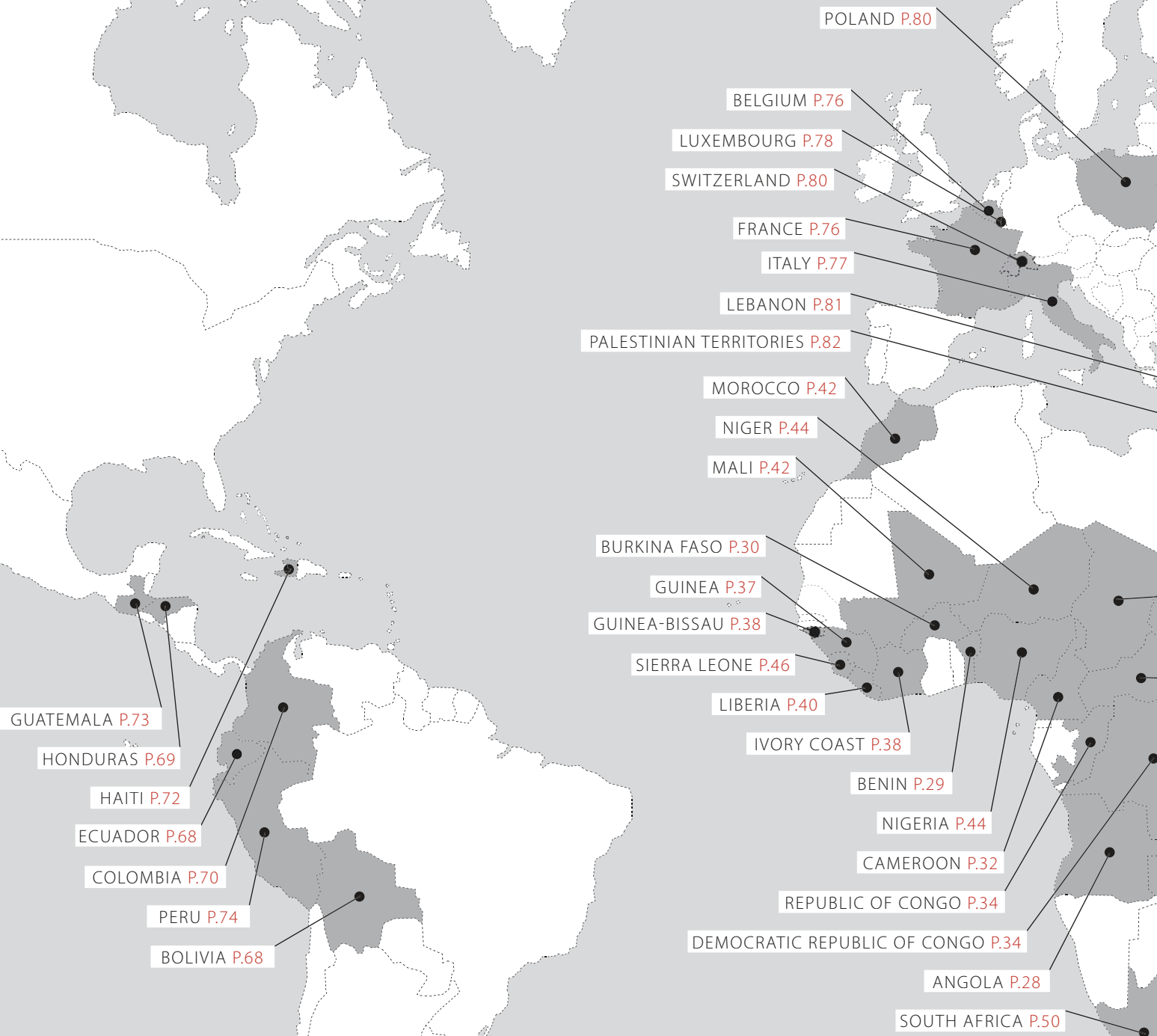
Patients in the post-operation ward at the MSF Bon Marché Hospital, Bunia, Democratic Republic of Congo, May 2005.

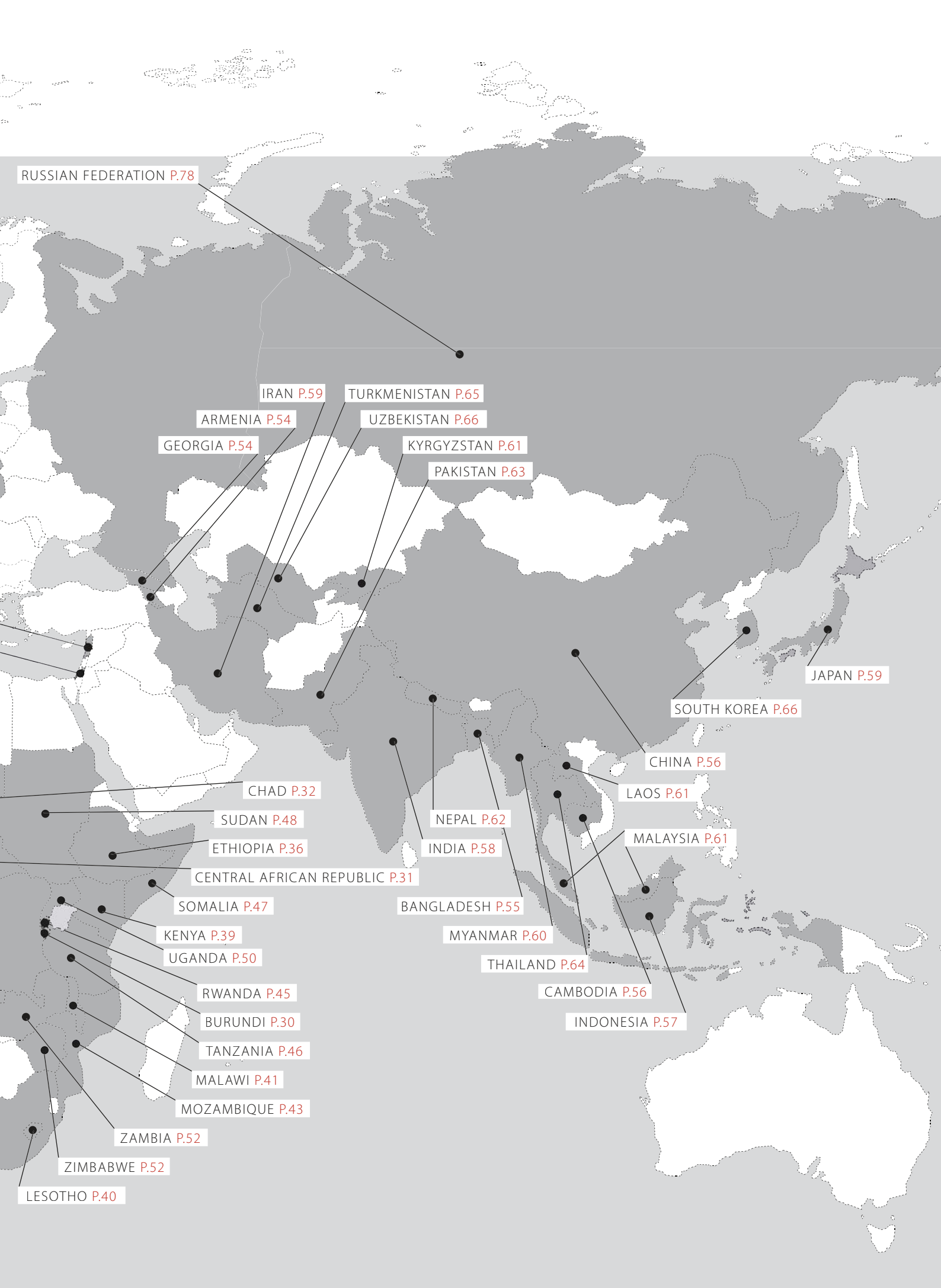
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MSF Missions around the World





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The Year in Review



In July 2006, amid intensifying armed conflict between Israeli Defense Forces (IDF) and Lebanese Hezbollah fighters, MSF launched an emergency intervention to help address medical-humanitarian needs. Assistance was offered on the Israeli side dealing with civilian deaths and injured from rocket attacks; however the nature of the conflict was such that there were greater needs and less available assistance in Lebanon.

With a high intensity bombardment cutting major roads and bridges throughout the country, transportation was difficult and dangerous, compelling MSF to make public statements reminding those engaged in the conflict that they had a responsibility to allow assistance to reach civilians caught in the fighting. Though vociferous in such

demands, MSF retained its neutrality by refraining from commenting on specific military decisions of either side. This independent and impartial approach to the provision of aid allowed us to move and assist in a context where almost all movement was prevented.

The difficulties reaching people in need in Lebanon are illustrative of a growing problem of access that MSF has confronted over the past year. Despite the relative simplicity of our mission – to provide impartial medical-humanitarian assistance to those in need and prevent loss of life – our ability to obtain access to patients can rarely be

Many of the people we help are trapped within highly charged and complex social and political contexts that create significant barriers to the provision of aid.



An MSF convoy transporting emergency medical supplies and fuel remained stuck north of the Litani River after an airstrike destroyed the last bridge. Four tonnes of supplies were carried by hand over 500 metres using a human chain. A tree trunk spanning the river was used as a makeshift bridge.

assumed. Many of the people we help are trapped within highly charged and complex social and political contexts that create significant barriers to the provision of aid.

Security concerns

At the time of writing, humanitarian organisations have been reducing activities

or pulling out of Darfur, Sudan. Over a million people have been living a survival existence with 'adequate' health parameters for over two years in camps in Sudan and Chad, disguising an utter lack of hope and despair that pervades these islands of assistance. These are the lucky ones who manage to have sustained contact with the

diminishing and underfunded aid made available to them. Outside the camps, especially in West and North Darfur, violence against civilians continues, accompanied by a significant increase in targeted attacks against aid workers including MSF staff, making land travel and logistical assistance close to impossible.

MSF has been working in Darfur since early 2004 and intends to stay as long as we are able to be effective, although the situation is becoming increasingly precarious. Serious security incidents have forced us to reduce activities in the Jebel Marra region, despite an ongoing cholera outbreak, and we can no longer send surgical referrals by road for emergency care. This reduction in the ability to provide basic assistance is likely to have a critical impact on an already fragile health situation.

Likewise in Sri Lanka, a country where we worked for many years during the conflict, seventeen aid workers from the NGO Action Contre la Faim were executed in July 2006. The perpetrators of this outrage have not been identified. With such attacks on clearly identified aid workers, there is a grave concern for the future of assistance in this country. MSF is struggling to get access to areas where there is no humanitarian assistance at all in this brutal civil war.

An unhealthy mix

Over the past year, there has been a mounting distrust toward aid organisations by those who have the power to grant us access. This mistrust is not always misplaced. The practice of some nongovernmental organisations (NGOs), private contractors and many governments doing 'humanitarian' work with a specific political aim causes confusion, and reduces the acceptance of the universal nature of humanitarian assistance. This contributes to a climate where groups opposed to any underlying political aim use confusion as an excuse to attack aid workers.

This mounting distrust is just one of the ongoing challenges of providing emergency assistance discussed in an article in these pages by Marilyn McHarg, who underscores our need to adapt to and anticipate not only a changing humanitarian landscape, but also dynamic social, political and even geographical environments in order to identify

Numbers mean little without reflecting on the relevance of the assistance and the quality of our work.

where and how we can best provide effective assistance. Addressing the problem of access, she proposes that new strategies must necessarily be developed to carry out our work. As this report goes to press, we are launching a new project to provide reconstructive surgery for wounded Iraqis in Jordan and working with Iraqi medical groups to assist them in responding to the effects of daily violence in that country.

Coordination: not a panacea

With an ever-growing number of aid organisations, there are now increasing attempts to coordinate humanitarian assistance to control and direct this assistance in a certain direction. Superficially coordination can have positive results allowing various agencies to use their strengths within a comprehensive response; however, “lack of coordination” is currently used as a blanket excuse for every failing of aid assistance. In some cases, it is not a failure of aid but rather a deliberate and politically motivated lack of access to aid for people in need. The intricacies and potential dangers of coordination being provided as a sole response to the failures of aid in the past is discussed in this report by Fabien Dubuet and Emmanuel Tronc, who outline MSF’s position whilst the UN implements changes in its system of aid assessment and delivery. MSF remains careful to separate itself from these processes, instead relying on independence of assessment and action to respond to specific needs of specific populations, rather than contributing to a global framework of dubious origins and effectiveness. Independent and impartial assessment is not only a principled, but also a practical approach that allows us safe and rapid access to people in need.

Effective responses

Despite our concerns around these issues, our records over the past year show a massive volume of medical care to individuals and families around the world: this includes doing more life-saving surgery, treating more malaria, and offering mental health support to more people than ever before. MSF in 2005 provided medical-humanitarian assistance to over 10 million people, including assistance in major emergency responses following an October earthquake in Asia, and treatment for

26,000 people with cholera in Angola in the spring of 2006, the largest outbreak of this disease in that country in over a decade. But these numbers mean little without reflecting on the relevance of the assistance and the quality of our work: each patient is much more than a statistic and we must be sure that if we treat someone for malaria, for example, that they get a humane consultation, the right diagnosis and treatment.

Particularly when we have access to field-appropriate medical and logistical tools, we are able to adopt new methods of treatment to provide relevant and quality care. A novel approach to an old problem of treating malnourished children, mobile feeding centres and the availability of an effective, portable nutritional rehabilitation product helped MSF carry out its largest and most successful response to child malnutrition in Niger in 2005. 63,000 severely malnourished children were admitted to programmes, where record cure rates were achieved. Dr. Milton Tectonidis explains this intervention and its importance in an essay within this report – an undertaking that allowed us to demonstrate that death by malnutrition is not necessarily inevitable and can more and more be equated with death by neglect.

Similarly, as we continue to provide a full package of HIV/AIDS prevention and treatment to people and communities in 32 countries, our developing strategy is to decentralise care and increase the number of sites where treatment is available – an approach described in this report by our team in Thyolo, Malawi. The size of scale-up that is truly needed, however, continues to be limited by a shortage of human resources and the state of health systems in many countries. It is unrealistic to believe that these issues will be solved sufficiently to treat everyone with HIV/AIDS. A comprehensive response to this epidemic is precluded by a disgraceful lack of drugs, diagnostics and monitoring tools developed for resource-poor countries, who instead must make do with the detritus of western-focused research. More appropriate tools are urgently needed to address this crisis head-on, to treat many more people despite the human resources and structural crises. While we are buoyed by the outcomes of

our interventions in 2005/2006, we also recognise that MSF can only offer immediate and time-limited solutions. It must be clear that the modest improvements we can make should be viewed neither as an opportunity for governments and international organisations to abdicate their responsibilities, nor an alibi for political inaction. Speaking out and raising awareness of this neglect is how we avoid covering up the problem. This year, we include in this report a selection of photos of people from the Democratic Republic of Congo – where human needs have largely been ignored by the international community.

Self-criticism is an essential element of MSF and the 19 sections of MSF went through an internal process this past year aimed at improving our operations and governance structure. Developing from this is a commitment to maintain the transparency of our actions and concretely increase the accountability we display to those we assist and the donors that generously assist our work, for it is reliance on individual donors that allows us to act quickly and independently and in response to human needs.

We see this accountability as a potent tool to reflect openly on our operations and improve them significantly as we meet new challenges and obstacles. MSF will continue to look for new ways to manoeuvre past whatever barriers may arise, logistical, security or political and assist those who are being neglected – firmly grounded in our identity, and our intention to provide quality medical care for people who would otherwise have none.

Rowan Gillies, M.B.B.S.

President, MSF International Council

Marine Buissonnière

MSF Secretary General



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The Challenge of an Emergency in a World in Flux

As the world has changed, so has our response to emergencies. In the past, a typical MSF emergency intervention saw us responding to refugees within defined camps bordering war zones, to malnourished children located in geographic pockets, to communities suffering from cholera outbreaks or meningitis epidemics, and other emergency situations such as periodic floods, droughts or earthquakes.

With the effects of the tsunami, malnutrition in Niger and cholera in DRC, among many others, MSF has continued to focus on responding to those most in need.

As a medical-humanitarian organisation, emergencies within crisis situations have always been at the heart of our action, and our response has focused on medical interventions. With time and experience, our technical capacity to respond to urgent medical needs has improved. Our inflatable hospital in Mansehra, Pakistan, an earthquake setting where pre-existing infrastructure had collapsed, is but one example of the evolution of emergency medical action and resulting capacity to implement highly developed medical, surgical, and intensive care services.

Although these types of emergencies continue, the character and complexity of our contexts places new demands on us. To a large extent, more conventional wars between states have been replaced by internationally influenced guerrilla wars fought within countries. Underlying these conflicts, ideological motivations or territorial gains are more the exception, with economic motivations becoming more the rule. Civilians, normally seen as those to be protected in conflicts, are often used as commodities of war and become trapped or targeted as a result. The violence against civilians is frequently used as a means of diminishing opposing elements, meanwhile abduction or looting of civilians – sometimes children, as in Uganda, where up to 20,000 children have been kidnapped and inducted into the Lord's Resistance Army – have become standard strategies in gaining strength against an enemy.

Changing perceptions

With this degradation, there has been a weakening of respect for aid and humanitarian interventions. Increasingly, belligerents of war perceive us as either feeding into or aggravating warring agendas, much the same way they view the civilians we aim to support. With many warring actors fragmented along various lines, it has become increasingly difficult to negotiate our presence and also to maintain the security of MSF staff in areas where access is accomplished.

Added to this, there are more and more aid organisations and agencies involved in the business of aid. Many have different values, goals and strategies that confuse the perception of MSF. We have always believed that our reliance on principles such as impartiality and independence secures our capacity to safely intervene where needs are greatest. However, the multiplicity of actors has blurred our distinction and with it, increased the risk of being erroneously seen as part of political or even military agendas. This limits our capacity to engage in unhindered action for those most in need.

Displaced within borders

Accessing populations also becomes more difficult with the changes in population movements. In the past, populations facing war would displace themselves to safer areas beyond their borders and cluster into camps. The classic situation was characterised by groupings of people in distinct locations where health risks were increased because of the stress of displacement and crowding under austere conditions. We have increased our capacity to clearly identify those in need and quickly provide needs-based responses in these situations. But today, more and more people displace themselves within their borders, integrating into cities, smaller communities or other open settings so their locations are not as evident, making needs

identification and response more difficult. In Colombia, for example, ongoing conflict has caused the displacement of over two million people and many are in need of medical and psychological care; however, these people are scattered and sometimes hidden within urban centres, requiring us to seek out those needing assistance and launch multiple projects to reach a more diffuse population.

More recent global developments have also impacted on needs and our capacity to respond. As polarisation between various fundamentalist western elements and extremist Islamic groups intensifies, the capacity for organisations such as MSF to independently respond to any humanitarian needs, free from any falsely based accusations of political alliances, becomes increasingly limited and poses greater security risks. Aid workers are not in these contexts to choose sides or to die, rather they are there to save others' lives, and as global polarisation becomes more entrenched, overcoming these barriers in order to respond to emergencies becomes increasingly difficult.

Assisting in middle-income countries

As major humanitarian crises occur more in middle-income countries, the type of our emergency response has required adaptation. Historically, MSF has mostly responded to situations in sub-Saharan Africa, where infrastructure collapse has meant few staff were available and disease patterns typically included tropical illnesses such as malaria, diarrhoea and many other infectious diseases. Within middle-income countries such as Lebanon and Iraq, our classic emergency response has been tested with the presence of sufficient numbers of capable staff and epidemiological patterns that are more typical of western countries, with chronic diseases being among the most urgent. Our medical policies, supplies and protocols need to encompass chronic diseases such as cardiac disease, diabetes, asthma and epilepsy, among others.

These middle-income contexts have also challenged MSF to develop new strategies and play a more secondary role whilst engaging in more partnerships. In the summer of 2006 our medical activities in Lebanon were in some ways unusual for MSF, conducted alongside well-developed medical resources and included helping provide supplies and treatment for chronic diseases, kidney disease in particular. It is likely we will be called upon to assist in this manner in the future.

Learning from natural disasters

MSF has responded to a number of natural disasters through the years, but these emergencies have not been seen as one of our main interventions. Usually, MSF has struggled to find a role, as the most urgent needs tend to be related to rescue, followed by logistical support. Most needs are answered by armies, national actors, and through local solidarities. The incredible local response of Sri Lankans to the 2004 tsunami limited our need to intervene there. Similarly, the Pakistani army was highly effective in its activities following the October 2005 earthquake in southern Asia.

The needs for medical response in these situations, although present, do not always amount to substantial medical interventions. Pakistan



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was an exception. With destruction of small buildings in remote areas, there were relatively more injured demanding a medical response, and fewer deaths. But usually this is not the case – survivors of earthquakes and other natural disasters usually present limited injuries, whilst their major needs include shelter, water, sanitation, and food. All interventions MSF can do, but usually on a small scale and in support of medical interventions.

In the future, however, factors including increasing environmental degradation and climate change may well contribute to changes in epidemiological patterns and a greater number of natural disasters such as droughts and floods. Although these events are highly unpredictable in nature, we should be aware of what exactly we are able to provide to people in distress and be ready to respond with the strengths we have developed.

By accepting our limits, but continuing to develop our core strengths, we can advance our response. It is clear there are others better able to respond in the first phase of natural disasters and intervening in the very first hours of a rescue phase requires an expertise and logistical capacity that MSF does not have. We are better placed to direct our efforts in the survival phase – this work has synergies with interventions in other settings and facilitates the development of our specialities instead of potentially diluting them by broadening our scope. Emergency surgery is a particular activity we have identified as a focus area. We are increasing our capacity for emergency surgery and other specialised medical services – for example we now routinely send nephrologists to the field to treat crush syndrome, a condition characterised by renal (kidney) failure and often seen in people who have survived a building collapse precipitated by earthquakes or bombings. Mental health, nutrition and monitoring for epidemics amongst displaced persons in crowded living spaces are also areas that overlap with our medical interventions elsewhere. These are aspects we need to further build up and adapt to evolving situations.

Treating emerging diseases

Changes in epidemiological patterns are among the greatest challenges ahead for MSF. Recent increases in frequency of viral haem-

orrhagic diseases such as Ebola in parts of Africa have demanded highly specialised and culturally adapted responses, which so far have been limited in success due to the complexity resulting from the interplay between cultural orientations and needed medical interventions. In Angola in 2005, an outbreak of Marburg haemorrhagic fever required us to wear bio-safety gear, which frightened local community members. Further, people with the illness had to be isolated to prevent the spread of this highly infectious disease. Many of these patients died, so it was perceived that people separated out by MSF were meant to die, and community members became reluctant to seek help for those who were sick. Such misunderstandings underscore the need for cultural sensitivity in situations where we cannot anticipate how our tools and approaches may be received.

Likewise, a recent MSF intervention in a plague outbreak in Ituri, Democratic Republic of Congo (DRC) highlighted the need for MSF to continue in its pursuit of understanding such diseases, their spread, and necessary treatment within various contexts – in this case, an isolated war setting. Emerging diseases such as avian flu also demand highly specialised responses. But like any intervention by MSF, choices must be made and an avian flu outbreak highlights this dilemma more than ever. Our capacity to take on such a pandemic will be limited, though it should not inhibit our preparedness to do what is possible, where it is possible.

2005 has been a demanding year for MSF in terms of emergency response. With the effects of the tsunami, malnutrition in Niger and cholera in DRC, among many others, MSF has continued to focus on responding to those most in need. Although these responses in their own right were of value and laid further foundation to whatever emergency responses are required in the future, the challenges ahead in this changing world will place further demands on us. Ours is a challenge of continued adaptation and evolution in order to ensure we are assisting those most in need on a medical basis and to the best of our abilities.

Acute Malnutrition: A highly prevalent,

“...‘regular’ starvation has to be distinguished from violent outbursts of famines...

Problems of: (i) existence of much regular starvation, (ii) worsening trend of regular starvation, and (iii) sudden outbreak of acute starvation, are quite distinct...”

(Amartya Sen, *Poverty and Famines* 1981)

How is it that MSF managed to admit 63,000 severely malnourished children into its programmes in Niger in 2005, the largest nutritional intervention in the organisation’s history? Niger is not the image most would associate with recent famines – civil war, violence, population displacement, severe food shortage, massive malnutrition (including adults), disease and epidemic – the typical picture of excess death due to catastrophic famine in the 20th century .



frequently fatal, imminently treatable, neglected disease

Regular starvation in Niger and beyond

Debate ensued over the nature of the Niger crisis in 2005 and the appropriateness of the response, as international relief efforts were finally stepped up in July. There were objections to the use of the term famine to describe the emergency, and resistance to providing free food aid as a response until late into the hunger gap period, when food reserves from the previous year's harvest were exhausted, and the steep price of staple food items on the market had broken all previous records.

Niger is a country with chronically high levels of what Nobel Prize winning economist Amartya Sen calls "regular starvation". Other terms used are *chronic hunger* or *under-nutrition*. The Food & Agricultural Organization estimates there are over 800 million undernourished, having access to less than their daily requirement in food energy to be normally active. Economists view chronic food shortage in such large populations as a failure of development. Many public health advocates actually play down the link between food scarcity and childhood malnutrition in poor countries, insisting instead on "inadequate infant and young child feeding practices", or, to a lesser extent, on poor access to health services or clean water. Outside of major crises, the usual proposed package of preventive and curative child health interventions rarely includes the treatment of even the severest cases of acute malnutrition.¹

Severe acute malnutrition defines a form of malnutrition that bears a particularly high risk of death but which nevertheless responds rapidly to treatment. Individual cases are diagnosed either on the basis of the degree of emaciation or "wasting," as measured by the weight to height ratio, or by the circumference of the mid-upper arm (marasmus); or by the presence of "water in the tissues" (oedematous malnutrition or Kwashiorkor). Moderate cases of acute malnutrition are those with a slightly less abnormal weight to height ratio. Unicef estimates there are over 60 million children suffering from acute



malnutrition (wasting) at any given moment. Thirteen million of them are severely wasted, whilst many others are affected by Kwashiorkor. Acute malnutrition is implicated in over five million preventable deaths yearly amongst young children.²

The Maradi region alone accounted for 39,353 admissions for severe malnutrition to MSF therapeutic feeding programmes in Niger in 2005. Over 95% of cases occurred amongst children less than 30 months old, and the majority (over 60%) were admitted during a three-month period between mid-July and mid-October corresponding to the classic hunger gap (over 80% between June and November). Yearly admissions in Maradi were four times higher than the number admitted into the MSF programme in 2004. In some southern, rural cantons of Maradi in 2005, almost half the children between six and 24 months of age developed severe acute malnutrition during the year and were admitted to an MSF therapeutic feeding programme.

It is inconceivable that infant and child feeding practices can account for such large seasonal and yearly variations in admissions for severe acute malnutrition in Niger. Nor can this variation be explained by increased exposure to disease and poor access to healthcare or clean water. Such variations are largely due to nutritional stress in the hunger gap period, particularly in years following poor harvests. At these times, the quality and limited diversity of the diet is often even more limiting than the caloric and protein content of available food.

Over the past 20 years, clinical nutrition research has increasingly concentrated

on the role played by micronutrient dietary deficiencies, typically associated with the monotonous, cereal-based diets of rural-poor populations, in growth failure and malnutrition. Deficiencies in trace metals, sulphur, phosphorus, certain vitamins and other micronutrients have particularly deleterious effects on young children in the first two, critical years of life.³ Many easy-to-use, fortified, nutrient-rich products specifically designed for this age group to help prevent deficiency exist on the market in developed countries for those with the means to purchase them. Any attempt to reverse the high rates of malnutrition in countries such as Niger has to address the difficulty poor, rural populations face in providing a sufficiently nutrient-rich diet for their young, rapidly growing children.

Stepping up the treatment of acute malnutrition

Results obtained in Niger in 2005 in rehabilitating large numbers of severely malnourished children are exceptional. Over 91% of severely malnourished patients from Maradi region (34,247 children) exited the programme cured, that is, no longer acutely malnourished. Providing individualised, therapeutic treatment to such large numbers of patients had never been accomplished in the large famines of the recent past in Ethiopia, Somalia and Sudan. What has changed? Until recently the World Health Organization (WHO) recommended that all cases of severe acute malnutrition be treated with therapeutic (high energy, nutrient fortified) milks, in therapeutic feeding centres or inpatient wards of hospitals.⁴ Although high cure rates are obtained by humanitarian agencies using therapeutic milks in feeding centres during major crises, such specialised centres represent a significant investment in staff and infrastructure, are costly, and have limited capacity at any one time.⁵ Moreover, demands on a patient's family posed by prolonged inpatient feeding (generally several weeks) discourages participation, lowers programme coverage and increases the number of children who default before cure.

It is not completely surprising then, that outside large emergencies, the treatment



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Blanket Feeding, Tanout, Niger, October 2005. Food assistance (enriched wheat and oil) is provided for families identified with malnourished children.

of severe acute malnutrition has not been seen as a priority by international public health consultants, and that few countries with limited resources have made attempts to integrate the treatment of acute malnutrition into their healthcare services. In the case of Niger, a country where there are, depending on the season and year, between 250,000 and 500,000 acutely malnourished children at any given time, no effective nutritional rehabilitation programmes for severely malnourished patients existed outside the MSF Maradi programme until July 2005.

The introduction of Ready to Use Therapeutic Foods (RUTF) over five years ago is changing perceptions and practices.⁶ These nutrient-rich products designed for rapid weight gain do not require preparation or the addition of water, and the energy-dense paste is impossible to contaminate. They are tailored for malnourished children with poor appetites and small stomachs who need to consume high quantities of calories. Small, severely malnourished children can gain one to two kilograms in a few weeks.

These factors make such products ideal for outpatient use, and mothers quickly grasp the therapeutic nature of the product. The MSF experience in Niger in 2005 shows that most cases of severe, acute malnutrition can be cured through attendance at outpatient centres at regular, weekly intervals. Over 65% of severely malnourished children were admitted directly into outpatient care, and the majority never required hospitalisation during the entire course of their

treatment. Almost 85% of all admissions finished their treatment as outpatients. The average time to cure was less than a month. Inpatient units are needed to handle referrals for complications such as anorexia, weight loss, severe infection or anaemia. There were almost 1000 deaths amongst patients admitted to MSF inpatient centres in Maradi in 2005; however, over 6200 others were discharged cured or referred back to an outpatient programme after having spent less than two weeks on average as inpatients.

The availability of a simple to use and effective therapeutic product permitted MSF to admit record numbers of patients into its feeding programmes in Niger in 2005. Such new products and strategies open new possibilities for nutritional intervention in large emergencies, and in situations with high levels of childhood malnutrition. In Maradi in 2006, MSF is treating all malnourished, severe and moderate, with the same therapeutic treatment regimen. The severely malnourished have higher rates of mortality, but most malnutrition-related deaths occur amongst the far more numerous, moderately malnourished group. On an individual level, all are at increased risk of death and disease, and most can be quickly cured when the best available therapeutic, nutritional product is given to them. MSF is looking at ways to further simplify outpatient management of acute malnutrition. By reducing the frequency of follow-up visits, it is possible to further increase capacity and efficiency, helping mothers who have to travel significant distances to attend scheduled consultations. It may be possible to bypass the time

consuming procedure of taking each child's height and rely on the measurement of the mid-upper arm circumference (MUAC) and weight alone. Some of these new ideas are currently being implemented in northern Kenya, where three years of drought have led to high malnutrition rates amongst pastoral populations.

Clearly, efforts to address the underlying causes of malnutrition are critical and must be supported. However, new therapeutic products and outpatient treatment strategies make it possible to offer curative treatment **now**, to much larger numbers of patients, including in situations of chronic hunger, where most cases of acute malnutrition and excess death are occurring. This will be all the more true if RUTF products can be made less costly and more widely available. There is no reason why this can't be done. As treatment of acute malnutrition becomes simpler and cheaper, it may no longer be perceived exclusively as a tragic dilemma requiring sustained, long-term efforts and solutions, but also as a highly prevalent, frequently lethal, neglected and imminently treatable disease, calling for immediate and effective medical care.



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1. Jones G et al. How many child deaths can we prevent this year? *Lancet* 2003; 362: 65-71.

2. Black RE et al. Where and why are 10 million children dying every year? *Lancet* 2003; 361: 2226-2234.

3. Shrimpton R et al. Worldwide timing of growth faltering: Implications for nutritional interventions. *Pediatrics* 2001; 107: e75.

4. Golden MH, Briend A. Treatment of malnutrition in refugee camps. *Lancet* 1993; 342:360.

5. Collins S. Changing the way we address severe malnutrition during famine. *Lancet* 2001; 358: 498-501.

6. Briend A et al. Ready-to-use therapeutic food for treatment of marasmus. *Lancet* 1999; 353: 1767-1768

Doing More by Doing Less

Decentralising HIV/AIDS care in rural Malawi

The Thyolo region of southern Malawi is a verdant area of tea estates. Bright green tea fields are cut through by reddish tracks, linking the many communities spread out in small villages. One of 28 districts in the country, it is also the area that is perhaps hardest hit by HIV/AIDS, with 20% of people now testing positive for the HIV virus.

Despite this grim statistic, concerted efforts are being made to provide treatment in this district of 575,000 residents. The Malawian Ministry of Health (MOH) has a national programme to address HIV/AIDS, there is currently a supply of drugs for patients, and MSF has been present in the Thyolo health district since 1997, helping to organise and provide effective care for those suffering from the disease.

Whilst have had many successes, establishing an efficient system of treatment delivery has been challenging, particularly given the rising number of people presenting themselves for treatment. HIV/AIDS education, testing, and successful treatment of opportunistic infections – conditions such as pneumonia that can claim the lives of people with HIV – have led to more people surviving the virus and there are now over 10,000 people without access to antiretroviral treatment (ART) who urgently need these life-prolonging drugs.

Accessing ART has not been easy for everyone here with an HIV+ test result, particularly with the initial national strategy of providing the drugs only at hospital-based clinics. The two hospitals in Thyolo district are now grossly insufficient to handle the thousands of people who need ART. For many, hospital-based care has also proven to be inconvenient and cumbersome. Long trips by foot to the hospital are unrealistic for people who aren't feeling well, are expensive, and increase the risk of people discontinuing or not even initiating treatment.



One patient living in Namileme, 25 kilometres from the nearest hospital, describes her experience:

“I left at 3:30 am on foot to Thyolo hospital to try to get antiretroviral medicine (ARVs), arriving at 9:30 am after four hours of hard walking. I waited in the group counselling room until 12:00 pm and as I was very hungry and thirsty, left to the market to find something small to eat. When I returned, I was told the session was already over and I must return one week later. I now had to walk back home for another four hours without anything! Now I must walk back twice to Thyolo hospital, once for a group counselling session and then again for an individual counselling session before I can get ARVs. The nurse says this is to make sure I will be committed to taking ARVs, but I already know very well that I really need the ARVs and I am ready to take the medicines. It’s just so hard to get them.”

The usual process for obtaining antiretrovirals involves educational group counselling, followed by a one-week period so patients can consider making the commitment to treatment. Patients then return for individual counselling to understand how to take their ARVs properly. With such activities based at the hospitals, many people lose valuable hours they need to earn a living. On children’s clinic days, both mothers and children were exhausted upon arrival, practically falling asleep during counselling sessions! Motorised transportation is a quicker way to get to the hospitals, but costs are prohibitive for most, and during the heavy rainy season, transportation is also difficult as the dirt tracks turn to mud, often doubling travelling time or stopping service altogether.

When less is more

Having set a goal of providing ART to 10,000 people by the end of 2007, it became clear we needed a new approach. Our motto became “do more by doing less.” We needed to get drugs to many more people before their disease progressed to the point where they required more intensive medical care. We also needed a faster, less cumbersome and more patient friendly system.

“I always used to go to Thyolo hospital with my guardian, a relative who helps me comply with my treatment, and it was expensive to pay for two transport fees. Now I get exactly the same service at my local health centre”.

Patient at Konjeni health centre, a decentralised site.

Offering patient-centred care

Our solution was to decentralise antiretroviral treatment, moving follow-up for stabilised patients on ART out of the hospitals and into nine local health centres.

To maintain quality care, we developed criteria to define eligible patients and to identify the necessary characteristics for the selection of health centres. All staff who would be providing ART were also required to undergo training. These workers are supported by a mobile MSF team that travels to the health centres for supervision of treatment and counselling and dispensing ARV drugs. The health centre teams continue the regular follow-up activities with continuous support from MSF.

This approach is helping to “demedicalise” HIV, empowering individuals and community members to be more involved in caring for those who have the virus. Communities are embracing this wholeheartedly, developing networks that engage in a range of supportive and innovative activities, such as checking in with peers at community meetings to make sure pills are being taken properly, and documenting life-affirming “before and after” photographs of people on treatment and living with HIV, which helps to reduce the stigma of the disease.

Today there are over 2000 people who have formed an association linked to the National Association of People Living with AIDS (NAPWA). Members are identifying ways they can help each other, undertaking projects such as organising vegetable, maize and fish farms to help feed people who are poor and unwell, and creating vocational training and income generation activities for HIV/AIDS orphans. This community involvement has been a positive force in our efforts at decentralisation.

A dearth of human resources

The numbers show that decentralisation is working – in one village alone we rapidly went from 20 to 150 patients on ART. But this new approach also comes with its own challenges, the most serious impediment being the lack of adequate and well-trained medical personnel. As in many other African countries, there is a chronic shortage of human resources here. Malawi graduated only 16 new doctors in 2005, and only one remains in the country. The government is permitting us to train medical assistants to provide ART at the health centre level because there simply are not enough medical doctors or clinical officers to do so.

The pre-existing health centre staff who are now involved in decentralised HIV activities are understandably feeling overstretched. HIV care is an added activity when they have many other responsi-

bilities and administration duties. Other priorities – primary healthcare, vaccination programmes, training workshops or providing relief for colleagues on annual leave – compete with HIV care and sometimes result in health centre clinics not opening when they are supposed to. Absenteeism amongst medical staff is also a problem and can be attributed, in part, to low salaries. Although we have topped-up health staff salaries as a compensation for the increased workload, there is a limit to how much work one can do in one day. The lack of human resources is the most crucial obstacle to our decentralisation effort.

These difficulties are compounded by a poor health infrastructure. Operating ART clinics and general outpatient consultation simultaneously in the same room with a lot of staff and patient movement can compromise confidentiality, and some patients have complained about sitting with other patients from the same areas in their health centre. We have tried to put up partitions to split rooms in two, but this does not always work because rooms are small to begin with. We now need to refurbish and rehabilitate some of the nine public health centres and in some cases, build extensions to accommodate clinic rooms. For now, we are simply doing the best we can with what we have.

Simplified treatments are key

As we now begin to initiate treatment at local sites, simplified treatments will be the backbone of successful decentralisation. It is the most practical response in the face of human resource shortages, and gives patients and caregivers as much control as possible for their care. Antiretroviral drugs must be effective and of acceptable international standard, easy to administer with a light pill burden (twice a day, triple drug combination), and child friendly for young patients – easily breakable, for example. In this resource-poor setting, drugs requiring no refrigeration are needed, as well as a schedule of drug intake that has no relation to food.

Other avenues exist for simplification. In Malawi, laboratory services to do a CD4 count (an index of immune system function) are a rare commodity and are usually not available in decentralised sites. We have found that with treatment provided far away from labs, blood specimens sometimes “spoil” before they can get to the lab to be analysed. Sometimes blood must be collected twice for a single analysis.

Though a baseline CD4 count is normally required as a pre-condition to start antiretroviral treatment, most patients we see are in advanced stages of the illness (WHO stages III & IV) and exhibit clinical symptoms that can lead to a decision to initiate ART without a blood analysis. In this environment, a thorough medical history and physical examination are a reliable way to select patients needing ARV treatment.

Reaching more patients, saving more lives

Scaling up ART to treat more people is a challenge, especially as the caseload increases. Decentralisation is not an easy process and it is not a cheap venture to provide patients with treatment. Research and development into paediatric diagnostic tools and drugs, simplified treatment protocols, and affordable secondline medications for

those who need to change drugs will really help us leap forward. But despite our limitations and multiple constraints on resources, this is proving to be a good approach for getting treatment into the hands of more people who, quite literally, will not live without it. Our staff sees a visible difference in the health and vibrancy of the patients we treat, as a result of being able to access the care they need. From one of our patients at a decentralised site in Milongwe:

“I have spent a lot of money trying to access ARVs at Thyolo but I did not succeed. The first two weeks of taking ARVs are wonderful. I felt the difference. I actually can feel life coming back.”



© Julie Rémy

To participate in decentralisation in Thyolo, patients must:

- have been on standard firstline ART for a minimum of 3 months
- demonstrate good treatment adherence
- be stable on ART without opportunistic infections
- not have any specific psychosocial considerations
- live at least 10 km or more from the main Thyolo ART Clinic, but close to the approved health centre

United Nations: deceptive humanitarian reforms?

Responding to many of the same crises and often working alongside United Nations relief efforts within the field, Médecins Sans Frontières has given much consideration to the nature of humanitarian aid offered under the UN relief system. Increasingly, there has been a feeling of a great discrepancy between the needs to be covered quickly and the effectiveness of the UN response.

The past two years have raised many questions regarding the operational engagement of the United Nations agencies: there have been inappropriate or slow UN responses to emergencies in Niger, the Eastern Democratic Republic of Congo, Sudan and Somalia; difficulty understanding strategies and agendas, such as in Northern Uganda, the Caucasus and in Colombia; poor coordination of their delivery partners in Indonesia following the tsunami or more recently the earthquake in Pakistan, and the virtual absence of UN aid in very fragile regions such as the Central African Republic.

Spurred on by increasingly public failures to adequately respond to the needs of displaced persons in various contexts – Darfur being the most egregious example, the UN, on occasion of its sixtieth anniversary, initiated a series of reforms intended to improve its response to humanitarian crises. Marked by the modification of its emergency fund to establish the Central Emergency Response Fund (CERF) in December 2005, these changes fall within the scope of a wider process of organisational reform proposed by the UN Secretary General under pressure from many Member States.¹

MSF and current reforms: independence and pragmatism

Officially, reform aims to increase the role and authority of humanitarian coordinators in the field to better defend humanitarian space and principles. Everything rests on two pillars. The first is financial resources that are more predictable and more readily available in emergency situations through the new CERF. The second is a mechanism (“cluster system”) allowing the humanitarian coordinator in a given country to clearly identify and quickly mobilise the agency responsible for overseeing a response to particular needs, with the aim of eliminating any gaps between sectors. This “cluster lead” then relies on the other members of its cluster to carry out a response: the UN operational agencies and NGOs it will mobilise to address an identified need.

MSF continues to follow this process of reform with attention to its potential implications for the organisation of emergency relief and the response to humanitarian needs in the field. We have abstained from publicly taking position on the current reforms, as we considered it did not fall within the competence of a medical-humanitarian organisation to comment on, or make proposals regarding the internal workings of the UN. The current reforms are also a UN process: clearly stated, we will not be a member of the clusters and the action of MSF will not be placed under the responsibility of UN

humanitarian coordinators nor be accountable to them. In the face of the challenges to be met, however, we can only welcome the willingness of the United Nations to improve their humanitarian response.

We must also take a critical look at the possible effects of the reforms on the effectiveness of aid. While it is doubtless too soon to fully evaluate the impact of proposed changes, the slowness of the UN response to the recent cholera outbreak in Angola, including at the peak of the crisis in May 2006, or in the face of the latest population displacements in Katanga province, Democratic Republic of Congo (DRC) makes one wonder whether the reform will deliver better assistance for those most in need. In DRC, the military operations launched in November 2005 by the Congolese armed forces against certain Mai-Mai groups resulted in the displacement of several tens of thousands of people, yet the World Food Programme needed several months to become fully operational. In Northern Uganda, chosen as a pilot country for the implementation of reforms, the needs for water and latrines were not always met in most districts more than six months after the reforms came into effect.

Placed respectively in charge of the nutrition and health clusters, Unicef and the World Health Organization (WHO) have a chance to play a leading role promoting and adopting new strategies for the treatment of malnutrition, following the discovery of a new therapeutic product (in the form of an enriched ready-to-use paste). Given this possibility, their position and operational decisions surrounding this issue will also constitute a full-scale test to see if the new coordinated cluster structure results in any real improvements in meeting human needs.

Whilst determined to retain its independence in the face of current reforms, MSF will continue a dialogue with the UN operational agencies and also accepts the need for context-related, operation-oriented coordination between the head offices as well as in the field. MSF will maintain its independence of analysis and action and resources so as not to jeopardise the strictly humanitarian and impartial nature of our organisation, particularly in conflict situations, where it is critical to keep the trust of the belligerents to be able to reach those who require our assistance.

Coordination: to what end?

Coordination cannot be an end in itself; it must be useful, guided by the reality of the situation on the ground and directed toward concrete action. The limits of the mechanisms of coordination must be recognised: faced with political interference in humanitarian aid, the solution resides not in multiplication or strengthening of technical measures, but rather in the need for humanitarian organisations and the international community to highlight political constraints and ascribe responsibilities. The setting up of coord-

1. “In larger freedom: towards development, security and human rights for all”, Report of the Secretary-General, 24 March 2005 (A/59/2005).
2. Tsunami Evaluation Coalition, Joint evaluation of the international response to the Indian Ocean tsunami, July 2006.
3. “Note of Guidance on Integrated Missions”. This document issued by the General Secretary of the United Nations was adopted on 17 January 2006 by the UN policy com-

mittee. This body is made up of the most senior officials of the worldwide organisation and is responsible for advising the Secretary General and strategic decision making.
4. Faced with the increase in the number of peacekeeping operations in the 1990s and the failure of the international community in the management of certain internal conflicts, a number of analyses concluded that there was a need for better coordination between the different aspects of crisis response through the creation of suitable institutional

dination structures at national (Joint Monitoring Committee) and decentralised (District Disaster Management Committees) levels did not, for example, help to improve the quality of assistance provided in Northern Uganda.

It is also crucial not to maintain the illusion that a unified aid system steered by the UN Office for the Coordination of Humanitarian Affairs (OCHA) or any other agency would lead to an automatic significant improvement in the efficiency of relief efforts. Presented as a model of coordination, the international response to the tsunami at the end of 2004 was nonetheless severely criticised by an international evaluation mission.² According to the conclusions of that investigation, the international relief effort did respond to the actual needs of the affected populations, but was driven more by political and media considerations. Faced with the scale of the public response, the humanitarian organisations spent the money “quickly and ostentatiously” and “to find something to do”.

The humanitarian landscape is currently made up of a large number of actors with widely differing aims, resources and modus operandi. It is not only impossible and unrealistic to believe that all these actors can work in perfect synergy under a single banner, but it can also be at times perilous, as some actors operate with mixed agendas, the humanitarian goals falling second to political, security or developmental objectives and resulting in unmet needs. The existence of a diversity of approaches is what helped save the lives of thousands of children in Niger in 2005, illustrating that independent actors may well offer people in need the best chance at effective assistance. Further, diverse approaches to humanitarian aid help assure that if one strategy fails, all do not fail, with deadly consequences. We have already seen this to be the case in contexts such as East Timor and Angola.

The increasing politicisation of humanitarian action

According to United Nations official line, the reforms initiated in 2005 should better defend the humanitarian space and principles and improve the efficiency of the UN’s crisis response. This can be doubted, however, in light of the UN Secretary General’s note on integrated missions, adopted on 17 January 2006.³ This document reaffirms the central role of integration for the mounting of UN peacekeeping missions. It is not only a matter of achieving “a more consistent UN system” in the field, but also of “ensuring efficient coordination between the peacekeeping mission, the UN’s operational agencies and non-UN partners.” The note also specifies that the UN presence must be based on a clear and shared understanding of the priorities and the willingness of all actors to contribute to the achievement of shared objectives – subject to reorientation based on the global objective of the UN mission.

This document clearly shows that in the UN’s view, humanitarian action remains subordinate to the UN’s political arm and that humanitarian aid comes second to the political objectives pursued

Nine different clusters have been validated by the members of the Inter-Agency Standing Committee (IASC) in the UN’s cluster system. These clusters are:

- Nutrition
- Water and hygiene
- Health
- Coordination and camp management for displaced people
- Emergency shelters
- Protection
- Logistics
- Means of communication
- Re-launch of the economy in the post-conflict stage

This organisation applies mainly to relief efforts in favour of internally displaced populations.

by the peacekeeping missions. The DRC provides a perfect illustration of this: the weakness of the international assistance given to Katanga and the slow response of the UN’s operational agencies to the renewed displacements of populations that occurred at the end of 2005/ beginning of 2006 were linked to the reticence of the Security Council and donors to examine the situation in this “Presidential province”, for highly diplomatic reasons.

MSF has on a number of occasions publicly stressed the risks of the politicisation and the militarisation of the system of aid brought about by the “coherence agenda”⁴ and integrated missions, in particular in conflict situations. This approach has notably led in the past to certain groups in need being excluded from immediate assistance in Angola, Sierra Leone and Burundi⁵. In Sierra Leone, for example, the UN in 1997 withdrew staff and cut off emergency assistance to support its political aim of weakening the AFRC/RUF, the result of which was deliberate and unnecessary suffering and starvation of the population. This year, Darfur and the occupied Palestinian Territories served once again to remind us that humanitarian action constitutes a crisis management instrument. In April 2006, the World Food Programme (WFP) announced a halving of food rations to the people displaced by fighting in Darfur because of a lack of finance. This was brought about because the donor countries had decided to make assistance to populations conditional upon the signing of a peace agreement.


Following the victory of Hamas in the January 2006 parliamentary election, several countries including the United States and the European Union decided to suspend their bilateral financial aid to the Palestinian Authority whilst proposing to redistribute these funds towards international relief organisations. Humanitarian action thus became a palliative for a retaliatory measure and was effectively asked to act as a substitute for the Palestinian Authority.

Improving the effectiveness of relief actions depends mainly on upholding and implementing humanitarian principles by the operational agencies of the UN (WFP, Unicef, HCR) and by the NGOs, in other words, strengthening the impartiality and independence of humanitarian action. The increasing politicisation of the international system of aid over the past few years does little to inspire optimism, particularly as the majority of humanitarian relief actors are actively contributing to the process – or do not have the means to escape from it.

mechanisms. Within the UN system, this dynamic led to the implementation of “integrated missions” consisting in placing all UN activities in the field under the authority of the UN Secretary General’s Special Representative. See in particular “Renewing the United Nations-A Programme for reform”, A/51/950 and “Report of the Panel on United Nations Peace Operations” (the Brahimi report), A/55/305-S/2000/809.

5. For more information, see in particular “Angolans left to die: abandoning the humanitarian imperative”, MSF report, 30 October 2003 and Nicolas de Torrenté, “Humanitarianism Sacrificed: Integration’s False Promise”, in *Ethics and International Affairs*, volume 18, 2004.

Democratic Republic of Congo



As a medical-humanitarian organisation, MSF seeks to help people most in need, and for years the DRC has been at, or near, the top of our list. The longstanding war and the collapse of the public health system have resulted in widespread acute medical needs. MSF teams, composed of international and Congolese aid workers, are active in all corners of this huge country striving to reach those most at risk.

It is a struggle to do anything other than respond to the most serious emergencies. The complex and diverse nature of the violence, neglect, and discrimination in the DRC challenges any notion of simple, blanket solutions to redress even the immediate causes of so much death and suffering. Whilst MSF does not purport to provide a solution, we want to draw attention to what the Congolese people are enduring.

More than 3.8 million people have died in the Congo conflict since 1998. The majority of people die from disease and malnutrition.

Bon Marché Hospital, Bunia, May, 2005

o: Forgotten War





Internally displaced people of the Hema tribe at the Tche camp, Ituri District. In January 2003, renewed fighting forced tens of thousands of people to flee for their lives into the surrounding forests and abandon their few possessions to local militias, with some 80,000 finding precarious refuge in Djugu territory north of Bunia. MSF carried out an emergency intervention in four displacement camps in Gina and Tche, in the highlands, and Tchomia and Kakwa, on the shores of Lake Albert.

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At a hospital in Bunia, a mother tries to soothe her two young children suffering from malaria and dysentery.





© Joachim Ladefoged/VII

A girl behind a mosquito net inside a compound shared by nine commercial sex workers in Kinshasa. Up to 160,000 people in Kinshasa are living with HIV/AIDS and few have access to treatment. In addition to providing antiretroviral therapy to over 1300 patients, MSF has started a new project aimed at treating commercial sex workers who have HIV/AIDS.



An AIDS patient being cared for by MSF doctors at a hospital in the eastern town of Bukavu, Congo, June 2005. Throughout the country an estimated 1.1 million Congolese are living with HIV/AIDS and many people have little or no access to comprehensive healthcare.

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© Gary Knight/VII

An MSF patient recovers at Bon Marché Hospital. A former coffee warehouse, the Bon Marché is the only fully functioning medical facility for hundreds of kilometres, offering free healthcare to all indigenous tribes. A range of medical care is provided here, with a particular focus on surgery for the war-wounded. Sexual violence is especially prevalent, and MSF has treated more than 3500 rape survivors since June 2003.



© Antonin Kratochvil/VII

A guard at the entrance of an AIDS clinic run by MSF in Bukavu, June 2005.



© Gary Knight/VII

A young child with high fever and many medical complications awaits emergency surgery at Bon Marché Hospital, Bunia. Whilst many people have lost their lives in the violence, the great majority have died from preventable diseases like malaria and measles.



© Ron Haviv/VII

Pictures can help.
Their essential quality is
to go behind the headlines
to offer glimpses of ordinary people's lives –
reminding us, and
the world at large,

that we must refuse to let
the unacceptable

become

normal.

Photos are part of a touring exhibition by the world-renowned VII Photo Agency photographers, who travelled with MSF in the Democratic Republic of Congo in 2005. The exhibit has visited Australia, Austria, Canada, DRC, Denmark, Hong Kong, Japan, Macau, Switzerland and the USA.

Bon Marché Hospital, Bunia

Medical conditions

Chagas Disease

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

The disease is transmitted by blood sucking insects (*Trypanosoma cruzi*) that live in cracks in the walls and roofs of mud and straw housing, common in rural areas and poor urban slums in Latin America. People can be infected but show no symptoms for years. Developing over time, chronic Chagas causes irreversible damage to the heart, oesophagus and colon, shortening life expectancy by an average of ten years. Heart failure is a common cause of death for adults with Chagas.

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

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

Cholera

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

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

to severe dehydration and death without rapid treatment. Required treatment is the immediate replacement of fluid and salts with a rehydration solution administered orally or intravenously.

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

In 2005/2006, MSF conducted major cholera interventions in countries including Angola, Democratic Republic of Congo, Guinea, Guinea-B and Ethiopia.

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 antiretrovirals help combat the virus and enable people to live longer, healthier lives without rapid degradation of their immune systems. It is simplest and easiest to take these drugs properly when they are combined into single pills (fixed-dose combination 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 antiretroviral treatment for patients in advanced clinical stages of the disease.

In 2005/2006 MSF provided care for over 100,000 people living with HIV/AIDS and antiretroviral therapy for more than 60,000 people across 65 projects in 32 countries.

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. This stage of 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 5 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 through its Access to Essential Medicines Campaign works to ensure the production and supply of eflornithine and urges for research and development aimed at new, easy-to-use drugs and accurate diagnostic tests.

MSF admitted 5204 new patients for treatment for human african trypanosomiasis in 2005.

Leishmaniasis (Kala Azar)

Largely unknown in the developed world, leishmaniasis is a tropical, parasitic disease caused by one of over 20 varieties of *Leishmania* and transmitted by bites from certain types of sandflies. The most severe form, visceral leishmaniasis, is also known as kala azar, Hindi for black fever. Over 90 per cent of cases occur in Bangladesh, Brazil, India, Nepal and Sudan. Without treatment, this form of leishmaniasis is fatal in almost 100 per cent of cases.

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

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

MSF through its Access to Essential Medicines campaign is urging for more research into suitable diagnostic techniques and affordable drugs to treat this neglected disease.

MSF treated over 7000 people for leishmaniasis in 2005.

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 are treated for malaria in Africa may not actually be infected with the parasite. An accurate diagnosis can be made through a count of parasites by microscope or a rapid dipstick test. Both methods are currently used by MSF in its projects.

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

MSF treated over 2.2 million people for malaria in 2005.

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 partial paralysis.

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 vaccinated over 100,000 people against meningitis in 2005.

Tuberculosis

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

This contagious disease affects the lungs and is spread through the air when infectious people cough, sneeze or talk. Not everyone will become ill, but ten percent of (HIV negative) infected people will develop active TB at some point in their lifetime, suffering from a persistent cough, fever, weight loss, chest pain and breathlessness in the lead up to death. TB is also a common opportunistic infection and leading cause of death amongst people with HIV.

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

In 2005, MSF treated over 20,000 people with TB in more than 20 countries worldwide.

MSF Projects
around the World
Africa



© Paolo Pellegrin/Magnum Photos

A child with cholera and his mother in an MSF-run cholera treatment centre in Malenje, Angola, May 2006.

Angola

After three decades of civil war, reconstruction of Angola's health infrastructure is starting to take the place of medical emergency assistance. The country's current health system, however, remains woefully inadequate and in February 2006 was challenged by the worst cholera outbreak ever recorded in the capital city of Luanda.

MSF, already present with numerous projects throughout the country, responded by setting up 10 cholera treatment centres (CTCs) in Luanda, receiving up to 400 admissions daily at the height of the outbreak. Another 15-20 treatment centres were set up to deal with the spread of the bacterial illness in other provinces. Treatment efforts were complemented by water and sanitation activities.

The required medical care for cholera includes the immediate replacement of fluids and electrolytes. MSF organized 40 "oral rehydration salt points" in Luanda, where patients could receive rehydration and more severe cases could be immediately referred to the closest CTC. This also helped reduce pressure on CTCs by offering effective treatment for those not needing hospitalisation, whilst reducing time between cholera detection and necessary referrals.

An educational component was part of the emergency response, including a cholera song broadcast by national and local radio networks. The number of cholera cases began to decline by mid-May and MSF started handing over the treatment centres to the Ministry of Health (MOH).

More than 53,000 people were infected and an estimated 2100 people died between mid-February and early September 2006. During its intervention, MSF treated more than 26,000 people and sent more than 400 tonnes of medical and logistical supplies to affected areas.

Treating people with HIV/AIDS, tuberculosis and malaria

In the provinces of Malanje, Lunda Norte and Bié, MSF in 2005/2006 continued to assist thousands of people with HIV/AIDS, tuberculosis (TB) and malaria. MSF has also

introduced new malaria treatment protocols using highly effective artemisinin-based combination therapy (ACT) and is urging the government, who has adopted ACT as its new treatment protocol, to make the drugs available across the country.

MSF also supports the health centre in Cuemba, Bié province, which provides medical care for approximately 84,000 local residents and Angolan refugees returning from other countries. In 2005, more than 40 patients were treated for TB at this location. MSF also supports the TB programme at the provincial hospital in Kuito, which serves approximately 500 patients receiving directly observed tuberculosis treatment.

In Luau, Moxico province, MSF supports the 53-bed hospital, which conducted more than 20,000 outpatient consultations in 2005 and admitted approximately 125 patients monthly. MSF also provides assistance at five area health posts, using mobile medical teams in this sparsely populated area. During 2005, teams performed over 30,000 medical consultations.

Numerous projects close

The country's stabilising situation has led MSF to hand over many of its activities, including projects in Mussende, Kwanza Sul province (March 2006); Kuvango and Vikungo, Huila province (March 2006); Cangola, Uige province (July 2006); Macocola and Buengas municipalities, Uige province (December 2006); Caxito, Bengo province (January 2006); Mavinga, Cuando Cubango (September 2006) and the Luau transit centre (September 2005).

MSF has worked in Angola since 1983.

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Inside a Cholera Treatment Centre

The atmosphere inside the cholera treatment centre (CTC) is somewhat chaotic. All the beds are full and some patients have to share a bed. Both medical and logistical staff are working flat out, the logisticians hastily putting up another tent to house twenty more beds, but the truth is they are running out of space. The CTC itself is quite basic: at the entrance there is a disinfection area where everyone is sprayed with chlorine, to kill the bacteria that cause cholera. Cholera is highly contagious so it's crucial that infected people are isolated and anyone who comes into contact with them is disinfected. There is also a triage area for newly arrived patients, a pharmacy, water points, latrines, and several large tents with rows upon rows of beds. Each bed has a hole in the middle and two buckets underneath, one labelled 'vómito' the other 'excremento'.

It would be easy to be shocked by the indignity of it all, but the only way to treat cholera is to allow patients to flush the bacteria out of their bodies and to rehydrate them as quickly as possible. For those who reach a centre in time, recovery is fast.

Benin

Benin is one of the more stable countries in Africa, though a poor one, with few natural resources and where over 33 per cent of its inhabitants subsist on less than a dollar per day. Malaria is a common cause of death, and HIV/AIDS is also a health concern.

MSF has developed a comprehensive HIV/AIDS project in the department of Mono-Couffo, a rural area where HIV prevalence, at 3.4 per cent, is reported to be the highest in the country. Activities include counselling, testing, treatment and an educational programme mounted in collaboration with local associations. MSF conducts an average of 620 medical consultations and initiates antiretrovirals (ARVs) for 35 new patients monthly. By the end of 2006, 900 patients will be taking ARVs.

Now that the project is well established, MSF is preparing its transfer to local health authorities and partners, whilst it continues to advocate for authorities to provide free treatment for all illnesses linked to HIV/AIDS.

Caring for Togolese refugees

Since June 2005, MSF has run a project to ensure medical care for up to 10,000 Togolese refugees in a camp at Agamé, in the south of Benin. In February 2006, violent confrontations between refugees and local residents resulted in the destruction of the camp and the medical outposts of MSF were looted. Refugees made a massive departure towards Lokassa, 12 kilometres from Agamé. One week later, many returned to the area and MSF was able to re-establish its activities, performing approximately 2000 consultations monthly for a population of 6690 refugees.

Diagnosing and treating patients with malaria

In September 2005, in the refugee camp of Agamé, 45 per cent of patients with fever were diagnosed as being affected by malaria. MSF intervened to provide more accurate diagnoses using a rapid qualitative test for malaria. MSF tested 3388 people with fever and treated the 1028 people requiring treatment with artemisinin-based combination therapy (ACT), currently the most effective antimalarial in this area.

MSF has worked in Benin since 1997.



reatment Centre Luanda, Angola, March, 2006

Most patients at the centre are put on intravenous drips containing Ringer's lactate fluid to rehydrate them. MSF staff work around the clock putting people on these drips, a doctor might do up to fifty IVs in one morning. Once patients are on the drips they must be constantly monitored. If too much is given to a young child, there is the risk of flooding their lungs. If it is not given quickly enough to an adult, they could die from dehydration.

When a cholera outbreak is first suspected, stool samples are used to diagnose the illness. By the time that a CTC is set up, such tests are hardly necessary. The majority of people coming to the centre will be infected, with the most severely affected easily identifiable by what one nurse describes as 'cholera eyes' – sunken eyes that show no recognition of the people around them, or their surroundings.

Most patients in this centre are from Boa Vista, one of Luanda's biggest slum areas where the cholera outbreak has been most severe. Yet parents such as Florinda Mateus, whose five-year old son is receiving treatment, find that with limited public transport, getting to the CTCs is not always easy:

"I saw the notices on TV about cholera so I knew to bring Nelo here, but the normal buses wouldn't take us so I had to call a taxi. They charged me 1500 kwanza, much more than usual, because they knew my son was ill." Other patients reported they were too scared of being robbed to come to the centre at night, so each morning the CTC sees a surge in patient numbers. Often this delay means patients are so dehydrated when they arrive at the centre that little can be done for them.

Public education is integrated into a cholera response, to help prevent the spread of the illness, but unfortunately cholera prevention is not just a question of knowledge. As Julia Parker, who helped organise such education in Angola says "The people we've been talking to in Luanda know they should wash their hands and treat their water but the conditions here just don't favour good hygiene."

Burkina Faso

People living in the poor West African nation of Burkina Faso have an average life expectancy of approximately 48 years. About 90 per cent of people earn their livelihood through subsistence agriculture, mostly cotton, in a country vulnerable to drought and desertification. Lack of access to safe and clean water is a problem for much of the population and the risk of infectious diseases is high.

MSF regularly intervenes to provide medical care during health emergencies. In 2005 there was a cholera outbreak from mid-August to November in the capital city of Ouagadougou. MSF worked in a cholera treatment centre, where it was involved in the treatment of 1050 people who had contracted the water-borne disease.

Meningitis is endemic in Burkina Faso and epidemics tend to break out during the major dry season, from January to March. In March 2006, the situation was particularly worrying, with the number of meningitis cases climbing to over 2000 persons in just seven weeks. MSF worked with the Ministry of Health to carry out a vaccination campaign and provided supervisory personnel, vaccine supplies and logistical support. In the districts of Banfora and Sindou, MSF teams managed the vaccination campaign and helped safeguard 400,000 people against this disease through immunisation.

Supplying patients with HIV treatment

In Ouagadougou, MSF has an established HIV/AIDS project in the Pissy health district, where an average of 1600 medical

consultations are provided each month. Antiretroviral treatment (ART) has been supplied to patients since April 2003, and approximately 85 new patients start treatment monthly. Approximately 3500 patients will be on ART by the end of 2006.

Health support for teenage street girls

Ouagadougou has a thriving sex trade and MSF has been offering health education and healthcare for teenage street girls since 2005. Services include treatment for sexually transmitted infections (STIs), obstetrical care and psychological support for survivors of sexual violence. There are also efforts to improve the legal protection available to these teenagers. MSF trains local health workers so they are able to treat girls with STIs. By July 2006, the project had reached 300 teenagers.

MSF also provided medical care and psychological assistance to 700 of the capital's street children over the past seven years. A local organisation took on this project in April 2006.

MSF has worked in Burkina Faso since 1995.



© Anthony Jacopucci

Burundi

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An average family in Burundi has to work for two weeks to care for those who would otherwise do without, using mobile

A country with a long history of ethnic conflict, Burundi in 2005 continued along a road of relative peace, seeing the democratic election of a new, power-sharing government headed by Pierre Nkurunziza. The country's war-shattered economy and infrastructure are high on the government's development agenda, but a cost-recovery system of healthcare means that many Burundians still lack access to basic medical services, despite a May 2006 announcement of free medical care for pregnant women and children under five years of age.

Offering low cost primary healthcare

MSF supports a number of hospitals throughout the country, where health services are provided for very low fees, with free access for the most vulnerable. Malaria, a treatable but otherwise potentially fatal disease, represents up to 50 per cent of MSF medical consultations at health centres countrywide.

In Karuzi province, MSF works in the newly rebuilt, 180-bed Buhiga Hospital, offering surgery, maternity and paediatric care. MSF also supports 12 primary healthcare centres in the province (450,000 consultations in 2005), and runs a therapeutic feeding centre that treated 10,669 children in 2005.

In Ruyigi district, MSF provides primary healthcare in seven health centres (180,000 consultations in 2005, with 93,000 cases of malaria treated) and provides support to a hospital in Kininya. Medical services include tuberculosis treatment, ante and post-natal care, surgery and physical and psychological care for women survivors of sexual violence. There is also testing and treatment for HIV. A similar project is running in Kazanza province, where MSF works out of a 100-bed hospital in Musema and four health

Central African Republic



afford a medical consultation. MSF provides free health-
e clinics to reach remote villages.

centres that conducted 96,500 consulta-
tions in 2005.

Responding to women's healthcare needs

MSF runs a specialised health centre for women survivors of sexual violence in Burundi's capital city, Bujumbura. The "centre des femmes" provides medical and psychological care as well as services for family planning and sexually transmitted infections. The team also focuses on education and raising awareness about sexual violence. On average 123 women were treated monthly in 2005.

There is little capacity to deal with emergency obstetric cases in Bujumbura. In 2006, MSF began construction of a 30-bed gynaecologic-obstetric reference hospital with a surgical unit in Kabezi, 20 minutes outside the city centre, to provide emergency care for women throughout the province.

Helping Rwandan asylum seekers

In 2005/2006, some 20,000 Rwandans streamed across the border, citing harassment by Rwandan authorities and fear of neighbourhood tribunals established to prosecute genocide suspects. MSF established a clinic in Musasa and offered basic healthcare to asylum seekers in the Musasa and Songore camps. MSF also extended its services to Burundians, some of whom walk up to six hours to receive free and quality medical care. In the first seven months of 2006, MSF performed 63,675 medical consultations here, seeing mainly respiratory tract infections and malaria.

MSF closes the Centre de Blessés

The scaling down of fighting in and around Bujumbura led MSF to close its 'war wounded' health centre in March 2006. The project ran for ten years and recorded 1101 new admissions in 2005.

MSF has worked in Burundi since 1992.



© Tom Koene

The civilian population in the north of the Central African Republic (CAR) is bearing the brunt of an ongoing conflict between rebel and government forces. Violence between armed groups has led to the torching of entire villages and attacks on civilians, causing many people to flee to the bush, where they attempt to survive the most primitive living conditions. The fighting has caused a total collapse of the healthcare system.

MSF runs ten mobile clinics near Markounda, along the border with Chad, assisting thousands of people, many of whom suffer from malaria, worm infestation or acute respiratory infections – conditions often caused by living in the open. By May 2006, teams were conducting over 8000 medical consultations monthly. MSF vaccinates adults and children against measles and other common infectious diseases as a preventive measure. Plastic sheeting, blankets and soap are also distributed.

To care for patients requiring more intensive treatment, MSF set up a 16-bed hospital in Markounda. Each week up to 15 people are admitted to the facility and several hundred patients receive care through the hospital's outpatient department. In May 2006, MSF also began working in the 40-bed regional referral hospital in the city of Boguila Kota, southwest of Markounda.

In March 2006, MSF started providing medical care in the northwestern town of Paoua. In April, the team began conducting mobile medical consultations along roads near deserted villages. On average, 400 consultations are carried out each week, with approximately 60 per cent of patients under the age of five. Malaria is the main

"There were 400 people attending a clinic in one village. Suddenly one of them thought they heard a vehicle approaching from a distance. All 400 rose and fled into the bush within seconds, leaving the MSF workers standing alone and stunned."

Simon Collins, MSF doctor

illness seen here, affecting more than one-third of patients. Others suffer from maladies including respiratory infections, bloody diarrhoea or snakebites. Patients needing more care are referred to Paoua Hospital, where another MSF team works after having rehabilitated the facility. Approximately 500 people receive medical consultations and 50 patients are hospitalised weekly.

Handing over sleeping sickness activities

From 2001 to mid-2006, MSF ran a Human African Trypanosomiasis (sleeping sickness) programme in the Zemio, Mboki and Obo areas of the southeastern province Haut-Mbomou. The project was handed over to the Ministry of Health and national sleeping sickness programme in April 2006, once disease levels had dropped significantly. During its project, MSF screened more than 76,000 people and treated 1509 individuals.

MSF continues to screen and treat people with malaria in the area. The team trains laboratory staff and supervises five health centres in the Haut-Mbomou. A mobile health clinic operates close to Mboki town, performing approximately 1400 outpatient consultations monthly, many for people with malaria. Another 200 people are hospitalised each month for more intensive treatment.

In November 2005, MSF also responded to a measles outbreak in Mboki and vaccinated a total of 4500 children.

MSF has worked in the Central African Republic since 1997.

Chad

© Ton Koene



A child receives an oral polio vaccine in one of the camps housing refugees from Central African Republic.

Chad experienced bouts of instability in 2005/2006. Several attempted coups on the government culminated in a large-scale rebel attack on N'Djamena in April 2006, resulting in hundreds of civilian and military casualties. Earlier, in December 2005, clashes between government forces and Chadian rebel groups broke out in and around Adré, located at the Sudanese border. Since then, rebels or armed fighters have undertaken regular violent attacks at villages on both sides of the border.

Helping the wounded and displaced

Surgical capacity is necessary to treat people affected by violence. In the Adré hospital, MSF provides basic healthcare and basic and emergency surgery to residents and Sudanese persons who have fled Darfur and are now living in refugee camps in Chad. Healthcare and surgery are provided in the 50-bed hospital of Iriba, further north, and basic healthcare is available in a health centre at the border town of Tiné.

MSF has improved surgical facilities in the hospital of the provincial capital of Abéché and has readied medical materials such as kits and dressings to treat any war-wounds resulting from flaring violence in the area.

The sustained instability in eastern Chad has led to further population displacement along the border stretch. South of Adré, MSF operates fixed and mobile clinics to provide healthcare, non-food items and drinkable water to thousands of villagers and displaced people in and around the villages of Borota, Alacha, Adé, Koloy and Dogdoré. In June 2006, more than 5000 children were vaccinated against measles in this area.

Refugees from Darfur and Central African Republic

MSF provides medical care – including paediatric and maternal care – and psychosocial support to approximately 80,000 Sudanese refugees in four refugee camps. MSF also treats the surrounding Chadian population. Teams are involved in addressing the consequences of sexual violence, malnutrition, providing health education and controlling communicable diseases.

Since June 2005, increasing violence in the neighbouring Central African Republic prompted some 15,000 villagers to flee into southern Chad. MSF teams assist Central Africans on both sides of the border. In Goré, Chad, MSF supports the 50-bed hospital and two health posts in the Amboko extension and Gondje.

Malaria, measles and meningitis

MSF runs a malaria project in Bongor district, bordering Cameroon. During the endemic season in 2005, almost 40,000 people were tested and treated with artemisinin-based combination therapy (ACT).

In Bongor's district hospital, MSF provides surgical training for local doctors and anaesthetist training for nurses. In April 2006 the mobile surgical team relocated to N'Djamena to provide care for 49 persons seriously injured by violence.

Throughout the year, MSF regularly responds to emergencies such as measles, meningitis and cholera epidemics throughout the country. In May 2006, MSF vaccinated over 50,000 people against meningitis.

MSF has worked in Chad since 1981.

Cameroon

Buruli Ulcer is a largely neglected health problem for the people of Cameroon. Untreated, this disease destroys the skin and underlying tissues, causing large ulcerations, possible infection of the bone, and deformities, usually of the arms and legs. Buruli affects mostly children under the age of 15, some of whom may lose their limbs or face permanent disability without early medical care.

MSF runs a Buruli Ulcer project in the Akonolinga district of Cameroon, where it is estimated that more than 400 persons are suffering from Buruli in a rural population of close to 100,000. MSF works together with the local health authorities, health-care staff and school and community representatives to increase awareness about the disease and offer wound care, medical treatment, surgery and physiotherapy. Treatment is organised in the district hospital at the "Pavillion Buruli" and can last up to several months. MSF also supplies medical materials, training, support and supervision and maintains and rehabilitates infrastructure and equipment.

Case detection is steadily increasing because of growing awareness and credibility of the treatment services in the Akonolinga district hospital, where 145 persons were successfully treated in 2005. Between January and the end of July 2006, 98 new cases were diagnosed and admitted for treatment.

Helping develop a national HIV/AIDS programme

MSF's HIV/AIDS work continues to focus on access to HIV counselling and testing and care and antiretroviral (ARV) treatment with gradual involvement of local and national actors. The MSF HIV/AIDS projects in Cameroon have been serving as "pilot" projects both for MSF and the HIV/AIDS National Programme of Cameroon.



MSF nurse Pat Murphy manages the Buruli clinic, giving medicine and emotional support to patients receiving treatment. Patients are often stigmatised and face profound psychological and social hardships. Many with Buruli, especially children, find themselves alone and isolated from their families and communities.

By the end of July 2006, MSF was involved in the support, care and treatment for more than 4000 people with HIV/AIDS – 1300 on ARV treatment – in the districts of Nylon and New Bell in the city of Douala. In Yaoundé, MSF supported the care and treatment of more than 2200 people with HIV/AIDS (1300 on ARVs), through its long-term support to the Military Hospital and a new project at the Presbyterian district hospital of Djoungolo.

The system of financial participation by patients for HIV testing, care and treatment continues to be a major obstacle for increasing access to testing and treatment in Cameroon, despite several governmental decisions in the last three years on cost reduction and fee waivers for indigents and children. MSF aims to work closely with local associations, activists and actors to lobby for the removal of barriers to HIV prevention, care and treatment.

MSF has worked in Cameroon since 2000.

Buruli Ulcer: A Mystifying Disease

Tania, a young Cameroonese athlete, was a 100-metre track champion when she found out she had Buruli. “It all started with a little spot on my left ankle. It was in the middle of a competition and I did not want to get distracted or stressed. But weeks passed and the spot became bigger and purulent. I decided to go see a “mother”, a traditional healer. She informed me it was *onwondo* or Buruli Ulcer.

I was shocked. It was a terrible blow to my family, my coach and me. After two years of being treated by traditional medicine and the local nurse, and after another nodule appeared on my left elbow, I found out about MSF and decided to go visit them at the Buruli department of the Akonolinga hospital. I had to have an operation and the nurses looked after me day after day, cleaning and changing the dressing. Today, more than five years later, I am smiling again. I know I will be able to have a normal life and I’m so thankful to those who helped me. But I want to tell those affected by the ulcer: please do not wait, go and visit the Buruli ward at Akonolinga as early as possible.”

Lack of awareness of Buruli by health workers and affected communities means that the disease is usually detected at a late stage. Other factors for not seeking medical advice are financial constraints, beliefs that the treatment does not work, fear of surgery and anaesthesia or superstition and stigma.

“The delayed recourse to surgery – the main treatment for the ulcer – is much more traumatic than if carried out early, when it is highly effective. At a later stage, wide excisions or removal of the affected skin area, including healthy tissues, are recommended to stop the infection and prevent recurrence or relapse at the same site. It requires skin grafting and means a long stay in hospital,” explains a former coordinator of the Akonolinga project.

Patients suffering from Buruli Ulcer currently receive eight weeks of antibiotics as well as wound dressing and surgery. Although initial results of the antibiotic treatment seem to reduce the need for surgery, more evidence is needed before concluding its effectiveness.

Named after a county in Uganda, Buruli is caused by mycobacterium ulcerans, a bacteria related to tuberculosis and leprosy. Scientists do not yet know how the disease is transmitted, but it does not appear to be contagious. Currently diagnosed primarily by clinical symptoms, Buruli needs more research for rapid and accurate diagnosis and effective treatment.

The World Health Organization estimates that 100,000 people are suffering from this tropical disease, which has been reported in over 30 countries worldwide, particularly in West Africa, Central and South America, Southeast Asia and parts of Australia.

Republic of Congo (Congo-Brazzaville)

Renewed fighting between government forces and Ninja rebels in Congo's southern Pool region has caused increased hardship for civilians living in this war-torn country. The recent violence follows years of bloody conflict that destroyed the region's infrastructure including its healthcare system. The fighting also caused many healthcare workers to flee. As a result, most people living in the Pool region today cannot obtain basic medical care.

In Pool's Kindamba district, MSF performs more than 2400 consultations monthly, at regional referral hospitals and through mobile clinics. The team offers in and out-patient care, emergency surgery, and maternal and childcare, including immunisations. In Mindouli district, another 2400 patients are seen monthly at mobile clinics and in the district hospital. Mental health services are also offered through local counsellors and social workers, who help people overcome trauma related to the region's violent past.

HIV/AIDS care

MSF assists HIV-positive patients at a new programme in Mindouli. Counselling services and a patient support group have started and the first patient with advanced AIDS began receiving antiretrovirals (ARVs) in February 2006. HIV-positive patients are often co-infected with tuberculosis (TB) and MSF provides integrated care for co-infected patients in Kindamba and Mindouli. MSF is urging the Ministry of Health (MOH) to integrate TB and HIV/AIDS care into its basic healthcare services.

Endemic diseases

Malaria accounts for a large proportion of illness and death in this country. Advocacy work by MSF and others has led to a change in the malaria protocol from chloroquine and fansidar to more effective artemisinin-based combination therapy (ACT). Close to 1000 people were treated for malaria in the first two months of 2006 alone.

Sleeping sickness (Human African Trypanosomiasis), a parasitic disease spread through bites of the tsetse fly, is also endemic here. After 20 years of screening and treatment, MSF closed its last project because of sharply reduced rates of the illness, but has urged the MOH to integrate such activities into its healthcare services.

Handover of Kinkala project

In May 2006, after performing 90,000 consultations and rehabilitating health structures, MSF handed over a basic healthcare project in Kinkala, Pool's provincial capital, to the MOH. MSF had also begun providing HIV/AIDS treatment in Kinkala; these patients will continue to receive care through the programme in Mindouli.

Prior to the project handover, MSF sent a surgeon and anaesthetist to Kinkala to perform vesico-vaginal fistula surgery on 20 women. Caused by prolonged labour and other obstetric complications, fistulas result in chronic incontinence, leading to social isolation. The surgery helps women to function normally and, it is hoped, will facilitate a return to their homes and families.

MSF has worked in the Republic of Congo since 1997.

Democratic Republic of Congo

Millions of people continue to live in crisis throughout Democratic Republic of Congo (DRC) and the medical situation remains grave. Five surveys conducted by MSF in different parts of the country in 2005 showed excess mortality – more than double the commonly accepted emergency threshold – and the absence of or exclusion from medical care for large parts of the population.

Fighting continued to affect regions in the eastern provinces of North Kivu, South Kivu and Katanga as well as Ituri district, causing the displacement of tens of thousands of people. Many live in the bush without adequate shelter, water, medical care or food and under the continuous threat of insecurity. Others have fled to villages and are hosted by local populations or live in camps. Against this backdrop of violence, 2006 witnessed the first and relatively peaceful presidential and parliamentary elections in the DRC in 40 years.

Katanga province

Fighting between local militias and the Congolese National Army (FARDC) flared up in late 2005, and in northern Katanga, thousands of people were once again forced from their homes.

For most people in central and northern Katanga, upheavals and displacements have become commonplace since the war began in 1996. Malnutrition is one result of ongoing violence, which prevents people from farming their lands for fear of being attacked by armed groups.

In November 2005, the small town of Dubie was overwhelmed when over 18,000 displaced persons arrived in a matter of weeks. Already running a make-shift hospital and a network of five health centres, MSF rapidly erected three emergency camps. In the first three weeks of January, MSF carried out 1224 medical consultations and began a mass vaccination campaign against measles.

Responding to urgent needs for the displaced, in early 2006 MSF started a programme around Lake Upemba, in the centre of the province. With people living

“Hundreds of thousands of people are suffering multiple displacements, direct violence by a variety of armed groups, malnutrition and outbreaks of preventable diseases. This reality has become so commonplace in many areas that it goes virtually unnoticed.”

Excerpt from a speech delivered by MSF staff Helen O’Neill at the United Nations Security Council Arria Formula meeting, January 24, 2006.

in squalid conditions on the lake banks, in straw huts or on floating islets, MSF opened a healthcare centre, launched a measles vaccination campaign and distributed supplies such as plastic sheeting, blankets and cooking utensils for displaced families. A cholera epidemic also struck the region around Upemba and Kikondja, leading MSF to open an emergency programme, treating 1742 cholera patients over 20 weeks.

MSF also worked in Nyunzu, Pweto, Mitwaba, Shamwana, Ankoro and Mukubu, providing primary and secondary health services to displaced and resident populations and responding to emergencies caused by epidemics and displacement.

North Kivu

Bordering Rwanda and Uganda to the east of the DRC, North Kivu has been a theatre of fighting between various local and foreign militia as well as the Congolese army and UN blue helmets. Militias, as well as poor and unpaid soldiers, exert enormous pressure on civilians, who are subject to looting, extortion, rape and other violence on an almost daily basis. In Rutshuru hospital in 2005, 26 per cent of monthly surgical interventions were for war-related trauma. In 2005, 1292 survivors of rape were treated by MSF in Beni, Kayna and Rutshuru.

In early 2006, at least 40,000 people fled their homes around Rutshuru, reaching the villages of Kanyabayonga, Kayna and Kirumba. Many others remained in the

bush, subject to violence and looting. MSF opened two health posts in Kanyabayonga, where most of the displaced persons were hosted, and MSF teams continue to work in Rutshuru and Kayna hospitals, providing medical and surgical care. A therapeutic feeding centre is also running in Kayna.

Ituri

In Bunia, capital of Ituri district, MSF continues to run the ‘Bon Marché’, a comprehensive hospital that includes a focus on providing care to survivors of sexual violence. More than 4500 people aged between eight months and 80 years were treated here between April 2003 and December 2005. In June 2006, MSF teams also began providing clinical treatment and monitoring when a pneumonic plague outbreak occurred several hundred kilometres north of Bunia town in the area of Rety. Two isolation centres for the treatment of patients were set up in Kwandroma and in Vedza and 376 patients were treated.

Treating HIV/AIDS and Sexually Transmitted Infections (STIs)

HIV/AIDS is a major focus for MSF in the DRC. In Bukavu, South Kivu, MSF provides comprehensive HIV/AIDS care with counselling, testing and treatment of opportunistic infections, as well as antiretroviral treatment (ART). The objective is to treat 1500 patients with ART by the end of 2006. Two Karibu clinics opened in the north-eastern town of Kisangani, in June 2005 and May 2006, and provide a combined total of 3000 medical consultations month-

ly. Medical care is complemented by targeted health education concerning the transmission and prevention of sexually transmitted infections, HIV and issues surrounding sexual violence.

In addition to a long-running project in Kinshasa, which treats about 1900 patients with ART, a new HIV/AIDS programme opened in Dungu in Oriental Province in July 2005. Following rehabilitation of the hospital, which was destroyed during fighting, MSF began providing essential medicine and training Congolese staff. One aspect of the training focuses on treatment of the deadly Human African Trypanosomiasis (sleeping sickness), which MSF treats in a separate project in Isangi, Oriental Province.

Multiple emergency interventions in 2005/2006

The eruption of violence and disease is frequent in DRC and MSF teams are required to be mobile and react at short notice, often on a large scale. To help facilitate this, quick-reaction teams known by the French acronym PUC (Pool d’Urgence Congo) have been established in three major towns. Major interventions in 2005 and 2006 included a typhoid fever outbreak in Kikwit and a major measles campaign in Mbuji Mayi, during which 380,000 children under 5 years of age were vaccinated.

MSF has worked in Democratic Republic of Congo since 1981.

“People arriving in Dubie were in a really bad state as they had walked hundreds of kilometres to get here, half-naked, with barely any food.

Many mothers had given birth en route and some people did not survive. You just wouldn’t believe such a situation exists unless you actually see it.”

Megan Craven, MSF nurse



An MSF nurse covers evening clinic in the hospital makeshift tent in Dubie, Katanga. Malnutrition, malaria, cholera and tuberculosis make up the largest percentage of diseases that kill in the DRC.

Ethiopia



A colour-coded measuring tape is used to examine the arm of young boy in an MSF feeding centre. If the tape shows red, the child will receive treatment. El Kere, Ethiopia, June 2006.

Ethiopia remains one of Africa's poorest countries, with a very low income per capita and a population that is almost two-thirds illiterate. Its economy is highly dependent on agriculture, which in turn is largely dependent on rainfall.

Many Ethiopians rely on food aid from abroad – in 2005, the UN reported between five and seven million people dependent on food aid out of a total population of 77 million. In years of poor harvest, as many as 14 million people risk lack of food, therefore the drought of the past year was of particular concern to MSF teams located in the southeast of the country.

In Cherratti and Barre in the Ogaden, also known as the 'Somali Region' of Ethiopia, MSF started a therapeutic feeding programme for severely malnourished children in March 2006. Because of the nomadic nature of much of the population here, the project was adapted to become ambulatory, with MSF teams moving around the region rather than operating out of a fixed location. Nutritional assessment missions were also carried out in the Afder and Gode Regions in January and February and monitoring continued throughout 2006.

MSF is supporting primary healthcare activities in Cheratti district, performing up to 100 consultations per day at the health centre, and offering emergency, inpatient and birth delivery capacity as well as ante-natal care and therapeutic feeding. In

August 2005, the project expanded to include tuberculosis (TB) treatment and by the end of May 2006, 191 patients had been enrolled.

A second tuberculosis project is based in Galaha in the arid and remote Afar Region, situated in the east of the country. Like the population of the Somali Region, the Afars are nomadic, moving every three or four months in search of grazing areas and water for their livestock. Given that a full TB course of treatment takes six to seven months, with drugs administered daily, MSF has had to find an adapted approach for treatment. The solution was to create a village of 400 huts centred around a health centre. Patients are required to live in the village under close medical supervision for four months and are then provided with a further three months of medication they can take on their own. Since the project began in 2001, more than 2400 patients have been treated and the project enrolls approximately 40 new patients per month.

Treating patients with kala azar

Whilst national treatment guidelines for kala azar (visceral leishmaniasis) are being reviewed, the disease remains a huge chal-

lenge in Ethiopia. There is still a very limited availability of the necessary drugs, even in areas where the disease is endemic. Transmitted by the sand-fly, the disease attacks the immune system causing fever, wasting, an enlarged spleen, anaemia and death if left untreated. Today, kala azar is still widespread in many parts of the country.

In the district of Libokemkem in the north-eastern Amhara Region, MSF treated 1150 patients for kala azar in the last eight months of 2005. In Humera, a town on the border with Sudan and Eritrea, MSF focuses on patients co-infected with HIV and kala azar and treated 1823 patients in 2005. A third project is based in nearby Abdurafi.

Because much of the country lacks even the most rudimentary care, MSF runs primary health facilities in a number of locations. Malaria remains a big concern despite a recent change in Ministry of Health (MOH) protocol to more effective drugs. In Amhara and Tigray, MSF treated approximately 76,000 patients and then withdrew from most projects in 2006 with improved response capacity from the government. In Foguera district, Amhara, MSF continues to run a programme that has supported the treatment of 49,448 patients with malaria.

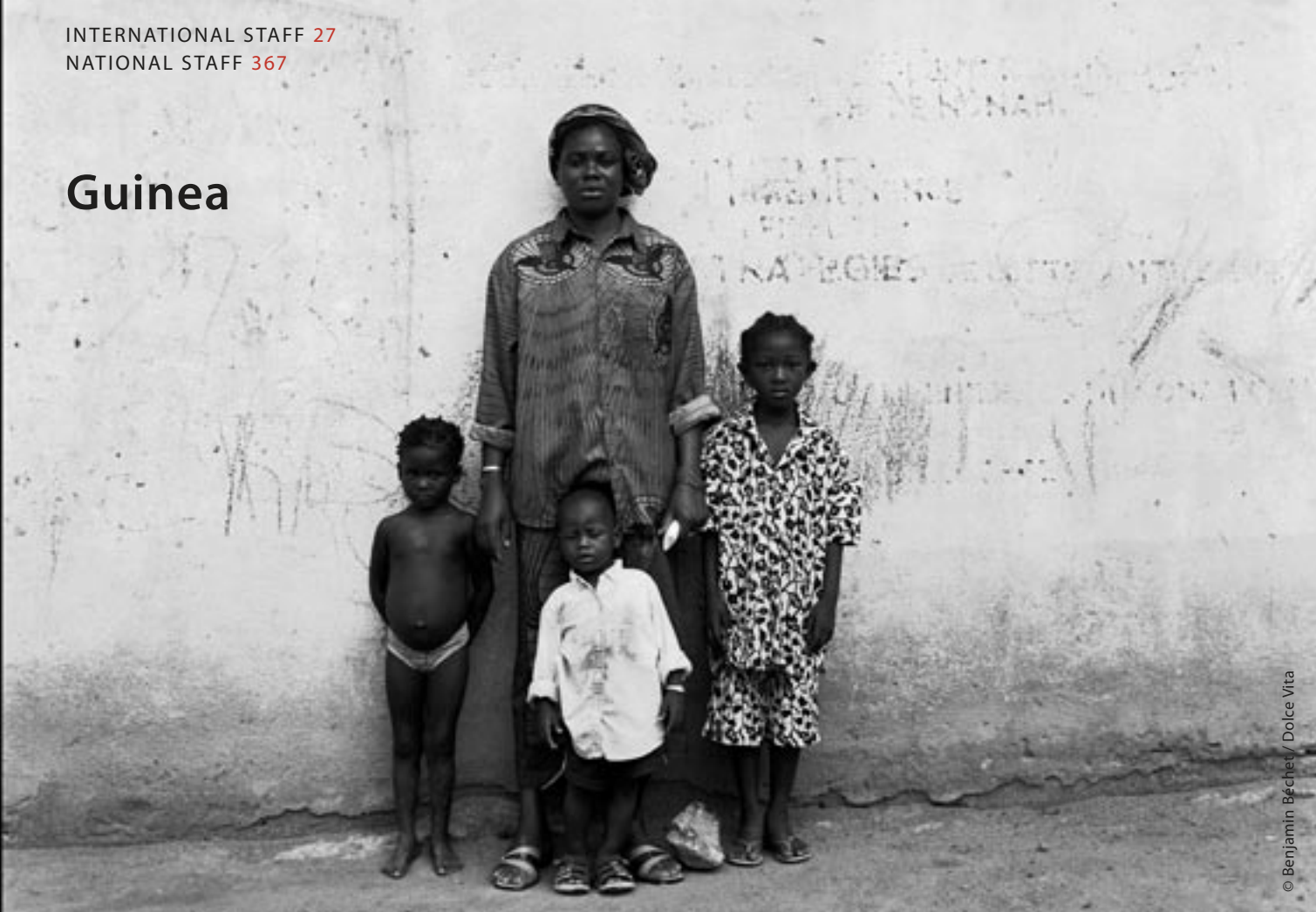
Emergency interventions for meningitis and cholera

In January 2006, cases of meningitis were reported in the Welayita region of southern Ethiopia. MSF worked with the MOH to respond to this epidemic, providing medicines and treatment training to medical personnel at health centres. MSF also launched a vaccination campaign, reaching 25,000 persons before handing over activities to the MOH.

In the western region of Gambella, where up to 70,000 displaced persons in camps are in urgent need of medical assistance, MSF has established a fixed health centre just outside the main town of Itang. A mobile team is ensuring the most vulnerable communities are receiving basic healthcare and referral for treatment. In May 2006, the team conducted an emergency intervention, treating about 2000 cases of cholera.

MSF has worked in Ethiopia since 1984.

Guinea



© Benjamin Béchery / Dolce Vita

The people of Guinea live in a country with significant poverty and periodic instability, leading to a lack of healthcare. Even when patients can get to a health centre and afford to pay for medical services, shortages of medicines and supplies means they may have to go without effective treatment.

This is frequently the case for those with malaria, which accounts for about 30 per cent of hospitalisations country-wide. Through its projects in Dabola, MSF has confirmed that artemisinin derivatives (ACT) are the most effective drugs for the illness. MSF continues to offer rapid testing and ACT for malaria at Dabola hospital and the nine health centres of Dabola prefecture, where 4537 people were treated for malaria in the first half of 2006. Although the government now intends to use ACT, it has been unable to provide the drugs because of a lack of funding.

Helping large numbers of refugees

Over the past decade, Guinea has become host to tens of thousands of refugees from neighbouring Liberia and Sierra Leone. Whilst the majority of refugees have been repatriated, some remain in camps, where MSF provides healthcare to them and the surrounding Guinean host population. In Forest Guinea, MSF works in the Lainé

camp near N'zérékoré, home to approximately 19,000 Liberians. In addition to primary healthcare, voluntary HIV/AIDS counselling and testing was introduced in January 2006, and in mid-April the first patient was put on antiretroviral medications (ARVs).

MSF also runs a comprehensive HIV/AIDS programme of counselling, testing and treatment in Conakry and Guéckédou. Drugs and medical material are provided to enable treatment of severe opportunistic infections. MSF has also trained counsellors and lab technicians and supplied health centres with HIV test kits. By the end of June 2006, 850 patients were receiving life-extending ARVs.

Responding to infectious disease outbreaks

MSF assisted the Ministry of Health (MOH) in August 2005 to address a cholera outbreak in Boké and Conakry, by setting up

three cholera treatment centres (CTC) in Conakry and treating more than 3000 patients. In Boké, MSF provided medical supplies. A second cholera emergency began in February 2006 in the Forest Guinea region, where MSF treated 1171 suspected cases.

In early January 2006, MSF conducted a three-week long vaccination campaign following an outbreak of yellow fever in the Boké area, and immunised 369,000 people. In May, following a meningitis outbreak in the prefecture of Mandiana, MSF immunised 175,000 people.

Handover of tuberculosis project

Actively involved in Guinea's National Programme for the Fight Against Tuberculosis since 1988, MSF has trained doctors and health workers to better manage TB, supplied drugs and laboratory equipment, and increased awareness of the disease. In 2005, MSF handed over its last activities in the Conakry region to the Ministry of Health. MSF is now focusing only on TB patients co-infected with HIV/AIDS.

MSF has worked in Guinea since 1984.

Guinea-Bissau

The West African country of Guinea-Bissau has a precarious infrastructure, lacking a general water and electricity supply even in its capital, Bissau. In addition to common diseases such as malaria and TB, there have been recent epidemics of cholera, measles and meningitis – the most recent taking place in 2005.



© MSF

The first cases of cholera emerged on June 11, 2005 in Bissau, the capital. The disease spread quickly to other regions and by the end of August, the entire country was affected. MSF responded to a government appeal for help, sending teams into Oio province, Bissau city, Sao Domingos and Bijagos. By the end of the intervention, MSF had treated 5242 patients of the more than 23,000 recorded in the country.

MSF worked continuously in Guinea-Bissau from 1998 until 2000. MSF keeps in regular contact with the authorities to help with any health emergencies that arise.

Ivory Coast



© Espen Rasmussen

Sporadic violence and instability continue in the Ivory Coast, despite a peace agreement signed between the government and rebel forces in 2003.

The country has effectively been cut in two and the healthcare system was decimated through the conflict that began in 2002. Ministry of Health (MOH) staff are slowly returning and medical services are resuming, but there remains little or no healthcare for most of the population.

As well as providing basic healthcare in both the north and south, MSF is pioneering new ways of delivering HIV care in the west of the country, proving that this is possible in a place where fighting can break out at any time.

HIV prevalence is estimated up to 15 per cent in some areas. Previously, HIV/AIDS care was administered by doctors in hospitals, but for many people with HIV this is not viable for a host of reasons, including distance and the difficulty in accessing hospital care because of conflict. As an alternative, MSF is training nurses and clinical officers to provide care in health clinics. Education and communications activities encourage people to come forward for voluntary counselling and testing, with free antiretroviral therapy (ART) and treatment of opportunistic infections provided for those in need.

In Danané, MSF in 2005 built a new hospital unit for pregnant women with HIV, dedicated to providing treatment that will prevent these women from passing the virus on to their babies. In its first four months, five per cent of the 922 women tested were found to be HIV positive. In Bin Houye, MSF is supporting Ministry of Health HIV/AIDS treatment programmes in three health cen-

tres and has started voluntary counselling and testing services. MSF also supports the government's HIV/AIDS programme in Man.

Providing essential healthcare

At hospitals in Danané, Bouaké and Man, MSF continues to provide essential medical care, including paediatric consultations, emergency medicine, obstetric and gynaecological care and surgery. In 2005, MSF teams in Bouaké provided approximately 4500 consultations monthly and in Man more than 8000. Mobile clinics are used to provide basic healthcare in more isolated areas and in the "zone of confidence", the buffer area between the north and south, where MSF runs a hospital in Bangolo and a health centre in Kouibly.

In January 2006, whilst many organisations were forced to evacuate amidst riots and demonstrations against international organisations – labelled occupying forces by certain groups – MSF teams in Guiglo were able to continue their work, providing primary healthcare for up to 6000 displaced persons and the local population (3200 consultations per month) and treating severely malnourished children in a therapeutic feeding centre.

Handover of prison project

After eight years working in MACA prison, formally the Maison d'Arrêt et de Correction d'Abidjan, MSF successfully handed this project to the MOH at the end of 2005.

MSF has worked in the Ivory Coast since 1990.

Kenya

“When we opened the office in El Wak, people would turn up at the door literally begging for water”

MSF emergency co-ordinator Ibrahim Younis

In the early months of 2006, the consequences of three consecutively failed rainy seasons tipped the mainly pastoral population of northern Kenya over the brink. With the onset of child malnutrition, MSF set up a therapeutic feeding programme in the northeastern town of El Wak, treated over 500 children for severe acute malnutrition and immunised 19,000 against measles. Responding to the urgent need for water, MSF trucked hundreds of thousands of gallons to five districts in the region.

Across the north of Kenya, the drought had a devastating impact on livestock. In El Wak, the bleached white earth became littered with carcasses of goats, cows, donkeys and camels – a crippling blow to the people of this neglected region. In this part of Kenya, animals are the lifeblood, serving as wealth as well as the primary source of nutrition.

An MSF nutritional survey in March showed 30 per cent of children to be severely malnourished and many more teetering on the edge. When torrential rains eventually began in April, children already weakened by malnutrition developed diarrhoea and respiratory infections. Their nutritional status also worsened. During the month of May, the admission rate in El Wak increased by 50 per cent over previous monthly averages, and MSF began to see children suffering from kwashiorkor, the form of severe malnutrition that creates swelling and is caused by insufficient protein and acute infections, all a result of insufficient food intake.

In May, a second intervention was started 400 km west, in three of the most arid regions in Marsabit District. MSF adopted a simplified strategy and ensured maximum mobility of the team to effectively reach the scattered, pastoral population displaced by ongoing inter-clan conflict and widespread loss of livestock. Two mobile teams provided biweekly medico-nutritional assistance in 35 sites in villages or peripheral settlements. By the end of June, 700 children at risk of death were enrolled in the treatment programme and some severe cases were referred to health structures including the district hospital, where MSF set up a therapeutic facility.



Improving HIV/AIDS care

For the past decade, the primary focus of MSF's work in Kenya has been HIV/AIDS. MSF provides a comprehensive package of care, from testing through to treatment, in the slums of the capital, Nairobi, as well as Homa Bay and Busia in the west of the country. By March 2006, over 8500 people were receiving antiretroviral treatment (ART) from MSF sites and over 17,000 were enrolled in the projects.

In Homa Bay and the Kibera and Mathare slums of Nairobi, MSF has specialised in the treatment of HIV/AIDS and tuberculosis (TB) co-infection. Immune systems weakened by AIDS help to fuel tuberculosis and one of the objectives of the projects is to develop an optimum treatment strategy. MSF is piloting the field application of high-tech diagnostic methods to increase TB case detection amongst patients who are co-infected with TB and HIV. In the sprawling Kibera slum, MSF runs three clinics, two including HIV/AIDS as one part of a full primary healthcare package, with a particular focus on mother-to-child healthcare. Early diagnosis of children born to HIV-positive mothers is now accessible at all these sites and there has been a significant increase in treatment of infected infants below 18 months of age.

Handover to local authorities

After building an HIV/AIDS clinic on the grounds of Mbagathi District Hospital, Dagoretti district, Nairobi, MSF has been providing comprehensive HIV/AIDS care alongside health authorities. MSF is now supporting the Ministry of Health to take over this project.

The goal of increasing access to treatment is showing the need to decentralise, and make care available at a greater number of sites – not only through peripheral health structures but also directly through the community, which is increasingly committed to participating in the follow-up of newly tested patients and supporting people new to treatment.

In Kenya as a whole, only about 75,000 of the more than 200,000 HIV/AIDS patients who urgently need antiretroviral therapy now receive the drugs, according to the health ministry. In June 2006, the government made the positive step of providing free HIV/AIDS care in all public health facilities: a vital move given more than 60 per cent of Kenya's 33 million people live on less than one dollar a day and about 1.2 million Kenyans are HIV-positive.

MSF has worked in Kenya since 1987.

Liberia

In July 2006, electricity was partially restored to Monrovia, the capital of Liberia, following a fourteen-year blackout. Stand-pipe water also became available in parts of the city for the first time in years. Rehabilitation efforts are starting to bear fruit in this country, now rebuilding after a 14-year civil war, but Liberia still lacks operational health facilities and personnel. In 2005, about 90 per cent of all healthcare services were provided by faith based-organisations or international NGOs such as MSF.

In 2005/2006 many Liberians who fled the fighting during the war returned home from temporary camps and MSF began closing camp-based health and sanitation programmes and established new ones in the capital and around the country.

Providing healthcare in the capital
MSF has provided full support to hospitals in Monrovia since 1999. MSF runs a 150-bed hospital in the Mamba Point area and provides specialist paediatric and obstetrics inpatient services at Island and Benson hospitals. After six years of supporting Redemption Hospital, MSF handed over its management to Liberian health authorities in November 2005. MSF also supports two primary care clinics in Monrovia, providing over 10,000 consultations monthly.

Cholera thrives in the crowded conditions of Monrovia, with disease outbreaks occurring regularly. In August 2005, at the height of an outbreak, MSF teams intervened and treated 350 suspected cholera patients per week. Later in the year, the MSF-supported cholera treatment unit was handed back to Liberian health authorities.

Lesotho



Patients waiting outside one of the 14 health centres in the Scott Health Service Area.

Lesotho, a small mountain kingdom landlocked by South Africa, has the third highest HIV prevalence in the world. With 28.9 per cent of adults infected, it comes after only Botswana and Swaziland, and is the poorest of the three.

MSF arrived in Lesotho in January 2006 with the goal of launching a decentralised approach to HIV/AIDS care and treatment. Whilst HIV/AIDS care is typically only available at major centres in resource-poor countries, here the programme would offer access beyond hospitals and urban areas, providing HIV care and antiretroviral therapy (ART) at 14 clinics in Scott Health Service Area (HSA), a rural health district with a population of 220,000.

The team has benefited from the many years of experience MSF has accumulated operating AIDS treatment programmes elsewhere, particularly in Khayelitsha and Lusikisiki in nearby South Africa. Key factors were built into the programme from the start, such as provision of free HIV/AIDS care and treatment; delegation of tasks to lower levels of health workers; simplification of treatment guidelines; and protocols and empowerment for persons living with HIV/AIDS (PLWHAs).

In less than six months, the MSF team trained more than 100 nurses, village health workers, peer educators, and

PLWHAs; enrolled more than 1000 people into HIV care; and initiated ART for nearly 300 people. Mobile medical teams visit each health centre on a weekly basis, many in remote, mountainous areas, to provide direct clinical care for patients and offer on-the-spot supervision and training for nurses. Intensive support is also provided in the outpatient department, wards, laboratory, and pharmacy at Scott Hospital.

Essential to the project has been the development of strong partnerships with the health staff and management and PLWHAs in Scott HSA (one of the many health districts managed by the Christian Health Association of Lesotho), as well as the Ministry of Health and Social Welfare, which provides all antiretrovirals for the programme through a grant from the Global Fund. Through these partnerships, MSF aims to reduce AIDS-related deaths whilst strengthening the capacity of health workers and communities to cope over the long term with Lesotho's truly overwhelming HIV/AIDS emergency.

MSF began working in Lesotho in 2006.

Malawi

With the security environment stabilising, MSF is developing health programmes focusing on tuberculosis, HIV/AIDS and reproductive health. A paediatric tuberculosis programme at Island Hospital encourages caregivers to help children to take their drugs correctly. A specialist mother and child healthcare centre was opened in early 2005 to improve reproductive health, conducting approximately 1500 ante-natal and 1300 family planning consultations monthly in 2005/2006.

Helping survivors of sexual violence

Since 2003, MSF has provided medical treatment and psychological support to survivors of sexual violence. MSF staff also conduct outreach activities and information sessions in markets, schools, churches, mosques and clinics to raise awareness about sexual violence and to encourage survivors to seek care. In 2005, over 1400 persons were seen through MSF-supported structures. Half of them were under the age of 18.

Medical care around the country

In Saclepea, Nimba county, MSF runs a health clinic next to a camp housing about 1000 Ivorian refugees. In 2005/2006, approximately 3000 outpatient medical consultations were conducted here monthly. A new women's health unit was also created, offering family planning services and treatment for sexually transmitted infections.

MSF also runs several health clinics and provides care to survivors of sexual violence in Grand Bassa and River Cess counties, and runs a hospital providing free care. A community-based programme in Grand Bassa treated 271 malnourished children from January to July 2006.

MSF has worked in Liberia since 1990.



© Chris Hondros/Getty

A pregnant woman receives antimalarial drugs and iron from an MSF clinical officer at the Thyolo District Hospital.

HIV/AIDS has dramatically reduced average life expectancy in Malawi to below the age of 40. It has left 700,000 orphans and vulnerable children. Close to a million people in the country are now HIV-positive. The disease has contributed to a huge shortage of qualified health staff, which complicates efforts to address the disease, whilst approximately 170,000 people are in desperate need of antiretroviral (ARV) treatment.

The government has been increasing the number of treatment sites to provide greater access to life-extending care. MSF is closely involved in this decentralisation in the southern district of Thyolo, where the number of treatment sites has risen from one to seven and close to 6000 patients were using ARVs by July 2006. MSF also conducts a programme at the district hospital, started in 2002, to prevent mother-to-child transmission of the disease. By mid-2006, over 2000 women had made use of this programme.

MSF provides a comprehensive HIV/AIDS programme in the country's central Dowa district, with teams at district hospitals and several health centres. Aside from the local residents, care is provided for refugees coming from a number of African countries and now living in a camp in Dzaleka. By the end of April 2006, 424 patients, including 22 children, were receiving ARVs from MSF in Dowa. A support group has also been created for HIV-positive children aged six and over, with high attendance.

In the Chiradzulu district, MSF was providing ARVs to 6491 patients by the end of

2005, including 1300 patients who have been on ARVs for two years and more than 200 patients who have successfully used this therapy for more than three years. Another 250 new patients begin treatment monthly. MSF also treats medically complicated cases including patients on second-line treatment (for whom firstline drugs have failed), patients with Kaposi's Sarcoma – an AIDS related cancer – and children. MSF also cooperates with the regional hospital providing care in the adult medical and paediatric wards, where approximately 700 patients are admitted monthly.

Distributing food

Malawians in 2005 experienced food shortages resulting from the worst drought in over a decade, and MSF provided nutritional support to help HIV-positive patients and other vulnerable groups. In September 2005, MSF started feeding malnourished patients, and had distributed approximately 80 tonnes of food by the end of the year.

MSF has worked in Malawi since 1986.

© Julie Rémy

Morocco



An MSF team provides assistance to sub-Saharan immigrants made with plastics and other materials supplied by MSF and

In October 2005, approximately 3000 sub-Saharan immigrants were rounded up from the coastal Spanish *villes autónomas* of Ceuta and Melilla, and the cities of Rabat and Casablanca. They were put in buses by Moroccan police forces and driven to the Sahara region of the country, near borders with Mauritania and Algeria. Here more than 1000 people were dumped in the desert without any food, water, or access to healthcare.

MSF immediately intervened, providing emergency medical care, distributing food, water and blankets and denouncing this inhumane treatment. Over 100 people were treated for wounds and bruises, some caused by failed attempts to jump over fences into the Spanish territories before being expelled to the desert. Many other contusions were caused by rubber bullets and beatings, claimed by victims to have resulted from violent force used by Spanish and Moroccan authorities.

In total, more than 4000 people, some asylum seekers, were involved in a massive expulsion. Eventually more than 3500 persons were repatriated to Mali and Senegal, whilst others were relocated or dispersed on their own.

These were some of the thousands of illegal immigrants that arrive in Morocco every year, en route to Spain and the European Union. Increasingly tight border controls find many of these people stuck in an inhospitable situation with difficulties accessing food, water or healthcare.

Only weeks earlier, in September, MSF released a two-year report of medical data and testimonials from its healthcare projects in Tangier, Nador and Oujda. *Violence and Immigration, a Report on Irregular Sub-Saharan Immigrants in Morocco*, showed an alarming 25 per cent of medical consulta-

Mali

People living in Mali, a country located in the middle of Africa's meningitis belt, suffer from recurrent epidemics of meningitis, cholera, measles and yellow fever. In 2005/2006, MSF responded to a number of health emergencies in this country where the majority of its 13.8 million inhabitants are without access to basic healthcare.



© Mickael Therer

Mali was then confronted with a number of meningitis cases in March 2006. Working in conjunction with the MOH, MSF supervised vaccinations, furnished free treatment for patients and organised transportation, necessary refrigeration for vaccines and other logistics for the districts of Koutiala and Sélingué. In total, 179,539 people were vaccinated.

Increasing access to healthcare

Malaria is the leading cause of death in the country. Although the government has updated its malaria drug protocol to use artemisinin derivatives (ACT), insufficient quantities and high prices preclude this protocol from being used throughout the country. In July 2005, MSF began a project addressing malaria in Kangaba, offering ACT to those diagnosed with rapid malaria tests at community healthcare centres.

MSF has also been developing a programme, in cooperation with five other NGOs, to reduce maternal-infant mortality in the northern regions of Gao, Timbuktu and Kidal. Equipping health centres, increasing community education related to maternal health and performing obstetric surgeries (such as fistula surgery) are the principal components of this programme.

Withdrawal from training project

After five years of MSF support, the nursing school "Sahel Formation" has provided regions in the north with more than 300 qualified nurses and lab assistants in a zone that previously suffered from a complete lack of health personnel. The school remains open, and MSF has now withdrawn from the project.

MSF has worked in Mali since 1992.

In the northwest part of the country, a cholera epidemic broke out in Kayes and Nara between June 2005 and January 2006. MSF teams backed up the Ministry of Health (MOH) by taking charge of patient care, controlling hygiene measures and educating the population about the disease. A total of 914 people were affected.

From September to November 2005, an intervention to identify and treat malnutrition was carried out in Goundam, an hour's travel from Timbuktu. Out of 5000 children evaluated for malnutrition, 54 were hospitalised and 228 were treated as outpatients. National personnel at health centres are now familiar with the techniques of nutritional surveillance and will continue to monitor for child malnutrition.



in the "Kilometre Six", next to Tangier. Their shacks are living conditions are precarious.

Mozambique

An estimated 16 per cent of Mozambique's population is affected by AIDS, creating an urgent need for effective, accessible HIV/AIDS care in a country where the majority of the population lives in rural areas and below the poverty threshold. MSF is helping to address the epidemic through comprehensive HIV/AIDS projects throughout the country.

tions between April 2003 and May 2005 were for violence-related injuries, 62 per cent of the most severe cases claimed to have been inflicted by Moroccan and Spanish security forces.

MSF has worked with the sub-Saharan immigrant population in Morocco since 2003, providing medical care to immigrants with the support of the Moroccan health facilities. Vaccinations, ante-natal care and family planning are necessary for this vulnerable population and MSF runs mobile clinics and monitors the community for disease outbreaks. MSF provided 4245 medical consultations in the past year, caring for approximately 2500 people in Tangier, Nador and Oujda. MSF also provides shelter, blankets and relief materials to improve hygiene and help immigrants attain minimum standards of living.

In early 2006, following continuous pressure from security forces and the deaths of 15 people, the majority of immigrants in the north of the country moved to urban areas, whilst a few hundred remained in bad conditions in the forests. MSF continues to provide assistance to the forest dwellers through mobile clinics.

The Spanish government has now raised the height of border fences separating Spain from Morocco in Ceuta and Melilla, resulting in fewer concentrations of immigrants in these areas and fewer MSF interventions. However, MSF continues to advocate for more humane treatment of sub-Saharan immigrants based on these interventions, and monitors the health situation of potentially vulnerable populations in the Moroccan Sahara region as well as Algeria and north Mauritania – the departure point for immigrants heading to the Canary Islands, and an area to which few international organisations have access.

MSF has worked in Morocco since 1997.

In the capital city of Maputo, MSF was treating over 5600 patients with antiretrovirals (ARVs) by the spring of 2006. MSF is working with the Ministry of Health (MOH) to make care available beyond main hospitals and at the primary healthcare level – decentralising care for asymptomatic cases that do not require such intense medical supervision, and patients who have recovered immunity through their treatment. Training local staff is a significant part of this effort, as is field research aimed at simplifying the treatment for patients suffering from HIV/AIDS and tuberculosis.

In Niassa province, MSF has an ongoing project in Lichinga district. Here, 650 patients were treated in the spring of 2006, with 400 of them undergoing treatment with ARVs. MSF is looking at decentralising comprehensive HIV/AIDS care, aiming for its programme to be integrated into the public health system.

Midway through the country, in Tete province, MSF was providing ARVs to more than

1639 people by the spring of 2006, as part of another comprehensive HIV/AIDS programme that includes education, voluntary counselling, testing and treatment. In all MSF sites, activities were developed to prevent HIV transmission from mother to child. These have been well integrated into the public health system.

Preventing the spread of cholera

In January 2006, torrential rain fell in Sofala province, creating ideal conditions for cholera, the potentially deadly, water-borne disease that can spread rapidly without adequate sanitation. When the first cases of cholera appeared, MSF teams from Tete helped local authorities treat patients and stop the spread of the disease by providing equipment and logistical expertise. MSF also organised training in logistics and hygiene so local health workers are better able to deal with future outbreaks of cholera.

MSF has worked in Mozambique since 1984.



Nigeria



© David Levene

HIV/AIDS is a massive problem in Africa's most populous country. Many people in urgent need of treatment for AIDS and related illnesses find that the medical attention they need is unaffordable or unavailable.

In Lagos, MSF has established a comprehensive HIV/AIDS programme, providing care to more than 1500 people infected with HIV. Over 1000 patients are receiving the antiretroviral (ARV) medicines they need at General Hospital Lagos. MSF and civil society groups advocate for access to free treatment and actively promote the use of lower cost, generic ARVs to help expand this treatment. Whilst progress has been made to increase the availability of first-generation ARV medicines, access to newer, field-adapted AIDS drugs is an ongoing challenge. Research in the Lagos project has shown an acute and growing need for affordable second-line medications – the newer AIDS drug formulations for patients who develop resistance to a first combination of medicines and must change their treatment. In 2005/2006, MSF, treatment advocates and civil society groups publicly urged pharmaceutical companies to make these AIDS drug formulations immediately available to patients in Nigeria and other developing countries, achieving some success with initial shipments of the heat-stable, secondline drug lopinavir/ritonavir to Nigeria in July 2006.

Multiple health emergencies

In response to a nutritional crisis in several areas of northern Nigeria, MSF in mid-

Niger

Since 2005, MSF has been running an emergency operation to treat tens of thousands of children suffering from severe acute malnutrition in various parts of Niger. The therapeutic feeding strategy now utilises outpatient clinics and ready-to-use therapeutic foods, enabling MSF to treat far more children than in the past. Recovery rates climbed to more than 90 per cent in Niger in 2005.

In mid-2005, MSF opened seven new inpatient centres in Maradi province, two in Tahoua province, and 27 ambulatory centres. When malnutrition levels began to fall, most of these centres were closed or handed over to other nongovernmental organisations (NGO). Staff then concentrated on helping children in southern Maradi, where there continued to be a high rate of malnutrition. In August, MSF started working in the Tanout area of northern Zinder province, setting up a therapeutic feeding centre (TFC) and 11 outpatient feeding centres. The TFC was closed in January 2006 after treating more than 3500 children. MSF also provided care in the Ouallam district of the Tilaberi region during 2005, treating 501 severely malnourished and 2355 moderately malnourished children in the last four months of the year. The programme was handed over to another NGO in late December 2005.

In 2006, MSF teams continued working in the regions of Zinder, Maradi, and Tahoua treating both severe and moderate cases of malnutrition. By June 2006, more than 25,000 children were receiving malnutrition-related medical care from MSF teams. About 2000 children were being admitted to its nutritional programmes each week. Because a sick child is at greater risk of

developing acute malnutrition, MSF is working with the Ministry of Health to offer free care to children under five in most of the health centres in the Maradi region. MSF opened two paediatric units in Maradi in July 2005 to handle cases of severe malaria, acute respiratory infection and acute diarrhoea. More than 50,000 consultations and 2000 hospitalisations were carried out in these two hospitals during 2005. From January through May 2006, MSF carried out 30,000 consultations and 900 hospitalisations.

Distributing food

In October 2005, the Niger government, backed by the UN's World Food Programme, called for food distributions to end. This was done two weeks after the harvest so as not to destabilise the market. MSF called for these distributions to be redirected towards the areas where families were suffering from acute malnutrition. MSF teams began to distribute a proportion of the UN aid to the most affected villages to the south of Zinder in late October. In southern Maradi, MSF distributed 130,000 food rations for moderately malnourished children.

Meningitis outbreak

In February 2006, a meningitis outbreak occurred in the southern districts of Maradi province. MSF started a vaccination campaign, immunising more than 800,000 people during February and March. Staff also cared for some of the patients already diagnosed with the life-threatening disease.

MSF has worked in Niger intermittently since 1985.



© Henk Braam

Rwanda

2005 conducted emergency interventions in Borno, Katsina and Sokoto states and treated more than 15,000 severely malnourished children at three stabilisation centres and dozens of outpatient therapeutic feeding sites. Mobile teams travelled to remote communities to provide nutritional education, healthcare and high caloric food supplements for children not requiring hospitalisation. MSF also conducted over 14,000 paediatric consultations, and treated many of these children for malaria. By the end of the year, fewer and fewer children were admitted for treatment, and MSF closed down or handed over projects to local health authorities between January and March 2006.

When a cholera outbreak occurred in northern Borno state in October 2005, MSF set up a treatment site and cared for more than 1300 patients within two months. MSF also responded to a meningitis outbreak in Jigawa state from April to June 2006. MSF strengthened case management in three hospitals, directly treated 527 patients, and conducted a vaccination campaign in four local governmental areas from May to mid-June, vaccinating nearly 150,000 people.

The southern oil-rich Niger Delta region is the site of regular, violent clashes between various groups struggling for oil and in October 2005, MSF opened a surgical programme for trauma victims in Port Harcourt. From January to May 2006, MSF staff performed 471 operations and admitted 561 emergency patients. More than a quarter of the emergencies treated in May were for violence-related injuries such as gunshot wounds, stabbings, beatings, rape, and domestic violence.

Malaria project closed

In November 2005, MSF ended its malaria project in Bayelsa state, also located in the Delta region. Local authorities were not willing to improve health facilities and medical staffing, making it difficult for MSF to implement artemisinin-based combination therapy (ACT) in this malaria-prone region. While quinine is still of use, MSF has proven that ACT is the most effective treatment for malaria.

MSF has worked in Nigeria since 1996.

Rwandans are confronting numerous consequences of the genocide that began in 1994 and killed approximately 800,000 of the country's eight million people. Many people lost family members and the horrific events that took place are having a lasting impact on many aspects of their lives. As a result of the genocide, there is now a gender imbalance within the country, a large number of widows heading households, and a lack of trained professionals such as judges, technicians, administrators and doctors. MSF is operating projects to provide maternal healthcare services and help people cope with HIV/AIDS.

Some of Africa's highest maternal mortality rates are found in Rwanda, with approximately 1071 women dying for every 100,000 live births. MSF is improving reproductive health in Northern Province – formerly Ruhengeri Province – a region with inadequate access to both basic healthcare and reproductive health services.

MSF works in the maternity ward of the provincial hospital and six health centres in the Burera district. Working closely with community actors, this programme has three main areas of intervention: obstetrical emergencies; implementation of family planning; and maintenance of all general reproductive health services including ante-natal, delivery and post-natal care. Assistance for women survivors of sexual abuse, including psychological support, was also integrated in 2006.

Admissions have risen steeply since MSF implemented very low flat fees aimed at improving access to care. Some 1464 admissions were recorded the first quarter of 2006 in the maternity ward alone, doubling the number of admissions over the

previous fee system. Free services are also ensured for the poorest sections of society.

HIV/AIDS programmes

In Kigali, MSF operates a comprehensive HIV/AIDS project aimed at preventing the spread of HIV and providing treatment to those who are infected, offering care at two health centres for some 7600 people living with HIV/AIDS. Of those patients, 2200 people are receiving antiretroviral medicines, including 260 children. MSF is also helping implement the national AIDS protocol and promoting access to generic antiretrovirals, the less expensive alternative to patented brands.

MSF has worked in Rwanda since 1991.

Sierra Leone

Sierra Leone is still recovering from years of civil war, which shattered its healthcare system and left most civilians unable to obtain basic medical care. With the government and many donor countries focusing on development projects, medical emergencies remain unaddressed in many districts. MSF is providing medical care to some of the country's most vulnerable inhabitants: children, pregnant women and refugees.

Many women in Sierra Leone die from complications during pregnancy or delivery, and close to one out of five babies dies during or just after birth. MSF is helping mothers and babies by reducing medical risks and making needed medical care more available. Women often live far from hospitals, so in Kambia and Tonkolili districts, MSF has established "maternity houses" where women in their final weeks of pregnancy can stay until they deliver. In these facilities, MSF treats HIV-positive pregnant women to prevent mother-to-child transmission of the virus. MSF staff is also integrating HIV and tuberculosis (TB) care in MSF-supported public health units, and in the maternal and paediatric wards of secondary health facilities. Teams train and supervise staff and supply medicines and other medical materials. MSF clinics see approximately 2000 patients per month in each district.

Helping refugees

By the end of 2005, an estimated 20,000 Liberians were living in refugee camps in Sierra Leone, having fled their own country during its civil war. In 2005, MSF provided

medical care in eight camps within Bo, Moyamba, and Kenema districts. With increasing repatriation and camp populations decreasing in some areas, MSF handed over activities in three camps in April 2006 but continued to provide healthcare to refugees and the local population in clinics located beside five other camps. Approximately 20,000 patients are seen every month in Southern province, including 10,000 patients for malaria. An outbreak of measles occurred in the Tobanda camp and nearby villages in November 2005, and MSF immunised 3363 children.

MSF has worked closely with the Ministry of Health (MOH) to change the national malaria treatment protocol from chloroquine to the more effective artemisinin-based combination therapy (ACT). Today ACT is available in the health facilities supported by MSF, but not in other health structures. MSF continues to work with the MOH to have ACT more widely available and to prepare health staff and communities to use it correctly.

MSF has worked in Sierra Leone since 1986.

Tanzania

Tanzania has not escaped the African AIDS epidemic. An estimated 120,000 people die each year from HIV/AIDS-related illnesses here – many never having received a diagnosis or appropriate care.

MSF runs a project to treat HIV/AIDS patients in the remote, southwestern Makete district. The team provides comprehensive care including antiretroviral (ARV) treatment. By mid-2006, 1216 patients were receiving care through the project, including 583 people taking ARVs. The team is also training community members and healthcare workers and providing needed medical supplies.

Providing care in emergencies

Between September and December 2005, political violence surrounding presidential elections in Zanzibar, a semi-autonomous island off the coast, led to many injuries among civilians. MSF provided care to some of the wounded, caring for approximately 275 people.

In February 2006, MSF travelled north to the Kibondo area in northern Kigoma, when approximately 7000 Burundian refugees, "fleeing hunger", entered the country. Thousands of refugees gathered in transit camps set up to accommodate only 100 people, so many slept out in the open. As only a few international NGOs were providing assistance, MSF began working in the Nyakimonomono way station in March. The team ran an outpatient clinic conducting about 180 medical consultations daily, distributed water, built shelters and monitored the group's nutritional situation. By mid-2006, most of the refugees had left the area and MSF ended its intervention.

Malaria project closes in Zanzibar

A malaria project based on the island of Zanzibar was closed in December 2005 after the project had achieved its goal of increasing access to ACT malaria treatment – the most effective treatment for malaria – in the districts of Unguja and Pemba.

MSF has worked in Tanzania since 1993.



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Somalia

"We do over 40,000 consultations per year in two hospitals but this barely scratches the surface. People come from up to 700 km away to get medical care, because there is nothing else available to them. Across great swathes of the country there is literally no possibility of access to medical treatment."

MSF head of mission, Colin McIlreavy

In February 2006, the new government of Somalia met for the first time. Even agreeing on a regular location to convene proved arduous. With the old capital Mogadishu imploding into all-out war in April, the temporary solution for the transitional federal government was a converted food warehouse in the southern town of Baidoa.

Following a fourteen-year period without a functioning government, Somalia's new political leaders are faced with the job of rehabilitating a country ripped apart by rival warlords and with some of the worst health indicators in the world. Complicating their task is the rise of the Islamic Courts, which took control of large swathes of south and central Somalia by July 2006.

The country has virtually no health infrastructure. People rely on the occasional private pharmacy or clinic for care, but these are out of financial reach for most. The only free healthcare is provided by organisations such as MSF. Yet with unpredictable and regular outbreaks of violence, international agencies are scarce in south and central Somalia, and MSF also temporarily evacuates its missions on a regular basis. MSF operates projects in seven locations across south and central Somalia, including the capital Mogadishu. A clinic in the Yaqshid quarter stands as one of the few public health facilities in the north of the city, absorbing many patients from the neighbouring districts. The number of consultations here are far beyond what a single facility can adequately absorb. In 2005,

109,000 outpatient and 7900 ante and post-natal care consultations were provided at this clinic. Direct beneficiaries are the 150,000 people of Yaqshid North district, although the catchment population is close to a quarter of a million people. In addition to seeing high numbers of people with medical concerns such as respiratory infections and intestinal parasites, MSF is the only organisation in the area treating epilepsy, asthma and other chronic health conditions.

In Middle Shabelle, MSF attends to primary healthcare in two districts – Jowhar and Mahady – through six outpatient dispensaries, seeing many patients with respiratory infections and skin diseases. In 2006, MSF ran a measles vaccination campaign in these districts, reaching 36,340 children aged 6 months to 15 years. In Yaqshid North area, 54,897 children were vaccinated.

The situation in Somalia worsened in 2005/2006 with a severe drought that decimated livestock and left many southern parts of the country with dwindling reserves of food and water. In early 2006, the MSF-run hospital in the town of Dinsor bolstered its team to provide mobile out-

reach activities, whilst the therapeutic feeding centre treated more than 600 children for severe malnutrition between January and June, a figure almost ten times higher than the previous year. Even in a 'normal' year, malnutrition is a chronic problem in many parts of Somalia. MSF projects in Galkayo, Marare, Bakool, Galgaduud and Dinsor contain nutritional components that treat children year round.

Whilst news of the drought reached the public in 2006, most gaps in healthcare go unnoticed. Diseases such as kala azar and tuberculosis are rampant in the country – in Bakool alone there were 543 admissions for kala azar in the first half of 2006, most of these children under age five.

MSF opened new projects in the towns of Dhusa Mareb and Guri El in the Galgaduud region in early 2006. In Dhusa Mareb, the regional capital of Galgaduud, the town's hospital had not functioned since the last government collapsed in 1991. In the Istarlin Hospital in Guri El town, all but the most rudimentary medicines and equipment were unavailable and the few remaining staff were unpaid and lacked training. With MSF support, the two hospitals were already treating a combined total of nearly 3000 patients per month by mid-2006. Patients present at the clinic for injuries resulting from car accidents and gunshots and trauma as an indirect result of violent conflict, including injuries sustained by children playing with grenades.

MSF has worked in Somalia since 1991.

Sudan

“The health situation hasn’t improved and there are still only a few organisations that are offering medical assistance.

For many Sudanese living in the areas where MSF works, life is just as difficult now as it was before the peace accord.”

Christoph Hippchen, MSF coordinator, southern Sudan

Sudan is the site of MSF’s largest operations, with hundreds of international and thousands of national staff working in over 30 separate locations.

At the end of 2005, whilst a much-heralded January peace agreement between the Khartoum government in the north and the SPLA/M rebel group in the south had held, sporadic fighting and a slow pace of change heightened fears that stability will not last the six-year period before the south votes in a referendum on self-determination. Armed conflicts continued to simmer in the south, east, and in the Darfur region to the west, where fighting and violence against the population has raged for over three years, driving over two million people from their homes.

Violence continues in parts of southern Sudan

By July 2006, the expected increase in aid following the signing of peace accords was slow in arriving. Hundreds of thousands of Sudanese returning from the north or from camps in surrounding countries found a country ill-prepared for their homecoming, with no transportation system, hardly any health infrastructure, and occasional outbreaks of violence.

On 10 April, armed militia attacked the village of Ulang, where MSF operates a clinic that treated 11,000 outpatients in 2005. Most of the patients and villagers, along with MSF staff, fled in search of safety. Thirty-one people were reported killed and dozens injured; 15 were treated in the MSF hospital in the nearby town of Nasir.

Subsequent outbreaks and threats of violence forced MSF international staff to evacuate from Nasir and from clinics in Wudier, Lankien and Pieri. In Pieri, most of the patients in the MSF clinic, including 120 patients being treated for tuberculosis (TB), were forced to flee. Medical equipment, drugs and food for the patients were looted, leaving the clinic effectively destroyed.

In November 2005, MSF was also forced to evacuate its sleeping sickness project in Tambura in the Western Equatoria region because of fighting.

Within this climate of violence, lack of healthcare continues to be the biggest threat to the people of southern Sudan. Health facilities are rare and despite areas opening up with the end of war, the absence of a transport system is a huge barrier to access. This also represents a challenge for humanitarian work, since much of the country is only accessible by air – an option limited during a rainy season that reduces much of the Upper Nile region to swamp.

MSF offers primary healthcare in multiple locations including Marial Lou and Akuem in the Bahr El Ghazal province and Ler and Wudier in the Upper Nile. In the Upper Nile province alone, MSF treated 250,000 outpatients at six locations in 2005. MSF also operates a 200-bed hospital in Kajo Keji in Equatoria, where 200 patients were treated for sleeping sickness in the first half of 2006. This is the only hospital in southern Sudan providing HIV treatment, with 50 patients taking antiretrovirals as of July.

A new project was opened in April 2006 in Bor in Jonglei Province. The town of Bor has become host to thousands of people who have returned to the south following the end of the war. With only a dilapidated hospital and few medical facilities, the town is ill-equipped to deal with any influx. MSF is currently upgrading the hospital to be a referral structure with a fully functional surgical unit and capacity for 100 inpatients.

In the town of Pibor, several hundred kilometres to the east, MSF teams have carried out over 5000 consultations monthly, working out of tents during the construction of a new primary health centre. This number includes outreach consultations in the smaller health units of Lekuanguole and Gumuruk, difficult to reach overland and obliging MSF to use boats if the river swells enough during the rainy season. In Unity State, an area still disputed between north and south, MSF works in

the Bentiu hospital, where a total of 17,125 consultations were provided in 2005.

Responding to staggering needs in Darfur

In 2004, MSF launched the biggest humanitarian operation in the organisation’s history to provide assistance for the people in Darfur. Two years later, MSF still had 170 international and over 2600 Sudanese staff working in 18 locations, where health needs remained staggering. In North Darfur State in December 2005 alone, MSF carried out just under 20,000 medical consultations.

Numerous attacks against humanitarian workers have drastically reduced the ability to deploy aid and reach people in need. Despite ceasefires and peace agreements, over a million remain in camps, totally reliant on humanitarian aid for their survival, whilst violence still rages around them.

Examples are manifold. On May 8, 2006, a truck arrived at the MSF clinic in the town of Muhajariya, northeast of the South Darfur capital of Nyala. “The truck backed up towards the clinic,” described MSF nurse Lisa Blaker. “When the doors of the truck opened and the tarp billowed up, I saw injured people piled on top of each other.”

Of the 46 patients, 30 were civilians, many requiring urgent surgery because of gunshot wounds to their abdomens, shoulders, arms, legs and chests. Two patients died as a result of their injuries. Some patients described how their husbands, children and other family members were shot down and killed in front of them.

The team in Muhajariya admitted 127 patients with violent trauma in April 2006 alone. The 35-bed hospital is regularly overstretched with the volume of patients requiring care.

A number of new projects were opened in Jebel Marra, a mountainous area in the centre of Darfur, in the spring of 2006. MSF began working in two health posts in Lugo and Bouley, with a referral system to an expanded health centre in Kaguoro. Clinics also opened in Killin and Gorni. By July, security constraints required evacuations



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and prevented adequate access in this region. MSF was unable to respond to a cholera outbreak in Jebel Marra because of a lack of security, and the level of malnutrition in the area began increasing, as people were trapped in the mountains and difficult to get to.

MSF also runs a hospital in Niertiti, a town of around 3000 residents and as many as ten times that number of displaced in the foothills of Jebel Marra. This hospital admitted 1128 patients in the first half of 2006.

Since 2004, MSF has worked in Mornay, a camp for displaced persons housing about 80,000 people. An MSF-constructed health centre and hospital conduct an average of 4900 medical consultations monthly. Healthcare services are also provided by MSF for displaced living in the Shangil and Shadat camps and Shangil Tobaya village, though this project was evacuated on July 23 after a security incident.

Kalma is one of the largest displacement camps in the world, where MSF runs a primary health clinic with almost 1000 consultations weekly and a women's health centre that includes treatment for sexual and gender based violence. The project is com-

plemented by community outreach and a mental health programme to help people cope with the profound psychosocial stress they are experiencing.

MSF also provides primary and emergency healthcare and nutritional support to more than 100,000 persons, more than half of them displaced, in the more stable government areas of Kabakabiya and Serif Umra.

Assisting marginalised populations in the east

Sporadic fighting also continued over the past year in Sudan's eastern Red Sea and Kassala states. On the outskirts of Port Sudan, MSF runs the Tagadom Hospital, which treats a marginalised population coming mainly from nearby shantytowns. The hospital includes a home visitor network, set up to care for displaced persons in the area, and a focus on maternal healthcare. By mid 2006, 5000 consultations were performed here each month.

Handover of Mygoma orphanage

Since 2003, MSF has been working in Mygoma orphanage, Khartoum, where the mortality rate of children was a staggering 80 per cent. After collaborating with local authorities, rehabilitating the institution

and providing psychological, medical and nutritional care to these children, the mortality average within the orphanage was reduced to 2.9 per cent. MSF will hand the project to local partners by the end of 2006.

MSF calls for more humanitarian support in Darfur

The situation in the camps in Darfur continues to be precarious, with a reported 2.1 million people completely dependent on external aid. In May 2006, MSF issued an alert highlighting the dwindling donor interest in the crisis. With the World Food Programme forced to reduce food rations because of a lack of financing, a serious nutritional crisis also threatened displaced persons, whilst other vital services such as drinking water supplies and hospital support were also affected by budget cuts.

As of July 2006, ongoing security incidents caused MSF to continue to evacuate projects intermittently.

MSF has worked in Sudan since 1979.

South Africa



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South Africa has the largest number of people with HIV in the world, with about six million infected. Since 1999, MSF has provided care and treatment for people with HIV in poor areas of the country. In 2001, the first patients were enrolled into antiretroviral (ARV) therapy in Khayelitsha, the largest township near Cape Town and eventually the first site in the country to provide ARVs at the primary care level.

By July 2006, the Khayelitsha HIV/AIDS clinics – run in partnership with the Western Cape Department of Health – were providing care to 8000 patients and ARV therapy to 4000 people, enrolling more than 200 new patients monthly. With plans to scale-up ARV treatment to 15,000 people by 2010 and a high demand for services, the model is being further decentralised. Intense efforts of clinics' organisation, triage of patients, redefinition of staff roles and referrals are being implemented.

Given the extremely high incidence of tuberculosis (TB) in the township and the high level of TB-HIV co-infection (about 60 per cent), an integrated response to the TB and HIV epidemic has been developed at the Ubuntu clinic in Khayelitsha, now the busiest primary care clinic in the province.

Central to the Khayelitsha programme in 2005/2006 has been the transfer of clinical responsibilities from MSF staff to human resources recruited by the provincial government. Drugs, including ARVs, are fully procured by the government whilst MSF continues to provide managerial and technical support.

In Khayelitsha, MSF has also catalysed the establishment of services dedicated to vulnerable groups. The Simelela rape survivors centre is a response to the high degree of

sexual violence against women and children in South African townships. Simelela provides medical care and psychosocial support and has integrated with other service providers to offer forensic examination and police assistance to rape survivors in a single location.

After four years of presence in Lusikisiki, one of the poorest areas in the Eastern Cape, the handover of MSF's HIV/AIDS programme to the Eastern Cape Department of Health is expected to be finalised by the end of 2006. This highly decentralised, nurse-based model is a good example of how to provide HIV/AIDS care to a scattered rural population with a high prevalence of infection. Currently 2100 patients receive ARV treatment through a central hospital and 12 feeder clinics.

Coupled to all MSF's clinical interventions is a strong community component implemented in partnership with the Treatment Action Campaign (TAC). TAC volunteers provide intense community education about HIV/AIDS, developing treatment literacy and generating greater awareness about available support and the rights of persons living with HIV.

MSF first worked in South Africa in the mid 1980s and returned in 1999 to respond to the needs of people affected by HIV/AIDS.

Uganda



For nearly 20 years, people in northern Uganda have suffered from brutal conflict between government forces and rebel groups including the Lord's Resistance Army (LRA).

Large-scale displacements mandated by the government have added to the misery. By mid-2006, almost two million people – nearly 90 per cent of the population of the north – had been uprooted to 200 camps. Unable to work or farm, these people are completely reliant on external assistance.

Whilst direct violence began to subside in 2005/2006, many people continued to die from preventable diseases including malaria, respiratory tract infections and diarrhoea. Most of the displaced living in the northern districts of Gulu, Lira, Pader and Kitgum barely manage to survive their deplorable living conditions.

Providing basic healthcare in the camps

In Lira district, MSF provides healthcare in six camps and runs a therapeutic feeding centre in Lira town with a capacity for 360 children. The feeding centre also offers tuberculosis (TB) treatment and in January 2006, MSF started counselling and testing children suspected to have HIV/AIDS. In February, 78 of 158 children tested were found to be HIV-positive. The team treats the children's opportunistic infections and is exploring ways to set up antiretroviral (ARV) treatment.

In Kitgum district, MSF offers basic healthcare in five camps. The team also provides mental health support, care for survivors of sexual violence and makes



"It is no exaggeration to say that over the past two decades, the fabric of society has been torn apart. The effect of living in the camps has crushed the life out of many people. Alcoholism is rife and violence, especially domestic violence, is common. What we treat is only the tip of the iceberg...people are not living in the camps, they are surviving. Nothing more."

MSF staff Amaia Esparza

© Jean-Marc Giboux

referrals to secondary facilities. In Kitgum town, MSF has established a clinic for children under the age of five, where up to 1500 patients were treated in one month of 2006 alone, 356 with malaria.

MSF cooperated with the NGO Interplast Holland in December 2005 and April 2006 to provide reconstructive surgery in Kitgum town for civilians mutilated during the conflict. Six patients with war-related injuries were treated as well as 18 with cleft lip and palate conditions or burns.

In neighbouring Pader district, MSF works in the Atanga and Pader Town Council camps. In the village of Patongo, where a single camp houses close to 40,000 people, MSF provides up to 1000 weekly medical consultations at a health centre managed in tandem with Uganda's Ministry of Health. Malaria, respiratory infections and diarrhoea are the most common ailments treated. MSF has built an 8-bed structure – including an isolation ward for patients suffering from bloody diarrhoea, meningitis and measles – to complement the existing 15-bed inpatient ward, which was insufficient to meet the area's needs.

In camps in Gulu, MSF offers basic health-care, giving special attention to young children and pregnant women and those suffering from malaria. The team carries out water and sanitation work and health and hygiene promotion among the local population.

Over the years, the LRA is reputed to have kidnapped more than 20,000 children to fill its fighting ranks, although it is thought to have only one-tenth that number of soldiers today. Every night as many as 4000 children stream into shelters including the Lacor shelter, near Gulu town. Walking as far as 10 kilometres, these "night commuters" are a vivid symbol of the violence in the region. MSF provides basic healthcare and mental health counselling for many of these children.

Focusing on HIV/AIDS

In the northwestern Arua district, MSF provides comprehensive HIV/AIDS care to thousands of people, with 2500 receiving ARVs. Between 100 and 150 new patients are admitted to the programme every month, including patients from neighbouring Sudan and the Democratic Republic of Congo (DRC). TB is the most common killer of persons living with HIV/AIDS, and MSF is working to integrate care for persons with both diseases, completing construction of a 40-bed isolation ward in Arua in 2005/2006.

Malaria and meningitis

In Nakapiripirit, along the border with Kenya, MSF sees increasing numbers of patients suffering from kala azar and malaria at Amudat Hospital and three peripheral health centres. In July 2006, 300 malaria patients and 60 patients with kala azar were receiving treatment. An outbreak

of meningitis at the end of 2005 caused MSF to launch a mass vaccination campaign that reached 40,000 children.

Improving water supply and sanitation

The growing population in rural camps has stretched the water supply, such that people began collecting contaminated rainwater from the street or from surrounding rivers and springs, leading to an increase in water-related illnesses. MSF has started improving the water supply and sanitation facilities in a number of locations.

Almost a quarter of the population has no access to latrines and those who do must share one with at least 60 other people. Waste management is virtually nonexistent and the burning of waste poses fire hazards to grass-roofed huts during the region's dry season. MSF is drilling boreholes, repairing hand pumps, rehabilitating springs, constructing waste pumps and building latrines to increase the availability of safe drinking water and sanitation facilities.

Increased insecurity

Violent ambushes against civilian and humanitarian vehicles in the final months of 2005 led to the suspension of MSF international staff travelling to the camps in northern Uganda for almost three months. Killings of aid workers and civilians compelled MSF in November to call on all armed groups to respect the safety of civilians and their freedom of movement, as well as the independence and safety of humanitarian aid workers. Throughout the north, MSF continued to provide emergency medical relief through the efforts of national staff, and by February 2006, with improvements in the security situation, most international staff had returned.

Helping refugees from DRC

In February 2006, MSF in Kisoro district distributed blankets, soap and fresh water amongst 10,000 refugees who had fled an attack on Rutshuru, DRC. Shortly thereafter, half the refugees were moved to the Naki Valley camp under pressure from national authorities. The rest returned to DRC.

MSF has worked in Uganda since 1980.

Zambia



In the second half of 2005, the first cases of what became a massive cholera outbreak were reported in the Lukanga swamps, 250 kilometres north of Zambia's capital city, Lusaka. A perpetual problem during Zambia's November to April rainy season, this water-borne disease has the potential to accelerate rapidly in impoverished areas with inadequate sanitation.

MSF immediately began an emergency intervention, taking over management of emergency medical activities in Lusaka in December, when the number of cases rose to 200 per week.

MSF set up two cholera treatment centres in the city with a total of 500 beds. By late January 2006, MSF had developed the capacity to treat more than 475 people weekly. MSF trucked chlorinated water to hard-hit neighborhoods, distributing 70,000 liters of water each week at the height of the outbreak. The team also implemented disinfection measures and hygienic burial activities. MSF staff fanned out in the community to promote strict hygiene measures and distributed information on ways to control the disease's spread through pamphlets, drama performances in schools and markets and on radio and television.

In March, the number of cholera cases started to decline and MSF was able to close its intervention at the end of the month, having treated 3028 patients. In

total, 5557 cholera cases were reported and 151 people died.

Expanding AIDS care

Approximately 1.6 million of the country's 11 million people are estimated to be HIV-positive and more than 100,000 people die each year from the disease. In response to this crisis, MSF works in two districts of the country to provide comprehensive HIV/AIDS care to some of the most vulnerable. MSF runs projects in the poor and rural northeastern Nchelenge district in Luapula province and in the Kapiri M'Poshi district of Central province, where MSF recently built a specialised antiretroviral (ARV) clinic inside Kapiri District Hospital. Testing activities are finding between 30 and 40 per cent of people infected with HIV in these locations. By mid-2006, approximately 6000 people were receiving HIV/AIDS related care from MSF at these locations, and an estimated 2000 were receiving ARV treatment.

MSF has worked in Zambia since 1999.

Zimbabwe

Grinding poverty, political violence and HIV/AIDS are wreaking havoc on the health of many Zimbabweans. Dramatic inflation rates in recent years have made medical care out of reach for most people, who bear the costs for most consultations, inpatient care, laboratory services and transportation.

Between May and July 2005, an estimated 700,000 people were made homeless as the Zimbabwean government demolished illegal settlements and marketplaces in a number of cities. MSF assisted displaced persons near Harare, conducting over 20,000 medical consultations from January to April 2006 at projects in the Epworth, Hopely Farm and Bellapaise Farm settlements. The team also distributed blankets and plastic sheeting.

In early February 2006, heavy rains spread cholera to urban and rural areas of the country. MSF assisted the Ministry of Health by setting up cholera treatment centres in the provinces of Manicaland, Mashonaland East and the Epworth section of Harare. Teams also provided medical and logistical supplies, transported patients and trained health workers. MSF installed and repaired water systems in health centres and organised health promotion activities. By July 2006, over 900 cases of cholera had been treated.

HIV/AIDS care

Almost one-quarter of the adult population of Zimbabwe is infected with HIV and more than 3200 people die from HIV/AIDS-related illnesses each week. In the southern city of Bulawayo, Matabeleland province, Gweru in Midlands province, the Tsholotsho district of Matabeleland, North province and Buhera district of Manicaland province, MSF provides HIV/AIDS-related care to thousands and treats almost 3000 with antiretroviral (ARV) medicines. Malnourished children admitted at projects are tested for HIV/AIDS and given care as needed. MSF is improving laboratory testing facilities and supporting efforts to decentralise treatment to rural clinics, making HIV/AIDS care more accessible for those living in isolated areas.

MSF has worked in Zimbabwe since 2000.

Asia and the Caucasus



Congolese doctor examines a child at the health centre in Bir Pani, Pakistan.

Armenia

Following the collapse of the Soviet Union, tuberculosis (TB) has risen steadily in Armenia within an inadequate healthcare system. The current system does not offer treatment for the drug-resistant form of TB because of its complexity: treatment is long and costly, causes severe side effects, and essential medicines are not readily available.



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In September 2005 MSF, in collaboration with the Ministry of Health (MOH) and the City Hall Mayor, established a TB programme in Yerevan and began treating patients in two pilot districts – Malatia-Sebastia and Shengavit. By May 2006, 65 persons were being treated for standard TB and 25 patients for the multi-drug resistant strain of the disease. MSF renovated two TB dispensaries in Yerevan, where patients are hospitalised. Once the intensive phase of treatment (up to a year) is over, patients are followed for several months through a system of TB “cabinets” that include facilities for collection of sputum samples, directly observed treatment rooms and a basic laboratory. A dedicated drug-resistant unit at the Republican TB hospital in Abovian is also undergoing renovation.

Addressing sexually transmitted infections

In the Shirak region of northwestern Armenia, MSF runs a sexually transmitted infections (STIs) management and prevention project. MSF is present in six local health polyclinics, where it focuses on confidential testing and treatment of STIs, ensuring access to care is free for all. Awareness and education about STIs and HIV/AIDS are important components of this project. MSF actively lobbies the MOH to adjust the national protocols for STI care – a primary goal is to obtain inclusion of antiretroviral drugs on the Republic’s essential drugs list, so they can be import-

ed. Over 5000 consultations on STI/HIV have taken place since the project’s inception.

Alternative treatments for mental illness

In Armenia, psychiatric institutionalisation has been the frequent solution for persons with mental illness and there is a strong stigma surrounding mental health issues in much of the country. Since 2004, MSF has been supporting and developing outpatient mental health services in an attempt to provide alternative means of care.

MSF has developed a programme emphasising a multidisciplinary approach to mental illness in the deprived province of Gegharkunik Marz. Between June 2005 and May 2006, 6488 psychiatric consultations, 434 psychological consultations and 1724 social worker interventions were recorded. The programme includes a strong information and education component, addressing and challenging the stigma of mental illness. Day centres, offering a range of therapeutic activities and skills workshops for the mentally ill, have now been handed to local partner Mission Armenia, and MSF plans to hand its mental health projects to the MOH by the end of 2006.

MSF also provides assistance to the primary healthcare system in this region, renovating ailing health structures in Kharchaghbyur, Tsjambarak, Vardenis, Geghamasar and Daprabak; and providing training and medical supplies to local staff. From June 2005 to May 2006, 14,292 primary care consultations were conducted by MSF-supervised doctors. International donor presence and funds for healthcare infrastructure and support have increased significantly over the past year and MSF will be phasing out its primary healthcare support in this region by the end of 2006.

MSF has worked in Armenia since 1988.

Georgia

© Alexander Glyadyelov

Georgia, a former Soviet state, has high levels of poverty and in recent years has seen only marginal improvements in the standard of living. Economic stagnation and ongoing territorial disputes over South Ossetia and Abkhazia continue to threaten destabilisation of the country.

Tuberculosis in Abkhazia

The bitter secessionist war fought by the Abkhaz against Georgia in the early 1990s resulted in a political stalemate: Abkhazia has created its own government and institutions, but these are not internationally recognised and it is therefore not entitled to external donor support. MSF remains one of the few international humanitarian organisations operating in this isolated region.

MSF’s Health Access Programme, which targets the vulnerable and elderly, operates through the City hospital in Sukhumi, Abkhazia’s capital, and supports a network of eleven dispensaries in the region. Doctors working in these facilities are given incentives by MSF to ensure they provide free drugs and consultations to the most vulnerable. An average of 2200 consultations were performed monthly in 2005. A mobile medical team in Sukhumi also visits people who are house-bound, and provides palliative care to cancer patients who have no other way of accessing pain relief.

In a region adjacent to Sukhumi, MSF runs a tuberculosis (TB) and multi-drug-resistant tuberculosis (MDR-TB) programme in Gulripsh hospital. Since 1999, over 1500 patients have been treated for standard TB, and innovations in 2005 included the introduction of ‘self-administered treatment’ where patients are allowed to leave the hospital after initial

Bangladesh

In April 2006, an MSF survey revealed high mortality rates and increased malnourishment of small children in a makeshift camp near the town of Teknaf, in the southeastern tip of Bangladesh. The camp is home to more than 5000 Rohingya refugees – ethnic Muslims who fled neighbouring Myanmar, where they are subjected to widespread repression. The camp is a squalid and crowded stretch of land where people live packed into shelters constructed from wood and small pieces of plastic.

treatment and can continue taking medication with minimal supervision.

The MSF team also attempts to help patients with MDR-TB deal with a complicated drug regimen and unpleasant side effects from treatment. When patients test negative for TB, they can go home, but must attend an ambulatory facility daily to receive medication and make monthly visits to the doctor. In 2005, a psychologist joined the programme to help support individuals who have had treatment setbacks and have been hospitalised for extended periods. Working with a team of health educators, the psychologist also holds group sessions to support those in the ambulatory treatment phase. MSF has admitted 100 patients to the programme since 2001.

Surgical care

In Georgia, MSF provides surgical assistance to the population of the Pankisi valley, some of whom are Chechens displaced by the war. The surgical department of Akhmeta hospital and the Douisi surgical post receive drugs and materials and 30 operations per month are performed in Akhmeta. An average of 150 consultations and 50 minor surgeries are done per month in the Pankisi valley.

At the end of 2005 MSF handed over a primary healthcare programme in the Varketili-Vazisubani district of Tbilisi, the capital of Georgia. Six hundred patients with chronic illnesses were transferred to the care of Caritas. MSF continues to facilitate access to specialist care and surgery for patients from Abkhazia and Pankisi.

MSF has worked in Georgia since 1993.

MSF has set up a small clinic and provides basic health and maternal care to the population in the camp and surrounding area. Malnourished children are enrolled in an ambulatory nutrition programme. An MSF technician improves the water quality and hygiene conditions in the camp; plastic sheeting and much-needed mosquito nets are also distributed.

On the border with India and Myanmar (Burma), MSF continues to work in the Chittagong Hill Tracts. This mountainous region is difficult to access and for decades was ravaged by conflict and forced displacement. Until a peace accord was signed between the government and the main rebel party in 1997, this area was characterised by internal strife and violence against the tribal population. Today, ethnic fighting flares up sporadically, but the area is relatively stable overall and has seen an increase in local efforts for development.

Reducing the impact of malaria

As all of Bangladesh, the southeast region is characterised by general poverty and a lack of education in remote areas. The population in this particular area also suffers badly from malaria. Although this tropical disease can be treated, in the Chittagong Hill Tracts many people die from malaria, especially children. MSF is running three clinics and a dozen mobile clinics and treatment sites in the districts of Khagrachari and Rangamati, where basic healthcare is provided with a special focus on tackling malaria. Mobile teams take the fast-acting malaria combination therapy to remote villages, seeing more than 80,000 patients every year. Health educators also teach villagers about malaria prevention, basic hygiene and pre-natal care. Midwives, together with a team of birth attendants, look after pregnant women and newborns and ensure that patients are referred to a hospital when any complications arise.

MSF has worked in Bangladesh since 1985.



Cambodia

In Cambodia, where approximately 180,000 people are estimated to be HIV-positive, MSF is currently focusing its work on treating people with HIV/AIDS. Government and NGO efforts, including those of MSF, have increased treatment access and by the end of 2005, Cambodia had 30 treatment centres. Over half of the 12,335 patients receiving antiretroviral treatment (ART) were being treated at seven MSF-supported centres.



© Juan Carlos Tomasi

In the nation's capital, Phnom Penh, MSF works in Norodom Sihanouk hospital, where over 2300 people are now following a regimen of ARVs. In 2005, an average of 63 patients per month was added to the programme. Tuberculosis is the most common opportunistic infection for persons who are HIV-positive and MSF offers integrated treatment for those co-infected with TB and HIV at all its treatment centres.

On the grounds of Siem Reap Hospital, MSF runs a Chronic Diseases Clinic (CDC) where over 2500 HIV/AIDS consultations were provided per month in 2005. Consultations and care are also provided for people with other chronic illnesses such as diabetes and hypertension. MSF treated approximately 40 diabetics monthly in 2005.

MSF runs CDCs to the west of Siem Reap in Sotnikum, and at Takeo Provincial Hospital in the south of the country. Combined, these centres currently have over 1200 HIV/AIDS patients on a regimen of ARVs, 176 of them children.

Together with the Ministry of Health (MOH) and other NGOs, MSF is supporting decentralisation of treatment from CDCs to provide more localised access to treatment. In the towns of Kampong Trach and Poipet, over 500 patients were receiving treatment in decentralised sites by July 2006.

An HIV/AIDS clinic at the provincial hospital in Kompong Cham is the only one available to see patients, not only from its own province, but also from the neighbouring provinces of Kompong Thom, Kratie and Stung Treng. By the end of 2006 it is expected that 1600 patients will be receiving treatment at this location.

Treating tuberculosis

MSF runs a tuberculosis (TB) project in Sotnikum and in 2005 introduced a community TB programme in 180 remote villages, providing community-based TB treatment with the goal of increasing treatment access whilst ensuring adherence. Village volunteers are assigned patients and help ensure that medication is taken. This programme is supported by bi-weekly visits from a medical home care team.

Malaria projects

MSF has run a malaria project in the Sotnikum area over the past five years, which will be handed over to the MOH by the end of 2006.

MSF has also operated a malaria outreach project in the isolated Pailin area, utilising village malaria workers to screen people, and providing effective artemisinin-based combination therapy (ACT) for this increasingly drug-resistant illness. In 2005 over 7000 people were treated, and the activities will be handed over to the MOH at the end of 2006. MSF is currently assessing the effectiveness of a recently developed and effective antimalarial drug, Artekin, in this setting.

MSF has worked in Cambodia since 1989.

China



According to UNAIDS, up to 650,000 people in China are infected with HIV. Although the healthcare system generally operates on a market-oriented, fee-for-service approach, the Chinese government has launched a comprehensive AIDS response and has begun providing free antiretroviral treatment to AIDS patients using a combination of Chinese and imported antiretroviral medicines. MSF continues to operate a model for HIV/AIDS programmes within the country.

Since December 2003, MSF has been treating AIDS patients in a small clinic located on the premises of the Guangxi Centre for Disease Control in Nanning City. Here, an average of 315 consultations are performed monthly and 276 patients receive free antiretroviral (ARV) treatment. MSF was initially the only provider of free ARVs in the province of Guanxi; now, several government-run sites have also opened. The MSF project has been distinctive because of its strong emphasis on confidentiality and counselling.

In central China, the spread of HIV/AIDS is atypical. Most people here contracted HIV from unhygienic blood collection and transfusion practices when selling their blood plasma, a common practice undertaken by villagers to supplement their incomes. In Xiangfan, Hubei province, MSF manages a treatment clinic in collaboration with the Xiangfan Centre for Disease Control. More than 360 patients are registered in the clinic and 140 patients receive free ARVs. Care includes home visits and a strong educational component. All MSF projects in China are highly community-oriented, with MSF facilitating patient support groups and providing information to patients' families, health workers and the wider community.

Indonesia

The December 2004 tsunami continued to define MSF action in Indonesia throughout the second half of 2005, with medical activities centred mainly, but not exclusively, in Aceh.

MSF was one of the first international aid organisations to reach Aceh after the tsunami and at its peak was running projects in eight districts. These addressed a wide range of emergency medical needs with vaccinations, mobile clinics, mental health programmes, surgery and the distribution of non-food items.

By the end of the year, the health situation in Aceh had returned to pre-tsunami levels and MSF programmes decreased accordingly. By this stage, MSF had rehabilitated 27 health structures, a hospital and almost 300 wells; conducted over 40,000 medical consultations and provided over 2000 individual counselling sessions. Over the course of the year, MSF had been reorienting its programmes, placing more emphasis on reaching out to inland communities whose access to healthcare had been restricted by years of civil war and reinforcing its mental health care for these, as well as victims of the tsunami. Today, MSF maintains a more streamlined but just as committed team in Aceh, focusing on mental health in three districts with a particular focus on working with people affected by conflict. The team performs surgery in Sigli hospital and provides primary healthcare to a population of approximately 475,000 through clinics, training, drug donation and health promotion.

Across the rest of Indonesia, MSF continued to respond to outbreaks of disease, including malaria in Alor and measles in Sumba, and further developed its tuberculosis project in Ambon. In 2006 MSF's emergency capacity in Indonesia was stretched as teams used boat, plane and foot to reach people affected by simultaneous epidemics of cholera and measles in the remote island of Papua. This island has some of the worst health indicators for the whole of Indonesia, with a high burden of infectious disease and communities living out of reach of even basic healthcare. Mobile teams were still operating in the

Asmat area, where MSF vaccinated over 13,500 children for measles. Here MSF is offering measles follow-up care and addressing other health needs.

MSF was just closing its cholera programme in Papua when the June 2006 earthquake hit Java's cultural capital, Yogyakarta. Emergency team members flew straight from Papua to Yogyakarta, with the first members arriving on the same day as the earthquake and trucks filled with emergency supplies soon to follow. Although the majority of needs were swiftly covered by Indonesian emergency services, hospitals were overwhelmed. An MSF surgical team worked alongside other Indonesian and international teams to help clear the backlog of patients waiting for surgery, and a tented 100-bed, post-operative ward was assembled to ease overcrowding in the hospitals and provide quality post-operative care to patients from all over the city. Psychologists offering training to Indonesian medical staff and counselling those traumatised by the earthquake continue to work in the region.

MSF has worked in Indonesia since 1995.



© Chien Min Chung

Blocked from Henan

MSF has been trying since 2002 to work in Xiangfan's neighbouring province of Henan, where an estimated 300,000 or more people are in need of HIV/AIDS treatment, many infected with HIV from selling their blood. One-fifth of the patients in the Xiangfan project come from Henan, and the demand from people in that province to be enrolled in treatment increased significantly in 2006. Despite repeated attempts to establish a Henan programme, provincial authorities continue to refuse MSF access to the province.

Advocating for drug access

MSF is advocating at the national level for China to facilitate access to AIDS medicines, particularly for fixed dose combination pills (FDCs) that can simplify treatment. Intellectual property protection and other factors currently block the use of FDCs, resulting in restrictions in drug choice, lack of availability of needed drugs, and high prices for some medicines. Production capacity exists for many drugs that are either not available or too expensive in China, but patent barriers often block generic manufacturing. A team of a pharmacist, campaigner and lawyer work full-time to document, raise awareness of and overcome various barriers to accessing medicines.

Handover of children's shelter

Since 2000, MSF had been running a project for street children in Baoji, Shaanxi province. This crisis centre and shelter was established to provide medical, psychological and social care for street children. In 2005, 109 children were taken into the shelter. After helping create a local NGO to take over the management of this project, MSF withdrew from Baoji in March 2006.

MSF has worked in China since 1988.



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India



Civilians in India's northeastern Assam and Manipur states continue to be affected by recurring outbreaks of political violence along religious and ethnic lines. Over the last five years, more than 150,000 people have fled their homes because of violence.

Indian authorities estimated that approximately 1500 people in Indian-controlled Kashmir lost their lives and 6000 were injured in the powerful earthquake that struck northeast Afghanistan, the north of Pakistan, and northwest India on October 8, 2005.

MSF launched an emergency aid operation to assist those in need in both India and Pakistan, where the epicentre of the earthquake was located. In India, MSF aid comprised the distribution of thousands of blankets, tents, sets of clothes and bottles of water, two tonnes of food and a tonne of medical supplies to help the injured and the 140,000 people rendered homeless.

MSF offered significant mental health support to earthquake victims who were brought to the provincial capital, Srinagar, for medical treatment. Team members conducted mental health counselling at four area hospitals where people received medical care. MSF later extended its mental health programme, offering both individual and group therapeutic activities for people in the districts of Tangdhar and Baramulla, areas strongly affected by the quake. A mobile medical clinic was launched in the Kupwara district, treating approximately 40 patients daily. MSF also trained community counsellors to provide mental health support for villagers during the winter months, when snow cut off remote areas from outside assistance.

These activities were carried out in addition to the mental healthcare MSF offers people living in Jammu-Kashmir state, a conflict-prone region claimed by both India and Pakistan. Working from various locations in and near Srinagar, in 2005 MSF aided approximately 1500 people with mental health problems related to the area's tensions and conflict.

Providing care to the internally displaced

In the Karbi Anglong region of Assam state, ethnic violence forced 40,000 persons to flee to camps or shelters in towns and MSF began providing urgently needed assistance in October 2005. Malaria is an illness of concern in Assam and teams used artemisinin-based combination therapy (ACT) to treat approximately 10,000 malaria patients a month. Mobile clinics are used to reach people in more than 50 camps, where MSF sees many children with respiratory infections, diarrhoea and malnourishment. In early 2006, MSF carried out a measles vaccination campaign in the camps, trucked in clean water and installed taps on water tanks.

MSF is also active in neighbouring Manipur state, operating four primary healthcare clinics in the district of Churachanpur and a clinic to treat people with sexually transmitted infections. Because of the state's high rate of HIV infection, in March 2006, MSF began integrating HIV/AIDS care into the state's existing health programme. By mid-year, 200 patients were receiving care from MSF, including antiretroviral (ARV) treatment. Another HIV/AIDS project opened in Mumbai to help patients excluded from the national care programme and those co-infected with TB. As of June 2006, 124 patients were receiving comprehensive care including 47 using ARVs.

Following the 2004 tsunami, MSF provided aid to survivors in the southern region of Tamil Nadu. Working in 28 coastal villages, the team provided psychological counselling to a total of 770 people (5600 sessions), handing these activities over to a local partner organisation in December 2005. Prior to this handover, MSF assisted people affected by flooding in the region in November, distributing 3000 blankets and providing 1300 consultations to the affected population.

In June 2005, MSF handed over a six-year-long tuberculosis (TB) programme in Mumbai to local health authorities and redirected its attention to the care of TB patients co-infected with HIV/AIDS.

MSF has worked in India since 1999.

Iran



© Sibylle Gerstl

Iran has become home to hundreds of thousands of Afghan refugees over the past decades. Since 2002, the Iranian government has put intermittent pressure on its Afghan population to repatriate and nearly two million people have left Iran.

Still, an estimated one million Afghans remain, many intending to stay. No longer considered refugees by the authorities, and since 2004 without rights to private healthcare, they face barriers in access to medical services.

MSF has been providing care to the Afghan population through both fixed and mobile clinics in Mashhad and Zahedan. In 2005, MSF conducted a total of 130,000 medical consultations in these projects – seeing primarily upper respiratory infections and diarrhoea – and made 2280 hospital referrals, many for emergency care or surgery.

In the economically deprived Zahedan, MSF has seen an increasing number of consultations and hospital referrals over the past two years. Approximately 55 per cent of the population in this area relies on MSF for access to medical consultation. In its two clinics providing primary care, 72,349 consultations were performed in 2005, and 1168 families were visited monthly in their homes.

Mashhad is Iran's second largest city. In 2005, MSF ceased activity of three mobile clinics travelling to surrounding villages, and added a second fixed clinic in

Mashhad to improve access to care. A total of 56,884 consultations were performed in 2005, and 635 families were visited per month in their homes.

Toward the end of 2005, MSF conducted a community based epidemiological survey to better understand the beneficiary population, which has changed since 2002. The survey showed that over 80 per cent of the population has been present in Iran for more than 10 years, and many had access to jobs and primary healthcare, particularly in Mashhad. MSF will therefore be closing its Mashhad programme in 2006 and focusing its efforts on improving primary and secondary healthcare access for the more vulnerable population of Zahedan.

Providing post-earthquake assistance

In March of 2006, MSF distributed hygiene kits and food to 1000 families in two villages following an earthquake in Lorestan, approximately 400 km southwest of Tehran. Medical assistance was also provided to people in isolated areas.

MSF provided aid in Iran following the 1990 earthquake and has worked there continuously since 1995.

Japan

Whilst all Japanese nationals are entitled to universal healthcare, the rules and requirements for access effectively exclude a large proportion of Japan's homeless persons. The largest homeless community, approximately 7757 people, is found in Osaka prefecture and its capital Osaka City, where men aged 50 to 60 account for three quarters of the homeless population. Too young to collect a pension and too old to compete for a decreasing pool of jobs, many suffer from chronic conditions such as hypertension and diabetes that require ongoing access to medical care.

Nishinari Socio-Medical Centre in the heart of Kamagasaki, the city traditionally considered the core for daily workers and the homeless of Osaka, remains the only response to the medical needs of the homeless, but the structure is well beyond its capacity. Without healthcare or social services, people have scattered into riversides, parks and train terminals.

MSF has made several attempts to establish a fixed health centre in the area to restore healthcare for the homeless, but discrimination against this population is fierce and widespread and has prevented the establishment of a fixed clinic. MSF has met with continual opposition from some of the local communities and authorities.

In 2005, MSF mobile clinics visited four parks on alternating weeks and conducted 1268 medical consultations, following 270 patients on file. The team treated chronic conditions including hypertension, diabetes, joint pain and gastritis and referred those requiring hospitalisation or specialised care to health facilities in the area. Patient histories were also collected in 2005, enabling the MSF team to better understand the mechanisms of socio-medical exclusion.

MSF has worked in Japan since 2004.

Myanmar



© Claude Mahoudeau

Under military rule since 1962, Myanmar (Burma) is largely cut-off from the outside world. Much of the population is poor and many lack access to healthcare, including numerous minority groups, who remain under continuous pressure and regular violent attacks from the junta. MSF has worked in the country since 1992, providing primary care and attempting to reach the most vulnerable in order to reduce their suffering. Particular attention is given to those with malaria, tuberculosis (TB) and sexually transmitted infections (STIs). Gaining access to carry out independent humanitarian action has been challenging, and MSF continues to press the military authorities to gain access to people in need.

In 2005, more than 460,131 medical consultations were conducted in MSF-supported clinics in the capital of Yangon as well as Rakhine, Kachin and Shan states. In these locations, MSF conducted over 6000 consultations for those with HIV and by July 2006, had approximately 1888 patients following antiretroviral treatment (ART). Over 400,000 people were screened for malaria, with 175,000 treated. Required treatment was started by 4310 of the close to 14,000 people that were screened for TB.

Health education – mostly concerning sexually transmitted infections – is a large part of MSF's work, and half a million people in these areas were reached in 2005. More than 40,000 medical consultations were conducted for people with sexually transmitted infections (STI) and over two million condoms were distributed.

In western Rakhine state, MSF provides basic healthcare, seeing many patients

with malaria, malnutrition and HIV/AIDS, including a large proportion of Rakhine Muslims (Rohingya) who are denied citizenship and access to healthcare. In 2005, MSF tested 350,000 people for malaria and treated 150,000 with the disease. Approximately 3000 severely and moderately malnourished children were treated.

Southern Myanmar

In Dawei and Myeik districts, MSF aims to improve diagnosis and treatment for malaria, tuberculosis, HIV/AIDS and STIs, with specific attention to the vulnerable populations: ethnic minorities, community sex workers and migrant populations – via fixed and mobile clinics.

In Kayah state, at the border with Thailand, a place of continuing conflict between the junta's army and ethnic groups, MSF is also assisting the population, mostly of the Karenni people, through two fixed clinics and two mobile teams. Through all these

projects in southern Myanmar, MSF in 2005 treated over 100,000 patients including over 22,000 for malaria. Approximately 370 persons with HIV are following antiretroviral treatment.

Problems of access

Projects focusing mainly on malaria treatment for vulnerable ethnic minorities in Mon and Karen states were closed in March 2006, as teams could not secure adequate humanitarian space to operate its programmes independently and without making unacceptable compromises to the authorities.

MSF has worked in Myanmar since 1992.

Kyrgyzstan

Within the prison system in Kyrgyzstan, the incidence of tuberculosis (TB) is up to 25 times higher than in the civilian sector, where the contagious disease is present at already alarmingly high rates. Crowded prison conditions provide an ideal environment for the tuberculosis bacilli to spread into the air quickly and easily through coughing, sneezing, or even talking.

In 2005, MSF saw a role in helping Kyrgyzstan confront its growing TB problem and opened a tuberculosis programme in September. The project is focused on two detention centres, one in Bishkek and a second in a nearby prison colony. High quality TB drugs were imported into the country and MSF initiated medical training, the preparation of health education material and started seeing patients.

By May 2006, 242 patients had been treated for TB. Early in May, MSF also began to rehabilitate the laboratory in one of 11 colonies for sentenced detainees and some cells in SIZO 1, a pre-trial detention centre in Bishkek, in order to provide better TB care. The rehabilitation focuses on the separation of infected patients and the provision of a safe environment for sputum collection.

As more data are collected, it is becoming apparent that many people in Kyrgyzstan are multi-drug-resistant (MDR-TB), exhibiting a strain of the disease that renders the two best anti-tuberculosis treatments, rifampicin and isoniazid, largely ineffective. Treatment is possible, but it is extremely rigorous and difficult for the patients, taking up to two years and normally requiring lengthy hospitalisation. MSF will be assessing the prevalence of MDR-TB in the prison system throughout 2006.

MSF has worked in Kyrgyzstan since 2005 and previously operated an HIV/AIDS and STI prevention project from 1996 to 2001.

Laos

National authorities and many international organisations do not perceive HIV/AIDS to be a major health problem in Laos. The prevalence is low, with an estimated 600 to 3600 people living with HIV/AIDS. Because of the low prevalence and limited investment in prevention, there is little awareness of the disease and risk of a rapid spread among vulnerable groups. With the current HIV response in Laos, UNAIDS estimates there could be more than 18,000 people living with the virus by the year 2015.

Laotians have had only one place where they can access HIV/AIDS treatment: the MSF-supported care and treatment centre in the hospital of Savannakhet, a city in the south of the country. By July 2006, MSF was providing antiretrovirals (ARVs) for more than 400 people in this location. The service provides a full range of care for the patients in Savannakhet, including counselling, testing, treatment of opportunistic infections and access to ARVs.

Many patients treated in Savannakhet come from Vientiane, the country's capital, or even further north. Some people must travel up to 24 hours to get their treatment, which adds an extra burden and causes a range of problems including difficulties getting to the hospital or adhering properly to their care and drug regimens. MSF has convinced the authorities to open a second treatment centre in the country, in one of Vientiane's leading hospitals, Settatirat, where MSF will provide technical support, training and a temporary supply of ARVs.

MSF has demonstrated that HIV patients can be cared for within public health structures, and is continuing to advocate for a national strategy so that testing and treatment will be part of the Lao health structures, carried out by Lao health authorities.

MSF has worked in Laos since 1989.



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Malaysia

With its prosperous economy, Malaysia attracts high numbers of labourers from poorer countries in Southeast Asia. Many of them come from Indonesia and the Philippines and a large number stay in Malaysia without legal status. A specific group within this population is those who have fled violence and persecution in Aceh, Indonesia and Myanmar. They cannot be granted refugee status in the country, as Malaysia is not a signatory to the international refugee convention. This has major consequences for their acceptance in society and for obtaining essential services, including medical care. Accessing healthcare is problematic for all migrants, who find it difficult to pay the higher fees required of foreigners, even in the public health system. Refugees have even more difficulty, as health staff in public and private facilities have a legal obligation to report undocumented patients to the authorities.

MSF started working in Malaysia in 2004, supporting a Malaysian non-governmental organisation (NGO) in providing mobile clinics for refugees in and around Kuala Lumpur, setting up a system for referral to hospitals, and introducing mental health activities for the often traumatised refugees. Depression, anxiety-related disorders, thoughts of suicide and post-traumatic stress disorder are widespread.

The work has expanded to support this NGO in its medical work in detention centres, where arrested undocumented migrants are held, and at improvised settlements in the forests near major construction sites. The main disorders seen are upper respiratory tract infections, skin infections and gastritis, related to poor living conditions and psychological stress. MSF has supported the national NGO in medical and mental health services, offered weekly in three locations, to migrants living among the general population of Kuala Lumpur. The number of daily consultations averages between 80 and 100 per location. MSF is also establishing a network of Malaysian doctors and psychologists who volunteer some of their time to provide care to undocumented migrants.

MSF has worked in Malaysia since 2004.

Nepal



The team returns to the village of Radidjula. Equipment is frequently transported by donkeys on these remote mountain trails.

© Florian Larguier

Nepal's civilians remain caught in a violent struggle between government forces and Maoist rebels. The fighting has caused mostly civilian casualties – more than 13,000 people are estimated to have died in the bloodshed since 1996. Hundreds of thousands of people have now been displaced in a country where nearly half the population already lives below the poverty line.

Fighting has limited access to healthcare and worsened health conditions for most of the country's inhabitants. Many health workers have left their positions and movement between Maoist and government-controlled areas is difficult, making referrals and distribution of medical materials extremely problematic.

To provide assistance, MSF runs the 15-bed Salle Hospital in the capital of the Rukum district. MSF staff treat patients, supply medicines and clean water and manage waste disposal and hygiene. Each month, the team carries out approximately 2000 medical consultations, including 100 hospitalisations. MSF also supports outlying health posts in the same district, which conduct approximately 3000 medical consultations a month.

MSF is also active in the western Kalikot district. Starting in June 2005, MSF began rehabilitating the 15-bed district hospital so it could offer basic and secondary health care, reproductive healthcare, TB treatment, and emergency services. MSF also improved the power and water supply systems. MSF sees approximately 1600 patients per month in the outpatient department and admits patients to the hospital when required.

MSF expanded its activities with a new project in February 2006 in the Khotang district. MSF offers 24-hour healthcare to local residents including inpatient care and emergency obstetric care. The team is also rehabilitating Khotang's Diktel District Hospital and is recruiting badly needed health staff.

MSF has worked in Nepal since 2002.

Pakistan

On October 8, 2005 an earthquake measuring 7.6 on the Richter scale hit northeast Afghanistan, the north of Pakistan and northwest India. The epicentre was approximately 100 kilometres north of the Pakistani capital Islamabad, causing massive destruction in surrounding regions and killing an estimated 76,000 people.

The largest impact was in the north of Pakistan, where almost 80,000 people were wounded and another three million people were affected, many of whom instantly became homeless. The earthquake triggered a massive emergency relief operation by MSF, operating in both Pakistan and India.

In the immediate aftermath of the earthquake many victims were cut off from help, as mountain roads had been destroyed or blocked by landslides. Thousands of critically wounded had to be evacuated by helicopter, and others were not able to reach hospitals until several weeks later. The local population began to rescue injured people, and local health structures were the first to provide medical care. National health authorities deployed medical personnel from across the country whilst the Pakistani army mobilised helicopters, carried out evacuations, and loosened restrictions allowing a massive influx of international support.

The number of wounded put enormous strain on the heavily damaged health infrastructure. In the Azad Kashmir and the North Western Frontier Province of Pakistan only 199 out of 564 health facilities remained fully functional after the earthquake. Patients were often treated in makeshift hospitals and clinics, or along the road.

MSF, already present on both sides of the Line of Control between Pakistan and India-administered Kashmir, immediately switched to emergency mode. Within six

months, MSF undertook over 116,000 outpatient consultations to treat minor wounds and general pathologies and to identify more severe cases for referral to inpatient facilities. Over 30,000 people were vaccinated against diseases such as measles. Three hospitals were also set up to provide surgery and post-operative care for earthquake victims in Mansehra, Bagh and Hattian. Mental health treatment was integrated from the start of the MSF intervention, with over 11,000 consultations taking place in the first few months alone.

Though many actors were involved in providing aid, relief efforts were hampered by the remoteness of many locations, the damage to the infrastructure and deteriorating weather conditions. On 119 sites MSF conducted water and sanitation activities – constructing just over 1400 latrines and distributing around 30,000 hygiene kits from October to April. Still, water and sanitation remained a major problem for those who could not yet return home.

One of the main worries was the approaching winter and its potential impact on those whose homes had been destroyed. A medical and logistical race took place to treat as many wounded people as possible and to deliver tents, blankets and other non-food items before winter. MSF sent almost 2000 tonnes of medical and relief items to the affected area, benefiting approximately 83,000 families.

A fleet of helicopters from various armies, UN agencies and private contractors were deployed to distribute basic relief material and evacuate the wounded, and MSF hired two helicopters to lessen its logistical dependency on others and set its own priorities in visiting the various project areas.

Although conditions were harsh in some areas, no new medical emergencies arose during the winter, despite the presence of some 20,000 people from the destroyed cities of Muzaffarabad, Bagh and Mansehra dependent on medical, shelter, water and sanitation assistance. MSF continued to help those in the displaced camps around Muzaffarabad and Bagh by running a hospital and clinics, trucking in water and constructing permanent latrines.



© Bruno Stevens/Cosmos

Farza Bibi, 4, suffering from a broken arm and wrist, receives basic medical treatment at a mobile MSF consultation near Muzaffarabad, Pakistan, October 2005.

Ongoing programmes throughout Pakistan

Despite the intense activity required in the aftermath of the earthquake, MSF's regular programmes in Pakistan continued throughout 2005/2006.

MSF handed over its primary healthcare projects to the local Taraqee Foundation in the Mohammed Kheil Afghan refugee camp in western Baluchistan province in April 2006 after performing approximately 40,000 consultations. At the same time MSF started a project in Kuchlak, a slum at the outskirts of Quetta, where tens of thousands of Pashtuns from Afghanistan reside after having fled their country. Here MSF conducts about 130 mother and child consultations a day and screens for malnutrition.

In Kuram district, following the repatriation/relocation of most Afghan refugees, support to the Shasho hospital stopped in September 2005 and in April 2006 was redirected to inpatient and outpatient paediatric care at the nearby Alizai hospital. As in Kuram district, mother and child health was also the focus of MSF's basic healthcare programme in Leepa Valley and Lamnian, close to the Line of Control between Pakistan and India-administered Kashmir. By July 2006, MSF's permission to work near the Line of Control was retracted and activities in Leepa valley came to an end. By then, MSF had conducted almost 15,000 consultations, of which several hundred were for pregnant women.

MSF has worked in Pakistan since 2000.

Thailand

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At Mae Sot, MSF offers tuberculosis treatment to undocumented migrants and refugees from Myanmar. Formerly treatment required close medical observation and possible residence in a "tuberculosis village". In 2006 MSF introduced self-administered treatment, whereby patients visit a clinic once a month to see a doctor and receive a month's supply of medicine.

Free access to healthcare in Thailand is available only to registered Thai nationals or to persons with a specific registration status. Vulnerable groups such as ethnic minorities and migrant workers are often excluded from the health system, causing them to do without treatment for serious medical conditions including HIV. MSF has responded by providing healthcare to marginalised groups throughout the country.

Establishing non-discriminatory care for HIV/AIDS

MSF began its first-ever antiretroviral programme in Bang Kruai district hospital in 2000 using generic antiretroviral (ARV) drugs. Since then, MSF has worked closely with the Access to Essential Medicines campaign, local partners and the Thai government to establish localised HIV/AIDS programmes and MSF continues to advocate for large-scale generic production of ARVs in the country.

In Chiang Rai province, MSF is supporting two public hospitals that offer HIV/AIDS care to unregistered migrants from Laos and Myanmar. At the Mai Sai hospital, MSF provides free ARVs to unregistered minorities who lack access to healthcare. An MSF doctor works alongside hospital staff and MSF ensures drug supply, pays for lab tests and hospital referrals. At Chiang Saen district hospital, MSF offers HIV treatment and care to unregistered minorities and to people who cross into Thailand seeking care specifically for HIV/AIDS.

In Kuchinarai, Kalasin province, the district hospital in 2005 assumed responsibility for 160 MSF patients receiving firstline antiretrovirals. MSF is now focusing on a pilot programme to introduce secondline treatment, an alternative drug regimen for people who are not responding to the drugs they were initially prescribed. This involves understanding why initial drug regimens failed and ensuring that hospitals and hospital staff have the correct training, access to facilities and drug supply necessary to offer effective secondline treatment.

Treating patients in Bangkok prisons

MSF provides clinical support for HIV in two prisons in Bangkok: the medium security Minburi Remand Prison, and Bangkwang, a maximum security male prison where inmates are incarcerated for life. MSF provides medicines, training, covers lab costs and sends medical staff to work in the clinics several times a month. As of July 2006, 44 patients were taking ARVs.

Providing basic medical care to undocumented migrant workers

There are thought to be over two million migrant workers in Thailand, with more recent arrivals contributing to the post-tsunami reconstruction of hotels and tourist resorts in areas such as Phuket. Many of these workers remain undocumented and lack access to healthcare. MSF is using mobile clinics and a newly opened health centre in Phang Nha to provide basic medical care focusing on mother and child health, treatment of sexually transmitted infections and ensuring clean water and sanitation.

In 2005/2006, MSF also added 518 patients to its tuberculosis programme treating undocumented migrants in Mae Sot, Itak province. HIV testing and treatment is now systematically offered to tuberculosis patients because of high rates of HIV/TB co-infection, and treatment is now also available for persons with multi-drug-resistant tuberculosis.

Turkmenistan

Assisting Laotian refugees

In July 2005, with sanitation activities addressed by other actors, MSF began providing healthcare and a water supply to 6000 Laotian Hmong people who had taken refuge in Phetchabun in northern Thailand. The Hmong are an ethnic minority who largely aligned with the Americans during the Vietnam War, and cite marginalisation and persecution as reasons for fleeing their country even today. By October, 6094 medical consultations had been conducted in the camp, mostly for respiratory infections and diarrhoea. Other non-governmental organisations (NGOs) departed in October and MSF was the only remaining NGO, left in complete charge of the camp. MSF lobbied the United Nations High Commissioner for Refugees, NGOs and the Ministry of the Interior to take responsibility for this refugee population, with no results. As of July 2006, MSF continued to carry out 500 medical consultations weekly.

Handover of projects to the Thai government

In December 2005 MSF closed an HIV/AIDS project in Surin province, where 752 patients were receiving ARVs. All patients on firstline treatment were integrated into the national HIV/AIDS programme and MSF will provide drugs to the 33 patients on secondline treatment until December 2006.

In Phetburi, central Thailand, MSF has supported an HIV treatment programme by providing drugs, medical staff, technical support and training at Ban Laem District Hospital and the paediatric department of the Phetburi Provincial Hospital. Now the responsibility for approximately 120 adults and 70 children on ARVs has been handed over to the Ministry of Health and the project will close in 2006.

MSF has worked in Thailand since 1983.

Turkmenistan, one of the former Soviet republics, has been ruled by President Niyazov since it gained independence in 1991. Although accurate data on the prevalence of disease and the population's health status is very hard to obtain, it is clear the regime's national healthcare policies and practices are resulting in unmet health needs for a large number of people throughout the country.

Magdanly, close to the border of Afghanistan and Uzbekistan, is the focal point of MSF's work. The area is home to about 40,000 people, mostly of Uzbek ethnic origin, and some immigrants (former refugees) from neighbouring Tajikistan. MSF works in collaboration with the Ministry of Health (MOH) in Magdanly Town Hospital and four primary health posts in Magdanly District.

In 2005, MSF saw more than 38,000 ambulatory patients and 2000 hospitalised patients. MSF provides free consultations and drugs and supports the efforts of the hospital's local health workers through training, equipment and the direct involvement of MSF staff. MSF teams participate in the management of infectious diseases, respiratory illnesses, neo-natal complications and conditions related to poor nutrition of babies and infants. MSF also provides materials, training and technical support to the hospital laboratory, ensuring proper medical waste management and the creation of hygienic and patient-friendly facilities. Safe blood transfusion practices are also promoted.

Ensuring reproductive healthcare

Extensive rehabilitation, especially of the water and sanitation systems, was carried out in the maternity ward and intensive care areas of the hospital in 2005. MSF devoted much attention to lifesaving efforts in the maternity ward, where an average of 75 babies are born every month. Many premature babies are now saved as a result of the MSF-initiated Intensive Care Baby Room.

The Magdanly project was expanded in 2005/2006 to include maternal healthcare: ante-natal, delivery, and post-natal care, and assistance to hospital staff in the management of prevalent female pathologies,

gynaecological conditions and obstetric complications.

Through its reproductive health activities, MSF increased efforts to raise awareness about the prevention, recognition and management of a variety of sexually transmitted infections (STIs). HIV/AIDS – the existence of which Turkmen health authorities have difficulty acknowledging – also has MSF's specific attention.

In September 2005, after four months of denied access, MSF successfully negotiated with national health authorities for permission to continue its work in primary health posts of Magdanly district. Teams are once again able to provide child, maternal and reproductive health services to the area's rural communities.

MSF has worked in Turkmenistan since 1999.

South Korea

The present conditions in North Korea make it impossible to provide independent and impartial humanitarian assistance directly inside the country and reach those that need it most. In 2005/2006, MSF provided care to North Korean refugees through projects operating out of South Korea.

In Seoul, MSF has been the only foreign organisation present in the transit governmental centre of Hanawon, where North Korean refugees are placed for their first three months upon arrival in the country. MSF has developed mental healthcare activities in Hanawon to help refugees cope with symptoms of trauma – over 200 patients received MSF psychological support in 2005.

Following strong lobbying by MSF, positive measures have been undertaken by South Korean authorities to provide much-needed psychological support for North Koreans both within and after they leave the transit centre. In April 2006, 150 mental health professionals attended a conference mounted in collaboration with the University of Psychiatry, Seoul, to discuss therapeutic approaches to care and review the three years of the MSF mental health project. Responsibility for the provision of psychological assistance to refugees was then handed over to local authorities.

MSF worked in North Korea from 1995 to 1998 and has worked with North Korean refugees since 1998.

Uzbekistan



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MSF is one of the few humanitarian organisations present in Uzbekistan, where a combination of increasing economic hardship and deterioration of tuberculosis services in the 1990s has led to an increased incidence of tuberculosis (TB). This is most evident in the region of Karakalpakstan, which is also confronting economic problems caused by massive environmental degradation in the Aral Sea area.

In 2001/2002, MSF conducted a drug resistance survey in Karakalpakstan, showing levels of multi-drug-resistant TB (MDR-TB) that are among the highest in the world. Thirteen per cent of people never before treated for TB were infected with MDR-TB, and 40 per cent of re-treatment cases were infected with this strain. MDR-TB is defined as resistance to the two most powerful anti-TB drugs, isoniazid and rifampicin. It is a man-made phenomenon caused by poor patient management, poor adherence to prescribed regimens, poor programme management, or a combination of these factors.

MSF began its MDR-TB programme in Uzbekistan 2003, focusing its activities in Nukus City and Chimbay District in the autonomous republic of Karakalpakstan. By May 2006, a total of 246 MDR-TB patients had been enrolled in the programme.

MDR-TB is a very difficult disease. Treatment has very unpleasant side effects and involves hospitalisation for six to 12

months. Afterwards, patients have to be treated in the ambulatory phase for about a year. The MSF team continues to try to improve the quality of life for patients by offering psychosocial assistance to them and their families, placing much emphasis in 2005/2006 on the supervision of patients who are living in the community, but who must still take medication six days per week.

In collaboration with the Ministry of Health, MSF recently opened an additional inpatient TB ward in the TB 1 hospital of Nukus City. The ward has 30 inpatient beds designated for patients with PDR-TB (poly drug resistant tuberculosis), yet another form of tuberculosis that shows resistance to certain drug protocols.

MSF has worked in Uzbekistan since 1997.

The Americas



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Bolivia



© Amanda Sans

Bolivia is home to a large indigenous population, many of whom are poor, geographically isolated and have little access to healthcare. Up to 40 per cent of people are affected by Chagas disease in some rural areas, the highest prevalence in Latin America. Diseases preventable with vaccines also continue to be an unresolved health problem.

MSF has focused on helping Bolivians with Chagas, the deadly parasitic disease that can be transmitted through a “bug bite” and eventually attacks the heart and digestive system. MSF currently operates projects in semi-urban areas and in the city of Sucre, Chuquisaca department. As Chagas cannot be effectively treated in adults, emphasis is on diagnosis and treatment for Chagas in youth under 18, and by July 2006, 193 patients had been treated with good results. MSF continues to support the Ministry of Health’s Chagas prevention activities, trains medical and community health staff, and conducts community education. Lobbying and advocacy to improve access to diagnosis and treatment for Chagas is also ongoing.

In O’Connor province, Tarija department, MSF is testing and treating youth under 15 for Chagas, attempting to reduce its impact. By July 2006, MSF had screened a total of 7083 youths and treated over 1200 in this rural area. Strategies to diagnose congenital Chagas in unborn babies have also been implemented. MSF is now integrating these activities into public health structures, aiming to hand over the project

to local authorities at the end of 2006. Awareness and advocacy efforts have also been robust with MSF participating in national and international Chagas forums and media activities, lobbying at the department level and contributing to the Chagas department network.

Flooding in Bolivia

Unrelenting rains caused flooding in Bolivia’s highlands and the Amazon basin in January 2006, drawing extensive humanitarian aid. After assessing the health situation, MSF provided safe drinking water to approximately 600 families in Gualberto Villarroel province, La Paz department.

Neglected diseases project closes

In April 2006, MSF closed a neglected diseases project aimed at the diagnosis and treatment of tuberculosis, malaria, leprosy and leishmaniasis in Pando, because epidemiological surveillance showed these diseases were not as prevalent as expected. After training local health staff, MSF handed over diagnosis activities to the Ministry of Health.

MSF has worked in Bolivia since 1986.

Ecuador

The health system of Ecuador is fragmented throughout various institutions, making the implementation of national policies for diseases such as HIV/AIDS, malaria and tuberculosis very difficult. Up to 40 per cent of the population has no access to healthcare, in part, because of financial shortfalls in the public health sector.

MSF is working to improve healthcare for people with HIV/AIDS in the Flor de Bastión slum of Guayaquil, Ecuador’s largest city. Here MSF provides care to 540 persons with HIV, 281 of them receiving antiretroviral treatment. In 2005/2006, MSF has been decentralising care from the referral hospital to maternity clinics and health centres, promoting better patient access to diagnosis, care and follow-up.

The disease carries a strong stigma and in 2005/2006, MSF worked on breaking down myths and stigmas attached to HIV – particularly amongst health staff – through educational workshops and sensitivity training and contributed to forums on HIV in different areas of the country.

Advocating for drugs to expand treatment

Generic medicines, the cheaper alternative to branded drugs, are key to expanding treatment for HIV/AIDS. Registering drugs in Ecuador is a complicated process, and the use of qualified generic medicines is being introduced slowly given strong pressure from pharmaceutical companies to use branded drugs. MSF has been defending registration of generics with the goal of including them in the national HIV/AIDS protocol, and the National AIDS Plan is now giving greater consideration to generics because of their lower cost. MSF has also been lobbying for fixed-dose treatment (whereby different drugs are combined into single pills) to become part of the national protocol. Fixed doses make it simpler and easier for patients to take their medicines and helps improve treatment adherence.

MSF is working on a progressive handover of the Guayaquil HIV/AIDS project to the Ministry of Health, which should be completed in 2008.

MSF has worked in Ecuador since 1996.

Honduras



© David Pierre / Strates

L.A., a person living with AIDS, Tela, Honduras.

Every year, about 20,000 to 30,000 Hondurans migrate from the countryside to the capital, many establishing themselves in squat slums within the centre of Tegucigalpa. With high rates of divorce, alcohol and drug abuse, family structure is fast-disappearing and many young children prefer to live on the streets. Easy prey for druglords and prostitution, these young people engage in high-risk behaviours and live amidst a climate of violence – yet they are routinely denied access to state healthcare.

Since April 2005 MSF, in cooperation with local organisations, has operated a therapeutic day centre for street children and youth in the heart of Tegucigalpa. The project offers medical, psychosocial and social-educational assistance to street children and youth up to age 24 in an effort to reduce high-risk behaviour and provide healthcare. Almost 400 youths are now registered at the centre, which receives approximately 35 visits per day.

Medical consultations number approximately 180 per month, most frequently for respiratory infections, skin diseases and trauma caused by violence. Sexual and reproductive health care are emphasised in response to the needs of girls and adolescents exposed to the risk of pregnancy, sexual exploitation, violence and sexually transmitted infections. Psychological care is an important part of the services offered,

with the centre's psychologist seeing approximately 35 clients per month for symptoms of depression and anxiety alone.

In 2005, the centre piloted psycho-educational group work. One group was created for young pregnant women and mothers to exchange experiences and learn about sexual, reproductive and natal care. The second group, "Los Listos" (quick witted) was aimed at male members and brings up issues of violence and drug abuse. Facilitated by a psychologist and education specialist, members discuss topics including problems of substance abuse and difficulties living on the street. Girls soon lobbied for a similar group of their own, and in December 2005, a female "Las Listas" was created. In a separate endeavour, a number of well-attended informational HIV prevention sessions were also held in 2005/2006.

Lending antiretroviral medicines to the government

After transferring an HIV/AIDS project in Tela to national authorities in September 2005, MSF intervened in November 2005 and January 2006, lending antiretrovirals to prevent impending interruption of treatment not only for its former patients, but for all 3000 patients enrolled in the national antiretroviral programme. At both times, drug stocks were about to run out because of untimely ordering of drugs by the Honduran government. MSF expressed public concern for these patients, and to date no further difficulties obtaining these drugs, financed by the Global Fund, have been reported.

MSF has worked in Honduras since 1998.

Colombia

Now in its fifth decade, ongoing violent conflict in Colombia has caused the displacement of over two million people. Whilst many people in remote villages find themselves cut off from basic healthcare services, including immunisation programmes, those who have fled to urban shantytowns are subject to poverty, disease and rampant violence. Many people throughout the country are also suffering from mental disorders including acute trauma caused by witnessing or being victims of violent events, but areas affected by violence are often isolated and rarely benefit from visits by healthcare workers.



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Expanding care through fixed and mobile clinics

In 2005/2006 MSF continued to provide essential medical services in numerous urban and rural areas of the country, using both fixed health posts and mobile clinics. In addition to basic healthcare, many programmes include vaccinations, reproductive healthcare, dentistry and psychosocial support.

In the northeastern department of Norte de Santander, MSF conducted medical outreach activities in isolated rural areas within the El Catatumbo region. Approximately 750 patients were seen each month at two fixed sites and through mobile activities.

In the provinces of Córdoba, Chocó and Antioquía, MSF in 2005/2006 expanded its activities, establishing a fixed clinic for people who had returned to Saiza, Córdoba, and starting a second one in Ríos Sucio, Chocó. Mobile clinics were used to provide healthcare to people living in outlying villages, treating approximately 900 patients monthly.

MSF also established a clinic for displaced persons living in the urban slums of Sincelejo. An average of 1250 patients was

treated per month, the most common ailments being respiratory infections, diarrhoeal diseases and acute viral infections. Near Bogotá, MSF assists the newly displaced in Soacha district, conducting medical consultations and providing mental health support for approximately 1000 displaced persons monthly. The team also informs displaced families about their right to healthcare and provides information on how they can gain access to the complicated government-run health system.

Psychosocial care is provided for people living in Florencia, Caquetá. Here approximately 700 are seen monthly, largely for depression and post-traumatic stress. In addition to providing healthcare via mobile brigades, MSF supports health facilities in the Barbaçoas region of Nariño province, by training health staff, providing support to rehabilitate rural health structures and implementing water-sanitation and waste management systems.

MSF is also providing medical and psychological assistance to victims of conflict in Tolima and northern Huila departments, an area of fighting, massacres and displacement. In 2005, MSF visited more than 20 different sites and conducted over 14,000 medical and over 4400 psychological consultations in this area.

When an evaluation carried out in Ibagué, the capital of Tolima department, revealed that displaced persons had to wait on average three months before obtaining assistance or medical coverage from government agencies, MSF opened a health centre in January 2006 to provide medical and psychological assistance to new arrivals. More than 1000 consultations were

conducted in the first four months, nearly 30 percent of them psychological consultations.

Offering medical assistance to survivors of sexual violence

In Chocó department, MSF is working in the jungle city of Quibdó, population 120,000. There are two roads connecting Quibdó to the rest of the country, but both are extremely unsafe because of the ongoing conflict.

Here MSF provides a package of sexual and reproductive healthcare services, targeting survivors of sexual violence in particular. MSF works in the maternity wards of San Francisco Regional and Ismael Roldan hospitals and also supports the city's five health centres, providing them with family planning methods, emergency contraception and drugs. Using mobile clinics, MSF also provides medical and psychological assistance in areas surrounding Quibdó. In its first three months of activities, MSF performed a total of over 3000 medical, family planning and psychological consultations through this project.

Providing help after violence and a natural disaster

In November 2005, fighting between army and guerilla forces escalated in the town of San Juancito and hundreds fled this part of Norte de Santander. Heavy rains caused flooding and landslides in the same region days later. In coordination with local authorities and the Colombian Red Cross, MSF provided two truckloads of emergency medical material, food, shelter and hygiene kits to approximately 300 displaced persons.

MSF staff held

On 3 February 2006, a local armed group in Norte de Santander detained five MSF staff members. Three team members, all Colombian staff, were released the following day. On 9 February, the final two international staff members were allowed to leave the village where they were being held. After extensive analysis and evaluation of the security situation in its projects in Colombia, MSF decided to cautiously continue its activities, with the exclusion of one area in Norte de Santander.

MSF has worked in Colombia since 1985.

The Human Cost of Colombian Conflict

"All families have suffered. Once I asked the pupils in my class, 11-year-old children, how many of them had lost a family member while the paramilitary were here. Out of 28 children, 20 told me they had at least one family member killed by the armed groups."
teacher from a rural community



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Colombia is a thriving country with a lively culture and growing level of progress. It has modern cities and flourishing scientific and education centres. But behind this upbeat image, an extremely violent, internal conflict has carried on unabated for decades. Fuelled by drug trafficking and foreign military assistance, the struggle by guerrillas, paramilitary groups and government forces to control territory and resources continues to take a high toll on the civilian population. People who live in conflict zones in rural Colombia are often perceived as resources for the armed actors who operate locally.

"We were taken somewhere and they started to threaten us and talk about chainsaws. After awhile, they let us go. I grabbed my kids and we left immediately for another town. We left only with the clothes we were wearing; we walked all night and part of the day, and the kids kept asking for food..."
mother from a rural community

Violence is the leading cause of death in Colombia. During the last decade, the homicide rate has been approximately 60 per 100,000 inhabitants, one of the highest rates in the world. For every person who dies as a result of violence, many more struggle to survive it, often burdened by a range of physical and mental problems.

"The man was found wandering around town. He said he was feeling bad, but he could not explain what was wrong. He kept talking and crying...tears went down his cheeks and when we asked him why he was crying, he said "Am I crying?" and he cleaned his face, started crying again and kept repeating he did not feel well. He was disoriented, confused, with mental blackouts, he could not remember what had happened."
community leader, rural area

"My mother cannot sleep...if she hears a motorbike out in the streets she wakes up and cannot fall asleep again...the thing is that last week we had to pick up our brother-in-law. He was almost unrecognizable. They had beaten him up, and his head was chopped off. I can't get that image out of my head."
young man living in an urban slum

From *Living in Fear, Colombia's Cycle of Violence*, a 64-page report compiled by MSF to raise awareness of the human cost of the conflict by giving a voice to those who must bear its harsh consequences.

Haiti

Although increasing violence before Haiti's national elections in February 2006 briefly focused world attention on this poor island nation, violence has ravaged the capital, Port-au-Prince, in waves since President Jean-Bertrand Aristide was forced to leave the country in early 2004. Civilians suffer from clashes amongst armed factions and between armed groups and UN soldiers. Fear, lack of infrastructure and high healthcare costs prevent more than half of the country's population from accessing basic medical services.

MSF provides free emergency medical and surgical care to people at the 56-bed trauma centre at St. Joseph's Hospital in the Turgeau neighborhood. During 2005, more than 7000 people received emergency medical assistance, almost 2500 of them direct victims of violence. Half of those treated for such injuries were women, children or elderly. MSF also treated more than 100 survivors of rape during 2005 and gave referrals for further psychological care and legal assistance.

The enormous civilian cost of Haiti's violence caused MSF to speak out in January 2006, calling on all parties to respect the safety of civilians and allow immediate access to emergency medical care. MSF also called on all armed actors to respect the safety of national and international aid workers after a wave of kidnappings.

Responding to specialised needs

Specialised care for patients in need of physical rehabilitation or mental healthcare is provided by MSF in the capital's Pacot neighborhood. This includes post-surgical rehabilitation for patients with fractures from car accidents, paralysis from gunshot wounds, amputated limbs or those with serious burns. More than 256 patients were admitted for treatment in 2005 and an additional 613 people received outpatient physical therapy. Eighty-seven patients received psychological support.

In one of the city's most violent areas, Cité Soleil, MSF operates the 75-bed Choscal Hospital and primary healthcare centre in Chapi. More than 3000 consultations are carried out monthly, including maternal and child healthcare and surgical consultations.

MSF also works in the communes of Petite Rivière, supporting health structures and providing basic healthcare with a special focus on maternal and child health.

Haiti has the highest level of maternal mortality in the Americas, with 523 deaths per 100,000 births. In March 2006, MSF opened the 60-bed Jude Anne Hospital in the capital's Delmas area. The project specifically targets women living in the most violent parts of the city, who have difficulty accessing appropriate care, in part, because of poverty and violence. Medical care is provided for women with pregnancies presenting dangers to the mother and child, as well as treatment to help prevent mother-to-child transmission of HIV. Emergency obstetric care services are available around the clock. Between March and June 2006, the team performed more than 1200 deliveries and 450 surgical interventions, including 250 caesarean sections.

Project handover

In June 2006, MSF handed over the activities of its primary healthcare project in the Decayette area to a local NGO. The project had focused on maternal and child health including pregnancy care, treatment of sexually transmitted infections and child immunisations.

MSF has worked in Haiti since 1991.



"We see about three gunshot victims a day. There are gunshot wounds that would kill someone eventually, but more slowly – maybe their bowel or liver is perforated and there is slow bleeding – where if you operate, you can actually do something to stop them from dying."

Dr. James Smith, MSF surgeon

Guatemala

In October 2005, tens of thousands of people throughout Central America lost their homes, livelihoods and access to clean water when tropical storm Stan struck the region, causing landslides, flooding lowlands, contaminating drinking wells and displacing an estimated 30,000 people. Around 1.5 million people were directly affected. Although the Guatemalan government responded rapidly, help was needed to reach all of the areas hit by the storm.

MSF was one of the first international organisations to arrive, bringing 11.5 tonnes of relief materials to the Atilán Lake area, including basic emergency medical materials, blankets, mattresses and drinkable water. Within one week, MSF had provided 60,000 litres of drinking water and first aid for people living in shelters in dozens of communities in Atilán, Chiquimulilla, Coatepeque, San Marcos and Escuintla municipalities.

Providing post-emergency assistance

Once the initial emergency phase was over, MSF focused on rehabilitating water systems, fixing infrastructure and resettling families. MSF also offered mental health support to people traumatised by the disaster in a number of locations and provided medical consultations in cooperation with local doctors.

A large part of the intervention involved the distribution of items such as hygiene kits to help reduce the possibility of water-borne diseases. Overall, MSF distributed 5000 kits to nearly 25,000 people in one month and gave out more than 15,000 mosquito nets to prevent malaria. MSF also set up an epidemiological surveillance system, based on a network of health centres, to monitor for outbreaks of Hepatitis A, malaria, dengue fever and diarrhoea. In the



A blood sample is taken to test a child for Chagas disease, Olopa, Chiquimula.

months following the storm, there was no significant increase justifying a medical intervention.

Helping those with HIV/AIDS

Approximately 61,000 Guatemalans are living with HIV/AIDS. Despite external support, national HIV/AIDS programmes have been slow in starting and national health institutions have done little to address the AIDS pandemic. There is a lack of specialist centres and staff, and HIV/AIDS care has been highly centralised, available only in Guatemala City.

MSF provides HIV/AIDS care in the city's Yaloc clinic, where 4000 medical consultations were performed and 803 patients were receiving life-extending antiretrovirals (ARVs) by the end of 2005. MSF is also advocating for planned treatment protocols for patients co-infected with HIV and TB.

Halting the spread of a deadly influenza

In March 2006, MSF responded to an outbreak of influenza A in Roosevelt Hospital, which affected immuno-compromised HIV patients and killed more than 20 people. MSF provided vaccines for hospital staff and patients who were able to provide a good immune response. Vaccinations were also sent for hospital staff in Coatepeque and Puerto Barrios.

Handing over projects for HIV/AIDS, Chagas and street kids

MSF has been promoting decentralisation of HIV/AIDS services to provide better access to people in remote areas such as Puerto Barrios, on the Caribbean coast.

During 2005, MSF made significant progress integrating all aspects of care (counselling, diagnosis, treatment for opportunistic infections, ARV treatment and follow-up) at all levels of healthcare delivery. This project will be handed over to the Ministry of Health (MOH) and the national AIDS programme in 2006.

Collaborating with local organisations, MSF has been providing comprehensive HIV/AIDS care in the town of Coatepeque and has begun the process of handing over the project (2000 patients, 500 on ARVs) to the MOH.

In the remote town of Olopa, MSF has been testing and treating people with Chagas disease, which can be fatal without early treatment. MSF in 2005/2006 screened almost 8000 children aged 15 and under, and treated the 104 children found to have the disease. Local staff have been trained to take on these activities and MSF will close this project in December 2006.

MSF's project for street children in Guatemala City's Tzité clinic performed 2702 medical and 719 psychological consultations in 2005. In mid-2006, MSF organised a regional symposium to share the team's seven-year experience with academics and practitioners, and plans to withdraw from this project at the end of the year.

After reaching a total of 11,000 students in 14 schools in Coatepeque, a sexual education programme was handed over to the Ministry of Education in February 2006.

MSF has worked in Guatemala since 1984.

Peru

Lurigancho is one of the most populated prisons in Latin America. Located in Lima, the prison houses more than 8500 inmates in a space designed for 1500 and up to 4000 visitors are received daily. In Lurigancho, the risk of contracting HIV is five to seven times higher than outside the prison.

Starting in 2001, MSF, together with the National Penitentiary Authority, developed a multidisciplinary project addressing sexually transmitted infections (STIs) and HIV/AIDS within the prison. The goals were to improve the quality of medical care and treatment of STIs, provide care for people with HIV/AIDS and to train and involve health professionals from disciplines such as psychology and education, who could then provide support to this vulnerable population.

From 2000 to 2005, over 1800 persons were treated for sexually transmitted infections. Voluntary HIV tests were taken by 5673 inmates and HIV prevalence decreased

from 8.2 per cent to 4.7 per cent in parallel with increased counselling.

In February 2006, after five years of developing the programme, MSF published *Lessons Learned: a multidisciplinary work experience in STI and HIV/AIDS in Lurigancho prison in Lima, Peru* and began handing over the project to local authorities. MSF will continue to support health workers inside Lurigancho throughout 2006.

A new model of HIV/AIDS care

In the Lima slum of Villa El Salvador, MSF runs a comprehensive HIV/AIDS project at the Centro Materno Infantil San José health clinic. Working closely with the Ministry of

Health, MSF has developed a programme of simplified testing, streamlined drug regimens and decentralised care. The project includes free and voluntary rapid testing close to patients' homes and the option of home-based care for those who cannot come to the clinic. Social and psychological support are provided and MSF is creating a range of educational tools to help patients and their families understand what is needed for successful HIV/AIDS care – not an easy task given the high level of illiteracy in Villa El Salvador.

By mid-2006, MSF had built a new clinic and 250 patients were being followed, including 181 patients receiving antiretroviral treatment. Providing community-based medical care and publicly addressing the issue of HIV/AIDS has been a breakthrough in an area where HIV is little understood and remains a stigma.

MSF has worked in Peru since 1985.



Europe and the Middle East



Chechen child swings in the back courtyard of the URIC Wolomin Refugee Centre, Poland.

Belgium

In Belgium, one of the only rights granted by law to undocumented migrants is the right to access healthcare. Sadly, in practice this is incredibly difficult, mostly because of red tape and patients' fear of saying who they are and where they live – required information in order to obtain treatment.

MSF has responded by providing healthcare to these people facing obstacles to health services in the regular system. In 2005, MSF conducted 140 medical and psychosocial consultations in clinics in Brussels and Antwerp. Seventy-four percent of these were undocumented migrants, whilst most of the others were asylum seekers waiting for a decision on their applications.

In addition to offering treatment, MSF strives to redirect patients toward the institutions that should take care of them, getting local and national authorities and welfare agencies to face up to their responsibilities and ensure care for the most vulnerable groups, care they are entitled to by law.

In July 2005, lobbying efforts reached a promising conclusion when MSF was able to stop its medical consultations in Liège after reaching an agreement with the local welfare agency. The agreement included the creation of a Relais Santé, aimed at guiding the patients through the adminis-

trative maze and at facilitating contacts with service providers and agencies in charge of paying the bills. While this is a major achievement, more structural changes are needed to facilitate easier access.

Handing-over of HIV testing activities

For the last 15 years, MSF's Elisa Centre has provided free and anonymous HIV testing in Brussels. On Jan. 1, 2006, after a huge media and lobby push, this service was finally taken over by the authorities and is now available in Brussels and Antwerp. Until then, Belgium was one of the only countries in Europe not offering free and anonymous HIV testing, despite recommendations from the World Health Organization.

The data collected by MSF during the project proves that vulnerable groups are more likely to come and get tested if it is both anonymous and free: in its last year of activity, 2000 tests were undertaken at the Elisa Centre, with 1.6 percent of people testing positive for HIV.

MSF has worked in Belgium since 1987.

France



© Julien Leveque

Whilst healthcare and legal solutions do exist, undocumented migrants in France experience many difficulties in obtaining the information and documents necessary to access state medical aid.

In 2005, MSF conducted 7100 medical consultations with migrants in ongoing programmes through medical/social clinics in Paris (4700) and Marseille (2400). Eighty-eight percent of those who received MSF care did not have medical coverage, although most were potentially entitled. MSF social workers conducted more than 2500 consultations to help patients obtain their rights to health coverage through social security and referred them to agencies for help with basic needs such as accommodation, meals, clothing, and legal information.

Although referral to specialists has been easy to manage, this was not the case for people suffering with mental disorders. New arrivals experience isolation and many have gone through a violent journey whilst trying to migrate, often from war-torn countries. In 2006 MSF intends to focus its medical activity toward those



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Italy



seeking asylum. Having come from countries with armed conflicts, many of these individuals suffer mental disorders directly or indirectly related to violence.

Offering cold-weather assistance in Calais

From November 2005 to March 2006, MSF was present in Calais to provide assistance to migrants intending to cross the channel towards England. Sleeping outdoors for an average of 20 days before leaving France, these migrants – mostly from conflict zones in the Horn of Africa and the Middle East – faced harsh winter weather and strict barriers to healthcare. Apart from emergency hospitalisation, they could not access any other due state medical aid.

Using a mobile clinic, an MSF physician saw an average of 20 patients per day and coordinated any necessary referrals. The majority of patients sought help for infections or orthopaedic conditions related to their journey. MSF also complemented food distributions with weather protection kits. By the end of March, MSF closed the project after ensuring that state agencies would improve their system and that another actor, Médecins Du Monde, was in place to continue primary care.

MSF has worked in France since 1987.

Italy receives thousands of migrants arriving by boat from Africa each year. Upon arrival, many of these people are weakened and in need of food, water and medical attention. In 2005/2006, MSF provided medical care for over 20,000 recent arrivals and migrant workers and opened new projects to reach more people in need.

Since 2003, MSF has opened health clinics for migrants lacking legal status in various regions of the country including Rome, Sicily and Campania. The clinics operate as part of the national healthcare service and use anonymous codes to protect patient identity. The clinics' goals are to treat these vulnerable people, inform them of their legal and healthcare rights and gradually hand over activities to local health authorities.

In mid-2005, MSF started a new project in Naples, providing healthcare for undocumented immigrants living in one of the most difficult, violent and complex Italian social-economic environments. Here immigrants live in ghettos completely excluded from the rest of Italian society.

At the end of 2005, a new project with clinics for undocumented immigrants was opened in the Sicilian town of Agrigento. One of the main problems detected by MSF in this area concerns mother and childcare, and barriers to accessing abortion.

Assistance at landings in the South
Lampedusa, a small island south of Sicily, is a landing spot for more than 12,000 immigrants per year. MSF offers initial medical screening at the harbour where boat people land after hazardous trips through the Mediterranean Sea, and follows up on any urgent medical referrals. Similar assistance is provided on Sicily's southern coast.

Seasonal farm workers' project

In southern Italy, where agriculture is the main economic activity, thousands of asylum seekers and undocumented immigrants work as day labourers on farms. In 2005/2006, MSF provided medical care to seasonal farm workers in Sicily, Puglia and Calabria. Main pathologies detected were related to harsh living and working conditions, such as gastrointestinal disorders, dermatological and respiratory diseases or musculoskeletal pathologies.

MSF has worked in Italy since 1999.



© Chris Maluszynski/Moment

MSF staff examine newly arrived migrants at the harbour landing of Lampedusa. MSF has not been given access to the overpopulated temporary migrant centre on the island.

Luxembourg

Luxembourg is one of the most developed and richest countries in the world, where the inhabitants enjoy high health standards. But hidden problems remain, one of them being the rapidly growing use of illegal and psychotropic drugs.

With approximately 50 per cent of youths under age 18 having already used illegal substances, Luxembourg has the highest prevalence of drug use by minors in Europe.

MSF has created the Solidarité Jeunes project to help these youths, working with them, their families and relevant institutions – including most secondary schools, several educational centres, and outreach programmes in the country. A special emphasis is put on collaboration with the juvenile justice system, where the MSF programme constitutes an alternative to the classic repression response. The programme provides psycho-medical, social and psychotherapeutic care for young users and their families. From mid-2005 to early 2006, efforts were geared toward expanding the services of Solidarité Jeunes by developing a concept of peer-intervention (called CHOICE) for first-time arrested drug users. From June 2005 to May 2006, MSF worked with a total of 263 adolescents and families.

Exploring the needs of immigrants

MSF continues to participate in a working group with other NGOs and the government, monitoring the medical and psychological situation of immigrants and asylum seekers entering the country. After launching guidelines describing access to the health system in Luxembourg for these vulnerable populations, the MSF-led working group began to scrutinise government procedures and practices concerning the expulsion of sick migrant people. The working group has submitted a proposition to the Ministries of Health and Immigration to clarify the criteria for such expulsions.

MSF has worked in Luxembourg since 1996.

Russian Federation

Eleven years after the start of the first Chechen conflict and despite official rhetoric claiming the situation has 'normalised', the majority of Chechens still struggle through lives burdened by fear, uncertainty and poverty. Thousands of Chechen refugees have been forced by Russian and Ingush authorities to repatriate from neighbouring Ingushetia. Their homes destroyed and lacking basic needs such as clean water and healthcare, many Chechens face grim conditions in overcrowded, temporary accommodation centres (TACs). Access to the republic remains a pressing problem.

In Grozny, the republic's capital, a mobile team provides primary healthcare to six TACs, and general, gynaecological and paediatric consultations in four polyclinics. These clinics see a total of 5600 patients per month.

MSF continues to distribute medicine and medical material to Grozny Maternity, which is the central maternity and referral hospital for all of Chechnya. In 2005, MSF provided drugs in support of 125,740 medical consultations in health structures in Shatoi, Sharoi and Itum Kale. In the rural region around Grozny – Grozny Selsky – MSF primary care mobile teams offer healthcare in 10 different village settlements. A primary healthcare clinic was also opened in May 2006 in Shelkovskiy district in the northeast, offering gynaecological, paediatric and general services.

High rates of psychological distress

Mental health problems are widespread among the long-suffering population and mental health services are a large component of MSF's programmes. A survey conducted by MSF in September 2005 in six Grozny TACs showed that 77 per cent of respondents were suffering from discernible symptoms of psychological distress. Fifteen MSF counsellors work closely with the mobile medical teams, and also offer 24-hour services for patients and staff in the republic's main trauma hospital – No. 9.

Expanding treatment for tuberculosis

MSF's tuberculosis (TB) programme expanded in 2005 to include a 4th dispensary, Karagalinskaya. By June 2006 it had enrolled over 750 patients from a catch-

ment area of 300,000 – indicating that rates of TB are very high. The programme supports the existing TB dispensary system with drugs and necessary equipment, and also provides specialist lab services. The directly observed treatment system (DOTS) has been adapted to the conflict setting and MSF provides food to boost the nutritional status of patients. MSF health educators hold individual sessions, group work and public information campaigns on TB.

To improve the living conditions of the displaced, MSF organised distributions of non-food items such as mattresses, blankets, stoves and building material. In 2006, MSF is constructing sanitary facilities (water tanks, showers, latrines) for around 200 families in some of the most precarious settlements of the Chechen capital.

MSF is also expanding and developing its surgical programmes in Grozny, providing training support and equipment to the neurosurgery and trauma wards of Hospital No. 9. A plastic and reconstructive surgery programme for patients suffering disabilities from violence or accident related trauma, including gunshot wounds, mine injuries and burns began in July 2006.

Providing ongoing care in Ingushetia

In neighbouring Ingushetia, which saw an increase in violent incidents in 2005, MSF continues to provide mobile general, maternal and paediatric clinics in Nazran, Sunzha and Malgobek districts. A medical clinic also opened in July 2005 in the Angusht IDP settlement. The clinics conduct about 2700 consultations per month. Winterisation works were carried out in several of the spontaneous settlements, which still house about 9000 Chechens.

Mental health services are a critical component of the programme, with a team of counsellors working in 25-30 spontaneous settlements. In close collaboration with a network of local volunteers, they identify people who could benefit from individual therapy and organise group sessions and community activities.

MSF worked in the North Caucasus from 1993 to 1997 and resumed activity in the region in 1999.

"We've been living in a constant state of alarm in Chechnya for so long that it ages and exhausts us and our physical health suffers"

Chechen doctor



A child in MSF's day centre for street children.

© Jorge Dirckx

Taking healthcare to the streets of Moscow

"We were sniffing not to be frozen over. When you sniff you feel warmer. You are doped and you don't care about the cold."

The homeless youth that MSF works with in Moscow generally live in and around trains, subway stations or markets, developing compromising survival strategies to cope with the hostile environment on the street. Some kids beg or work with street vendors, most are exploited and controlled by criminal groups, and others become involved in prostitution. In winter, living conditions make them prey to flu and pneumonia. Sniffing glue, drinking or injecting drugs are ways to cope with hunger, weather and loneliness.

Healthy growth is often interrupted through lack of adequate diet. Sexually transmitted infections, dermatological and gastric problems, as well as the high risk of HIV/AIDS and other infections are but a few of the many health challenges faced by this vulnerable population. MSF provides primary care and first aid, referring patients on to secondary care for more complex issues.

Over the past ten years, official bodies responsible for the care of minors have attempted to respond to the multifaceted needs of homeless and neglected children, but teenagers living on Moscow's streets are invariably excluded from society. Their access to a full range of health services is fraught with obstacles.

The official system of police – hospital-priut (temporary orphanage) is more focused on coercion than rehabilitation, and does not facilitate access to appropriate healthcare, or include street work. At the core of MSF's approach is outreach: every day and night, several teams of MSF medical and psychosocial staff walk the streets and visit the areas where street youth gather, treating kids on the spot if possible, and advising and accompanying kids to get more specialised services for treatment. MSF also runs a day centre where kids can participate in a range of therapeutic and educational activities and also shower, wash their clothes and take meals. The MSF multidisciplinary team supports each individual to make a sustained decision to leave the street, encouraging youths to come to terms with the difficulties of their past and take control of their future decisions.

The MSF street children and teenagers project focused much effort in 2005/2006 on developing networks with local organisations, establishing a partnership with a drug and alcohol rehabilitation clinic called NAN. In June 2006 a photo exhibition documenting the lives of the street kids, taken by the kids themselves, was also mounted in Moscow.

MSF believes there are, on any given day, 250 to 500 children living on the streets of Russia's capital. MSF works with an average of 80 kids each month, mostly boys of 15-16 years old.

MSF has worked in the Russian Federation since 1988.

Poland



Poland is hosting thousands of Chechen refugees seeking asylum in Western Europe. Following two wars and continuing violence and insecurity, thousands of Chechens thinking they no longer had a future in their own land have fled their country. At the start of November 2005, over 3500 people were held in 16 separate camps in Poland.

When asylum seekers cross the borders of the European Union via Poland, they are registered and sent to transit camps where they wait to receive refugee status. Only eight per cent of the Chechen asylum seekers actually receive this status, whilst many others obtain a temporary status to reside in Poland. According to the 'Dublin 2' rule, the first country of entry into the European Union must decide whether to give refugee status to an asylum seeker. If asylum seekers who entered the EU via Poland make their way to another EU country, they are sent back to Poland. However, for many Chechen refugees, Poland is only a transit point to go west, and not a host country. Many never intended to live in Poland and feel is still too close to home to feel safe.

Worn down by 10 years of violence and repeated trauma, the asylum seekers are unable to find the conditions necessary for their recovery. Intake records show that forty per cent of patients coming in for

consultation suffer from post-traumatic stress and experience recurring memories, nightmares and sleep problems. In the transit centers the Polish authorities provide shelter, food, medical care and social support, whilst MSF provides psychological care.

MSF began providing psychological support in August 2005 in seven transit camps, and now works in all 16 transit camps in Warsaw, Bialystok and Lublin. Psychologists provide individual consultations to help asylum seekers deal with trauma that has been building up over the past decade. Between August 2005 and April 2006, MSF carried out a total of 1336 individual consultations for 425 patients.

MSF began working in Poland in 2005.

Switzerland

Switzerland boasts one of the highest standards of living in the world, and many residents benefit from excellent healthcare. With substantial fees and/or health insurance required to see a doctor, however, barriers in accessing medical services exist for a sector of the population. Even at the primary care level, many people face difficulties getting even the most basic and necessary healthcare.

MSF has begun to address some of these unmet healthcare needs. In January 2006, after conducting a six-month study, MSF opened a project in the canton of Zurich to provide healthcare to marginalised populations. The health meeting point, called Meditrina, is located in the city district Kreis 4 and provides free medical consultations and very basic drugs for patients who remain anonymous. Free consultations are provided for all people of Swiss or other origin who are neither medically insured nor in possession of the necessary financial means to pay for the treatment they need. When necessary, Meditrina refers patients through its network of physicians, specialists, medical institutions and social organisations. If it turns out a public institution is responsible for an individual, the patient is referred.

MSF publicised the clinic through media, direct community contacts and social service organisations, and by the end of June 2006, 108 consultations had been carried out and the average number of patients visiting the centre continues to rise each week.

MSF previously operated a similar project in Fribourg, Switzerland. In 2004, this was handed over to a local organisation, Fri-Santé.

MSF has worked in Switzerland since 2003.



Lebanon



The village of Alta Chaab, southern Lebanon, August 2006.

In July 2006, civilians in Lebanon were trapped by an intensifying war between Lebanese Hezbollah fighters and the Israeli Defense Forces (IDF). Ongoing fighting, including bombings, caused hundreds of thousands of people to flee their homes and left many civilians with a limited capacity to meet basic needs including healthcare.

The first MSF team arrived one week after fighting began. MSF focused on providing emergency aid including medical care, fresh water and sanitation facilities to hundreds of thousands of displaced persons seeking refuge in Beirut, Saïda, Sour, Jezzine, Nabatiye and the Aley region. Assistance was also given to Lebanese refugees who had crossed into Syria. MSF supplied more than 60,000 displaced persons in Lebanon and 3500 refugees in Syria with relief items such as cooking and hygiene kits, mattresses, blankets, baby formula, and tents. Mental health support was also provided to help people cope with the trauma experienced by the war.

Whilst Lebanese medical staff were able to cope with the crisis, medical supplies began to diminish, especially stocks for the treatment of chronic diseases such as kidney disease. MSF helped replenish needed supplies, sending over 300 tonnes of material to Lebanon including relief items, med-

ical supplies and medicines, surgical kits, and logistical materials such as sanitation equipment and water bladders. Teams also worked with local medical teams to set up mobile clinics.

Hard to reach

The IDF imposed an air and sea blockade and carried out airstrikes on several bridges and important roads. MSF obtained safe passage by sea and worked with Greenpeace to transport 75 tonnes of essential supplies from Cyprus to Beirut aboard the Rainbow Warrior.

Ongoing airstrikes made it difficult to obtain access to people in need, particularly in the south. When the last functioning bridge across the Litani River in southern Lebanon was destroyed, a human chain was the only practical means for transporting four tonnes of supplies. Trucks, vans, ambulances and cars were targeted several times, making land transportation

extremely difficult and dangerous, and MSF spoke out about the lack of access caused by the imposition on any movement. MSF publicly refused to accept the paralysis of humanitarian assistance and reiterated its intention to use every possible means to reach those in need.

Ceasefire

When a ceasefire came into effect on 14 August, the majority of the displaced people returned home within a few days. During this phase, MSF assessed needs in areas that had previously been cut off by the fighting. It also brought medical and non-medical care primarily to the south and in the Bekaa Valley.

Throughout and following the conflict, Lebanese health staff and facilities addressed the majority of the medical needs and MSF provided a supportive role. Once the acute phase of the emergency ended, organisations began to arrive to help reconstruction efforts and MSF ended its activities. MSF continues to monitor the situation closely.

MSF has worked intermittently in Lebanon since the 1980s.

Palestinian Territories

Many people living in the Palestinian Territories experience direct violence, isolation, restrictions on movement, and difficulties accessing healthcare. The living conditions have psychological consequences for many individuals, manifesting as depression, anxiety, post-traumatic stress disorder or psychosomatic illness. MSF teams provide psychological and medical care and social work assistance to help.

In mid-2005, MSF readied for possible consequences of the Israeli government's plan to dismantle Israeli settlements in Gaza, preparing an emergency programme before the August withdrawal of nearly 8000 settlers. Ultimately, the army's action was carried out without major clashes.

In 2005, MSF undertook a large water and sanitation project in a disadvantaged area of Gaza known as Al Fara Towers, located in the Tuffah neighborhood of Khan Younis. MSF carried out a scabies eradication program in coordination with the local municipality, while logisticians fixed leaking indoor plumbing, constructed septic tanks, and distributed food kits and household items such as mattresses and blankets.

Throughout the year, MSF worked in the city of Nablus in the West Bank, diversifying its referral network. Through these efforts, the team is now well known in this city of about 150,000 people.

Approximately 35 per cent of MSF's patients in Nablus live in one of the three refugee camps, the majority live in the old city. Here the medical aspect of the programme supports work done by the team's psychologists. A social worker also plays a key role, referring patients to agencies for socioeconomic assistance.

In the West Bank district of Hebron, approximately 70 per cent of MSF's patients experienced a traumatic episode in the past year. MSF gives home-based treatment and support for individuals or families using a team including a psychologist, a social worker and a doctor. MSF is also trying to improve access to health services by making regular visits to the Bedouin communities living in the south of the district, and to populations residing in areas where movement restrictions make it nearly impossible for them to reach health services.

When the January 2006 legislative elections brought Hamas to power, the US, Canada, European Union and Japan decided to suspend their bilateral financial aid to the Palestinian Authority. However, they promised to continue to help the population meet its basic needs by reallocating part of those funds to the UN and other international aid organisations working in the territories. On 13 April 2006, MSF publicly denounced this plan.

MSF emphasised that although it was a government's choice to suspend aid, humanitarian actors could not be used in an attempt to veil retaliatory measures that would impact the entire population. It also pointed out that humanitarian aid groups lacked the competence, means and responsibility to act as a substitute for the Palestinian Authority. Instead, MSF said, meeting the basic needs of civilians living in the occupied territories was the responsibility of the state of Israel, as set out in the Geneva Conventions. MSF feared that this "instrumentalisation" of NGOs and confusion of roles and responsibilities would jeopardise NGOs' independence and could put them in danger in an already unstable context.

MSF has worked in the Palestinian Territories since 1988.



Project Handovers

MSF opens and closes a number of individual projects each year, responding to acute crises, handing over projects to other actors, and always monitoring and remaining flexible to the changing needs of patients within a given location. Several projects may be running simultaneously in a single country as needed. In 2005/2006, with the closure of the following single projects, MSF effectively ended its existing operations in Brazil, Sweden and the Ukraine.

Brazil

Fully functioning health centre handed over to local groups

The consequences of Brazilian inequality are dramatically clear in the populous slums of Rio de Janeiro, which has over 500 such communities. MSF started working here in 1997, and began a project in 2003 in Marcilio Dias, a slum where residents experience some of the highest levels of social exclusion and violence, resulting in a diminished access to healthcare.

MSF established the Marcilio Dias Health Centre, providing integrated primary healthcare, psychosocial services, and linkages for community support around issues such as domestic violence, teenage pregnancy and drug abuse. MSF has now handed over a functional and fully equipped health unit to local authorities and MOGEC, a nongovernmental community organisation created under the auspices of MSF in 1997. Over 43,000 consultations were provided during the 32-month duration of the project, and the centre provided access to healthcare for 14,776 people in 2005.

MSF worked in Brazil from 1991 to 2005.

Sweden

Swedish Red Cross takes on programme for undocumented migrants

Sweden is one of the few countries in the EU to charge full costs for emergency healthcare for undocumented migrants, the vast majority of whom cannot afford these costs. In 2004, MSF started a programme in Stockholm to provide medical assistance to this population.

A survey of 102 patients receiving care through MSF's network between July and September 2005 showed that the majority of patients were excluded from non-emergency and routine healthcare, including severe chronic diseases such as diabetes and asthma, as well as pregnancy. MSF launched public communications to draw attention to the issue and advocated for a change in the legal framework to provide better access to this vulnerable population. The campaign clearly contributed both to an increased

general awareness around the issue and a recent change in the political climate. Previously a sensitive political issue rarely spoken about, now four out of six political parties stand behind changing the legislation concerning healthcare for asylum seekers and other groups. In March 2006, the Swedish Red Cross committed to continue the medical programme for one year, whilst the government reviews legislation.

MSF worked in Sweden from 2004 to 2005.

Ukraine

Ministry of Health and NGOs continue care for patients with HIV/AIDS

HIV/AIDS knowledge is poor and stigma is high in Ukraine. MSF began to address HIV/AIDS here in 1999, launching a national education campaign in conjunction with the Ministry of Health and national NGOs; and setting up a continuum of care model that focused on ongoing care from awareness raising and pre HIV-test counselling, to psychosocial support designed to help patients cope with their illness and adhere to treatment.

Programmes were established in Odessa, Mykolayiv and Simferopol. Increased international financial commitment to HIV/AIDS in Ukraine allowed MSF to withdraw from the project, as ongoing care for patients is now ensured for the near future. The programme handover was marked by a press conference and the opening of a photo exhibition in Kiev in late 2005. The exhibit showed the lives of people living with HIV, testimony to the fact that people can cope with its effects, given affordable medical care and psychosocial support.

MSF worked in Ukraine from 1999 to 2005.

Overview of MSF Operations

Largest Interventions

In 2005, the largest countries of intervention remained Sudan, where MSF continued to provide assistance to hundreds of thousands displaced; Niger, where MSF mounted a large nutritional intervention and treated 63,000 severely malnourished children; and Democratic Republic of Congo, where violence affecting civilians continued throughout the year. MSF responses to the Tsunami and Central Asia earthquake are also reflected, with large relief operations deployed in Indonesia and Pakistan.

Based on project expenditures (excluding coordination)

1. SUDAN NORTH	6. SUDAN SOUTH
2. NIGER	7. LIBERIA
3. DEMOCRATIC REPUBLIC OF CONGO	8. ANGOLA
4. PAKISTAN	9. IVORY COAST
5. INDONESIA	10. CHAD

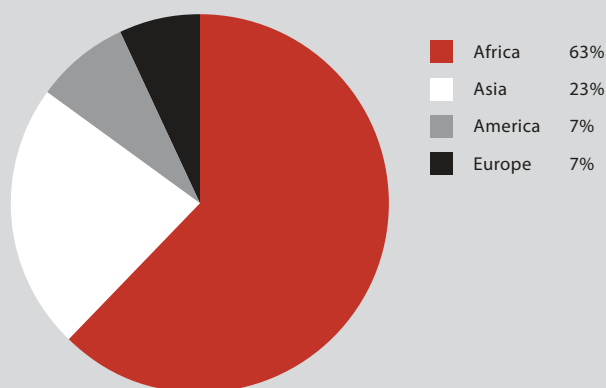
Activity Highlights

(non-exhaustive)	Definition	Total (in thousands)
OUTPATIENT	TOTAL NUMBER OF OUTPATIENT CONSULTATIONS	10,000
INPATIENT	TOTAL NUMBER OF ADMITTED PATIENTS	382
MALARIA	TOTAL NUMBER OF CONFIRMED CASES TREATED	2249
TF	NUMBER OF CHILDREN TREATED WITH THERAPEUTIC FEEDING IN 2005	130
DELIVERIES	TOTAL NUMBER OF WOMEN WHO DELIVERED BABIES	91
SEXUAL VIOLENCE	TOTAL NUMBER OF CASES FOR ANY TYPE OF SEXUAL VIOLENCE TREATED	12
SURGERY	TOTAL NUMBER OF MAJOR SURGICAL INTERVENTIONS	75
WAR TRAUMA	TOTAL NUMBER OF CONFLICT TRAUMA SURGERIES	8
HIV	TOTAL NUMBER OF HIV PATIENTS REGISTERED UNDER CARE AT END 2005	161
ARV	TOTAL NUMBER OF PATIENTS ON ANTIRETROVIRAL TREATMENT AT END 2005	60
TB	TOTAL NUMBER OF NEW ADMISSIONS TO TUBERCULOSIS TREATMENT IN 2005	22
MENTAL HEALTH	TOTAL NUMBER OF INDIVIDUAL PARTICIPANTS IN INDIVIDUAL OR GROUP MENTAL HEALTH ACTIVITIES	149
MEASLES VACCINATIONS	TOTAL NUMBER VACCINATED FOR MEASLES	806
YELLOW FEVER VACCINATIONS	TOTAL NUMBER VACCINATED FOR YELLOW FEVER	361

In 2005, MSF aggressively developed its activities in the field of malnutrition and more than doubled the number of children treated with therapeutic feeding. MSF also continued its investment in HIV/AIDS, more than doubling the number of patients under ARV between 2004 and 2005, and furthered its commitment to treating patients with tuberculosis.

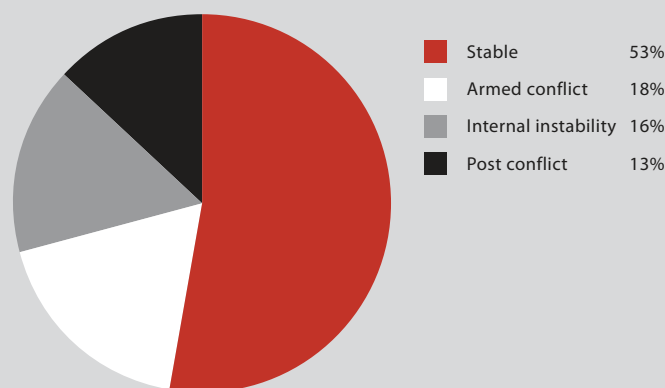
MSF pursued its commitment to assisting victims of violence, with 76% of its surgeries, 88% of its assistance to victims of sexual violence and 95% of war-trauma activities taking place in unstable contexts. Large-scale immunisation campaigns were also conducted against measles, yellow fever, and meningitis.

Project Locations



In 2005, 63% of all MSF projects were located in Africa, followed by 23% of projects in Asia, an increase over 2004 reflecting MSF deployment in natural disasters affecting Central and Southeast Asia in 2005. MSF closed and opened more than 25% of its projects during the year, attesting to MSF's dynamism and capacity to react to crises and develop operations according to context evolution.

Context of Interventions



In 2005, 47% of MSF projects took place in unstable settings – armed conflicts, internal instability and post-conflict. A full 20% of MSF assistance was targeted at displaced populations.

Audited Facts and Figures

Médecins Sans Frontières (MSF) is an international, medical humanitarian organisation that is also private and not-for-profit. MSF comprises 19 national branches in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom, the United States, and 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 Foundation Kikin, MSF-Logistique, SCI MSF, SCI Sabin, MSF Supply and Urgence Développement Alimentaires. As these organisations are controlled by MSF, they are included in the scope of the financial statements presented here.

The figures presented here describe MSF's finances on a combined international level. These 2005 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 according to international auditing standards. A copy of the full 2005 financial report may be obtained from the International Office upon request. In addition, each branch office of MSF publishes annual, audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

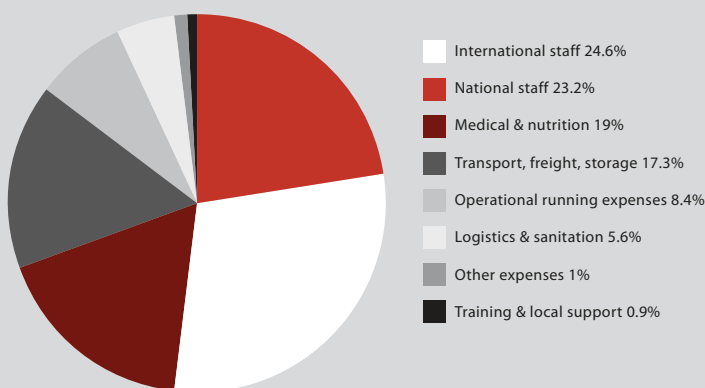
Owing to the fact that the Greek office rejoined the international movement in 2005, Greece is not included in the 2004 comparative figures presented here. However, for information purposes, its total expenditures in 2004 were 5.3 million euros. Its total income was 4.5 million euros and its total balance sheet amounted to 5.3 million euros.

The figures presented here are for the 2005 calendar year. The Activity Report itself covers the period mid-2005 to mid-2006. All amounts are in millions of euros.

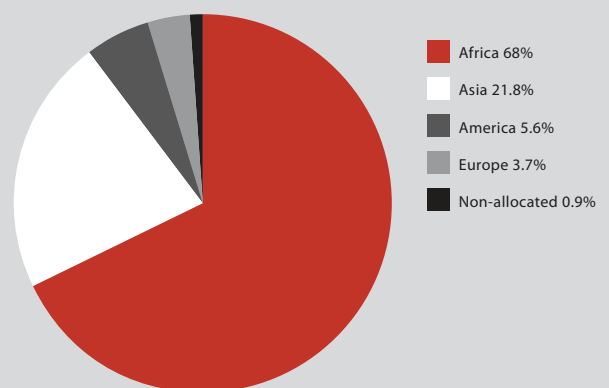
NB: Figures in these tables are rounded off and this may result in slight addition differences.

Where did the money go?

Programme expenses* by nature



Programme expenses* by continent



* project and coordination team expenses in country

Programme expenses by country/region (including coordination)

Countries/Regions	In M€	Countries/Regions	In M€	Countries/Regions	In M€	Countries/Regions	In M€
Africa		Asia/Middle East		Americas			
SUDAN	46.3	SIERRA LEONE	5.0	PAKISTAN	20.4	HAITI	5.5
DEMOCRATIC REPUBLIC OF CONGO	29.4	ZIMBABWE	3.8	INDONESIA	19.7	COLOMBIA	4.8
NIGER	23.4	REPUBLIC OF THE CONGO	3.2	MYANMAR	5.6	GUATEMALA	4.1
ANGOLA	14.3	GUINEA	3.1	CAMBODIA	4.5	ECUADOR	1.5
LIBERIA	13.6	ZAMBIA	2.9	INDIA	4.1	BOLIVIA	1.2
CHAD	9.2	BURKINA FASO	2.6	SRI LANKA	3.3	OTHER COUNTRIES*	2.4
IVORY COAST	8.3	RWANDA	2.5	THAILAND	3.1	TOTAL	19.5
NIGERIA	8.0	SOUTH AFRICA	2.3	ARMENIA	2.5	Europe	
BURUNDI	7.7	MALI	1.6	CHINA	2.2	CHECHNYA / INGUSHETIA /	
UGANDA	7.7	CENTRAL AFRICAN REPUBLIC	1.6	GEORGIA	1.7	DAGESTAN	4.3
KENYA	7.4	CAMEROON	1.3	UZBEKISTAN	1.6	RUSSIA	2.2
SOMALIA	7.3	TANZANIA	1.3	PALESTINIAN TERRITORIES	1.4	FRANCE	1.4
ETHIOPIA	7.2	MAURITANIA	1.3	BANGLADESH	1.3	BELGIUM	1.1
MOZAMBIQUE	6.3	GUINEA-BISSAU	1.1	IRAN	1.1	OTHER COUNTRIES*	3.6
MALAWI	5.3	OTHER COUNTRIES*	1.5	OTHER COUNTRIES*	3.2	OTHER COUNTRIES*	3.6
		TOTAL	236.5	TOTAL	75.7	TOTAL	12.6

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

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 2005, 86.1% of MSF's income came from private sources. More than 3.4 million individual donors and private funders worldwide made this possible. Additional public institutional agencies providing funding to MSF include among others, the governments of Belgium, Canada, Ireland, Luxembourg, The Netherlands, Norway, Spain, Sweden, Switzerland, and the United Kingdom.

Expenditures

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

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

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

Other retained earnings represent foundations' capital as well as technical accounts related to the combination process, including the conversion difference. MSF's retained earnings have been built up over the years by surpluses of income over expenses. As of the end of 2005, their available part (the unrestricted funds decreased by the conversion difference)

represents 9.1 months of activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, and/or a sudden drop of private and/or public institutional funding, and the sustainability of long-term programmes (e.g. ARV treatment programmes), as well as the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

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

Additional disclosures: Tsunami disaster

Public donations received in response to the December 2004 tsunami disaster resulted in contributions totalling 111 million euros, of which 36.4 million euros were received in 2004, and the balance in 2005. The funds received were used for tsunami-relief operations or "derestricted" with the consent of donors and spent where they are most needed within MSF's ongoing work. MSF spent a total of 24.5 million euros in 2004 and 2005 on operations in the regions affected by the tsunami – 1.7 million in 2004 and the remainder in 2005. In total 19.7 million euros were spent in Indonesia, 4.0m in Sri Lanka and 0.8m in India and Thailand. An amount of 2.3 million euros of restricted tsunami funds remains unspent at the end of 2005 and are carried in the balance sheet within liabilities as "unspent restricted funds". The remainder of the donations received were "derestricted" or "re-directed" with the consent of the donors – approximately 30 million euros of which were used to fund two other big emergencies that occurred in 2005 – the malnutrition crisis in Niger and the earthquake in Pakistan.

2005 2004

Income	In M€	In %	In M€	In %
Private Income	543.0	83.7%	342.8	74.8%
Public Institutional ECHO*, EU & DFID**	44.8	6.9%	55.9	12.2%
Public Institutional Other	45.5	7.0%	47.0	10.3%
Other Income	15.7	2.4%	12.4	2.7%
Total Income	649.0	100.0%	458.1	100.0%

How was the money spent?				
<i>Operations</i>	397.4	78.0%	321.5	76.3%
<i>Témoignage</i>	15.9	3.1%	14.5	3.4%
<i>Other humanitarian activities</i>	8.0	1.6%	7.9	1.9%
Total Social Mission	421.3	82.7%	343.9	81.7%
Fundraising	59.8	11.8%	49.2	11.7%
Management, general & administration	28.2	5.5%	28.0	6.6%
Total Expenditure	509.3	100.0%	421.1	100.0%
Net exchange gains & losses (realised and unrealised)	4.1		-2.8	
Surplus/(deficit)	143.7		34.2	

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

Balance sheet	In M€	In M€
(year-end financial position):		
Non-current assets	35.5	31.7
Current assets	66.6	91.2
Cash & equivalents	352.1	201.8
Total assets	454.2	324.7
<i>Permanently restricted funds</i>	2.8	2.8
<i>Unrestricted funds</i>	384.6	236.6
<i>Other retained earnings</i>	1.5	-3.7
Total retained earnings and equities	388.9	235.8
Non-current liabilities	8.5	7.6
Current liabilities	49.9	43.3
Unspent temporarily restricted funds	6.8	38.0
Total liabilities and retained earnings	65.2	324.7

HR Statistics				
International departures (full year):	4,768	100%	3,803	100%
Medical pool	1,276	27%	1,034	27%
Nurses & other paramedical pool	1,558	33%	1,257	33%
Non-medical pool	1,934	40%	1,512	40%
First time departures (full year):	1,466	(*) 31%	1,340	(*) 35%
(*) in % of the international departures				
Field positions:	28,083	100%	24,666	100%
International staff	2,227	8%	2,026	8%
National staff	25,855	92%	22,640	92%

* unaudited figures

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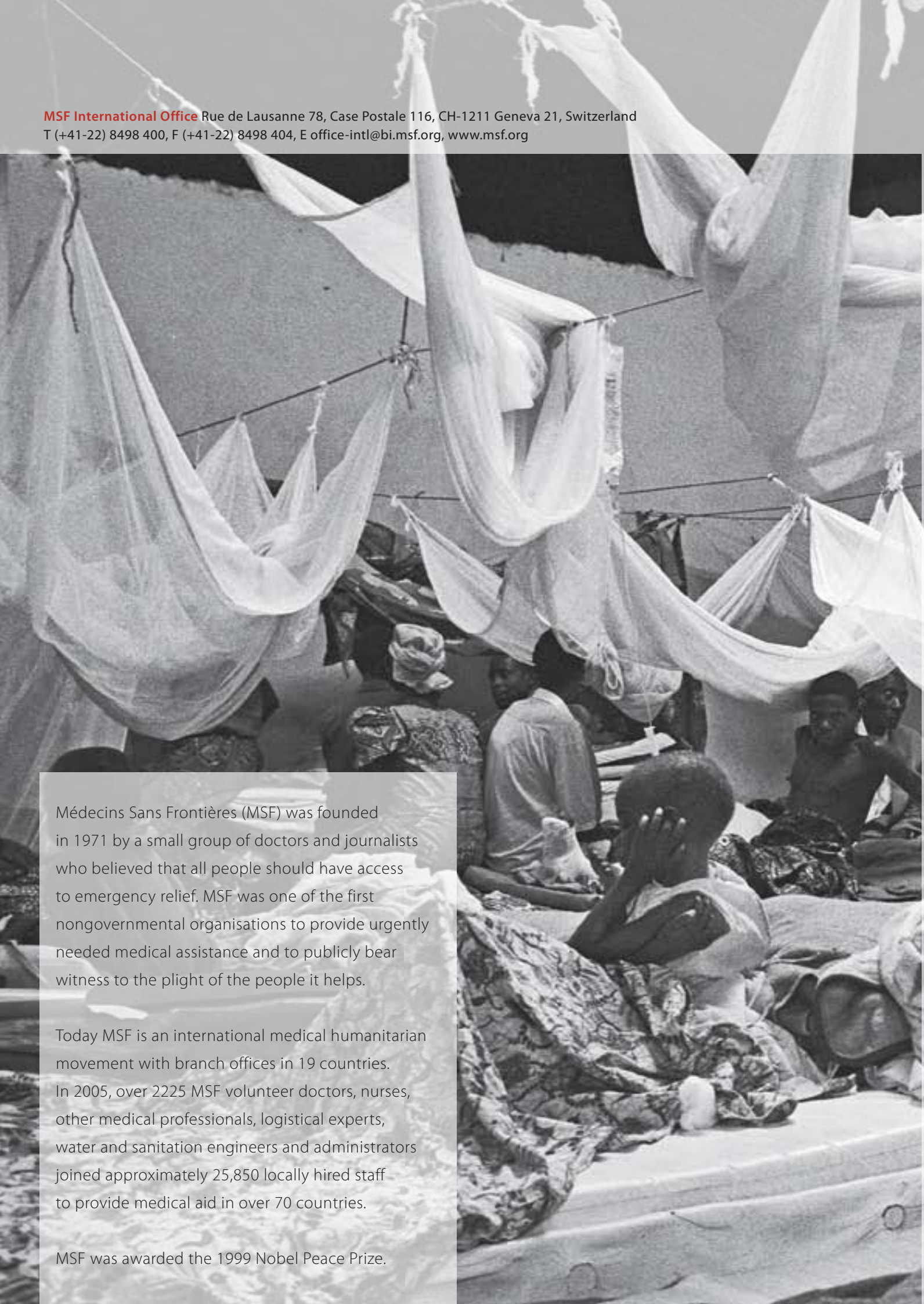
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The country texts in this report provide descriptive overviews of MSF work throughout the world between July 2005 and July 2006. Staffing figures represent the total of full-time staff equivalents per country for 2005. Country summaries are representational and, owing to space considerations, may not be entirely comprehensive.

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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 nongovernmental organisations to provide urgently needed medical assistance and to publicly bear witness to the plight of the people it helps.

Today MSF is an international medical humanitarian movement with branch offices in 19 countries. In 2005, over 2225 MSF volunteer doctors, nurses, other medical professionals, logistical experts, water and sanitation engineers and administrators joined approximately 25,850 locally hired staff to provide medical aid in over 70 countries.

MSF was awarded the 1999 Nobel Peace Prize.