



INTERNATIONAL ACTIVITY REPORT 2013

THE MÉDECINS SANS FRONTIÈRES CHARTER

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

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

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

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

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

The country texts in this report provide descriptive overviews of MSF's operational activities throughout the world between January and December 2013. Staffing figures represent the total full-time equivalent positions per country at the end of 2013.

Country summaries are representational and, owing to space considerations, may not be comprehensive. For more information on our activities in other languages, please visit one of the websites listed on p.100.

The place names and boundaries used in this report do not reflect any position by MSF on their legal status. Some patients' names have been changed for reasons of confidentiality.

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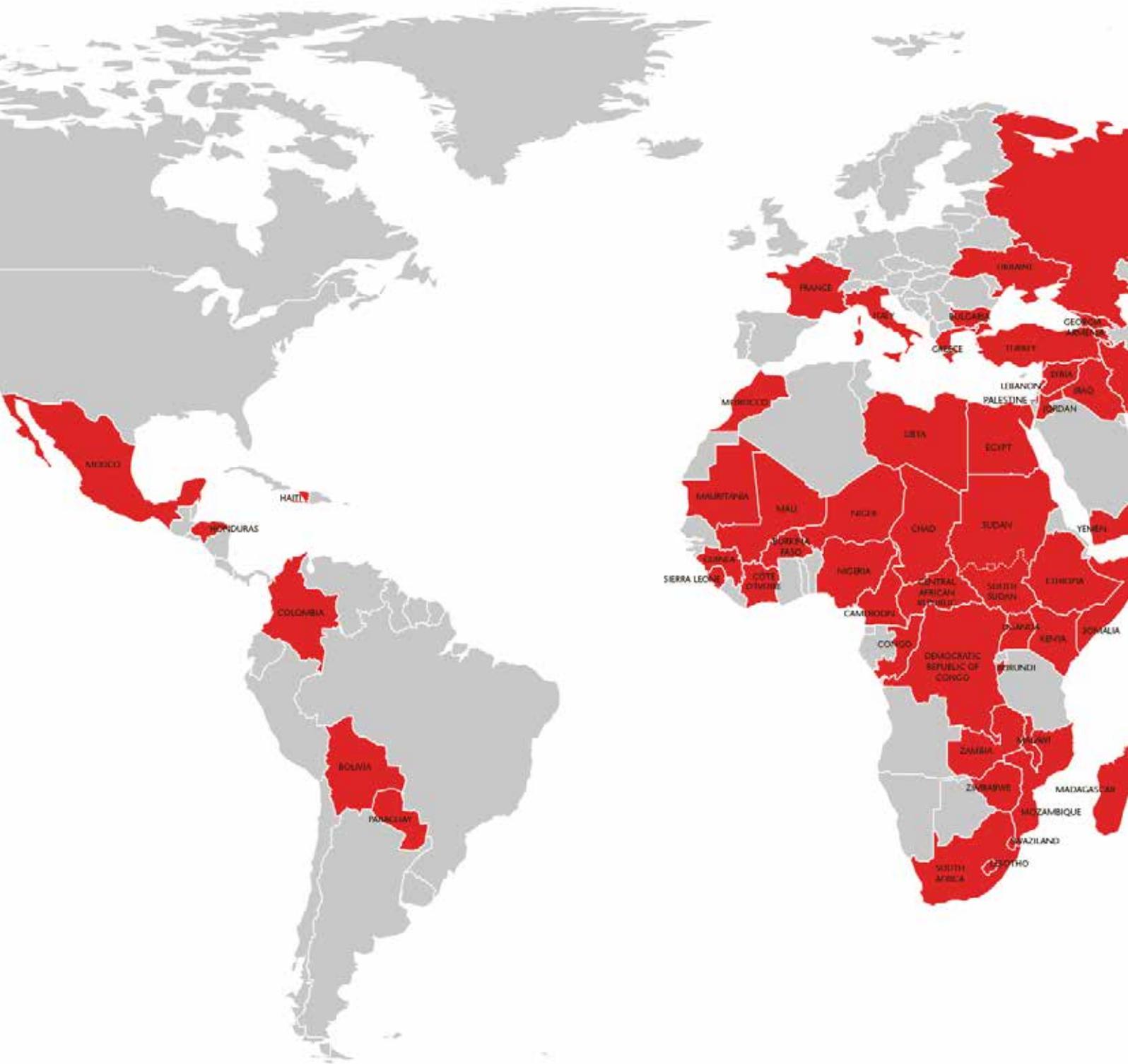


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THE YEAR IN REVIEW

Dr Joanne Liu, International President
Jérôme Oberreit, Secretary General

In August 2013, Médecins Sans Frontières (MSF) pulled out of Somalia after working in the country continuously for 22 years.

The last year has been one of exceptional circumstances, decisions and compromises, particularly with regards to Somalia and Syria. We have again seen profiteering from humanitarian organisations, in the form of robberies and the looting of medical structures, but the most striking thing we have witnessed is the failure of the global humanitarian aid system in countries such

as Central African Republic (CAR) and South Sudan.

Since its founding, MSF has faced different forms of violence against its patients, staff, health facilities and medical vehicles, and has also witnessed targeting of health systems in general. The situation in Somalia, however, became untenable in 2013 as the balance could no longer be found between the risks involved, the compromises we had to make – such as hiring armed guards and implementing remote management to support national staff – and our ability to provide medical care to the Somali people. Staff members had been threatened, attacked, kidnapped and even killed during

our time in Somalia, but it was when it became apparent that the parties with whom we were negotiating were in some cases actively involved in, or complacent towards, violent actions directed against MSF that we had no choice but to draw the line. A lack of respect and deliberate violations of medical humanitarianism for political and financial profit were putting the lives of our patients and staff at risk. We withdrew with heavy hearts.

In Syria, the civil war continued into its third year and it is estimated at present that nine million people are internally displaced in the country or have fled abroad as a result of



A staff member surveys what remains of the MSF office in Kitchanga, Democratic Republic of Congo, after a wave of violence engulfed the town.

© Giulio Di Sturco



A young Syrian refugee is examined by an MSF paediatrician at the mobile clinic in Voenna Rampa camp in Sofia. Thousands of Syrians have fled to neighbouring countries to escape the conflict.

the violence. This means that over 40 per cent of Syrians have been forced from their homes. Those remaining in Syria have had to endure ongoing and incessant violence, and entire cities have been decimated. The healthcare system has collapsed, resulting in outbreaks of preventable diseases such as measles and polio. Countless Syrians are desperate to access medical treatment, and are without services for everyday requirements like antenatal care, immunisations and the management of infections or chronic diseases. MSF operated aid programmes where working agreements could be negotiated, namely in opposition-held areas where instability was a constant challenge, and support was given to Syrian medical networks. Inpatient wards, outpatient consultations, surgery, and maternal and obstetric care were provided by MSF and vaccinations were undertaken. However, in a country where we should have been running some of our largest medical programmes, the opportunities to reach people and to respond in a timely manner to the enormous needs remained extremely limited; a forceful reminder of how access to medical care was by and large not respected and in many cases directly targeted by those involved in the conflict and used for political purposes. In Lebanon, Iraq, Turkey and Jordan, MSF continued to

provide healthcare for Syrians inside and outside the refugee camps.

The year was punctuated by numerous acute crises that left entire communities vulnerable, with little skilled medical help. In some cases, external assistance was their only lifeline and yet MSF often found itself alone tackling not just the medical but also the other humanitarian needs of the people affected.

Political events marked a descent into instability and brutal violence in both South Sudan and CAR, displacing thousands. In CAR, there was a presidential coup in March and subsequent political clashes spread throughout the country and inflamed religious divisions. By January 2014, it was estimated that over one million people had fled their homes, 245,000 of them crossing the border into neighbouring countries such as Chad and Cameroon. Hundreds of thousands of people were sheltering in the bush and others were living in displacement sites. By the end of 2013, nine MSF emergency projects were delivering healthcare in CAR alongside seven ongoing programmes, and over 800,000 medical consultations had been provided to people throughout the country.

In South Sudan, where people have come to rely in large part on MSF for healthcare, violence in Jonglei early in the year caused displacement, and in December, fighting between different factions of the army quickly spread throughout five states, causing people to flee their homes and destroying hopes of stability for the nascent country. More than 3,000 MSF staff continued to operate 16 programmes in nine states, and three emergency projects were opened to care for the displaced and war-wounded; further emergency programmes opened in neighbouring countries such as Uganda to provide aid to the refugees. December was only the beginning of what was to become a grave crisis of violence, civil war and human suffering in South Sudan.

Once again this year, MSF's largest programme expenditure was a response to the repeated displacement of people and the appalling lack of healthcare in Democratic Republic of Congo (DRC). While there is a large aid community in DRC, much of it is focused in Goma and areas of the country considered stable, the more remote areas of eastern DRC, where people are subjected to increasing conflict, banditry, widespread abuse and sexual violence, are largely neglected. In 2013,

heavy fighting caused massive displacement and inadequate living conditions meant diseases such as malaria, cholera and measles were rampant. MSF undertook a number of emergency projects and vaccination campaigns in the country and in total, more than 1.2 million children aged between six months and 15 years were vaccinated against measles.

Responding in the Philippines

This year we were shown once again that public sympathy for the plight of others is never as strong as in the wake of a natural disaster. While fundraisers continue to struggle to raise financial support for victims of war, individuals worldwide quickly dug into their pockets to assist survivors of the Philippines' Typhoon Haiyan in November. The great force of the storm, and the storm surge that followed, destroyed public health facilities, but due to the experience of local health workers and the preparedness of the Department of Health, medical needs were much smaller than feared. MSF sought to assist the Filipinos by providing medical care and relief supplies, while also rebuilding healthcare capacity. Numerous logistical challenges were encountered within the first days; even so, by the two-week mark MSF had a fast-growing team of international and

local staff in four hospitals and eight health centres, and was running mobile clinics in 37 locations.

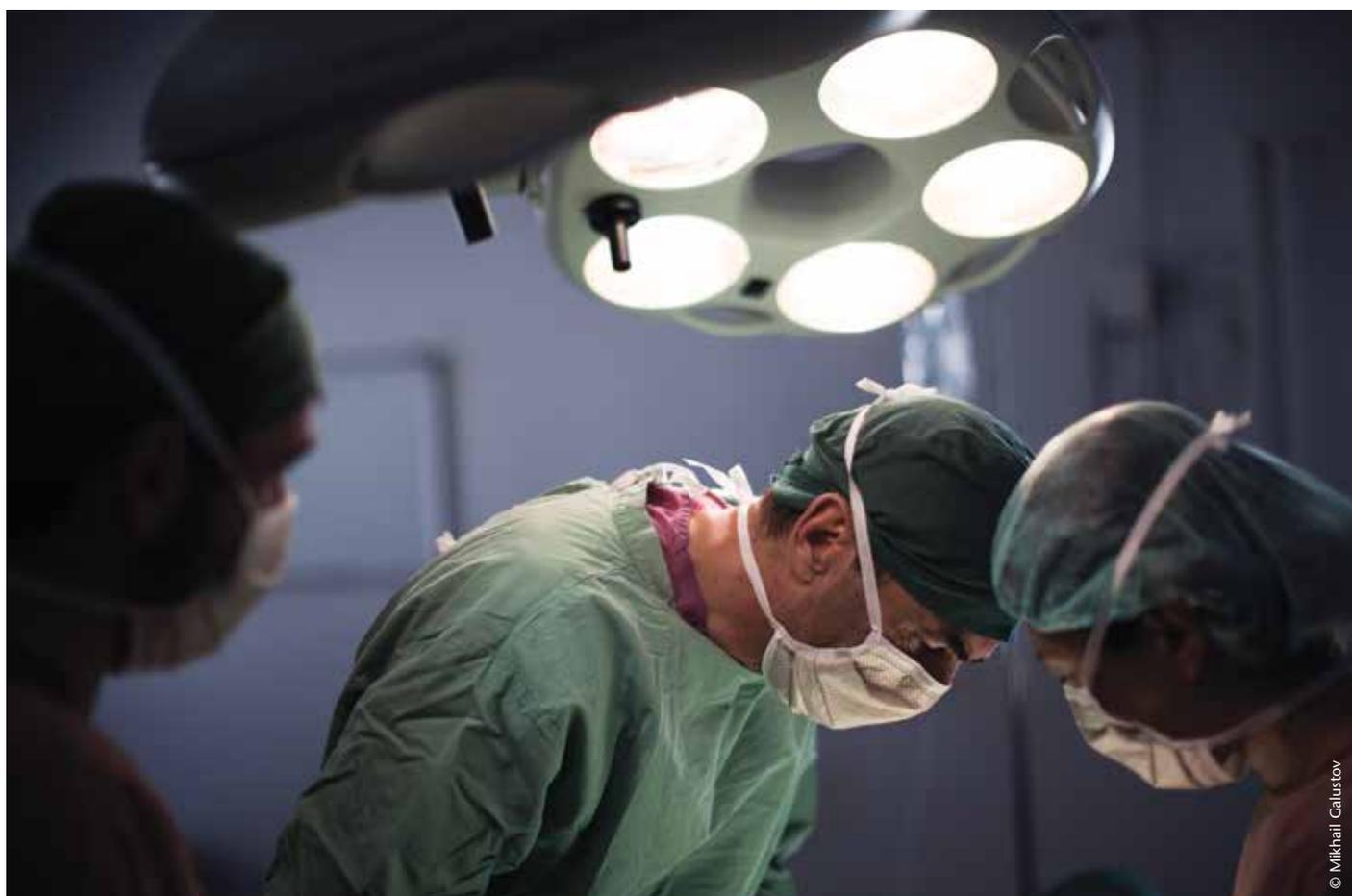
Speaking out for access to healthcare

MSF is a medical organisation but our work does not stop at the delivery of care; it is also about bearing witness in extreme situations. In October, MSF launched the Speaking Out website (speakingout.msf.org), making publicly accessible MSF *témoignage* documents on different crises through the history of the movement. These writings offer a window into the internal debates around operational challenges faced by the movement and the foundation of MSF's public positioning over the years.

There were many events that compelled MSF to make public statements and speak out in 2013. On 21 August, information was received from MSF-supported doctors based in three locations in the Damascus governorate of Syria that they had directly cared for approximately 3,600 people displaying neurotoxic symptoms. MSF was the most direct independent witness through the reliable doctor-to-doctor link we had developed in the country and we released a statement – an action not undertaken lightly – detailing what had been seen at the MSF-supported hospitals.

On 12 December, MSF published an open letter to Valerie Amos, UN Under-Secretary-General, about the situation in CAR and the UN humanitarian system's failure to respond adequately to the emergency or ensure minimum requirements for human life. MSF's deployment of staff and delivery of aid had shown that with principled humanitarianism, it was possible to provide widespread assistance. Less than a week later, MSF sent an open letter to member states of the 'High Level Group on Syria' meeting in Geneva, urging them to take action so that people blocked from receiving Damascus-controlled aid could obtain the assistance they needed through cross-border efforts.

Witnessing steady refugee flows from conflicts in Africa and the Middle East, MSF also spoke out about the restrictive and repressive migration policies in EU states. Teams have treated migrants in several overcrowded, ill-equipped detention centres that are contributing to deterioration in residents' physical and mental health. A December press release calling for the closure and refurbishment of the Lampedusa centre in Italy was heeded and MSF continued to provide healthcare for undocumented migrants in Italy, Greece and Bulgaria, all the while urging those responsible to provide living conditions that respect human dignity.



MSF doctors at Kunduz trauma centre in Afghanistan perform surgery on a man hit by a stray bullet.

© Mikhail Galustov



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Children under two were vaccinated with the pneumococcal conjugate vaccine (PCV) in Yida refugee camp in South Sudan this year. It was the first time PCV was used in the country.

MSF's Access Campaign also worked tirelessly, advocating for patients in light of the Transpacific Partnership Agreement (TPP) being negotiated between the USA and 11 Pacific Rim nations, as well as the India–European Commission trade agreement, continuing the Hands Off our Medicine campaign launched in 2010. Both these trade agreements include aggressive standards for intellectual property, extending drug patents and effectively blocking access to generic medicines for diseases including HIV – drugs that MSF purchases for millions of patients and that people in the developing world depend on for their treatment and survival.

Tackling malaria, tuberculosis (TB) and HIV

Seasonal Malaria Chemoprevention (SMC), a WHO-recommended preventive measure which has proven effective in Chad and Mali, was used in Niger for the first time in 2013. For four months during the rainy season, children received a course of antimalarial treatment and while usual methods of mosquito bite prevention, including the use of nets and sprays remain the basis of the programmes, SMC is proving useful to protect the health of children at risk from severe malaria in areas of high seasonal transmission.

In collaboration with the health authorities, MSF continued to respond to drug-resistant TB in the southern Caucasus. In KwaZulu-Natal, South Africa, the Bending the Curves project was introduced to tackle the high co-incidence of HIV and TB. Viral load technology, which monitors the amount of HIV virus in a patient, was introduced in areas of Mozambique this year, and in Swaziland the 'test early and treat early' effort continued.

Medical Care under Fire

The year's events were a harsh reminder that some choose to make medical aid a target for their own benefit. Teams withstood localised security incidents in places such as Afghanistan, Nigeria, Pakistan, South Sudan, Syria and Yemen. In DRC, four Congolese MSF staff, Chantal, Philippe, Richard and Romy, were abducted by an armed group while on an evaluation mission in July. At the time of writing, a dedicated team is still actively searching for them. On a more positive note, our colleagues Montserrat Serra and Blanca Thiebaut were released after having been held in captivity for 21 months. They had been abducted from Kenya's Dadaab refugee camp in 2011. The issue of incidents

targeting MSF and other humanitarian organisations is of significant concern, not only for security, but also for the ultimate impact these events and their consequences – temporary suspension or revocation of medical services – have on the health and survival of the people we aim to help. In 2013, MSF began researching such incidents, their impact and our response in the Medical Care under Fire project. We hope to identify ways to improve patients' safe access to healthcare and the security of healthcare structures and international and national medical teams.

MSF's work in 2013 felt at times like an uphill struggle. Despite the challenges, however, and the sheer number of people caught in crises this year – many traumatised by the violence, losses and uncertainty of conflict – our supporters and teams around the world delivered medical care to more than eight million people in their hour of need. We would like to take this opportunity to thank everyone who has made our work possible over the last year.

OVERVIEW OF ACTIVITIES

Largest country programmes based on project expenditure

1. Democratic Republic of Congo	6. Niger
2. South Sudan	7. Somalia
3. Haiti	8. Iraq
4. Syria	9. Chad
5. Central African Republic	10. Zimbabwe

The total budget for our programmes in these 10 countries is 323 million euros, **53 per cent** of MSF's operational budget.

Staff numbers

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

1. Democratic Republic of Congo	3,604
2. South Sudan	2,854
3. Haiti	2,324
4. Niger	1,879
5. Central African Republic	1,631

Outpatient consultations

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

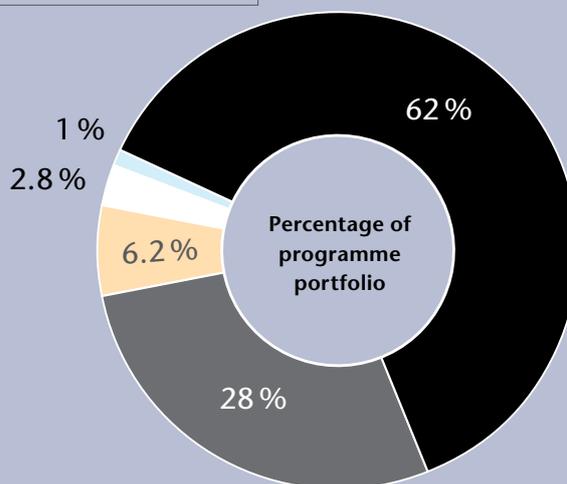
1. Democratic Republic of Congo	1,654,100
2. South Sudan	981,500
3. Niger	916,000
4. Central African Republic	816,300
5. Myanmar	519,100
6. Kenya	415,700
7. Afghanistan	370,000
8. Somalia	318,400
9. Mali	308,100
10. Swaziland	287,800

Programme locations

Number of programmes

■ Africa	240	■ Americas	24
■ Asia*	108	■ Europe	11
		■ Pacific	4

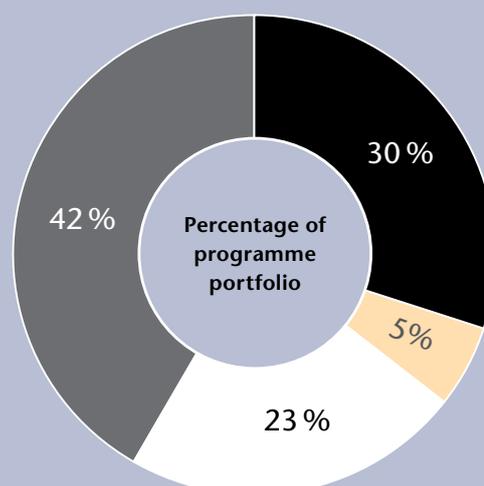
* Asia includes the Middle East and the Caucasus



Context of intervention

Number of programmes

■ Stable	161	■ Internal instability	88
■ Armed conflict	117	■ Post-conflict	21



2013 ACTIVITY HIGHLIGHTS

- **9,029,100**
Outpatient
Number of outpatient consultations
- **477,700**
Inpatient
Number of admitted patients
- **1,871,200**
Malaria
Total number of cases treated
- **233,800**
Therapeutic feeding centres
Number of severely malnourished children admitted to inpatient or outpatient feeding programmes
- **17,100**
Supplementary feeding centres
Number of moderately malnourished children admitted to supplementary feeding centres
- **341,600**
HIV
Number of HIV patients registered under care at end 2013
- **325,500**
Antiretroviral treatment (first-line)
Number of patients on first-line antiretroviral treatment at end 2013
- **5,500**
Antiretroviral treatment (second-line)
Number of patients on second-line antiretroviral treatment at end 2013 (first-line treatment failure)
- **18,500**
PMTCT – mother
Number of HIV-positive pregnant women who received prevention of mother-to-child transmission (PMTCT) treatment
- **16,800**
PMTCT – baby
Number of eligible babies born in 2013 who received post-exposure treatment
- **182,200**
Births
Number of women who delivered babies, including caesarean sections
- **77,350**
Surgical interventions
Number of major surgical interventions, including obstetric surgery, under general or spinal anaesthesia
- **11,100**
Sexual violence
Number of patients medically treated for sexual violence
- **29,900**
Tuberculosis (first-line)
Number of new admissions to tuberculosis first-line treatment
- **1,950**
Tuberculosis (second-line)
Number of new admissions to MDR tuberculosis treatment, second-line drugs
- **141,100**
Mental health (individual)
Number of individual mental health consultations
- **14,200**
Mental health (group)
Number of group counselling or mental health sessions
- **27,900**
Cholera
Number of people treated for cholera
- **2,497,250**
Measles vaccinations
Number of people vaccinated against measles in response to an outbreak
- **129,900**
Measles treatment
Number of people treated for measles
- **162,400**
Meningitis vaccinations
Number of people vaccinated against meningitis in response to an outbreak
- **1,750**
Meningitis treatment
Total number of people treated for meningitis

This data groups together direct, remote support and coordination activities. Note: these highlights give an overview of most MSF activities but cannot be considered exhaustive.

GLOSSARY OF DISEASES AND ACTIVITIES

Chagas disease

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

Diagnosis is complicated, requiring laboratory analysis of blood samples. There are currently only two medicines available to treat the disease: benznidazole and nifurtimox, which were both developed over 40 years ago. The cure rate is almost 100 per cent in newborns and infants, but as the gap between the date of infection and the beginning of treatment lengthens, the cure rate declines.

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

MSF treated 4,500 patients for Chagas disease in 2013.

Cholera

Cholera is a water-borne, acute gastrointestinal infection caused by the

Vibrio cholerae bacterium. It is transmitted by contaminated water or food, or direct contact with contaminated surfaces. In non-endemic areas, large outbreaks can occur suddenly and the infection can spread rapidly. Most people will suffer only a mild infection, but the illness can be very severe, causing profuse watery diarrhoea and vomiting that can lead to severe dehydration and death. Treatment consists of a rehydration solution – administered orally or intravenously – which replaces fluids and salts. Cholera is most common in densely populated settings where sanitation is poor and water supplies are not safe.

As soon as an outbreak is suspected, patients are treated in centres where infection control precautions are taken to avoid further transmission of the disease. Strict hygiene practices must be implemented and large quantities of safe water must be available.

MSF treated 27,900 people for cholera in 2013.

Health promotion

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

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

HIV/AIDS

The human immunodeficiency virus (HIV) is transmitted through blood and body fluids and gradually breaks down the immune system – usually over a three- to 15-year period, although 10 years is more usual – leading to acquired immunodeficiency syndrome, or AIDS. As the virus progresses, people begin to suffer from opportunistic infections. The most common opportunistic infection that leads to death is tuberculosis.

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

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

MSF provided care for 341,600 people living with HIV/AIDS and antiretroviral treatment for 331,000 people in 2013.

Kala azar (visceral leishmaniasis)

Largely unknown in high-income countries (although it is present in the Mediterranean basin), kala azar – Hindi for 'black fever' – is a tropical, parasitic disease transmitted through bites from certain types of sandfly. It is endemic in 76 countries, and of the estimated 200,000–400,000 annual cases, 90 per cent occur in Bangladesh, India, Ethiopia, South Sudan, Sudan and Brazil. Kala azar is characterised by fever, weight loss,

enlargement of the liver and spleen, anaemia and immune-system deficiencies. Without treatment, kala azar is almost always fatal.

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

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

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

MSF treated 5,300 patients for kala azar in 2013.

Malaria

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

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

In 2012, MSF used a seasonal chemoprevention strategy for the first time, in Chad and Mali. Children up to five years old took oral antimalarial treatment monthly over a period of three to four months during the peak season for the disease. In 2013, this was introduced in Niger.

MSF treated 1,871,200 people for malaria in 2013.



The triatomine bug, also known as the 'kissing bug', carries the parasite that causes Chagas. The disease can be asymptomatic for years but can be fatal if left untreated.

Malnutrition

A lack of food or essential nutrients causes malnutrition: children's growth falters and their susceptibility to common diseases increases. The critical age for malnutrition is from six months – when mothers generally start supplementing breast milk – to 24 months. However, children under five, adolescents, pregnant or breastfeeding women, the elderly and the chronically ill are also vulnerable.

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

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

MSF admitted 250,900 malnourished patients to nutrition programmes in 2013.

Measles

Measles is a highly contagious viral disease. Symptoms appear between eight and 13 days after exposure to the virus and include a runny nose, cough, eye infection, rash and high fever. There is no specific treatment for measles – patients are isolated and treated with vitamin A, and for any complications: these can include eye-related problems, stomatitis (a viral mouth infection), dehydration, protein deficiencies and respiratory tract infections.

Most people infected with measles recover within two to three weeks, and mortality rates in high-income countries are low. In developing countries, however, the mortality rate can be between 3 and 15 per cent, rising to 20 per cent where people are more vulnerable. Death is usually due to complications such as diarrhoea, dehydration, encephalitis (inflammation of the brain) or severe respiratory infection.

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

MSF treated 129,900 patients for measles and vaccinated 495,250 people in response to outbreaks in 2013.

continued overleaf >

continued *Glossary of diseases and activities* >

Meningococcal meningitis

Meningococcal meningitis is a bacterial infection of the thin membranes surrounding the brain and spinal cord. It can cause sudden and intense headaches, fever, nausea, vomiting, sensitivity to light and stiffness of the neck. Death can follow within hours of the onset of symptoms. Up to 50 per cent of people infected will die without treatment.

Six strains of the bacterium *Neisseria meningitidis* (A, B, C, W135, X and Y) are known to cause meningitis. People can be carriers without showing symptoms and transmit the bacteria when they cough or sneeze. Cases are diagnosed through the examination of a sample of spinal fluid and treatment consists of specific antibiotics. However, even with treatment, 10 per cent or more patients will die and as many as one in five survivors may suffer from after effects, including hearing loss and learning disabilities.

Meningitis occurs throughout the world, but the majority of infections and deaths are in Africa, particularly across the 'meningitis belt', an east-west geographical strip from Ethiopia to Senegal, where epidemics are most likely to be caused by meningococcus A. A new vaccine against this strain provides protection for at least 10 years and even prevents healthy carriers from transmitting the infection. Large preventive vaccination campaigns have now been carried out in Benin, Burkina Faso, Cameroon, Chad, Ghana, Mali, Niger, Nigeria, Senegal and Sudan and have resulted in a decrease in the number of new cases.

MSF treated 1,750 patients for meningitis and vaccinated 162,400 people against the disease in response to outbreaks in 2013.

Mental healthcare

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

Psychosocial care focuses on supporting patients to develop their own coping strategies after trauma. Counsellors help people to talk about their experiences and process their feelings so that general stress levels are reduced. MSF also offers group counselling, as a complementary approach.

MSF staff held 155,300 individual and group counselling sessions in 2013.

Relief items distribution

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

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

MSF distributed 146,650 relief kits in 2013.

Reproductive healthcare

Comprehensive neonatal and obstetric care form part of MSF's response to any emergency. Medical staff assist births and perform caesarean sections where necessary and feasible, and sick newborns and babies with a low birth weight receive medical care.

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

Good antenatal and obstetric care can prevent obstetric fistulas. An obstetric fistula is a hole between the vagina and rectum or bladder that is most often a result of prolonged, obstructed labour. It causes incontinence, which can lead to social stigma. Around two million women are estimated to have untreated obstetric fistulas; there are between 50,000 and 100,000 new cases each year. A number of MSF programmes carry out specialist obstetric fistula repair surgery.

MSF held more than 703,900 antenatal consultations in 2013.

Sexual violence

Sexual violence occurs in all societies and in all contexts at any time. Destabilisation of contexts

often results in increased levels of violence, including sexual violence. Sexual violence is particularly complex and stigmatising and has long-lasting consequences and can result in important health risks.

MSF medical care for victims of sexual violence covers preventive treatment against sexually transmitted infections, including HIV, syphilis and gonorrhoea, and vaccinations for tetanus and hepatitis B. Treatment of physical injuries, psychological support and the prevention and management of unwanted pregnancy are also part of the systematic care. MSF provides a medical certificate to all victims of violence.

Medical care is central to MSF's response to sexual violence, but stigma and fear may prevent many victims from coming forward. A proactive approach is necessary to raise awareness about the medical consequences of sexual violence and the availability of care. Where MSF sees large numbers of victims – especially in areas of conflict – advocacy action aims to raise awareness among local authorities, as well as the armed forces when they are involved in the assaults.

MSF medically treated 11,100 patients for sexual violence-related injuries in 2013.

Sleeping sickness (human African trypanosomiasis)

Generally known as sleeping sickness, human African trypanosomiasis is a parasitic infection transmitted by tsetse flies that occurs in sub-Saharan Africa. In its latter stage, it attacks the central nervous system, causing severe neurological disorders and frequently death. More than 95 per cent of reported cases are caused by the parasite *Trypanosoma brucei gambiense*, which is found in western and central Africa. The other 5 per cent of cases are caused by *Trypanosoma brucei rhodesiense*, which is found in eastern and southern Africa.

During the first stage, the disease is relatively easy to treat but difficult to diagnose, as symptoms such as fever and weakness are non-specific. The second stage begins when the parasite invades the central nervous system and the infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, convulsions and sleep disturbance. Accurate diagnosis of the illness requires a sample of spinal fluid.

Nifurtimox-eflornithine combination therapy or NECT, developed by MSF, Drugs for Neglected Diseases initiative (DNDi) and Epicentre, is now the World Health Organization recommended protocol. NECT is much safer than melarsoprol, the drug that was previously used to treat the disease, and which is a derivative of arsenic. Melarsoprol



© Francois Dumont/MSF

Supplies are unloaded at MSF's tent hospital in Guiuan in the aftermath of Typhoon Haiyan in the Philippines.

causes many side effects and can even kill the patient. It is hoped that the new molecules currently under clinical trial will lead to the development of a safe, effective treatment for both stages of the disease that can be administered orally.

MSF admitted 1,800 patients for sleeping sickness treatment in 2013.

Tuberculosis

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

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

Diagnosis of TB depends on a sputum or gastric fluid sample, which can be difficult to obtain from children. A new molecular test that can give results after just two hours and detect a certain level of drug resistance is now being used, but it is costly and still

requires a phlegm sample, as well as a reliable power supply.

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

MSF treated 29,900 patients for TB and 1,950 for MDR-TB in 2013.

Vaccinations

Immunisation is one of the most cost-effective medical interventions in public health. However, it is estimated that approximately two million people die every year from diseases that are preventable by a series of vaccines recommended for children by the World Health Organization. Currently, these are DTP (diphtheria, tetanus, pertussis), hepatitis B, *Haemophilus influenzae* type b (Hib), BCG (against tuberculosis), human papillomavirus, measles, pneumococcal conjugate, polio, rotavirus, rubella and

yellow fever – although not all vaccines are recommended everywhere.

In countries where vaccination coverage is generally low, MSF strives to offer routine vaccinations for children under five when possible as part of its basic healthcare programme. Vaccination also forms a key part of MSF's response to outbreaks of measles, yellow fever and meningitis. Large-scale vaccination campaigns involve awareness-raising activities regarding the benefits of immunisation as well as the set-up of vaccination posts in places where people are likely to gather. A typical campaign lasts between two and three weeks and can reach hundreds of thousands of people.

Water and sanitation

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

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

SOUTH SUDAN: A COUNTRY GRIPPED BY VIOLENCE

South Sudan gained independence from Sudan in July 2011, becoming Africa's first new country since Eritrea in 1993. Since then, however, hopes for the future of the young state have slowly crumbled and in 2013, as the government collapsed and intercommunal violence reached explosive levels, South Sudan edged towards civil war.

Jonglei state has seen some of the worst violence since independence, a result of conflicts that are rooted in cattle raiding. In March, however, the situation became even more unstable as the army launched an offensive against a rebel group led by David Yau Yau. In April, Médecins Sans Frontières (MSF) was forced to suspend activities in Pibor because of threats against staff and patients and was preparing to return in May, having secured the necessary assurances, when the hospital in Pibor was looted and rendered unusable. This was the sixth time an MSF medical facility had been looted or damaged in Jonglei state in two years. It is difficult and expensive to build hospitals in

South Sudan, and what takes a matter of hours to destroy can take months or even years to reconstruct, leaving many thousands of people without adequate healthcare.

As the fighting in Jonglei state intensified, almost the entire population of Pibor county sought refuge in the bush. People were too afraid to leave their hiding places to seek medical attention, and so MSF went to them: a small clinic was set up in Boma town, staff continued to run a health post in Gumuruk, and mobile clinics – some carried out by helicopter – conducted hundreds of consultations in the bush in southern Pibor. Before MSF could deliver assistance to those

in hiding though, requests for government permission to travel to opposition-held territory were repeatedly denied.

December violence

In Juba, amid a power struggle inside the ruling Sudan People's Liberation Movement (SPLM), South Sudan's president, Salva Kiir, sacked his cabinet in July and so rid himself of his main political rival, vice-president Riek Machar. What started as a political dispute exacerbated ethnic tensions in an already divided country. On 15 December, fighting broke out between battalions of the Sudan People's Liberation Army (SPLA), spilled onto the streets of the capital and resulted in Kiir accusing Machar of an attempted coup d'état. Conflict subsequently spread throughout the country, between those loyal to the government and those supporting the former vice-president. Civilians sought shelter in UN bases and in the bush, and many others crossed into neighbouring countries such as Uganda, Ethiopia and Kenya.



A hepatitis E ward at MSF's hospital in Batil refugee camp, Maban county.



The MSF hospital in Pibor after it had been purposefully damaged to render it inoperable.

Following the eruption of vicious fighting in Juba on 15 December, people fled for their lives and sheltered in two UN compounds. MSF set up clinics in both camps, and also provided Juba Teaching Hospital with drugs and medical supplies. As the situation in South Sudan deteriorated, MSF suspended activities for two days at the hospital in Malakal, Upper Nile state, because staff were unable to gain safe access due to outbreaks of violence. In the same month, staff had to be evacuated from Leer hospital owing to safety concerns.

Bor, the once bustling capital of Jonglei state, had become a ghost town by the end of the year as government troops and SPLM-in-Opposition (SPLM-IO) battled for control. It was the first major area to fall to the rebels after the December violence. Thousands of civilians fled to the town of Awerial, on the banks of the Nile in Lakes state, and MSF's emergency team supported two Ministry of Health clinics by providing consultations and obstetric care and donating medicines. Clean drinking water and measles vaccinations for children were a priority. With very little infrastructure in place, and an already weakened population, the risk of disease in makeshift camps such as Awerial and Minkamman loomed large and the situation will only be exacerbated once the rainy season starts and settlements begin to flood.

Sudanese refugees

Amid the mass internal displacement and instability that took hold of the nascent country in 2013, it could be forgotten that South Sudan is also home to hundreds of thousands of Sudanese refugees, the majority of who fled conflict in Sudan's South Kordofan



The conflict in South Sudan has displaced hundreds of thousands of people.

and Blue Nile states in 2011 and 2012. In refugee camps in Unity and Upper Nile states, cholera, malaria and measles are all a threat, and hepatitis E outbreaks have had a major impact on mortality in camps near the border with Sudan. MSF ran a number of vaccination campaigns in 2013. In April, more than 105,000 Sudanese refugees and 27,500 residents of Maban county were immunised against cholera; this was the first time MSF had used the two-dose oral vaccine as a preventive measure on such a large scale, in such a remote location. The pneumococcal conjugate vaccine was used for the first time in South Sudan in Yida camp, Unity state, in August.

MSF has been working in what is now South Sudan for 30 years and even before

this latest conflict access to healthcare was limited and providing it was a challenge. This is a barren region, with rivers, swamps, and barely any roads. By the end of the year, MSF's priority became identifying where needs were greatest, and responding accordingly even if it meant staff leaving ongoing, long-running projects focused on acute needs.

With interethnic tensions increasing, people's needs growing ever-greater and resources scarcer due to the departure of international organisations in December, as 2013 drew to a close the situation in South Sudan was poised to become dramatically worse.

For more details of MSF's response in South Sudan, see the country report, pp.82–83.

ADDRESSING WOMEN'S HEALTH NEEDS

Pregnancy and birth do not stop because of a conflict or crisis, and neither do any of the associated medical complications. Pregnant women make up five per cent of a general population at any given time but among refugees and displaced people, the percentage is often higher. In general, there are more women in displaced populations because often the men are fighting or have stayed behind to protect property.

Over the last 20 years, aid organisations have learned that the specific needs of women have to be addressed as part of an emergency response. Trends in maternal mortality¹ reveal a 47 per cent reduction in the number of maternal deaths worldwide between 1990 and 2010. This data is encouraging, but the reality of girls and women in many parts of the world has changed little. Differences between areas of the world are huge: in developed regions one in every 3,800 women risks dying from pregnancy- or childbirth-related complications, while in developing regions, it is one in 180 women, and in sub-Saharan Africa, one in 39 women.

In many situations where Médecins Sans Frontières (MSF) works, obstetric care is in a constant state of emergency; national health systems are disrupted, there are staff shortages, low salaries and little or no supplies. Conflict and crises further exacerbate the situation.

MSF's work with regards women's health focuses primarily on action that directly impacts mortality and suffering: obstetric and newborn care, postnatal care and safe abortion. MSF also offers a range of preventive actions that are known to contribute significantly to the reduction of maternal morbidity and mortality: antenatal care, the provision of contraceptives, prevention of mother-to-child transmission (PMTCT) of HIV/AIDS, and cervical cancer screening and treatment in pilot projects. In some programmes, MSF provides obstetric fistula repair.

Sexual violence occurs everywhere, but it tends to be more prevalent in crisis situations. The majority of people presenting after incidents of sexual violence in MSF projects are women and children, but men are also coming forward. All MSF operations are prepared to provide medical and psychological care to victims of sexual violence, as well as medico-legal certificates.

Complications during and after birth

Most maternal deaths occur during or immediately after birth, and MSF's primary commitment, therefore, is the provision of skilled obstetric and neonatal care. In 2013, over one-third of MSF projects offered obstetric care, and half of them had the surgical capacity to perform a caesarean section when needed. Maternal mortality in the maternity wards supported by MSF is low, which shows that even in remote areas of Afghanistan, for example, obstetric and neonatal care can and should be provided. MSF also treats women who have given birth at home and who arrive with postnatal complications such as a retained placenta, severe bleeding or infection.

Most post-partum complications for both mothers and newborns occur in the first 24 hours, and for this reason MSF encourages women to stay in the maternity unit for one day after delivery. This allows for early diagnosis and treatment of complications, and also supports the breastfeeding mother. At least one follow-up visit in the first week

after birth is recommended, either at the maternity unit or in the community.

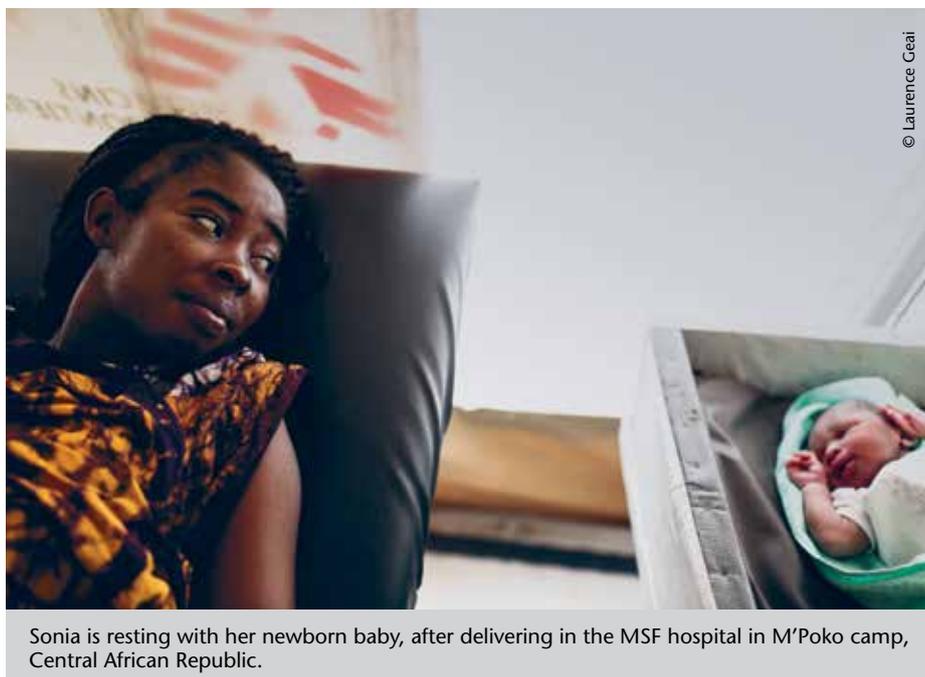
Consequences of unwanted pregnancy and unsafe abortion

Of the four main causes of maternal mortality, unsafe abortion is the one that is entirely preventable. Worldwide, it accounts for approximately 13 per cent of all maternal deaths; the figures are much higher in some regions such as Latin America and in areas where the population is living in displacement camps.

Girls and women with complications resulting from unsafe abortion frequently arrive in the emergency rooms of MSF facilities. Some come in bleeding and distressed, rather than in any real danger, and counselling and support will be all that they need. Others arrive with life-threatening complications and may require antibiotics, surgery, blood transfusions or time in intensive care, or all of the above.

Experience shows that many women and girls will seek unsafe abortion to terminate an unwanted pregnancy if no safe abortion care is available. They will do so risking their life, sometimes knowingly, because the alternative is unbearable. MSF provides safe abortion care to women and girls in need, whenever this is feasible.

MSF also makes a choice of contraceptives available and provides information and counselling to girls and women who want to



Sonia is resting with her newborn baby, after delivering in the MSF hospital in M'Poko camp, Central African Republic.

plan their pregnancies, and are in a position to do so. Contraception is the best method of preventing unwanted pregnancies. It allows young women to delay their first pregnancy and enables women who already have children to plan the timing of their next one. Women who have experienced life-threatening complications can also decide whether or not they are willing to risk carrying another child.

The role of antenatal care

Antenatal care alone does not prevent maternal death, but it is an important way for health staff to connect with expectant mothers. Some women may only attend one antenatal consultation at an MSF clinic, late in their pregnancy. MSF uses this opportunity to diagnose, manage and treat medical conditions that affect the mother and baby, to discuss birth preparation and to encourage women to deliver at the maternity unit.

In areas with a high rate of HIV, MSF offers testing to all pregnant women, primarily as part of their antenatal care, but also during or after birth. The transmission of the HIV virus from mother to baby – during pregnancy and birth and through breastfeeding – is the main source of HIV infection in infants. PMTCT is possible, and MSF provides appropriate treatment to women who have tested positive and treats their babies immediately after birth. Wherever possible, MSF also refers women for continuous HIV care after they have finished breastfeeding and arranges follow-up care for their babies.

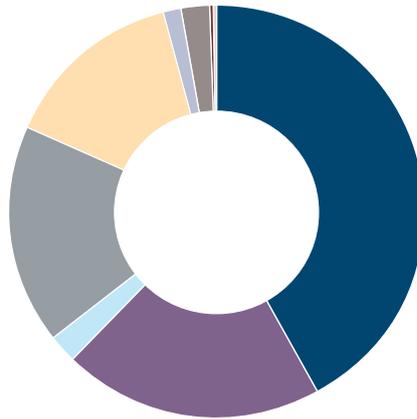
Cervical cancer

After breast cancer, cervical cancer is the main cause of cancer-related death in women worldwide. The majority of women who die from cervical cancer live in developing countries, and those with HIV/AIDS are particularly vulnerable.² In some projects, MSF has started screening and treating cervical cancer in its early stages.³ Abnormal cells are made visible to the eye through a simple colouring method⁴ and can be removed in the same visit, without the need for hospitalisation.

The challenge of societal roles

Many of the major challenges in the drive to prevent maternal death are a result of the roles that societies and communities attribute to girls and women. Early marriage, female genital mutilation, teenage pregnancy, multiple pregnancies, sexual violence: these are all factors that contribute to high maternal mortality, especially where there is no access to quality healthcare.

MSF recognises that women and girls have very specific medical needs, and provides the necessary care whenever possible. Today, a third of all MSF interventions, be they longer term or emergency projects, offer obstetric care.



Antenatal care (1st visit)	340,306
Vaginal deliveries	164,553
Caesarean sections	17,681
Contraception (consultations)	138,069
Postnatal care	114,356
Sexual violence care	11,062
PMTCT	18,489
Safe abortion care (provided or referred to a quality provider)	683
Obstetric fistula repair	804



Having successfully undergone obstetric fistula surgery, Nafissa recuperates in the *village des femmes* in Abéché, Chad.



A baby boy delivered by caesarean section at Bethany hospital, Tacloban, in the Philippines. After the typhoon, his mother walked for several days to reach medical help.

¹ WHO, UNICEF, UNFPA and The World Bank estimates – WHO 2012. ² In HIV-infected women, cervical cancer is more frequent and develops much faster. ³ Pre-cancerous lesions. ⁴ VILI/VIA diagnosis

CENTRAL AFRICAN REPUBLIC: DESCENT INTO CHAOS

Central African Republic (CAR) has known decades of violence, displacement and lack of medical access, and Médecins Sans Frontières (MSF) has been working there since 1996. This year, however, the country was confronted with a massive humanitarian crisis to which many in the international community, and the world in general, remained largely indifferent.

Towards the end of 2012, the Séléka – a coalition of rebel groups mainly from the north and east of the country – made their way towards the capital, Bangui. En route they took control of numerous towns and villages, forcing residents to flee into the bush to escape the violence. The presence of the Séléka exacerbated the ongoing conflict between farmers and pastoralists, and CAR's armed forces, FACA, withdrew from areas where they had been integral to keeping the situation under control. The anti-balaka (anti-machete) traditional self-defence groups started fighting the Séléka whom they perceived as pro-Muslim for favouring the pastoralists from the north.

Despite signing a peace deal with the government in January, the Séléka marched on Bangui in March and seized power claiming unfulfilled promises. President Bozizé

left for Cameroon (he himself had taken power by force in 2003), state security forces were disbanded, and rebel Michel Djotodia proclaimed himself president, suspended the constitution and dissolved parliament. In August he was officially sworn in. The coup left the country in chaos, and widespread violence and looting ensued as CAR remained at the mercy of armed groups.

Djotodia announced in September that he had officially disbanded the Séléka coalition, but many fighters refused to put down their weapons. They committed atrocities against civilians, and the anti-balaka – its ranks swelled with former soldiers, gangs and other self-defence groups – reciprocated with attacks on members of the Muslim community.

Displaced people found themselves living without access to safe water, facing food

shortages and malnutrition, and with an increased threat of malaria. Despite the huge rise in people's needs, however, the humanitarian presence in the country reached an almost record low. Many UN agencies and NGOs withdrew to the capital due to the lack of security, leaving much of the country without aid. In light of the situation on the ground MSF felt compelled to publish an open letter to Valerie Amos, UN Under-Secretary-General, on 12 December, citing the 'unacceptable performance of the United Nations humanitarian system in the Central African Republic over the last year' and Arjan Hehenkamp, General Director of MSF in the Netherlands, wrote a piece for *The Guardian* newspaper stating that 'The aid world has failed the people of the Central African Republic'.



Thousands of people fled to M'poko airport in Bangui to escape Séléka gunmen in August, blocking the runway and preventing flights from landing. By December MSF's airport clinic was addressing the medical needs of more than 100,000 displaced people who had taken refuge in the makeshift camp.



On 9 September, the anti-balaka targeted the town of Bouca and buildings were burned to the ground. Séléka fighters were executed, and civilians fled into the bush or sought shelter in the Catholic mission compound. Once the violence had subsided, MSF helped 400 families who had lost their homes.

© Juan Carlos Tomasi/MSF

Since the start of the conflict, tens of thousands of people have fled their homes to escape vigilantes armed with machetes and guns. In September in Bossangoa, 30,000 people sought refuge in the grounds of the Catholic mission, and 8,000 people from the Muslim community sheltered in a mosque.



© Camille Lepage / Polaris



© Marcus Bleasdale/VII

The woman pictured above is being rushed from a camp at the church in Bossongoa to the MSF-supported hospital for treatment. People are sheltering in large groups for safety, in the Catholic mission compound, in the hospital, in a school and next to the airstrip. Those in the bush are particularly at risk of contracting malaria – CAR’s number one killer – but all are living in precarious conditions with little access to sanitation facilities. In a country of over 4.5 million people, which already has some of the worst health indicators in the world, the crisis has heavily impacted the healthcare of civilians, as routine vaccinations have not taken place, HIV treatment regimens have been interrupted and levels of malnutrition and malaria have increased.

On 5 December, a wave of violence swept through Bangui as armed groups launched an offensive after the arrival of French troops to disarm the ex-Séléka. Attacks on Christians followed by revenge killings against Muslims took place around the country as the ex-Séléka withdrew. The anti-balaka increased the number of attacks against Muslim communities in the north and west of the country, as they saw these areas as potential political bases for the ex-Séléka. MSF treated hundreds of wounded people.



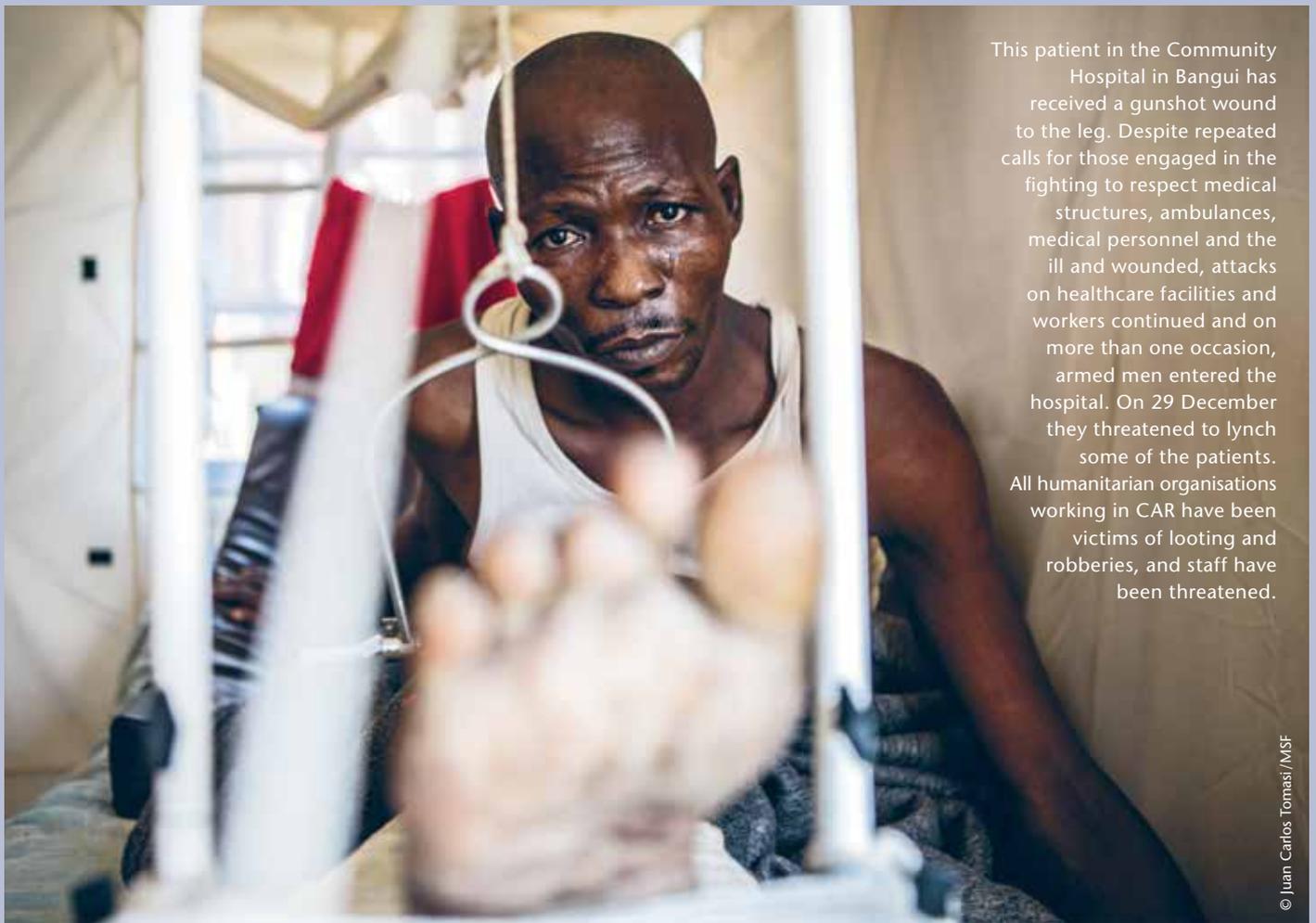
© Camille Lepage/Polaris

At the Community Hospital, MSF teams were treating 15 to 20 wounded a day during early December, predominantly for gunshot and machete wounds. Patients who had been tortured and beaten were seen at the hospital, and many people presented with defensive injuries to their heads, hands and arms. Amitié Hospital, Bangui’s main hospital, was attacked and looted, and health staff fled amid threats. Ten days after the unrest began, the UN Office for the Coordination of Humanitarian Affairs estimated that one in four residents of Bangui had been displaced.

Josianne

Displaced person who took refuge in the bush, Bria

“Since this all started, we flee, we sleep in the bush, we don’t eat well, we are bitten by mosquitoes. There are too many illnesses. We are always running. You can see for yourself what state we are in. We want peace.”



This patient in the Community Hospital in Bangui has received a gunshot wound to the leg. Despite repeated calls for those engaged in the fighting to respect medical structures, ambulances, medical personnel and the ill and wounded, attacks on healthcare facilities and workers continued and on more than one occasion, armed men entered the hospital. On 29 December they threatened to lynch some of the patients. All humanitarian organisations working in CAR have been victims of looting and robberies, and staff have been threatened.

© Juan Carlos Tomasi/MSF

The beginning of 2014 brought no respite for CAR. When Djotodia left power in January, Christian militias began attacking Muslim civilians and many were forced to flee to neighbouring countries such as Chad or Cameroon. MSF continues to treat the wounded and respond to the massive displacement of people; at the time of writing MSF has more than 300 international staff and 2,500 Central African staff working in the country. MSF and a handful of other organisations have shown that it is possible to keep working in CAR throughout the crisis, and even to expand operations. However, more international intervention is needed. The violence continues and the population of CAR live in fear.

For more details on MSF's response in CAR, see the country report, pp. 36–37.



© Marcus Bleasdale

Dr Sabine Roquefort
MSF doctor at the
Community Hospital, Bangui

“We are accustomed to working in very violent environments, but this organised, wilful intent to mutilate, wound and kill shocked me. The level of violence and suffering has struck me more powerfully than in any other conflict setting where I have worked.”

A DAY IN THE LIFE: MÉDECINS SANS FRONTIÈRES (MSF) CLINIC AT DERA MURAD JAMALI, BALOCHISTAN, PAKISTAN

Purchaser Mohammad Aslam sees the impact of Dera Murad Jamali's isolation every time he places an order for supplies. "We can't buy medicines locally – we have to order them from Islamabad every three months," he explains. "Sometimes we have a problem with international cargo and we have to ask other MSF hospitals or clinics in the country. Just this week we needed some injections and we asked Islamabad, who asked the MSF team in Chaman, who sent it to the MSF team in Quetta, and then Quetta sent it to us – it took more than two days."

There are few options for quality healthcare in the area, with the nearest major centre of Jacobabad about 40 kilometres away, and private clinics – of which there are only a small number – charging tens of thousands of rupees for caesarean sections, for example, an impossible cost for most families. As well as being excluded from medical care, the people here have been displaced by internal conflicts and affected by social violence. As Australian nurse David McGuinness says, there are many challenges when working for MSF in a location like Dera Murad Jamali: "Stories of loss, tales of terror, another bomb blast, another kidnapping, and children literally starving to death [but] the work being done here is invaluable and the impact it has on people is undeniable."

Dr Raj Batra was working for a public hospital before he joined MSF. "There were poor people who couldn't access healthcare and were being denied the proper treatment," he said. "When I read about MSF's independence and impartiality, I said I wanted to join." As the medical focal person in MSF's Dera Murad Jamali clinic, Dr Batra supports all the departments, including maternal and child health, the feeding programme for malnourished children and the mobile clinics. He explains: "The biggest challenge is that people in this area are not educated about health issues and often depend on home remedies. For example, with breastfeeding, women often avoid using the first milk from the mother. But we know how important that first milk is – with nutrition and antibodies for the baby."



Mohammad Aslam

Before MSF, I was working as a receptionist for an organisation that supported education in Nasirabad and Jaffarabad. The organisation also provided some voluntary support to the basic health units in the region.

I joined MSF in April 2009, for the professional experience and to help people in need. I was still getting to know the job and the organisation when MSF launched its response to the 2010 flood emergency. We had around 45 international and around 350 Pakistani staff working in Dera Murad Jamali. I realised the international staff and national staff had the same objective: to help those people affected by the floods.

A typical day

We start our working day at 8am with a meeting. I then spend time each day working on the project's medical supplies, receiving requests, organising quotations and making the purchases.

Once a month, I receive the medical orders from the teams in Dera Murad Jamali and send them supplies from our store. Once every three months, we send a big order for both medical and non-medical items to the capital, Islamabad. The medical team leader will talk to the logistics team about what's needed, and then logistics will talk to me about how we can arrange the supplies.

When we receive cargo from Islamabad, we enter it into the system and make sure that anything needing to be refrigerated is placed in the cold chain. Sometimes I'll also fill in as the assistant to the project coordinator.

In charge of the maternal and child health departments at the clinic is midwife Gaudesia Waitherero Kimani from Kenya. She is responsible for the birthing unit, antenatal and postnatal care, and the nursery. She draws on her experience working as a midwife with MSF in South Sudan to advise co-workers on the best medical treatment.

“We have many cases of pre-eclampsia and mothers haemorrhaging, which is life-threatening. In the nursery, it takes time and you have to be patient. The prognosis of the babies is very poor, due partly to lack of hygiene in the community and because many parents don’t come to the antenatal clinic for vaccinations, which would protect the baby.”

Gaudesia Waitherero Kimani

This is my third mission with MSF. I have also worked as a midwife in South Sudan, first for six months in the township of Raga and then for a year at a huge MSF project working with refugees in Maban. In South Sudan, MSF provides maternal and reproductive health services, including looking after mothers with complicated births and mothers with hepatitis E, which is a serious health issue there. In between my MSF missions, I work at a private hospital in Nairobi, Kenya.

When an emergency situation arises, the team pulls together – such as when fruit seller Shair Khan and his family were rushed to the MSF clinic with serious burns. Shair Khan had been awakened by his daughter’s shouts to find his tent engulfed by flames. His first thought was for his six children inside. “I went to the side of the tent and tore it, and took my children out,” he recalled. “Nine people, including me, were living in that tent – we were using candles for lighting.”

Once at Dera Murad Jamali hospital doctors began treatment and extra staff were called in. The mother – who had the worst burns – and one child were transferred to another hospital six hours’ drive away. Sadly the mother died but all the children were eventually discharged, and Gaudesia Waitherero Kimani still remembers the way the staff worked together that night. “Everyone still talks about it and how happy we were with the way we responded.” David McGuinness agrees, saying: “As I have seen on many occasions, the MSF staff worked through these difficulties together and committed themselves to the patients, to help achieve the best outcomes.”

Dr Raj Batra

Dr Raj Batra grew up in Jacobabad, where he completed his pre-medical studies. He was one of just 31 candidates (out of 1,650 applicants) from his district chosen to complete a Bachelor of Medicine at Chandka Medical College in 2001. After further training in Karachi, he began working as an ambulance paramedic with a Pakistani NGO (the Aman Foundation).

After he was injured in a road traffic accident, he began working as a doctor in telehealth and began an MBA in Health Management. He oversaw a project mapping all healthcare facilities in Karachi and neighbouring districts – the first of its kind in Pakistan – to make it easier for people to access health services.

Next he took a job looking after the health of workers in the textile industry in Karachi, and then in December 2013 joined MSF as the medical focal point in Dera Murad Jamali.

A typical day

A normal day starts with a meeting, where we share security updates such as any bombing incidents overnight or other incidences of violence. From the project side, we also discuss each team’s plans for the day. After that, I usually go to my office and might need to make a supply order, prepare a report or arrange reimbursements for staff. These jobs are really important to help with the smooth running of the project.

I’ll then join the staff doing the morning medical round of the hospital and take the opportunity to ask patients for feedback on our services. I might need to prepare short reports for the relevant staff to pass on any comments from patients.

I’m also responsible for the weekly medical meeting, where we gather and review cases, discuss medical issues and try to reach a consensus. If we can’t reach agreement on a medical issue, we might involve the project coordinator. I will work with the medical team leader to respond to health, operational, management and supply issues. I make sure that every protocol and policy is being followed in the project. I’m also responsible for the health of our Pakistani staff. If they are sick, I might need to refer them to the best facility for treatment. Basically I’m the person who works to coordinate all the medical teams. Coordination is the thing that holds us together.



OVERCOMING CHALLENGES TO MEET MSF'S VACCINATION AMBITIONS

Today, 10-month-old Roni will be vaccinated against one of the world's biggest killers of children his age: pneumonia. He waits patiently, perched on his mother's hip, as she gives his name and date of birth to the Médecins Sans Frontières (MSF) team working in Yida refugee camp in South Sudan.

While immunisation has always been a major part of MSF operations – with more than two million people protected against measles in 2013 alone, for example – the organisation recently upped its vaccination ambitions. This involves, in part, using the newest vaccines more systematically in MSF operations, including in emergencies, where children are at their most vulnerable. For example, Roni was one of several thousand children vaccinated by MSF in the Yida camp between July and September 2013 with two new vaccines that were not yet available in South

Sudan: pentavalent and the pneumococcal conjugate vaccine (PCV). MSF projects are also rolling out innovative strategies, seeking to show in Guinea, for instance, that a new oral cholera vaccine is effective in responding to outbreaks and even works as a useful preventive tool where cholera is endemic.

MSF's renewed commitment to vaccination as a medical priority centres on the ambition to strengthen routine immunisation, that is to say, the vaccines the World Health Organization (WHO) recommends all children should receive. Four priority countries have been chosen: Central African Republic (CAR), Chad, Democratic Republic of Congo (DRC) and South Sudan. There are many aspects to this work, and one is reducing 'missed opportunities' in MSF projects by screening eligible children for their vaccination status during clinic visits. Another is integrating immunisation into other paediatric programmes. MSF projects in Niger, Mali and Chad, for example, are already combining routine vaccination activities with other health measures such as seasonal malaria prevention. A third strategy is pursuing opportunities

to find those children over the age of one who haven't completed the recommended immunisation series and need to 'catch up'.

However, these new vaccination plans are in danger of being thwarted by the issue of price, and by the very nature of the vaccine product itself. MSF, through specific campaigning and advocacy, needs to address these issues, while also focusing on innovative operational activities and research.

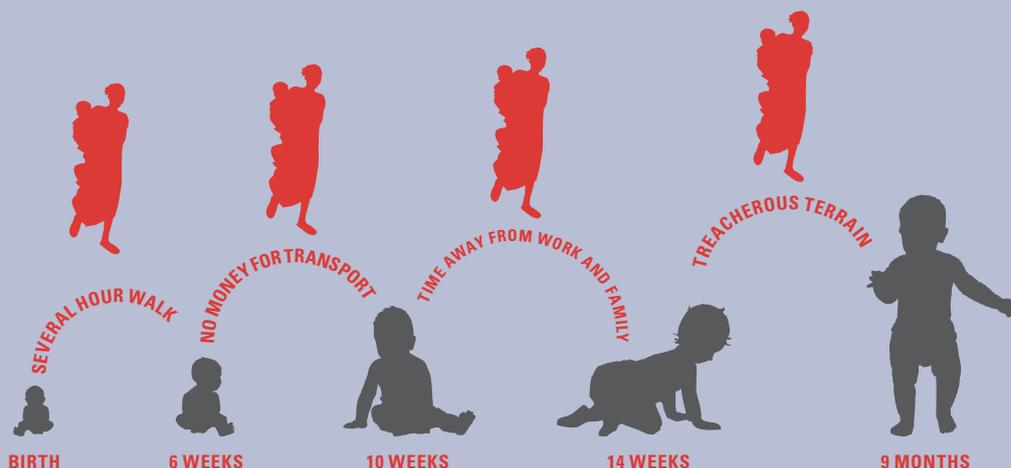
When price curtails ambitions

The GAVI Alliance – the foundation that procures vaccines on behalf of many developing countries – has been instrumental in negotiating substantially lower vaccine prices for the world's poorest countries. This has helped to improve availability of the newest vaccines in countries hardest hit by diseases like pneumonia.

These lower prices are, however, only available through specific purchasing channels, and MSF has not been able to systematically access the 'GAVI price'. Nor does GAVI have policy provisions that cater to emergency

WE NEED EASIER-TO-USE VACCINES

Five Vaccination Visits are Required Before a Baby's First Birthday.
This can be **Difficult for Caregivers** in Developing Countries



Schedule is WHO-recommended routine immunisations for children – http://www.who.int/immunization/policy/Immunization_routine_table2.pdf



© Ikram N'Gadi/MSF

Ice packs are prepared for the vaccinations that need to be kept in the cold chain. Vaccinations must be kept cold but not too cold, ideally between 2 and 8°C.

situations, as it is a development organisation focusing on the WHO's Expanded Programme on Immunization (EPI). WHO released new guidelines last year which recommend vaccinating in humanitarian emergencies, yet accessing vaccines at an affordable price and in a timely manner remains a hurdle.

With the escalation of the humanitarian crisis in South Sudan, MSF sought to vaccinate vulnerable children in Yida camp against pneumonia. It took 11 months to organise the campaign because of problems accessing the vaccines, an untenable timeline for an emergency response.

So why did it take so long? The reasons were complicated price negotiations with pharmaceutical companies GSK and Pfizer, and with the GAVI Alliance, and lengthy procurement processes. With the growing refugee crisis and MSF's frustration at the inability to purchase PCV at the GAVI price, the MSF Access Campaign went public in April 2013 with its Dear GAVI social media campaign, urging the alliance to open up its discounted prices to MSF and other humanitarian organisations. Ultimately, MSF was able to access PCV at a price of US\$7 per dose – still double the lowest global price paid by GAVI.

The Dear GAVI campaign brought mixed results, and while GAVI has publicly committed to making its prices available to humanitarian organisations if they use its procurement channels, MSF will still push to purchase vaccines at the lowest global price directly from pharmaceutical companies. These companies – who are ultimately responsible for pricing decisions – refuse to sell their vaccines to MSF at the cheapest possible price, so the Access Campaign continues to advocate for greater affordability and access.

Vaccines on ice

More than 22 million children each year go without the basic package of vaccines recommended by WHO, largely because delivering these products to remote areas is remarkably challenging. Vaccines are usually developed with wealthy-country conditions in mind: reliable and constant electricity to keep vaccines refrigerated; qualified health workers able to deliver injections; the means to safely dispose of syringes; and the relative ease for most caregivers to reach a vaccination point, meaning that the multiple visits needed to complete a complex immunisation schedule – a minimum of five – are feasible.

Little of this applies to many developing countries where the most vulnerable children live. MSF field logisticians say that the need for vaccines to be kept at the right temperatures, in a constant 'cold chain', is one of the biggest barriers to expanding the reach of vaccinations. For an MSF measles vaccination campaign in Chad, for example, 21,500 ice packs were required, and this involved 18 freezers and three freezer rooms. Then there is the added complexity that vaccines need to be kept cold, but not too cold – vaccines can accidentally freeze when they're stored against ice packs while on their way to vaccination points.

MSF is therefore campaigning for easier-to-use products, particularly vaccines that are more tolerant of heat for the very last stages of their journey from a health centre to the patient. This is being achieved in part through operational and clinical research: in 2013, MSF and its research arm Epicentre carried out a study to determine the stability and continued efficacy of a tetanus toxoid vaccine that was kept in a 'controlled temperature chain' at ambient temperatures of up to 40°C for up to 30 days. The results so far are promising, and once the data has been released it should be possible to use it to push for the vaccine to be re-labelled, allowing it

to be kept for a certain period of time outside the cold chain. Pushing pharmaceutical companies to re-label their vaccines for use outside the cold chain for even several days would be helpful for campaign and outreach programme vaccines.

This, however, is just the beginning as ultimately we need pharmaceutical companies to develop future products that prioritise thermostability, so that vaccines can be left out of the cold chain for at least a month.

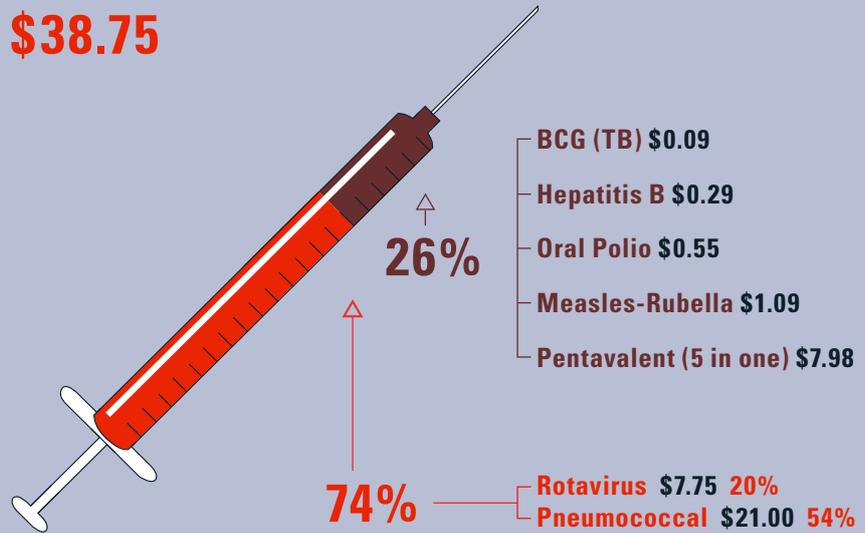
The cost of fully vaccinating a child has increased by 2,700 per cent since 2001, and humanitarian organisations and many countries are therefore finding it increasingly difficult to afford these essential health tools, and then there are the added problems of vaccines that require cold chain, and the complex logistics of a vaccination programme in remote areas. What MSF is witnessing in the field – children dying from vaccine-preventable diseases – is spurring us on to improve our programmes and to speak out about what changes the vaccine community needs to make. If we want to reach the 22 million children that go unvaccinated every year, GAVI, pharmaceutical companies and donors must work together. We need products that are better suited to the places where we work and to those who require them most, and we need access to them at the lowest prices.

WE NEED MORE AFFORDABLE VACCINES

Two New Vaccines Account For **74%** of the Cost to Vaccinate a Child

Total cost of vaccine package in a developing country:

\$38.75



UNICEF Vaccine Price Data: <http://uni.cf/mti97E>

All Measurements in US Dollars

Price per vaccine is based upon the WHO-recommended number of doses

Pentavalent vaccine protects against five diseases: Diphtheria, Tetanus, Pertussis, Hep B, Hib



© Ikram N'gadi/MSF

A number of vaccination campaigns took place this year, and nearly two and a half million people were vaccinated against measles in response to outbreaks.



© Yasuhiko Okuno

An MSF Community Testing Counsellor in Swaziland explains what HIV is, how it is transmitted and how it can be prevented.

ACTIVITIES BY COUNTRY

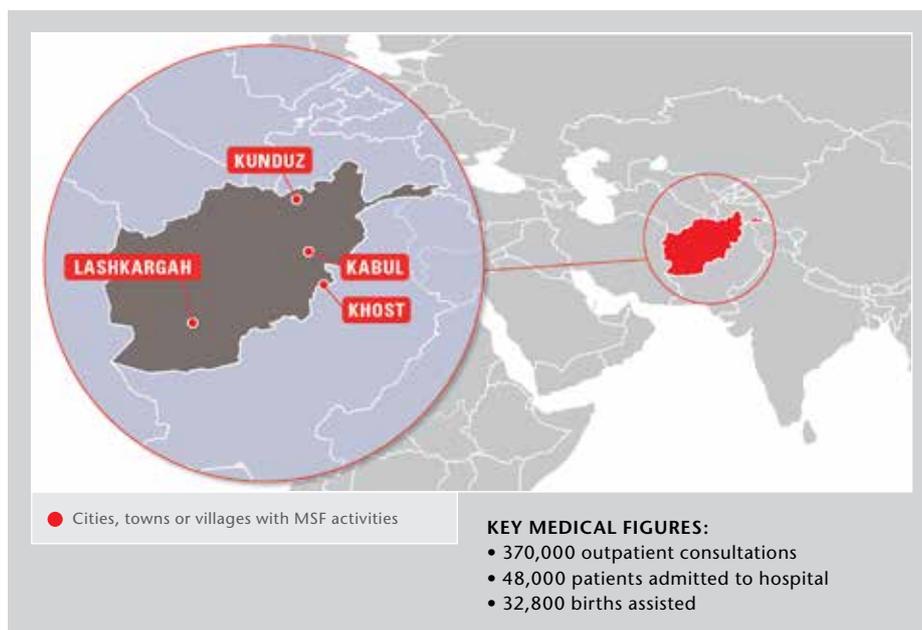
28	AFGHANISTAN	41	EGYPT	60	LEBANON	78	RUSSIAN FEDERATION
30	ARMENIA	42	DEMOCRATIC REPUBLIC OF CONGO	62	LESOTHO	79	SOUTH AFRICA
30	BOLIVIA	44	ETHIOPIA	63	LIBYA	80	SOMALIA
31	BANGLADESH	46	FRANCE	63	MADAGASCAR	82	SOUTH SUDAN
32	BULGARIA	46	GEORGIA	64	MALAWI	84	SUDAN
32	BURKINA FASO	47	GREECE	65	MALI	85	SWAZILAND
33	BURUNDI	47	GUINEA	66	MAURITANIA	86	SYRIA
33	CAMEROON	48	HAITI	66	MOROCCO	88	SIERRA LEONE
34	CAMBODIA	50	HONDURAS	67	MEXICO	88	TAJIKISTAN
34	CHINA	50	IRAN	68	MOZAMBIQUE	89	TURKEY
35	COLOMBIA	51	ITALY	69	MYANMAR	89	UKRAINE
36	CENTRAL AFRICAN REPUBLIC	51	LAOS	70	NIGER	90	UGANDA
38	CHAD	52	INDIA	72	NIGERIA	91	UZBEKISTAN
40	CONGO	54	IRAQ	73	PALESTINE	91	ZAMBIA
40	CÔTE D'IVOIRE	56	JORDAN	73	PAPUA NEW GUINEA	92	ZIMBABWE
41	DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA	57	KYRGYZSTAN	74	PAKISTAN	94	YEMEN
		58	KENYA	76	PHILIPPINES		
				78	PARAGUAY		

AFGHANISTAN

The number of people receiving critical medical care at Médecins Sans Frontières (MSF) hospitals has nearly doubled over the last two years, a clear indication of the medical needs in the country.

In 2013, the ongoing war and its consequences continued to restrict people's access to quality medical services – in particular to specialist healthcare.

Private clinics are unaffordable for most Afghans and many public hospitals are understaffed and overburdened. Many rural health clinics are dysfunctional, as qualified health staff have left the insecure areas, and the supply of reliable drugs and medical materials is irregular or non-existent. Insecurity can also prevent entire communities from travelling to hospitals. Afghanistan has some of the worst health indicators in the world according to the World Health Organization, and is still one of the riskiest places to be a pregnant woman or a young child. MSF focuses on ensuring people have better access to free, quality healthcare in some of the most conflict affected areas.



Ahmad Shah Baba hospital, Kabul

The number of people in Kabul has increased significantly as a result of migration, displacement and repatriation. In eastern Kabul, MSF has been upgrading Ahmad Shah Baba hospital to become a reliable district hospital, and has trained Afghan staff from the Ministry of Health

and MSF so that they can provide emergency and maternity services around the clock.

Major work completed in 2013 included a new waiting area, the relocation of the female outpatient department and the opening of a new maternity ward with 21 beds offering labour, delivery and post-delivery care. This year,



A woman delivers a baby via emergency caesarean section at the Ahmad Shah Baba hospital, Kabul.



© Robert Nickelsberg/Getty

At a clinic on the eastern outskirts of Kabul, Afghan men get their drug prescriptions filled.

staff assisted approximately 1,000 births every month. The hospital also provided treatment for malnourished children, admitting 500 children to the therapeutic feeding programme.

In January, MSF launched a mobile clinic to assist displaced people suffering as a result of Kabul's harsh winter. The team worked in six camps and conducted 2,000 consultations over a three-month period. From April, MSF operated mobile clinics in the Ahmad Shah Baba area to carry out antenatal and postnatal consultations, and vaccinations for children.

Trauma centre, Kunduz

In the northern province of Kunduz, the MSF trauma centre which opened in 2011 continued to provide free surgical care to victims of general trauma such as traffic accidents, as well as conflict-related injuries like gunshot wounds. As of this year, the hospital also admitted patients with moderate and severe head injuries. It was equipped in January with internal fixation facilities, and staff members were trained in the relevant medical protocols and techniques.

Extensive construction continued, and refurbishment of the old hospital building allowed the emergency room and operating theatres to be accommodated under one roof. More space was made available enabling better triage and treatment, and a third operating theatre was also completed. The outpatient and physiotherapy departments

were also moved into the building, facilitating access for patients returning for follow-up visits. More than 12,000 physiotherapy sessions were conducted during the year.

A mental health programme was launched in 2013 to provide psychological support to patients and families coping with traumatic events and bereavement. MSF also started health promotion activities in the hospital for patients and their caregivers.

The number of patients visiting the centre continued to increase. Staff treated a total of 17,000 people, about 10 per cent of whom were suffering from conflict-related injuries, and performed 4,500 surgical procedures, three times more than in 2012.

Khost maternity hospital

The 83-bed hospital in Khost is the only specialised maternity hospital in the area, and it aims to provide a safe and healthy environment for women to give birth. It focuses in particular on assisting with complicated deliveries and on reducing the high number of maternal and neonatal deaths in the province. Many patients travel long distances to access the free, high-quality care on offer. Staff assisted in the delivery of 12,000 babies and helped more than 2,000 women who had complications during pregnancy or labour.

The recruitment of qualified female medical staff in Khost has been a challenge. There is a general lack of skilled female medical staff

in Afghanistan and many qualified specialists prefer to live and work in the big cities. MSF international staff help fill the gap and also provide training.

Boost hospital, Lashkargah, Helmand province

An MSF team continued to support Boost hospital, one of only two functioning referral hospitals in southern Afghanistan, with surgery, internal medicine, and maternal, paediatric, intensive care and emergency services. The 250-bed hospital admitted an average of 1,300 patients monthly. A total of 66,000 patients were treated in the emergency room and 5,600 surgical procedures were performed.

Malnutrition remains one of the main causes of child mortality in Helmand province. The hospital's therapeutic feeding centre treated 3,200 malnourished children in 2013. Despite extensions in 2010 and 2011, the 90-bed paediatric ward overflowed with patients and approximately 200 children were admitted monthly. Following an evaluation of healthcare resources in the Lashkargah area, MSF decided to close the hospital's general outpatient department at the end of 2013, as basic health services were now available.

In February 2014, MSF published a report entitled *Between Rhetoric and Reality: The Ongoing Struggle to Access Healthcare in Afghanistan*, based on information collected in locations where teams operated in 2013.

ARMENIA



KEY MEDICAL FIGURES:
 • 119 patients under treatment for MDR-TB

arduous treatment. MSF has also helped implement infection control policies, measures and practices.

MSF worked with the Ministry of Health's programmes for DR-TB and nontuberculous mycobacterium infection (the same bacteria family but not classic TB) in Yerevan, Armarvir, Ararat, Shirak, Lori, Kotayk and Gegharkunik. A team also assisted the programme in Karabagh.

The National Tuberculosis Programme's 'compassionate use treatment' for patients with extensively drug-resistant TB (XDR-TB) was supported by MSF in 2013. As of December, 26 patients were receiving the treatment. Also this year, in a collaborative undertaking, a team of MSF and Ministry of Health TB pulmonary surgeons successfully operated on seven patients.

The MSF team aims to enhance the national programme's capacity to implement DR-TB response plans and enable the gradual handover of existing MSF activities in Armenia.



A member of the MSF flying TB surgery team examines a patient.

Armenia has one of the highest rates of drug-resistant tuberculosis (DR-TB) in the world.

TB has become a significant public health concern in Armenia. Since 2005, Médecins Sans Frontières (MSF) has been working in the country to improve diagnosis and treatment of DR-TB, and to support patients so that they can complete the

Tatev

17-year-old MDR-TB patient from Yerevan

At first, I had difficulty accepting that I needed to go to hospital, or that I had the disease even. I think most of all I was scared of taking the drugs. Maybe that's why I reacted as I did.

The first two days I took the drugs normally, but it got harder when I realised I would be taking them long term. It was a difficult period but I forced myself to believe the treatment would work, and that I would get rid of TB. That's my dream.

No. staff end 2013: 98 | Year MSF first worked in the country: 1988 | msf.org/armenia

BOLIVIA



Médecins Sans Frontières (MSF) handed over its Chagas programme in Aiquile after successfully establishing an integrated prevention, diagnosis and treatment strategy.

Chagas, a parasitic disease endemic in Latin America, is most commonly transmitted through the bites of infected *vinchuca* bugs, which are often found in cracks in the walls and roofs of rural adobe houses. The disease can be asymptomatic for many years, but if left untreated it may affect internal organs and can lead to heart failure and even death.

Treatment for Chagas in Narciso Campero province, where disease prevalence is estimated to be as high as 40 per cent, has always been difficult both geographically and financially. The majority of inhabitants

live in remote areas far from the urban hospitals and health centres that offer treatment, and which often charge a fee.

In 2009, MSF began an integrated Chagas programme in the communities of Aiquile, Omereque and Pasorapa. Working through community clinics and health centres, teams diagnosed and treated people aged one to 60 for Chagas, and trained local health staff. Significant efforts were made to raise awareness and the communities were involved in surveillance and control of Chagas through educational workshops, weekly meetings and a radio show.

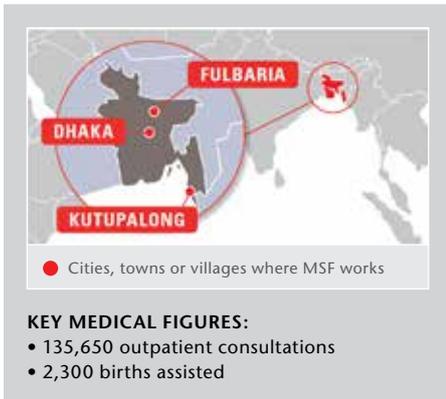
In September 2013, the project was handed over as planned to the Departmental Chagas Programme of the Ministry of Health and the province's Health Network Management. MSF is planning a new project in Aiquile, which will implement a sustainable treatment model that can be replicated in other locations.



In Bolivia, significant efforts are made to raise awareness of Chagas.

Year MSF first worked in the country: 1986 | msf.org/bolivia

BANGLADESH



People of the Rohingya ethnic and religious minority continued to cross into Bangladesh in 2013, fleeing severe discrimination and sporadic violence in Myanmar.

More than 200,000 Rohingya have escaped to Bangladesh from Myanmar over the past four decades and are losing hope of ever returning home. They suffer widespread discrimination, and as the majority are undocumented they are excluded from healthcare. At Cox's Bazar, Médecins Sans Frontières (MSF) continues to provide comprehensive medical assistance, including basic healthcare and maternal and mental health services, for both the host community and the 30,000 unregistered Rohingya in the makeshift camp at Kutupalong. The clinic also has a stabilisation unit for severely malnourished children, a small inpatient department and a diarrhoea treatment centre. MSF has an ambulance to transport severely ill patients to hospital for specialised treatment. More than 74,300 patients were treated at the clinic in 2013.

Dhaka, the capital city, has a population of 15 million. In Kamrangirchar, the city's largest slum, half a million people live on the bank of the Buriganga River, with very little access to the city's overstretched healthcare system. An MSF team runs a health centre in the slum, providing free, basic healthcare, and sexual and reproductive health services to young women.



Mothers and children waiting to be seen at the clinic in Kamrangirchar.

Many people living in the slum suffer from diarrhoea and skin conditions resulting from poor water quality and unhygienic living conditions. The MSF programme is therefore also developing a stronger focus on environmental health.

The project in Fulbaria treating primary kala azar began in 2010, and successfully introduced a treatment with liposomal amphotericin B. The project was handed over to the Ministry of Health in March this year, as they were in a position to manage it. MSF is currently awaiting permission from the ministry to start treating post-kala azar dermal leishmaniasis.

Emergency interventions

On 24 April, an eight-storey building housing garment factories that employed thousands of people collapsed in Savar, a subdistrict of Dhaka. Many of those who survived experienced symptoms of psychological trauma. An MSF team provided mental health support to 413 survivors and rescuers. MSF also gave psychological first aid to 28 people who had suffered burns from fire bombs thrown on public transport during pre-election violence in Dhaka on 12 December.

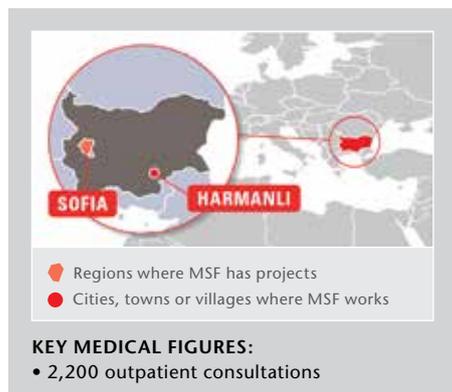
Noor

30 years old, brought her children to the MSF clinic in Kutupalong

I live with my husband and my five children in a house in the camp. We arrived five years ago from Myanmar because the situation was not good there. My three youngest children were all born here in the camp. The youngest was born in the MSF clinic nine months ago. Both mine and my husband's parents live in Myanmar so we are all alone and have to fend for ourselves. My husband can sometimes find work as a day labourer, as a rickshaw puller or carrying things, but sometimes this is difficult and then we do not have anything.

No. staff end 2013: 311 | Year MSF first worked in the country: 1985 | msf.org/bangladesh

BULGARIA



The sudden increase in refugee numbers in Bulgaria in 2013 led to overcrowding in accommodation centres, and a shortage of adequate healthcare.

More than 8,000 refugees, 70 per cent of them Syrians, crossed into Bulgaria this year and were transferred to various detention and reception centres. In November, Médecins Sans Frontières (MSF) began working in these centres, in close collaboration with the State Agency for Refugees, to respond to the humanitarian needs of the refugees. MSF has not worked in Bulgaria since 2005.

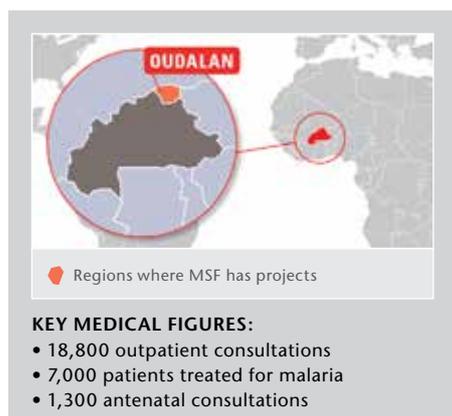
The influx of refugees resulted in pressure on the state system and a dramatic drop in standards of healthcare and hygiene at the centres. Vulnerable groups, including pregnant and breastfeeding women, children under five, patients with chronic diseases or mental health issues, disabled people and the elderly, needed to be identified on arrival and fast-tracked in order to guarantee them access to specialised care, food and suitable accommodation. During the cold winter months, MSF teams witnessed a lack of accommodation, electricity, bedding and

sanitation facilities. Medical care was also insufficient, with only emergency ambulance referrals to hospitals available. Consultations were provided on an ad hoc basis and there was no consistent supply of drugs.

Responding to the gaps in care, MSF started working in the Vrezdevna and Voenna Rampa centres in Sofia, and in Harmanli camp close to the Turkish border. Basic healthcare was provided, including antenatal care and midwifery. Mental health consultations were organised for those showing symptoms of psychological distress. Tools and procedures for medical and vulnerability screening were introduced, a system of access to healthcare was implemented and critical work to improve hygiene and sanitation was undertaken. MSF also ensured that services were available for those asylum seekers living outside the Vrezdevna and Voenna Rampa centres.

Year MSF first worked in the country: 1981 | msf.org/bulgaria

BURKINA FASO



The relocation of Malian refugees within Burkina Faso resulted in a reduction in Médecins Sans Frontières (MSF) activities in 2013.

The stream of Malians fleeing violence and attacks in their home country began in February 2012, and an emergency programme was opened by MSF to help meet their healthcare needs. Initially, most refugees gathered in camps near the Malian border, within the province of Oudalan. Later that year though, the Burkina government moved the camps further inland to ensure increased safety for the refugees.

At the beginning of 2013, due to deteriorating security in the Sahel zone, the authorities once again decided to relocate refugees. Within six months, 11,300 people who had been living in the camps where MSF was

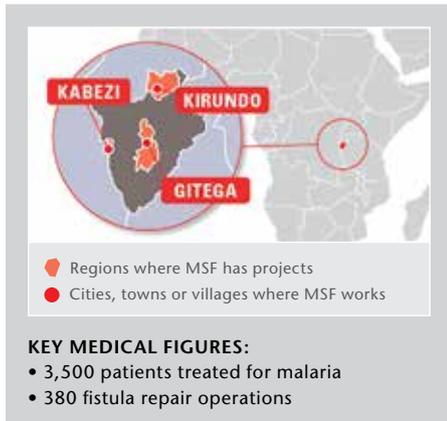
working – Ferrerio, Dibissi and Ngatourou-Niénié – had been moved to the inland camps of Goudoubo and Mentao. As a consequence, MSF scaled down its activities.

In April, MSF began a twice-weekly mobile clinic for people who remained in Dibissi camp, as well as the 6,200 residents in Gandafabou health district. The team provided basic healthcare consultations, vaccinations – primarily for tetanus and measles – and referrals to the hospital in Dori.

An estimated 43,000 refugees from Mali were present in Burkina Faso at the end of 2013.

No. staff end 2013: 91 | Year MSF first worked in the country: 1995 | msf.org/burkinafaso

BURUNDI



Improved access to emergency medical care in Burundi's rural Kabezi district has markedly reduced maternal deaths.

Women with obstetric complications in Kabezi had little access to appropriate healthcare until Médecins Sans Frontières (MSF) launched an emergency programme, the Centre for Obstetric Emergencies (CURGO), in 2006. Located in Kabezi hospital, the project offered free, high-quality emergency and surgical obstetric services. Referrals and ambulances were also provided so that women from 24 health centres were able to reach the CURGO, which admitted an average of 250 women per month in 2013.

After an MSF study in 2012 entitled *Safe Delivery: Reducing Maternal Mortality in Sierra Leone and Burundi* showed these efforts had reduced maternal deaths by 74 per cent, the team trained and coached Burundian medical staff, and handed the programme over to local authorities in 2013.

Providing fistula care

An MSF team continued to provide obstetric fistula treatment this year at the

Urumuri health centre in Gitega. Fistulas, a consequence of birth complications, cause not only pain but incontinence, which in turn often leads to social exclusion and sometimes rejection by friends and family. The package of care at Urumuri includes surgery, physiotherapy and social support, and is offered around the clock.

Malaria

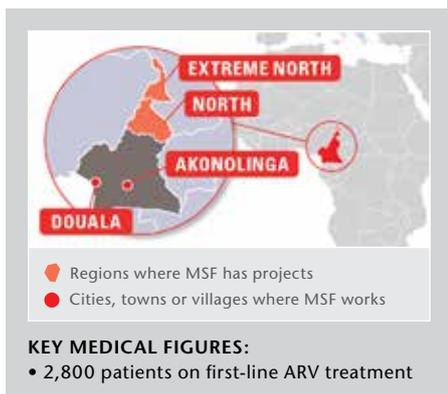
In 2013, MSF staff at the Kirundo malaria project continued to support 44 health centres and two hospitals with diagnosis and treatment of severe malaria.

Séverine an obstetric fistula patient

The MSF team welcomed me to the women's village. I feel good here; we dance together often. All the women here suffer from the same thing, and that helps us cope. I'm having the surgery in a week. I hope it will go well; I'm confident it will.

No. staff end 2013: 233 | Year MSF first worked in the country: 1992 | msf.org/burundi

CAMEROON



The centralised system and treatment costs pose barriers to healthcare for many people in Cameroon. Those with neglected diseases such as Buruli ulcer, seen mostly in rural areas, are particularly disadvantaged.

Buruli ulcer is a tropical disease that destroys skin and soft tissue, usually on a person's arms and legs. This can cause secondary infections, restrict their movement and cause permanent disability and scarring if left untreated. If the disease is detected early enough, the majority of patients can be cured with antibiotics, although surgery may also be necessary. It is still not known exactly how Buruli ulcer is transmitted. About half of those in Africa suffering from the disease are children.

People with suspected Buruli ulcer in Cameroon are examined and laboratory tests are performed. When positively diagnosed, they receive antibiotics, wound dressing, surgery and physiotherapy at the Buruli ulcer 'pavilion' run by Médecins Sans Frontières (MSF) in Akonolinga hospital. HIV testing is routinely offered to all patients; 12.5 per cent of people entering the programme during the year were found

to have HIV, nearly triple the estimated population prevalence. Those who test positive receive comprehensive care for both diseases. In total, the team treated 188 people with chronic wounds resulting from Buruli ulcer, applied more than 15,800 surgical dressings, admitted 48 new patients and carried out 78 surgical procedures.

Since November 2011, research has been underway to facilitate diagnosis of Buruli ulcer in those resource-limited countries where it has a high prevalence. The aim is to provide health professionals with an easy-to-follow diagnostic grid for identifying cases. The first phase of the study was completed this year, and in total 370 patients have been enrolled.

The HIV programme in Douala was handed over to the Ministry of Health in April, with tenofovir having been adopted as the first-line treatment.

No. staff end 2013: 79 | Year MSF first worked in the country: 1984 | msf.org/cameroon

CAMBODIA



● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

- 1,150 patients under treatment for TB

The prevalence of tuberculosis (TB) in Cambodia is one of the highest in the world, with more than 0.8 per cent of the population already infected and more than 60,000 people newly infected every year.

Fewer than 20 per cent of the people in Cambodia infected with TB are diagnosed each year, and as a result of this mortality rates

are very high. It is therefore essential to find new methods for better and earlier detection. In 2013, the TB department of Kampong Cham provincial hospital became fully operational, and offered detection, diagnosis and comprehensive care for TB patients and those suspected of having the disease, whether it was drug-sensitive, complicated or drug-resistant (DR-TB). People from around the province come to the hospital for testing. MSF also supports the diagnosis and follow-up of TB patients in Choeung Prey district. In Tboung Khmum district, MSF is aiming to screen all inhabitants aged over 55.

In Phnom Penh and Kandal provinces, MSF worked with a local organisation, the Cambodia Health Committee, and the national programme CENAT to treat 20 DR-TB patients and will continue to provide follow-up until they finish their treatment. Thanks to this collaboration, MSF monitored almost half of the diagnosed DR-TB patients in Cambodia in 2013.

Malaria in Preah Vihear district

MSF carried out a baseline survey this year, looking at the percentage of inhabitants in the district with the *Plasmodium falciparum*



Participants of the PCR Detection Rate Study being registered.

strain of malaria in their blood and more specifically at artemisinin resistance. In 2014, a project with a specific treatment protocol will be developed with the aim of demonstrating that artemisinin-resistant malaria can be eliminated.

Handover of prison project

MSF started working in two Phnom Penh prisons in 2006, in response to high HIV mortality rates. At the end of June 2013, the TB and HIV projects were handed over to two national programmes and other local partners as a result of improvements in care and the implementation of a long-term approach.

No. staff end 2013: 159 | Year MSF first worked in the country: 1979 | msf.org/cambodia

CHINA



● Regions where MSF has projects

People living with HIV/AIDS in China face difficulties accessing the necessary care.

Although the prevalence of HIV in China is low, providing an adequate response to people needing treatment remains a challenge. China initiated the 'Four Frees and One Care' policy in December 2003, providing HIV counselling and testing, antiretroviral treatment, prevention of mother-to-child transmission and schooling for children orphaned by AIDS, all free of charge, but many people with the disease have not benefited from these measures. According to the Ministry of Health, some regions and departments are not sufficiently concerned with HIV, and there is still widespread discrimination and stigma.

A Chinese NGO, Aids Care China (ACC), is developing quality care and treatment through private clinics, hoping to show the impact this can have on people's health

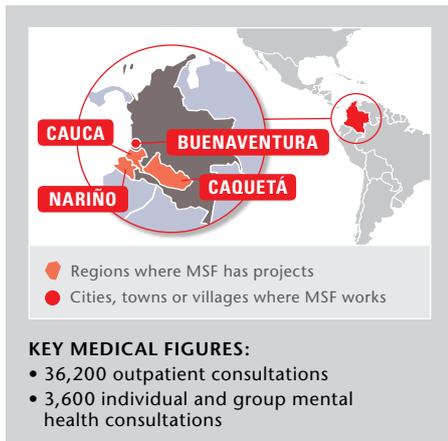
and influence reforms that will make care more widely available. In October 2011, at the request of ACC, Médecins Sans Frontières (MSF) started supporting a clinic near the China–Myanmar border in Jiegao, Yunnan province, where there are high numbers of Chinese and Burmese injecting drug users with HIV or HIV–TB and HIV–hepatitis C co-infection. In September, a four-person MSF team began providing medical expertise and staff management under a one-year agreement.

Flooding in Guangxi

In August, more than 127,000 people were affected by flooding and a landslide in Guiping, Guangxi province. MSF distributed hygiene kits, buckets, plastic sheeting and mosquito nets to 950 households.

No. staff end 2013: 5 | Year MSF first worked in the country: 1989 | msf.org/china

COLOMBIA



The testimonies of 4,400 Médecins Sans Frontières (MSF) patients revealed that 67 per cent of people in Colombia seeking mental health support had experienced at least one violence-related event.

The Colombian armed conflict has inflicted a heavy toll on people's health. In addition to the historic confrontation between the military and FARC and ELN guerrillas, new paramilitary groups and drug-trafficking cartels have appeared in recent years, creating different dynamics of violence. Most armed activity is registered in the southern departments of Caquetá, Cauca, Putumayo and Nariño, where civilians witness massacres and are subjected to threats, extortion, displacement, injuries caused by mines, torture, sexual violence, forced recruitment and other human rights violations.

Medical and psychological support is critical in such a context, yet healthcare access in these geographically remote areas is limited. MSF has a long-standing programme of mobile clinics and health posts to provide healthcare and mental health consultations to people in need. Basic medical care, a referral system for emergencies, sexual and reproductive health services including family planning, antenatal care, immunisations and check-ups for children and all available.



As part of MSF's support of the national TB programme in Buenaventura, a couple receive health education in their home.

In July, MSF published *The Less Visible Wounds: Mental health, violence and conflict in southern Colombia*, a report based on the testimonies of patients treated in the mental health component of the above programmes in 2012. The report drew attention to the debilitating effects of the violence and the fact that people caught up in armed conflict and other forms of brutality lack critical state support to address their psychological needs.

Focus on tuberculosis (TB)

TB has emerged as a major public health concern, particularly in the crowded seaport of Buenaventura, where 9.5 per cent of new cases are found to be drug-resistant. MSF works in two health facilities, and teams oversee an additional 15 medical stations. In 2013, 218 drug-sensitive TB patients began treatment, and 47 patients were included in the programme for drug- and multidrug-resistant TB.

In addition to providing support to the national strategy for TB detection and treatment, MSF started advocacy initiatives and discussions with partners and authorities to introduce bedaquiline as a treatment for patients with extremely resistant forms of the disease. Workshops and negotiations are ongoing.

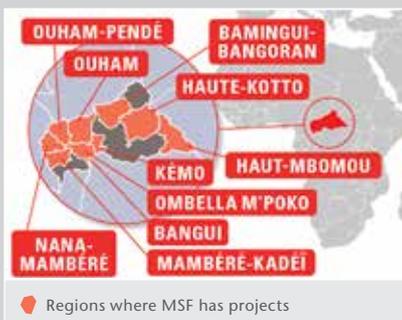
Programme closures

In February, given improvements to the health system in the area, MSF closed a project focused on reproductive healthcare in Buenaventura. In December, activities in rural Nariño were handed over to local health institutions due to better availability of healthcare.

A 50-year-old displaced woman from Cauca describes how her family has changed as a result of violence.

I haven't been able to sleep in several nights; I have dreams where I see the faces of my neighbours. I see them crying, pleading, asking for mercy. I wake up crying. I start thinking about our farm, about my plants in the garden, about my hens, and the cattle, and my dogs that wanted to come with us but that we had to scare away with stones so that they wouldn't follow us. I have never felt like this. I have never seen my husband so quiet; I have never seen him mourn in silence. And what can I say about my son? The boy is not the same as he was. Now there is no tenderness in his eyes; there is only anger and hatred.

CENTRAL AFRICAN REPUBLIC



KEY MEDICAL FIGURES:

- 816,300 outpatient consultations
- 3,300 surgical interventions
- 24,300 measles vaccinations

Escalating and extreme violence in the Central African Republic (CAR) over the year resulted in a massive, acute humanitarian crisis in addition to an existing chronic medical one.

For over 20 years, the small landlocked country of CAR has witnessed many political and military crises. Continual population displacement caused by pockets of armed conflict, combined with a poorly resourced,

dysfunctional healthcare system, prevents people from obtaining the treatment they need. Many die from easily preventable and treatable illnesses such as malaria, respiratory infections and diarrhoeal diseases. Prior to the current conflict, mortality rates in some regions were up to five times the emergency threshold.

In response to this chronic medical crisis, Médecins Sans Frontières (MSF) was providing basic healthcare through seven comprehensive projects – at Batangafo, Boguila, Carnot, Kabo, Ndélé, Paoua and Zémio – when the current emergency began to unfold. Despite some interruptions due to insecurity, these projects have adapted and continue to provide medical care to people in the communities, and to respond to localised emergencies caused by population displacement. Teams offer basic and specialist healthcare, mental health consultations, maternity, paediatric and nutritional services, surgery and HIV and tuberculosis (TB) care.

When 2013 began, the rebel group Séléka had recently seized several strategic towns, and in March they took the capital Bangui, leading to a presidential coup and the gradual destabilisation of the country over the course of the year. Increased tensions and violence, including assaults on civilians, spread into previously peaceful areas. In early September, armed self-defence groups, the 'anti-balakas', started to attack Séléka forces and civilian populations in the northwest.

Throughout this period, MSF provided free medical care to people wounded in attacks or displaced by violence. Mobile clinics were launched and teams supported government healthcare facilities, providing emergency aid to people wounded in attacks or in need of medical attention. Additional activities were started to ensure access to clean drinking water and improve hygiene for the displaced population.



Violence in Bouca forced many people to leave their homes, which were later destroyed, and seek refuge where they could.



© Juan Carlos Tomasi/MSF

Thousands of Bangui residents took refuge in M'poko airport in 2013, setting up a makeshift camp.

Short-term emergency projects opened and closed in the first half of the year in Damara and Sibut, supporting outpatient services at local hospitals. The Damara team also offered treatment to people who had temporarily fled into the bush. More than 12,800 consultations were carried out through these projects. Emergency projects also opened in 2013 in Bangui, Bouca, Bossangoa, Bria, Sibut, Damara and Gadzi, and emergency medical teams visited Yaloke and Bouar. Emergency surgery and basic healthcare were available for the wounded, and teams regularly treated patients for malaria, respiratory and skin infections, diarrhoeal diseases and malnutrition.

Beginning in December, violence and chaos took hold in Bangui. Despite the arrival of international forces in the capital, there were daily clashes, attacks, lynchings and reprisals. In the first two weeks of that month alone, the UN estimated that some 214,000 people were displaced by the conflict. Hundreds of thousands of people fled their homes and gathered in camps including Bangui airport (100,000 people), the monastery of Boy-Rabé (15,000) and the Don Bosco Centre (15,000).

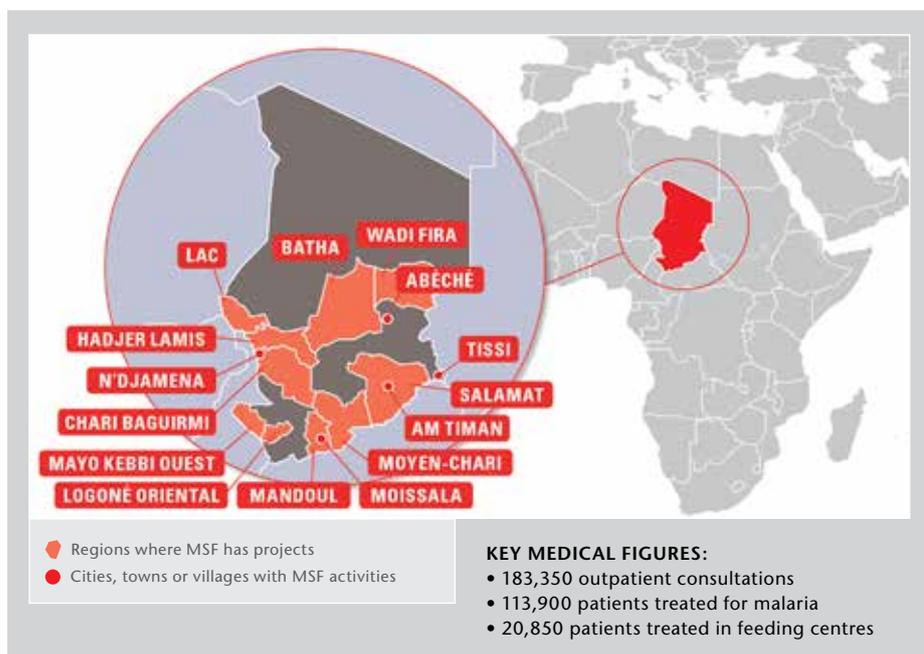
Living conditions were, and still are, deplorable. With hardly any other organisations providing emergency assistance, MSF undertook extensive work to ensure a clean water supply, basic standards of hygiene and human waste disposal: at the Don Bosco site, a team dug 20 emergency trench latrines and provided 30 cubic metres of water a day. They later built 150 latrines there, and a further 350 latrines in M'Poko airport camp. In addition, MSF ran a water treatment plant that produced 600,000 litres of clean drinking water per day and also distributed relief supplies to the displaced population of Bangui. MSF medical staff provided trauma surgery and basic health consultations. However, the basic needs of the displaced people in CAR remained unmet as there was insufficient mobilisation by other humanitarian organisations. At Castor health centre in Bangui, surgeons responded to 465 trauma cases in just three weeks. MSF also supported a Ministry of Health measles vaccination programme.

MSF repeatedly spoke out, asking that all parties involved in the conflict allow access to medical care for the sick and wounded and calling for an end to the violence against civilians, and patients and staff in healthcare facilities. MSF also denounced the lack of mobilisation of UN humanitarian agencies and called for the deployment of more means and resources – from the UN and other aid organisations – to provide an appropriate response to the extensive human needs. Towards the end of the year, MSF had more than 250 international and 2,500 Central African staff providing free medical care to approximately 600,000 people in seven hospitals, two health centres and 40 health posts. At the time of writing, MSF is the largest employer in CAR.

By year's end it was estimated that over 700,000 Central Africans were displaced inside CAR and that a further 75,000 had crossed into neighbouring countries.

No. staff end 2013: 1,631 | Year MSF first worked in the country: 1996 | msf.org/car

CHAD



Although the Chadian government has promised to increase investment in healthcare, the quality of care and health indicators are still poor, particularly for rural communities, children and refugees.

The mortality rate for children under five is high, and routine vaccination coverage is low. People often die from malnutrition and preventable diseases such as malaria and cholera, and disease epidemics are recurrent. Instability in the surrounding countries also means Chad is host to a high number of refugees. In 2013, some 60,000 new refugees arrived in the country, with urgent needs for basic and specialist medical care.

Focusing on malaria

Malaria, a mosquito-borne disease, is one of the main causes of death for children under five, but deaths can be prevented with simple measures such as the use of mosquito nets, preventive medicine and early detection and treatment.

For the past few years, teams from Médecins Sans Frontières (MSF) have worked on preventing and treating malaria in the Moissala and Bouna districts, Mandoul region. Teams focused on children with severe and complicated cases of the illness in Moissala hospital's

malaria unit. MSF also supported health centres and community health workers in rural areas with drug supplies and staff. Seasonal Malaria Chemoprevention – the distribution of antimalarials as a prevention strategy – was organised for children under five and pregnant women during the high season (July to October). The strategy had previously proven effective in reducing the number of people developing severe malaria. In 2013, prophylaxis was distributed to 53,000 children and teams recorded an overall reduction in malaria of 60 per cent in Moissala when compared to the previous year.

At Massakory hospital, Hadjer Lamis region, where MSF provided support in paediatric care, teams treated 36,600 patients during an acute peak in malaria cases between July and December. Children also received treatment for malnutrition in the hospital and surrounding health zones. A large water sanitation campaign for people's homes was launched to help prevent outbreaks of diarrhoea. This activity currently reaches 900 families in 20 villages.

From August to October there was an emergency intervention in response to high levels of malaria in the Salamat region. Based at Am Timan hospital, outreach activities expanded to ensure people in remote areas of the district could get the medical care they needed. An MSF team in Am Timan hospital also continued to provide basic and specialist care with a focus on women and children. Reproductive healthcare, emergency obstetric care and treatment for tuberculosis and HIV, including prevention of mother-to-child transmission of the virus, was offered. Teams carried out 5,280 outpatient consultations, assisted 1,895 births and tested 2,050 people for HIV. A paediatric nutrition programme based at the hospital and in nine outreach sites admitted 9,990 children for treatment. Six of these outreach sites were handed over to the Ministry of Health at the end of the year.

Providing assistance to Sudanese refugees

Renewed clashes in Darfur, Sudan, led to an influx of refugees in the Tissi area of Chad early in the year. MSF launched activities in Tissi town, establishing an emergency room to treat victims of violence, a health centre



A child being vaccinated as part of expanding coverage for displaced people.



An MSF nurse stabilises a patient in Tissi hospital prior to his evacuation to Abéché. Renewed clashes in Darfur early in the year resulted in an influx of Sudanese refugees.

in Ab Gadam camp, and a health post in Um Doukhum. People were suffering mainly from malaria, respiratory tract infections, diarrhoeal and skin diseases, and malnutrition. The team carried out 52,820 outpatient consultations and treated 10,400 people for malaria. MSF provided clean drinking water and built latrines to improve basic hygiene in Ab Gadam camp. In Goz Beida, a team carried out basic healthcare consultations, provided access to drinking water and distributed relief supplies such as blankets and washing kits to improve living conditions.

Extensive vaccination campaigns

Without routine vaccinations, children are at greater risk of infection, and the consequences can be fatal if they are also malnourished. MSF has been involved in expanding routine vaccination coverage in collaboration with the Ministry of Health, and organises vaccination campaigns

for displaced people and in response to outbreaks of disease. There were three measles vaccination campaigns in 2013, reaching 257,000 children in Ouaddai region in May, and 102,000 children in Guéréda and 68,100 children in Iriba in September.

Beginning in February, a vaccination campaign was carried out in Goz Beida for an outbreak of yellow fever, a mosquito-borne viral disease that can cause severe liver disease and death. A total of 161,300 people were vaccinated. In Salamat region, outbreaks led MSF to vaccinate 12,250 people against measles and 26,800 against meningitis.

Responding to emergencies

Following flooding in Maro, Moyen-Chari region, MSF provided assistance to refugees from Central African Republic living in Yaroungou and Moula camps, carrying out 12,200 basic health consultations, and offering nutritional support to 2,630 children,

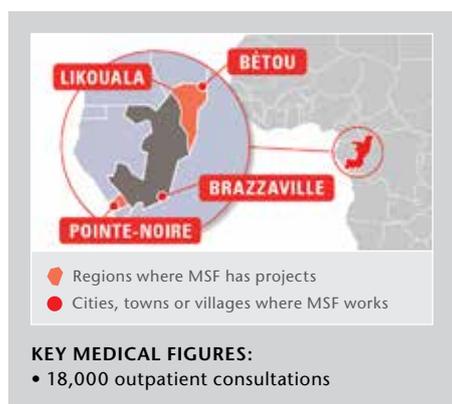
as well as immunisations. In August, assistance was also provided to refugees in Koldaga and Moissala.

Programme handovers

An MSF programme started in 2008 in Abéché provided medical, rehabilitative and psychosocial care to women with obstetric fistulas. Fistulas, a consequence of birth complications, cause not only pain but incontinence, which in turn often leads to social exclusion and sometimes rejection by friends and family. The programme handover to the Ministry of Health began at the end of 2013. The 45-bed *village des femmes* had welcomed around 850 women in total, and patients had benefited from rehabilitative surgery and post-operative care.

An emergency nutrition programme in Bokoro, Hadjer Lamis, was handed over to the health ministry in February.

CONGO



More than 36,000 refugees were repatriated from Congo to their home province of Équateur, Democratic Republic of Congo (DRC), in April.

In 2009, Médecins Sans Frontières (MSF) opened an emergency programme to meet the medical needs of refugees and the host community in Bétou district, Likouala, by expanding and strengthening services in Bétou hospital and health centres in the area. Some 450 patients were admitted to the hospital per month, and between November 2012 and May 2013, 9,800 people were treated for malaria alone.

As many children were suffering from preventable diseases such as tetanus, polio and measles, 13 teams carried out a district-wide, door-to-door vaccination campaign between December 2012 and May 2013, providing 97,500 vaccinations. With the improvement of the security situation in DRC and subsequent repatriation, MSF closed the Bétou project in June. The team had also worked with health authorities

to improve national control programmes against tuberculosis, HIV, leprosy and yaws.

Yaws treatment

Yaws is a contagious but treatable bacterial infection that causes skin lesions and can lead to disfigurement and disability. In the rainforest of northern Congo and in Bétou district, where yaws is endemic, MSF carried out a second round of treatment in April and May, targeting Aka pygmies in remote areas who had not received treatment in the first round.

Cholera emergency response

The cholera emergency response that began in Pointe-Noire in November 2012 was completed in May. In addition to opening a cholera treatment centre in Loandjili hospital and five rehydration centres, MSF trained medical staff and helped authorities implement preventive measures.

Year MSF first worked in the country: 1997 | msf.org/congo

CÔTE D'IVOIRE



Médecins Sans Frontières (MSF) has closed the last of its emergency programmes launched to meet healthcare needs during the Ivorian post-electoral crisis of 2010–2011.

Overall, the security situation has stabilised and 2013 was declared 'the year of health'. However, although there has been an increase in investment in healthcare, gaps persist, due to a lack of qualified staff and outdated technologies.

Teams from MSF gradually ceased activities that were originally set up to address the needs of people displaced during the 2011 armed conflict. Only the programme in Taï, along the border with Liberia, which consisted of support to the Ministry of Health teams in outpatient, paediatric and maternity services in a 20-bed hospital, continued until the end of March. A total of 27,338 consultations were carried out.

Work undertaken by teams in Duékoué and Abobo during the crisis resulted in a need for lifesaving maternal healthcare being identified. Women generally deliver their babies at home with traditional birth attendants and without effective emergency obstetric care when there are complications. This results in unnecessary suffering and the death of mothers and babies.

MSF is preparing to open a mother and child health programme with the Ministry of Health in Hambol region in 2014. Care will be provided for complicated deliveries, and antenatal and neonatal emergencies at the hospital in Katiola.

No. staff end 2013: 74 | Year MSF first worked in the country: 1990 | msf.org/cotedivoire

DPR KOREA



After developing an agreement with the government in May, Médecins Sans Frontières (MSF) opened a programme in the Democratic People's Republic of Korea (DPRK).

Medical assistance is not considered a top priority in DPRK and most help is steered towards self-sufficient food production, food aid and disease prevention strategies. Only a few international aid organisations are present in the country, and these face restrictions on their movements and on free access to patients.

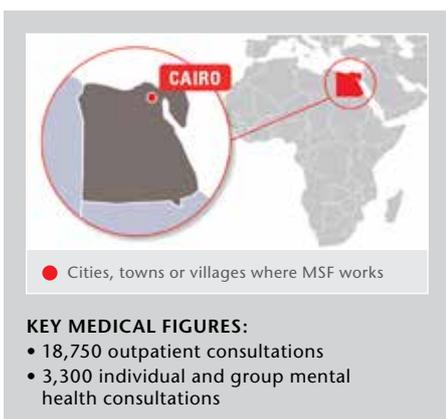
In this context, MSF has employed an adapted approach. After a long absence, MSF started working in the country again in 2012, and from the beginning of 2013, made visits on a regular basis to upgrade some medical practices related to mother

and child health in the district hospital of Anju, South Pyongan province. A memorandum of understanding was signed in May, outlining the framework of the collaboration between the government and MSF, and MSF's activities in the country.

In February, a team travelled to DPRK to start updating the medical knowledge of staff through training. The first module covered was 'Management of dehydration and shock among children', and then in June the team returned to complete the second training module, 'Life support in obstetric services'. In October, the third module, 'Management of malnutrition, respiratory and neurological diseases among children', was completed. The drugs and medical materials related to the modules were provided during each visit, as well as food for the hospitalised patients, their caregivers and the hospital staff. Follow-up monitoring and supervision was carried out during field visits.

No. staff end 2013: 5 | Year MSF first worked in the country: 1995 | msf.org/dprk

EGYPT



Migrants and people living in remote areas of Egypt have difficulty accessing medical services.

At Abu Elian clinic, on the outskirts of Cairo, Médecins Sans Frontières (MSF) offers healthcare to mothers and children under five. In 2013, an average of 1,700

consultations were carried out each month; 70 per cent of patients were young children suffering from respiratory tract infections, intestinal parasites, skin diseases and diarrhoea. MSF also provides transport and covers hospital costs for pregnant women in the clinic's 24-hour emergency referral system.

Assistance for vulnerable groups

Many migrants and refugees living in Egypt are victims of violence. In 2013, MSF continued to offer mental healthcare (742 new patients, 2,530 follow-up sessions) and treatment to victims of sexual violence (305 new cases, 960 follow-up sessions) at the Nasr City mental health clinic in Cairo.

Expanding treatment for hepatitis C

There is a very high prevalence of hepatitis C in Egypt; it is estimated that around 12 per cent of the general population are infected. For the last two years, MSF has been in discussions with the National Committee for Viral Hepatitis about a

hepatitis C project aiming to improve patient adherence to treatment by decentralising their medical care. In rural areas in particular, overcoming cost and distance could markedly improve patients' cure rates. Approval was received in early 2014 to launch the first phase of the project in Fayoum governorate, south of Cairo.

Winter relief and medical training

During the especially harsh 2013–2014 winter, MSF teams in Cairo and Alexandria supported vulnerable families who had been identified by local health partners, providing medical and psychiatric consultations and distributing washing kits and blankets.

MSF also trained a number of volunteer Egyptian doctors in Cairo, including some Egyptian Ministry of Health personnel, so that they could respond quickly and effectively to medical needs on the spot during demonstrations. Training included how to deal with large numbers of wounded.

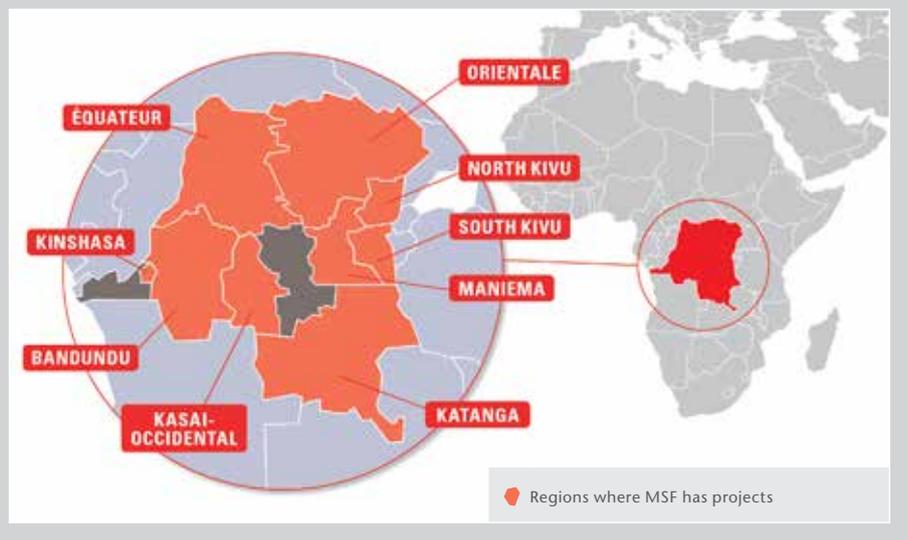
No. staff end 2013: 85 | Year MSF first worked in the country: 2010 | msf.org/egypt

DEMOCRATIC REPUBLIC OF CONGO

KEY MEDICAL FIGURES:

- 1,654,100 outpatient consultations
- 106,600 patients admitted to hospital
- 1,223,300 measles vaccinations (outbreak)
- 10,900 patients treated for cholera

Owing to a dysfunctional health system, people in Democratic Republic of Congo (DRC) lack basic healthcare, and in 2013 suffered numerous, preventable outbreaks of cholera, malaria and measles. The conflicts in the eastern provinces were also ongoing, displacing thousands.



Decades of conflict, lack of investment in the healthcare system and ongoing violence cause extreme hardship. Humanitarian aid is concentrated around big cities and places that are considered secure, but there is a need for a rapid, flexible humanitarian response to acute needs throughout the east of the country. Teams from Médecins Sans Frontières (MSF) are working to increase the availability of healthcare and respond to health emergencies.

While on an exploratory mission in July, Chantal, Philippe, Richard and Romy, four Congolese MSF staff, were abducted by an armed group during an attack on Kamango, North Kivu. At the time of writing, a dedicated team is still actively searching for them.

In 2013, measles epidemics continued to proliferate. Some health zones were overwhelmed by the number of cases, and MSF launched emergency campaigns, vaccinating more than 1.2 million children aged between six months and 15 years.

North Kivu

A health centre in Mugunga III camp for displaced people provided basic healthcare, dressings and aftercare for victims of sexual violence, carrying out more than 41,800 consultations and treating some 840 people for injuries resulting from sexual violence. A team focused on cholera prevention and treatment in Goma treated 1,660 patients. Displaced people at spontaneous sites around Bulengo also received healthcare from MSF, including psychosocial support for victims of sexual violence wanting to take legal action.

In the hospital in Rutshuru territory – a region controlled by M23 rebels until they were forced to pull out in October – MSF continued to offer comprehensive healthcare, including surgery, intensive and emergency care, and treatment for victims of sexual violence. More than 7,600 surgical procedures were performed during the year.

In Masisi, MSF provides full support to the general hospital (internal medicine, surgery, gynaecology, maternity services, paediatrics and neonatology) and to two health centres in Masisi and Nyabiondo. There is a 76-bed maternity village for women in their third trimester of high-risk pregnancies. MSF also works with community advisors to counsel victims of sexual violence. Until June, healthcare was provided to people in Rubaya camp and to the host population.

Comprehensive healthcare is provided at Mweso hospital, with psychiatric services integrated into the basic healthcare programme. The nearby Kitchanga project closed mid-year. The mental health and sexual violence programmes were absorbed into the Mweso-based project, which also took over activities in Mpati and Bibwe. Other activities were handed over to Merlin. Security incidents caused the suspension of the Mweso project twice in 2013, but the teams at Mweso hospital provided more than 140,000 consultations, carried out more than 1,300 surgeries and assisted more than 4,500 deliveries.

Basic healthcare, including the prevention of, and response to, epidemic outbreaks,

and integrated psychosocial care were provided in Pinga. A security threat caused the suspension of the project there in July and activities had not resumed by year's end. More than 34,389 outpatient consultations, 5,100 consultations for malaria and over 900 mental health sessions had been conducted in Pinga.

In March, an emergency measles vaccination campaign in Vuhovi reached more than 51,000 children.

South Kivu

South Kivu hosted more than 800,000 displaced people in 2013, most of them in the Kalehe and Shabunda territories, where MSF provides basic and specialist healthcare in Kalonge, Shabunda and Matili hospitals and in 15 health centres in the surrounding areas. MSF supports a hospital and three health centres in Minova, an area regularly affected by conflict and influxes of displaced people, and conducts mobile clinics to assist victims of violence.

In Fizi territory, MSF provides comprehensive basic and specialist healthcare, including surgery, reproductive health services, neonatal treatment, prevention of mother-to-child transmission of HIV, tuberculosis and cholera treatment, vaccinations, nutritional support and sexual violence aftercare at Baraka and Lulimba hospitals and six health centres. In addition, MSF supports two permanent cholera treatment centres (CTCs). A new 100-bed hospital was also built in Lulimba.



© Colin Delfosse

A resident of Rubaya camp in Masisi, North Kivu, looks out over the makeshift tents.

MSF emergency teams responded to a number of outbreaks of malaria, measles, rabies and cholera in South Kivu. Six cholera interventions were carried out in the province, more than 160,000 children were vaccinated against measles, and in Lemera over 100 people were vaccinated against rabies. During the malaria outbreak, 64,000 patients were treated in Fizi and 43,000 in the isolated Shabunda area.

More than 565,000 outpatient consultations were completed in South Kivu in 2013.

Katanga

Those in Katanga province receive very little humanitarian aid and suffer from a lack of quality health services and fees they cannot afford. MSF treats children in the paediatric unit of Kabalo hospital and 15 peripheral health centres, mainly for malaria. As a result of a measles outbreak in Kabalo, MSF provided hospital treatment and undertook a targeted vaccination campaign. When a nutritional survey indicated extensive malnourishment, one inpatient and three outpatient feeding centres were opened.

In April, MSF completed a cholera intervention in Lubumbashi that had begun the previous November. The team built an 80-bed CTC and treated a total of 5,904 patients.

Comprehensive health services continued in Shamwana and the surrounding area. Teams responded to cholera outbreaks in Kaiseng and Lukanzola and vaccinated over 150,300 children against measles in Moba.

A project in Kalemie aimed at reducing cholera was suspended in November after two consecutive attacks on MSF. A cholera vaccination campaign was also cancelled.

Oriente

In Geti, South Irumu, MSF continued to support the health centre and provided 59,567 consultations, an increase of 41 per cent on the previous year. Violent clashes between government and rebel forces in August caused massive population displacement in the area, and from September, MSF supported the maternity unit and operating theatre of Geti hospital to guarantee adequate healthcare for an increasing number of patients. During this time, teams assisted 726 births and operated on 106 trauma patients with conflict-related injuries. MSF also ran two mobile clinics, improved water and hygiene for displaced people, distributed 10,000 relief kits and conducted two measles vaccination campaigns, reaching a total of 42,567 children under 15.

MSF continued to work in the emergency department at Dingila hospital, and with Ministry of Health staff, screened and treated people for sleeping sickness at Ganga-Dingila and Ango, Bas-Uélé. Some 73,336 people were screened and 1,358 received treatment.

During an outbreak of measles in Bas-Uélé, MSF treated 30,200 patients in the health zones of Ganga-Dingila, Buta, Aketi, Bondo, Likati, Titule and Poko, and vaccinated

189,000 children in the health zones of Ganga-Dingila, Buta, Aketi, Bondo and Likati.

Kinshasa

The HIV programme based at Kabinda hospital has been increasingly decentralised and a community-based programme manages the distribution of antiretroviral (ARV) medication to stabilised patients. More than 5,500 patients are on treatment.

Popol 52 years old

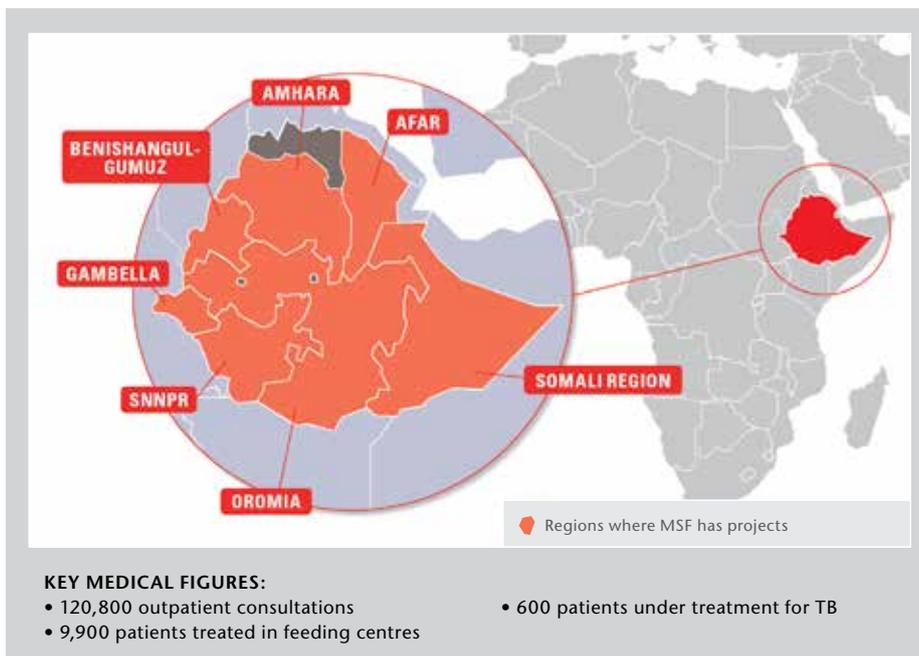
I did not want to tell anyone about my HIV status. After the screening, I had to start treatment, US\$200 treatment. But I had no money, not even US\$10. A doctor referred me [to MSF] for free care.

I am a salesman in a store; this is how I feed my wife, my daughter and my son. I was already working in this shop before, but I was sick all the time, I was no longer useful. So I was fired. I stayed at home. When I started ARVs, gradually I regained my health. But I had nothing to eat. A friend advised me to go to my ex-boss and explain. I told him that I was sick with HIV, but that I was taking the free drugs and had regained strength. The boss thought it brave that I came to talk to him like that, and gave me my job back.

ETHIOPIA

Nomadic people, refugees, people in conflict-affected areas and those located in the remotest parts of Ethiopia lack access to health services.

Responding to the lack of medical services for pregnant women and young children, Médecins Sans Frontières (MSF) runs a programme focused on maternal and child health in Sidama, Southern Nations, Nationalities and People's Region (SNNPR). People are seen at Mejo and Chire health centres, and through outreach activities in 15 locations. A maternity waiting home offers women with high risk births a place to stay for one to two weeks before delivery, so that they are close to emergency obstetric services. In 2013, the team provided 10,460 ante- and postnatal consultations, assisted 800 deliveries and vaccinated 19,260 children. The inpatient department saw 3,000 patients.



In Teru Woreda, Afar, which is affected by an ongoing drought, MSF provided medical care to 1,880 children.

Visceral leishmaniasis, or kala azar, a parasitic disease transmitted by the bite of an infected sandfly, is endemic and sometimes epidemic in Ethiopia. In Abdurafi, Amhara region, MSF provides treatment for people with kala azar and HIV/AIDS, and for those co-infected with tuberculosis (TB). MSF completed the handover of patients with simple HIV to the Bureau of Health in 2013. The Abdurafi programme also offers nutritional support for patients and treatment for malnourished children under five.

Filling healthcare gaps in Somali region

Underdevelopment, a shortage of qualified senior health workers and conflict between government forces and armed anti-government groups all pose barriers to healthcare in the Somali region. In Degehabur, MSF supported the regional hospital with emergency obstetric services, mental healthcare, assistance for victims of violence including sexual violence, treatment for malnutrition and TB. Basic healthcare was provided through mobile clinics in Birqod, Ararso and Degehabur woredas. Teams carried out 3,460 antenatal consultations and enrolled 960 children in nutrition programmes. Mental health activities, including counselling and therapy groups, were attended by 890 people, and 430 patients began TB treatment. A fully equipped 35-bed ward was built to provide better care for children requiring hospitalisation. Drugs and materials for the management of health activities were also provided. Improvements were made in water quality and supply in MSF-supported health facilities and a team completed a measles vaccination campaign with the Bureau of Health.

In the Wardher area, MSF supported Wardher hospital, focusing on specialist care for severely ill or malnourished children, maternity services and TB treatment. Basic healthcare was offered at Yucub health post, and two health centres in Danod and Yucub received support in the form of staff, medical supplies and training to provide quality health services to the surrounding population. Additionally, regular mobile clinics travelled to nine outlying locations and provided antenatal care, therapeutic feeding and immunisations. A free ambulance served another 12 villages. Teams treated 1,467 children for malnutrition, provided 2,242 women with antenatal care and assisted 325 deliveries.

Critical refugee assistance

Teams continued to provide specialist healthcare for Somali refugees and the host population in Dolo Ado, Liben zone, Somali region. Services include an inpatient



An arrival site in Gambella region for refugees from South Sudan.

department, emergency obstetric surgery and a therapeutic feeding centre for children. Teams vaccinated 12,180 children against measles and, in collaboration with the Regional Bureau of Health, also carried out several rounds of polio vaccination.

In the western region of Benishangul-Gumuz, a team provided aid to South Sudanese refugees. An evaluation of the emergency nutrition programme that started in 2012 in Bambasi camp showed that people's nutritional status had greatly improved. MSF continued to work with local authorities to improve healthcare and nutritional services in Bambasi, Tongo and at the new Ashura camp. Teams undertook 23,170 consultations and admitted 21,025 children to supplementary feeding programmes across all three camps.

In July, following an outbreak of violence in South Sudan, MSF started providing assistance to an estimated 3,000 refugees and 3,000 people in the host community of Raad, Gambella region. By the end of the year, teams had carried out 5,500 consultations, and vaccinated 1,280 children against measles and 1,980 against meningitis.

Responding to drought and deportation

The worst drought recorded in recent years in Afar region had a severe impact on people's health and nutrition. In April, MSF responded by sending a team to Teru Woreda, a harsh and difficult to reach area that lacks development support. Staff set up a supplementary feeding programme and an inpatient unit, and carried out mobile

treatment activities. More than 1,880 children received medical care.

In November, the government of Saudi Arabia began deporting 'illegal' foreign workers, resulting in the arrival of 154,837 Ethiopian men, women and children at Bole airport by the end of December. MSF provided psychosocial support to 15,673 people. One-fifth of those receiving individual consultations were found to have a mental illness and 40 were referred to the psychiatric hospital in Addis Ababa for further treatment.

Programme closures

TB is the second-most common cause of death in Ethiopia after malaria, and there are indications that drug-resistant forms of the disease are on the rise. MSF assisted the Bureau of Health in establishing an innovative programme for TB treatment in Dire Dawa. The team handed over the project after donating diagnostic equipment, fine-tuning medical protocols and making modifications to the TB ward and people's homes so that they could undergo treatment without a lengthy hospital stay.

The clinic in East Imey, Somali region, was handed over to the Bureau of Health in March, and the therapeutic feeding centre in Buramino refugee camp was closed in April. MSF also handed over the project providing inpatient, maternity and nutrition care at a health centre in Mattar, north of Gambella city, in June. In the first half of the year, teams carried out 33,140 health and 650 antenatal consultations, and assisted 170 births.

FRANCE



Médecins Sans Frontières (MSF) closed its programme for asylum seekers in Paris this year.

Since 2007, MSF has been providing medical and psychological care as well as social support to asylum seekers in Paris. Many have fled conflict zones or political persecution at home and find themselves living on the streets in France. Most have no health insurance and it is very hard for them to access any kind of medical care. Furthermore, many of them cannot speak French.

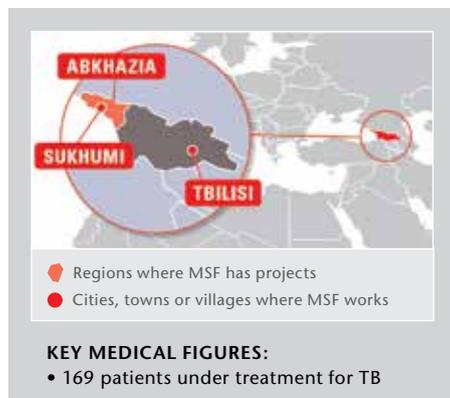
In 2013, an MSF team of nurses, doctors, psychologists and social workers continued to treat and support asylum seekers who had suffered repeated traumatic experiences

both at home and in exile. A particular emphasis was put on providing psychological care to those who did not speak French and could not access the necessary help elsewhere.

MSF, after assessing the limitations, decided to close its programme in France at the end of May 2013. The most pressing issues encountered by migrants in France are those linked to administrative and social problems, and these are currently beyond the remit of a medical humanitarian organisation.

Year MSF first worked in the country: 1987 | msf.org/france

GEORGIA



Lack of access as well as poor adherence to TB treatment were at the origin of the emergence of multidrug-resistant TB (MDR-TB), a form of the disease that does not respond to standard first-line drugs as the bacteria is resistant to two main antibiotics. Today, MDR-TB also spreads from one patient to another. Treatment for MDR-TB is available, but it takes up to two years on a course of several drugs to be cured. People must also tolerate difficult side effects, such as depression, loss of hearing, nausea and vomiting.

Médecins Sans Frontières (MSF) treats patients with MDR-TB in the autonomous republic of Abkhazia, and is also assisting with the development of the Abkhazian national programme. Activities include training, writing medical care protocols, laboratory support and the supply of equipment and drugs.

The Georgian national TB programme is well organised, and MSF is currently in discussions with the Georgian Ministry of Health regarding clinical trials for two new MDR-TB drugs which will shorten the length of treatment and should result in fewer side effects.

Care for the elderly

An MSF team continued to provide medical assistance to vulnerable people in an access to care programme that started in 1993. Most of the 50 patients are now aged 70 or older, and live in Sukhumi, Abkhazia and Tbilisi. They are bedridden and isolated, and suffer from serious chronic diseases. MSF offers eye care, as well as material support such as wheelchairs, and an MSF doctor carries out home visits.

No. staff end 2013: 39 | Year MSF first worked in the country: 1993 | msf.org/georgia

Tuberculosis (TB) remains a major challenge in Georgia, with many people suffering from multidrug-resistant strains of the disease.

GREECE



KEY MEDICAL FIGURES:

- 2,900 outpatient consultations
- 200 individual and group mental health consultations

Undocumented migrants and asylum seekers in Greece face long periods of detention in centres with limited access to basic services and healthcare.

Migrants and asylum seekers of all ages can find themselves summarily arrested and confined in detention centres for up to 18 months. They have little or no opportunity to communicate with their families, and their physical and mental health often deteriorates.

Médecins Sans Frontières (MSF) has responded to the situation by providing medical consultations and psychosocial support to people being held at detention centres in Komotini, Filakio and Drama, and in the police stations of Feres, Soufli, Tycheron and North Iasmos. Items including clothes, sleeping bags, towels and soap have also been distributed in centres to help people maintain a basic level of hygiene, health and dignity. These activities were handed over to the Hellenic Center for Disease Control and Prevention in April. Five months later, MSF resumed assistance at Filakio and Komotini, and Feres, Soufli and North Iasmos as no medical or humanitarian assistance was being provided by the authorities. The team also responded to two outbreaks of scabies – a parasitic skin infestation that spreads

rapidly in crowded conditions – in the detention facilities. More than 2,000 people were treated between January and April and September and December.

Healthcare out of reach

The financial crisis in Greece has led to the country's health budget being cut by almost 40 per cent, and state funds for medication have also been almost halved. As a consequence there is limited availability of medicine, not only for vulnerable groups like the unemployed and the uninsured, but also for the general population. In October, an MSF team began assisting people in need of healthcare at food distribution centres in Athens. On-the-spot care, including medical consultations, hospital referrals and psychosocial referrals for shelter and legal assistance were provided. Many patients were unemployed or elderly.

Freezing temperatures in early 2013 led authorities to open temporary emergency shelters to accommodate homeless people in Athens, and MSF launched an emergency intervention in January.

No. staff end 2013: 12 | Year MSF first worked in the country: 1991 | msf.org/greece

GUINEA



KEY MEDICAL FIGURES:

- 179,400 outpatient consultations
- 94,400 patients treated for malaria
- 13,600 patients on first-line ARV treatment

The healthcare system in Guinea is currently unable to meet all the needs of its people. Malaria remains a particular concern.

Malaria is a preventable and treatable illness transmitted by infected mosquitoes, and is a leading cause of illness and death in the country. Médecins Sans Frontières (MSF) has continued to work with the Ministry of Health on malaria prevention and treatment in Guéckédou, and the programme now supports the district hospital, seven health centres and 12 health posts. The MSF team has also trained 53 community health workers so that they can screen and treat people with uncomplicated malaria.

HIV

Although the prevalence of HIV is relatively low in Guinea, people who have the illness often cannot afford to pay the fees that are charged for antiretroviral drugs. Many HIV-positive people also fear disclosing their status due to the social stigma, and this creates another barrier to treatment. The HIV programme based in the capital Conakry, comprising one MSF ambulatory treatment centre and five

health centres supported by MSF, offers a free, comprehensive health package that includes psychosocial care, tuberculosis treatment for co-infected patients and prevention of mother-to-child transmission of the virus.

The HIV programme in Guéckédou was handed over to the Ministry of Health in 2013, as was the Matam maternal health programme.

Responding to cholera and meningitis outbreaks

During an outbreak of meningitis in May, an MSF team treated 132 patients, provided drugs to medical facilities and trained local staff. In June, an emergency cholera treatment centre was set up on Memgbe Island, Conakry. Eighty people who had contracted the water-borne disease were treated. There were no new cases or deaths after assistance had been provided.

No. staff end 2013: 327 | Year MSF first worked in the country: 1984 | msf.org/guinea

HAITI



● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

- 6,550 births assisted
- 13,600 surgical interventions
- 7,400 patients treated for cholera

More than three years after Haiti's devastating earthquake, the few public medical facilities in the country do not have the resources to meet the needs of most Haitians. Emergency services are particularly lacking.

Healthcare in Haiti remains largely privatised and most people do not have the financial means to pay for it. In 2013, Médecins Sans Frontières (MSF) continued to provide urgently needed free services to help fill some of the gaps.

Cholera, a water-borne infection that can lead to rapid dehydration and sometimes death, remains a health threat where there is poorly managed water and sanitation. Overall, living conditions in Haiti have improved over recent years, but in camps hygiene standards remain extremely poor and some people are without access to affordable drinking water.

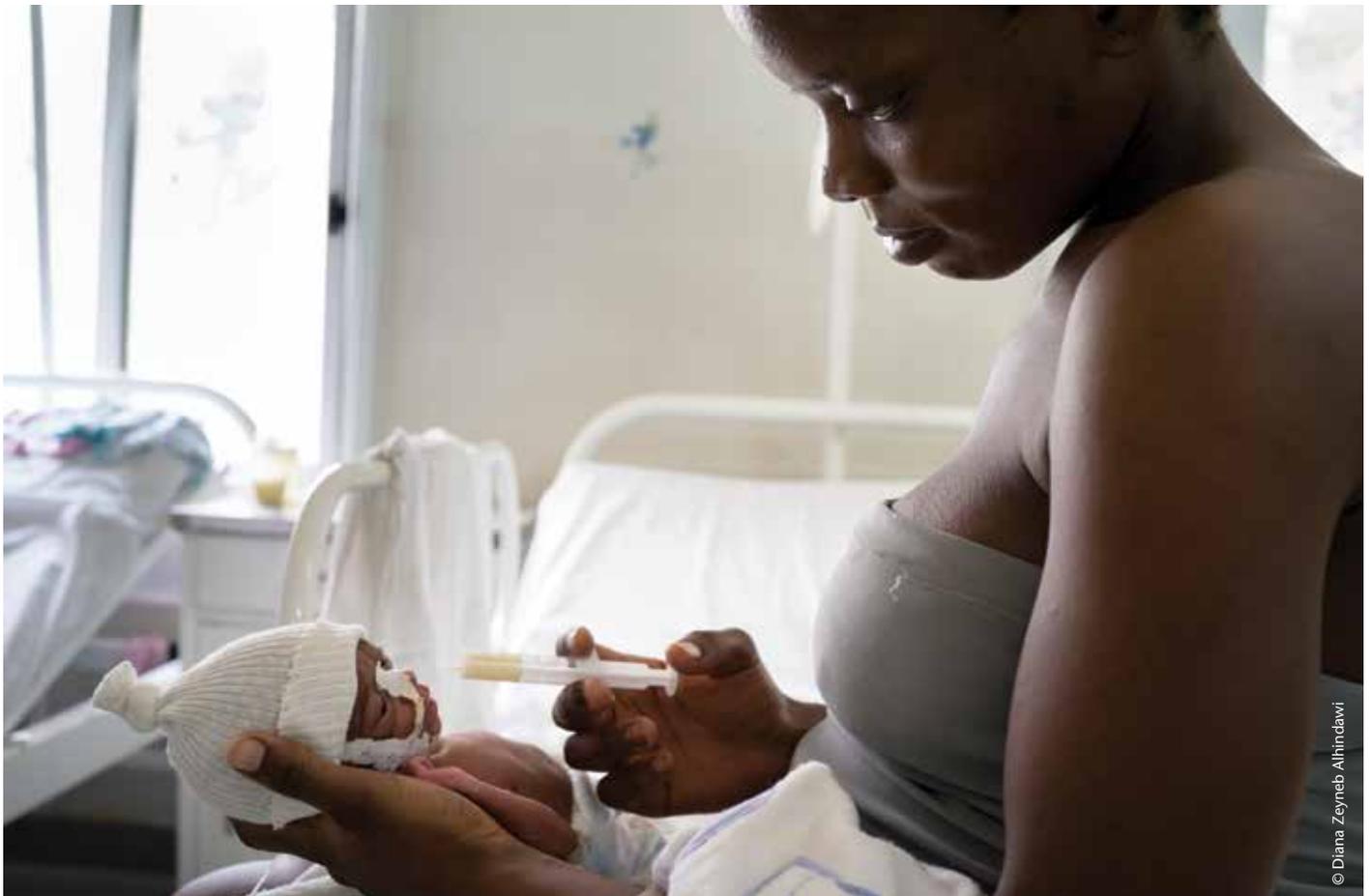
The cholera crisis that began within months of the 2010 earthquake persists, particularly during the rainy season, when the number of patients reaches epidemic levels. Since October 2010, more than 700,000 people have been infected with cholera. One-third of these have been treated by MSF. Teams continued to run cholera treatment centres (CTCs) in Delmas and Carrefour, in Port-au-Prince. Preventive measures included distribution of hygiene kits,

water chlorination points and educational activities. In 2013, more than 85,000 people learned about cholera prevention and 5,240 disinfection kits were distributed.

Historically there has been little emergency care available for people in Haiti unless they can afford to pay for it. MSF runs the Centre de Référence en Urgence Obstétricale (CRUO), a 130-bed hospital in Port-au-Prince providing free, 24-hour obstetric care for pregnant women suffering from complications such as pre-eclampsia, eclampsia, obstetric haemorrhage and uterine rupture. A full range of reproductive health services, including family planning, postnatal care and prevention of mother-to-child transmission of HIV is also offered. A 10-bed unit, the 'Cholernity', is available for pregnant mothers with cholera within the CRUO. Teams assisted 5,450 births during the year.

Decentralising care

MSF continued to manage the 160-bed temporary container hospital in the city of Léogâne, which had originally been set up to provide emergency services after



A mother feeds her premature baby in an MSF hospital in Port-au-Prince.

© Diana Zeyneb Alhindawi



The specialist burns unit in Port-au-Prince's Drouillard hospital is the only one in Haiti.

the earthquake. Aware of the fragility of the healthcare system after the disaster, MSF decided to extend its programme in order to support the Ministry of Health's aim of restoring services to the pre-earthquake level in the region. The hospital continued to provide basic healthcare for women and children this year, as well as specialist services, primarily for obstetric emergencies, and to run a cholera treatment unit. MSF has begun to reduce its activities in the hospital, and straightforward deliveries and antenatal care for uncomplicated pregnancies can already be managed in local health facilities. MSF has started to identify potential partners to handle complicated cases.

Drouillard hospital

A team provides trauma care to victims of accidents, burns and violence, including sexual violence, at the 130-bed Drouillard hospital in Port-au-Prince, close to Cité Soleil slum. Surgery, intensive care, orthopaedic and burn care, and physiotherapy are offered. Some 13,200 people were treated in 2013. More than one-third had been in road accidents, one-fifth were victims of violence (around 50 patients with bullet wounds

and 100 with knife wounds were admitted monthly) and one-quarter were injured in domestic accidents. A large percentage of patients who suffered burns in domestic accidents were children under five. Drouillard hospital is the only facility with a specialist burns unit in the country. MSF also maintains a unit in the hospital that can quickly be transformed into a 130-bed CTC, if required.

Martissant emergency and stabilisation centre

MSF provides paediatric care, internal medicine and maternity services, as well as psychological support for patients and caregivers at the Martissant emergency and stabilisation centre. The centre is open around the clock, offering free care to people in any kind of emergency medical situation. An ambulance service transports patients to appropriate hospitals for treatment. More than 100 patients were seen daily in 2013.

Tabarre

The Nap Kenbe surgical centre in Tabarre continued to provide free emergency and trauma services, orthopaedics, physiotherapy and post-operative care for people in eastern Port-au-Prince.

Manise 19 years old

I was living in Canaan camp with my cousin after the earthquake. I stayed in the tent and prepared food, while my cousin went out to work. One night, I went to collect some water. Two men arrived and dragged me into an empty tent.

I shouted so loudly one of them left. The other held on to me tightly and hit me many times. It was around 8pm and there were a number of passersby. No one came to help me.

I had no problems in my pregnancy until my feet began to swell. My health worsened and one day I lost consciousness and woke up in an MSF hospital. I saw the baby next to me but could not remember the birth ... I am worried I won't be able to feed my son once he is too old for breast milk. I am going to offer to do washing for people.

HONDURAS

The public healthcare system in Honduras cannot keep pace with victims of violence, leaving the most vulnerable people deprived of much-needed services.

Survivors of criminal violence in Honduras rarely seek medical or psychological help, fearful of their aggressors and deterred by the many barriers to healthcare. There are frequent shortages of skilled personnel and supplies at public hospitals and clinics, and health staff are reluctant to treat victims of violence for fear of repercussions.

Aiming to improve access to emergency medical care, Médecins Sans Frontières (MSF) continued to run a comprehensive programme offering quality treatment and follow-up to victims of violence in the capital city of Tegucigalpa. Teams worked to increase vulnerable people's access to emergency healthcare for trauma, medical emergencies, sexual violence and mental healthcare for victims of violence.

The emergency room of the university hospital Escuela, the main public hospital in the country, is always extremely busy, seeing some 260 patients per day. MSF helped

reorganise services and is working on improving emergency management to better deal with large influxes of patients and to reduce chances of death or permanent disability arising from inadequate trauma care.

A large street-based population, consisting of homeless people and people who work informally, such as street sellers and sex workers, are hyper-exposed to violence and are excluded from the health system. Mobile teams consisting of a social worker, a psychologist and a clinician visited 25 sites around the city each week in 2013, identifying inhabitants' medical, psychological and social needs. The teams provided on-the-spot first aid, preventive care and mental health support. More than 1,040 victims of violence, including 725 victims of sexual violence, were identified and treated across four MSF-supported health clinics.



KEY MEDICAL FIGURES:

- 1,500 individual and group mental health consultations
- 720 people treated after incidents of sexual violence

There is no national protocol for the treatment of victims of sexual violence in Honduras and this means that victims do not have access to adequate medical care. MSF is part of a Ministry of Health committee working to develop national health guidelines for the treatment and care of victims.

Dengue emergency

In San Pedro Sula, the country's second city, MSF responded to an epidemic of dengue haemorrhagic fever and treated more than 600 children in the paediatric ward of Mario Catarino hospital between August and November 2013. MSF also donated drugs and medical supplies to the hospital for the treatment of adults affected by dengue.

No. staff end 2013: 57 | Year MSF first worked in the country: 1974 | msf.org/honduras

IRAN

Rates of drug addiction in Iran remain high, yet many addicts have difficulty accessing the medical and psychological care they need.

The Iranian authorities have recognised that drug addiction and HIV infection are a growing public health concern, and have taken significant steps to initiate harm reduction and HIV/AIDS prevention among injected-drug users. However, the broad medical needs of high-risk groups remain acute, especially in Tehran, where drug users, sex workers and street children are stigmatised and are therefore unable to access the general health system.

In Darvazeh Ghar, one of the poorest neighbourhoods in Tehran, Médecins

Sans Frontières (MSF) continued to run a health centre dedicated to women and children under five who are excluded from healthcare, including undocumented refugees. Together with Iranian authorities and local organisations, MSF offered free, basic healthcare, including medical consultations for women and children, gynaecological care, family planning and postnatal care. A mental health programme started in September, with treatment and support provided by a psychiatrist and a psychologist.

Iran's Bureau for Aliens and Foreign Immigrants' Affairs estimates that the country hosts 850,000 refugees, most of them Afghans. While registered refugees are granted private health insurance, those who are undocumented have limited access to healthcare.



KEY MEDICAL FIGURES:

- 5,800 outpatient consultations
- 1,200 antenatal consultations
- 60 individual and group mental health consultations

No. staff end 2013: 30 | Year MSF first worked in the country: 1990 | msf.org/iran

ITALY

Migrants and asylum seekers face many health challenges upon arrival in Italy, in both reception and detention centres.

Victims of torture, human trafficking, sexual violence and people with mental health issues are particularly vulnerable on first arrival in Italy, but there are insufficient services to meet their needs. Crowded reception centres and poor living conditions in facilities for migrants pose further health risks.

Teams from Médecins Sans Frontières (MSF) provide medical and mental healthcare to migrants and asylum seekers in reception centres on Sicily and in Calabria. Basic healthcare is offered to undocumented migrants in Ragusa province, Sicily. In Pozzallo, MSF supports the local health authorities with medical triage of migrants on arrival. In December, MSF called for the temporary closure of the Lampedusa reception centre so that it could be refurbished to ensure minimum reception

standards and respect for human dignity. The authorities closed the centre and began making upgrades.

MSF continued a pilot project for the early diagnosis and treatment of tuberculosis among migrants hosted in reception and detention centres.

MSF teams also worked in Milan, Trapani, Caltanissetta and Rome, in collaboration with the Ministry of Health, the Ministry of Foreign Affairs and private companies responsible for managing reception and detention centres. In Lombardy, an MSF team worked with the NGO OIKOS in the Latin American migrant communities to ensure access to diagnosis and treatment of Chagas disease, which is endemic in their home countries.

A team also completed a three-month assessment of the ongoing healthcare needs of homeless patients discharged from hospitals in Milan, Rome and Palermo. A project will be launched in Milan in 2014.



A Syrian refugee whose family had escaped a chemical weapons attack and had travelled through Lebanon, Egypt and Libya before arriving in Pozzallo, Italy.

The trip was organised by armed men ... on board we had no water or food. Thirsty, we drank the used engine water. We stayed three days at sea before we were rescued near the Sicilian coast. All I want is a safe place for my family. Many Syrians are stuck in hell: caught between the battles, without doctors and food.

No. staff end 2013: 11 | Year MSF first worked in the country: 1999 | msf.org/italy

LAOS



Médecins Sans Frontières (MSF) stopped working in Laos in December 2013.

In 2011, MSF decided to launch a programme to provide obstetric and neonatal support and paediatric care for children under five, in five district hospitals and 10 health posts in Huaphan province, northeastern Laos. The aim was to reduce infant mortality, as well

as the number of deaths during pregnancy and childbirth, and an MSF team worked with the hospitals and health centres of Xiengkhor, Sop Bao, Ett, Xamtai and Kuan districts. Mobile medical clinics reached some of the most remote and disadvantaged communities in the province, and MSF worked to improve laboratory and pharmacy facilities in the area, as well as water, electricity and sanitation infrastructure.

The team found that low patient attendance rates, the scattered nature of the health facilities in the province, and the difficulties in recruiting qualified Lao staff and importing the necessary drugs meant that goals were not met and expected outcomes for training medical staff and treating patients were not reached. The decision was made not to continue the programme beyond the end of the year.



A midwife examines a patient, in the presence of her family.

No. staff end 2013: 46 | Year MSF first worked in the country: 1989 | msf.org/laos

INDIA

KEY MEDICAL FIGURES:

- 93,100 outpatient consultations
- 1,500 patients on first-line ARV treatment
- 820 patients under treatment for TB

Healthcare remains difficult to access for India's most isolated and marginalised populations.

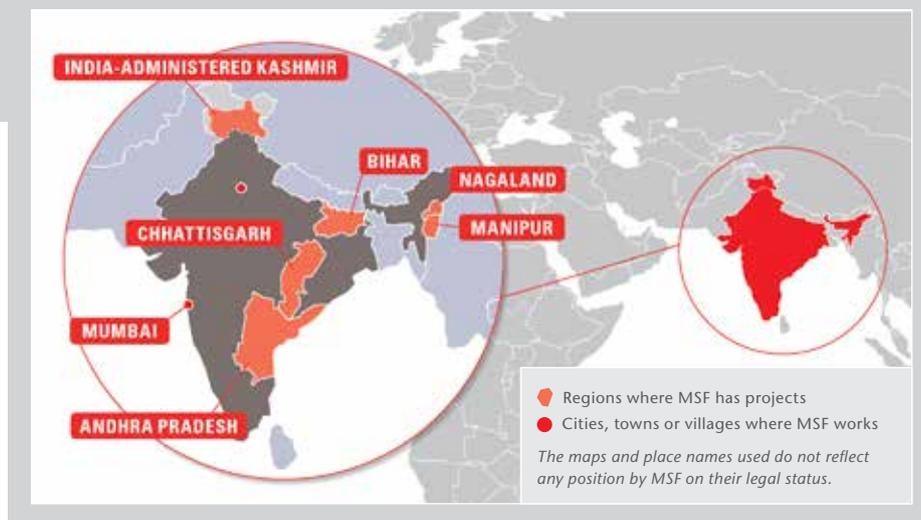
Longstanding, low-intensity conflict in Chhattisgarh and Andhra Pradesh has led to population displacement and reduced access to healthcare. Médecins Sans Frontières (MSF) teams continued to bring basic healthcare to people in villages through weekly mobile clinics in southern Chhattisgarh, and those living in displacement camps on the Andhra Pradesh side of the border. Patients suffered mainly from skin infections, general body pain, respiratory tract infections and malaria. A mother and child health programme offered antenatal care, immunisations and nutritional support for pregnant women and children in Bijapur, Chhattisgarh. Screening, diagnosis and treatment for tuberculosis (TB) were also available. In November, a clinic providing basic healthcare was opened in Mallampeta, a remote village on the border of Andhra Pradesh and Chhattisgarh. In 2013, MSF carried out nearly 52,600 consultations and treated approximately 8,465 people with malaria in the region.

Healthcare in Nagaland

Until recently there had been few health services available in remote Nagaland state, where the years of insurgency had stunted the area's development. Since 2010, MSF has supported Mon district hospital by refurbishing the buildings and upgrading key services including pharmacy and medical waste management, the laboratory, infection control measures, and water and sanitation. MSF has also provided staff training to improve medical management, with special focus on sexual and reproductive health and TB. The team carried out 30,365 outpatient consultations, assisted more than 680 deliveries and treated 15 patients for drug-resistant TB (DR-TB) in 2013. The project has been recognised by the government and local community for the significant impact it has had on people's access to healthcare in Mon district.

Improving access to HIV and TB care

In Mumbai, MSF continued to provide treatment for patients with HIV and



co-infections who have been excluded from government health services. In 2013, however, the focus shifted to responding to the public health crisis posed by DR-TB in the city. MSF treated patients with the most severe forms of DR-TB. The strategy is to treat a small but acute group of patients who cannot access the government healthcare system, and to use evidence from operational research to encourage the government to find ways and means to provide treatment for these people.

MSF runs a clinic offering outpatient care that provides third-line antiretroviral (ARV) therapy for patients with second-line ARV failure and treats patients co-infected with HIV and hepatitis B or C, or DR-TB. In addition, MSF supports a government

TB hospital with infection control and counselling services. Approximately 300 patients received treatment in 2013, including nearly 160 patients on second-line and third-line HIV regimens, approximately 50 patients with HIV and DR-TB co-infection, and about 80 patients with DR-TB.

In the northeastern state of Manipur, where the prevalence of adult HIV infections is the highest in the country, MSF offers HIV and TB care in three clinics in Churanchandpur and Chandel districts. One of the clinics is situated in the town of Moreh, right on the border with Myanmar. More than 560 patients started treatment for HIV this year (a total of 1,244 patients were receiving treatment by the end of 2013), 299 people



An MSF mobile clinic in a Chhattisgarh village.

began treatment for TB and 30 for multidrug-resistant TB (MDR-TB).

Mental healthcare

Decades of conflict in Kashmir have taken a toll on people's mental health, and needs persist for psychological support. A well-established MSF mental health programme continued at five fixed locations in Srinagar and Baramulla districts. Teams also visited victims of violence in Srinagar hospitals and provided psychological first aid – ensuring basic psychological, social and material needs were being met. Counselling services were launched in Pattan in June. A total of 2,530 individual mental health consultations were provided across the programme.

Heavy rains and landslides in Uttarakhand state in mid-June caused significant flash flooding in Uttarkashi, Chamoli, Rudraprayag and Pithogharh districts. The state is home to many holy Hindu sites and the majority of the estimated 10,000 people who lost their lives were pilgrims from all over India and the local population working

with them. MSF set up a three-month programme to support those suffering from acute distress in Rudraprayag district. More than 440 individual sessions and 37 group sessions were provided.

Treating kala azar and malnutrition in Bihar

People in Vaishali district, Bihar, live in an area where kala azar (visceral leishmaniasis), a parasitic disease transmitted by the bite of an infected sandfly, is endemic. The infection is almost always fatal if left untreated. MSF began responding to kala azar in 2007, introducing L-AmB 20mg/kg (liposomal amphotericin B) as a first-line treatment at Sadar district hospital and five health clinics. More than 10,000 patients were treated, with an initial cure rate of 98 per cent. Since 2012, MSF has collaborated with the Drugs for Neglected Diseases initiative (DNDi), implementing a pilot project examining the safety and effectiveness of two combination therapies, as well as an alternative, single-shot dosage

of L-AmB. Initial outcomes were encouraging and the pilot programme will expand to additional districts. If these new drug regimens are proven effective and safe, the research could potentially change national treatment protocols for the disease.

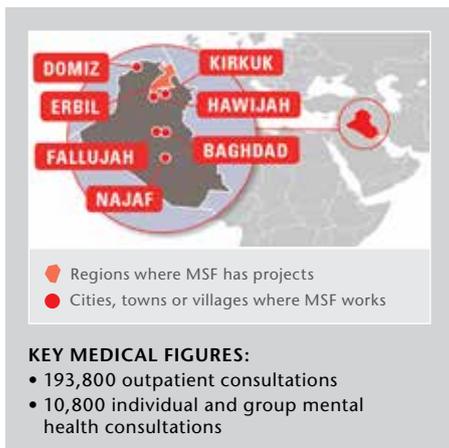
In the Darbhanga district of Bihar, child malnutrition is a chronic and under-reported health crisis. MSF teams provide weekly treatment for children with severe acute malnutrition through a community-based programme in Biraul block. In 2013, the programme expanded to cover an additional four blocks. MSF also began building a malnutrition intensive care unit inside a teaching hospital in Darbhanga to treat the most severe cases. MSF continues to work with health authorities to define a model of care for children with severe acute malnutrition that can be implemented within the public health system. Over 13,000 children under the age of five have been treated in Darbhanga since 2009.

No. staff end 2013: 672 | Year MSF first worked in the country: 1999 | msf.org/india



There are high levels of malnutrition in children aged between six months and five years in Bihar. Malnutrition bracelets like this one measure the circumference of a child's upper arm.

IRAQ



Thousands of Iraqis endure a lack of basic healthcare services, and access is further hampered by chronic insecurity. War has affected medical infrastructure in some areas.

There was a dramatic increase in violence in Iraq in 2013, and this further undermined the capacity of health facilities to respond adequately to medical needs. Médecins Sans Frontières (MSF) is focusing on filling some of the gaps in care, training staff and sharing knowledge at several hospitals.

Child and maternal health

In January, MSF began working with the neonatal care unit at Kirkuk general hospital, providing training and supervision to ensure basic standards of care for newborns and their mothers.

The Al-Zahra hospital is the main referral hospital for obstetrics, gynaecology and paediatrics in Najaf governorate. An MSF team trained doctors and nurses, implemented treatment protocols and introduced documentation and analysis methods. Support was also provided in hospital management, infection control, structure rehabilitation and maintenance. MSF trained hospital staff in case management

in order to try and reduce the number of neonatal deaths. Along with training and supervision, MSF placed an emphasis on infection control, pharmacy standardisation, sterilisation procedures and data collection. In 2013, 23,627 deliveries were registered at the hospital, with more than 6,000 infants requiring intensive care.

Hawijah hospital

More than 300 emergency surgical procedures were performed each month at the hospital in Hawijah, the only facility offering specialist services in the entire district. In addition to providing hands-on emergency surgical services around the clock, an MSF team conducted training in the management of emergency cases and infection control intervention. MSF also carried out assessments of health centres in Hawijah district to ascertain whether basic healthcare was available for the rural communities, and this information will be used as a reference to develop new activities.



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The Syrian crisis has resulted in a massive flow of refugees into Iraq, and more than 200,000 Syrians crossed into the Kurdish region of Iraq by the latter half of 2013.



© Diata Chasan/MSF

A sick baby with his mother and siblings in the paediatric ward of Hawijah hospital.

Caring for Syrians in refugee camps

The Syrian crisis has resulted in a massive flow of refugees into Iraq. According to the UN refugee agency, more than 200,000 Syrians had crossed into the Kurdish region of Iraq by the latter half of 2013. Borders are opened only intermittently and more than 50,000 refugees arrived within just a few days in mid-August. MSF opened a health clinic offering basic and mental healthcare in September at the Kawargosk camp in Erbil province, which hosts 12,500 refugees. A mobile clinic that ran from late September in the smaller Qushtapa camp (3,000 refugees), also in Erbil province, was handed over to the Department of Health in December 2013.

More than 18,900 consultations were conducted with refugees, and 30 per cent of these were for children under five. Respiratory infections were the main cause for consultations across all age groups.

MSF is also the main healthcare provider in Domiz camp. Initially designed to host 1,000 families, the camp population has swollen to 45,000 people. Despite the efforts of the local authorities, camp services cannot keep pace with needs

and overcrowding and poor living conditions have led to a deterioration in people's health. Each week MSF carries out some 2,400 medical consultations. Many patients suffer from upper respiratory tract infections and acute watery diarrhoea, but MSF also provides treatment for chronic diseases, reproductive health and mental health. Targeted distributions of washing kits and water and sanitation activities to ensure minimum standards of hygiene were completed in the first half of the year.

Referring victims of violence for reconstructive surgery

Many patients suffering from burns and other traumatic injuries cannot access the specialised care they need within the country. MSF runs a network of medical liaison officers (MLOs) located in Baghdad, Najaf, Kirkuk, Ninewa, Erbil, Al-Qadissiyah, Al-Anbar, Salah ad-Din, Al-Basrah and Diyala. They identify and refer patients to MSF's reconstructive surgery programme in Amman, Jordan. Patients receive orthopaedic, maxillofacial and plastic reconstructive surgery, along with physiotherapy and psychosocial support. The MLOs, together with administrative support based in Baghdad, managed the

admission and discharge of 185 patients, and provided follow-up for almost 400 patients in Iraq in 2013.

Reducing the stigma of mental illness

Mental illness is not openly discussed or treated in Iraq. MSF had been providing mental healthcare in Baghdad and Fallujah since 2009, responding to needs and aiming to reduce stigma. Individual counselling and a telephone helpline were offered. In 2013, psychologists treated 775 people in 2,027 counselling sessions, before the programme was handed over to the Ministry of Health in June.

Sharing expertise in health services

MSF supported the national Poisoning Control Center (PCC) in Baghdad through the donations of antidotes and the exchange of scientific knowledge. MSF also responded to a request from the health ministry's Department of Medical Rehabilitation for a possible collaboration concerning physiotherapy. Visits were made to various rehabilitative departments in Baghdad, and training for inpatient physiotherapy is being organised.

JORDAN

Médecins Sans Frontières (MSF) continued a reconstructive surgery programme in Jordan for victims of conflict, opened a trauma programme for war wounded from Syria, and expanded activities to help meet the needs of Syrian refugees and ease pressure on host communities.

In Amman, MSF runs a regional reconstructive surgery programme for patients suffering from severe injuries that require a level of integrated and specialised care that is difficult for them to access anywhere else. Many people initially receive treatment for wounds at other hospitals, and a network of doctors refers them to the reconstructive surgery hospital. Orthopaedic, maxillofacial and plastic reconstructive surgery is offered with essential complementary care that includes physiotherapy and psychosocial support. Patients are also provided with transportation and are accommodated at

an MSF rehabilitation centre. Surgeons performed 1,370 operations on patients from Syria, Iraq, Yemen and Gaza in 2013.

In addition, MSF conducted around 300 medical and surgical consultations per month for Syrian refugees at a special health clinic within the hospital compound. Physiotherapy services were also offered and a team provided physiotherapy and specialist referrals.

In August, MSF opened an emergency trauma project in the Ministry of Health hospital in Ar Ramtha, less than five kilometres from the border with Daraa governorate in Syria, an area which has seen some of the heaviest fighting in the conflict. Severely wounded patients crossing the border here are taken to Ar Ramtha hospital. They are the victims of bombings and shellings, and are caught in the middle of the violence and left with limited access to medical care. Since the project opened, the team has admitted 181 patients and performed 336 major surgical procedures. The facility also offers individual and group mental health and physiotherapy sessions.



KEY MEDICAL FIGURES:

- 320 individual and group mental health consultations

Maternal and child health in Irbid

Irbid has one of the highest concentrations of Syrian refugees outside of the camps – there were over 120,000 in the governorate by the end of 2013. An assessment of their health situation conducted by MSF in May and June showed that mothers and children were not getting adequate healthcare. MSF opened a programme in October offering consultations and inpatient care for refugees and people in need in host communities.

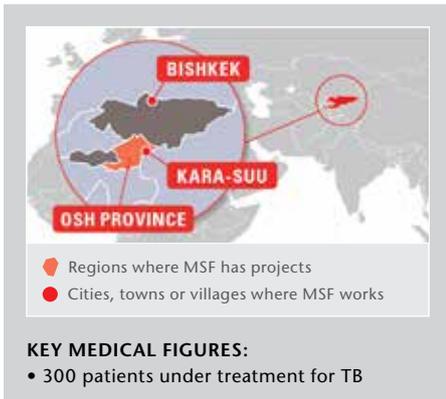
Filling a gap in paediatric care at Zaatari refugee camp, an MSF team ran a 24-hour hospital for children aged one to 10 from March to November. The project was closed when other health providers were able to meet the children's needs. More than 17,500 patients were treated over the course of the programme.

No. staff end 2013: 72 | Year MSF first worked in the country: 2006 | msf.org/jordan



MSF runs a regional reconstructive surgery programme in Amman.

KYRGYZSTAN



Médecins Sans Frontières (MSF) estimates the incidence of tuberculosis (TB) among prisoners in Kyrgyzstan to be 20 to 30 times higher than in the general population, with mortality rates as much as 60 times higher.

MSF continued to offer TB care to prisoners in the penitentiary system in Bishkek, the country's capital, which holds up to 9,000 inmates. In the institutions where prisoners are detained until sentencing, teams provided full health screening and put identified TB patients on treatment straightaway. Staff also diagnosed and treated inmates with multidrug-resistant TB (MDR-TB).

Using a comprehensive approach to TB patient management, MSF also supported treatment for co-occurring illnesses, and offered screening and vaccination for hepatitis B. Uninterrupted completion of treatment is crucial in order for it to be successful, and the team ensured follow-ups once individuals were released from prison. Having helped establish protocols, increased infection control and improved access to care, MSF plans to hand over the penitentiary project by the end of 2014.

MSF has also actively supported the development of a newly constructed national reference laboratory in Bishkek.



A doctor explains a lung x-ray to an XDR-TB patient in Kara-Suu hospital.

Promoting ambulatory care for TB

In Kara-Suu district, Osh province, where rates of TB are among the highest in the country, MSF supported the Kara-Suu hospital, which has 80 beds for TB and DR-TB patients. This project aims to become a model for effective walk-in treatment. Whenever possible, patients receive care through the community-based healthcare system, with ambulatory or home-based treatment, rather than being hospitalised. Psychosocial counselling for patients and their families, and social packages (nutritional support, hygiene kits and transport money) are provided to help patients adhere to treatment.

Rehabilitation of the hospital and basic health facilities was supported by MSF to ensure optimal infection control and better sanitary conditions for the patients. Teams also worked with health centre staff to improve clinical case management, and the detection of people suffering from TB, DR-TB and HIV-TB co-infection in the district. Comprehensive care was provided to people with drug-resistant forms of TB, and those with certain co-occurring illnesses.

Mukhtar

I still remember the day in the TB centre when my MSF doctors told me that I was cured and could stop the treatment. I had a strange feeling of happiness, which I really cannot find any words to describe. I still can't believe that the treatment has finished. I have conquered death. I want to thank you all and to say that good people can save the world.

Advocacy work has resulted in policy change and acceptance of the community-based treatment model by the Ministry of Health as the future strategy for TB care in the country.

No. staff end 2013: 130 | Year MSF first worked in the country: 2005 | msf.org/kyrgyzstan

KENYA

KEY MEDICAL FIGURES:

- 415,700 outpatient consultations
- 13,200 patients on first-line ARV treatment
- 2,000 patients treated after incidents of sexual violence

Médecins Sans Frontières (MSF) continued to fight HIV and tuberculosis (TB), and in the camps growing insecurity affected healthcare access for refugees.

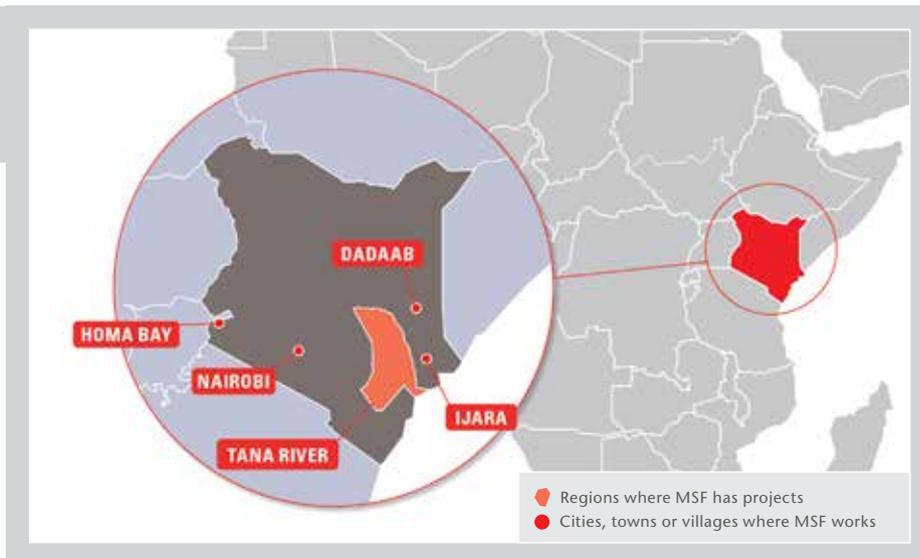
In the Dadaab refugee camps, home to over 340,000 Somalis, the general level of security has steadily deteriorated since the end of 2011. This has reduced access for aid workers, and MSF is unable to maintain a permanent presence of international staff in its hospital in Dagahaley. Many aid organisations have experienced a decrease in funding, leading to an overall reduction in assistance for refugees in Dadaab. The impact is visible: there is a lack of maintenance and investment in camp hygiene and shelter, which raises major health concerns and increases the risk of epidemics.

MSF manages a 100-bed hospital in Dagahaley, providing adult and paediatric care, maternity services, emergency surgery and treatment for HIV/AIDS and TB. Antenatal care, surgical dressings and mental health support are available through four health posts. Each month in 2013, on average, 18,000 outpatient consultations were carried out and over 700 people were admitted to hospital. More than 2,580 babies were delivered and some 4,100 children received treatment through outpatient and inpatient feeding programmes. Over 10,800 mental health consultations were also conducted.

In November, a Tripartite Agreement was signed by the UN refugee agency and the Kenyan and Somali governments, outlining practical and legal procedures for the voluntary return of hundreds of thousands of refugees to Somalia. An assessment conducted by MSF among patients in its medical facilities in Dagahaley camp in August found that four out of five people would choose not to return to Somalia given the current climate of insecurity.

Free healthcare in slum settlements

Three MSF clinics continued to provide free basic healthcare in the Kibera slum in Nairobi, as well as integrated treatment of HIV/AIDS, TB and chronic



non-communicable diseases. More than 330 people sought assistance at MSF’s 24-hour clinic for victims of sexual violence. Services included post-exposure prophylaxis, psychological support and medical treatment. In 2013, teams working in Kibera completed more than 142,000 outpatient consultations, and provided antiretroviral (ARV) treatment to over 4,300 HIV patients.

In February, MSF opened a new clinic in Kibera South that has been set up with the aim of gradually handing over management to the Ministry of Health over a period of five years. It is equipped to provide residents with basic healthcare and maternity services. There is an inpatient maternity ward, and an ambulance service for obstetric and other emergencies. Integrated management of

chronic diseases such as HIV, and any other illnesses, makes it a one-stop service, thus easing patients’ access to medical care and facilitating early diagnosis, treatment and follow-up. Health education sessions, counselling and social support are also offered to empower patients to manage their own health.

More than 60 per cent of all consultations at MSF’s Kibera clinics were for respiratory infections and diarrhoeal or skin diseases, a result of the poor hygiene and sanitation.

The Eastlands area of Nairobi, composed of poor suburbs and informal settlements, is home to a population of about two million. An average of 150 people who had been the victims of sexual violence came to the



Residents of the Kibera slum in Nairobi wait to be seen at an MSF clinic.

MSF clinic each month for medical and psychological aftercare. A team also treated around 476 patients with TB and 40 with drug-resistant TB. An MSF team carried out a health assessment in Eastlands to evaluate other needs and to explore the extent of sexual violence in the area. A proposal to expand the programme will be completed in 2014. The Blue House clinic, where MSF has been providing HIV care since 2001, was handed over to the AIDS Healthcare Foundation.

Addressing the HIV epidemic in Homa Bay

MSF continued the handover of the HIV programme at Homa Bay to the Ministry of Health and its partners, and expects to complete the process by 2015. Some 25,000 people have received care in the programme since 2001.

However, as a result of MSF's HIV impact in population survey in Ndhiwa, Homa Bay – which found one of the highest incidences of HIV in the world – MSF set up a new programme in 2013 to increase the response

to this epidemic. It will open in the first half of 2014.

Emergency interventions

An MSF emergency intervention had been underway in the Tana River delta region since the beginning of the year assisting victims of intercommunal violence, but the response was expanded when the area was subject to heavy flooding in April and many communities were displaced. Teams provided medical and mental health support to people from both the Orma and Pokomo communities. More than 4,900 health consultations and 160 individual and family mental health consultations were carried out. Staff also organised more than 830 community activities within the camps for displaced people, such as latrine construction, distribution of relief items, water treatment and sanitation services.

There was sporadic violence throughout the year in the Rahmu area of Mandera county, and during intense clashes between local armed militias in May, houses were destroyed and looted. An MSF team

distributed relief items to the people affected and donated drugs and medical material to Rahmu hospital, where several wounded were treated. MSF facilitated referrals and also conducted training for Ministry of Health staff. This emergency aid was completed in August.

Charles 43 years old

I felt hopeless after having been diagnosed with HIV in 2003. This was when stigma and discrimination was very high. Before MSF came, all I thought I could do was hide and wait to die just like I had witnessed my friends and neighbours fade away. I am now a family man with one wife and a pretty five-year-old girl. ARV treatment gave hope to the hopeless and I am now a beneficiary of the good free health services offered by MSF. As an activist, I continue to lobby for better policies to ensure that all Kenyans who need treatment can access it.

No. staff end 2013: 789 | Year MSF first worked in the country: 1987 | msf.org/kenya



An MSF team assisting flood victims in the Tana River region.

LEBANON

KEY MEDICAL FIGURES:

- 114,200 outpatient consultations
- 6,700 individual and group mental health consultations

An estimated one million Syrian refugees have made their way to Lebanon, a country with a population of only four million.

Despite tremendous efforts by the Lebanese authorities and the provision of international aid, the various structures and schemes put in place to assist refugees are unable to cope with their numbers.

As a consequence of the huge increase in new arrivals, tensions grew in 2013 and refugees were living in dire conditions with very little assistance. According to Médecins Sans Frontières (MSF) assessments, access to hospital care and free medicines for Syrian refugees were severely limited, and obstetric care was not available. It was difficult for them to benefit from health services because of the charges they had to pay – most had left everything behind and were struggling to support themselves.

In 2013, MSF was present in Tripoli, the Bekaa Valley, Beirut and Sidon (Saïda), delivering medical care to people directly or indirectly affected by the Syrian crisis, including Syrian refugees, irrespective of registration status, vulnerable Lebanese, Palestinian refugees, and Lebanese returnees from Syria.

The majority of Palestinian refugees from Syria have gathered in Sidon at the vastly overcrowded Ein-el-Hilweh refugee camp, where there are regular security incidents and clashes between political factions. The camp has existed since 1948 and is the largest Palestinian refugee camp in Lebanon, with an estimated population of 75,000. As many people are experiencing symptoms of trauma and distress, an MSF mental health programme at Human Call hospital and two clinics in the camp provide psychological support. They also offer medical and psychological care for victims of sexual violence. In June, a team began to carry out consultations for people with chronic diseases at Human Call hospital. Outside the camp, MSF offers mental healthcare to Palestinian and Syrian refugees, as well as local residents, at the Saïda governmental hospital and the Palestinian Red Crescent hospital. A team



implemented psychosocial activities for Syrian refugees living in unfinished buildings in the area.

In Tripoli, Lebanon's second largest city and home to most of the Syrian refugees, MSF provided medical care for acute and chronic diseases, reproductive healthcare and routine vaccinations at Dar al Zahraa hospital in Abou Samra district. Clinicians, staff training, emergency management and donations of medical supplies were provided to the Tripoli government hospital. A mental health programme run out of the government hospital was handed over to the International Medical

Corps in September. Treatment for acute diseases, reproductive healthcare and routine vaccinations were available at the Jabal Mohsen and the Bab el Tabbaneh dispensaries.

Bekaa Valley

A large number of Syrians crossing into Lebanon enter through the Bekaa Valley. Many people arriving here have suffered as a result of disrupted treatment for chronic diseases such as hypertension, asthma and diabetes. Those who stay in the region live in overcrowded conditions with host families or in scattered settlements in unheated abandoned or unfinished



An MSF staff member visits a Palestinian family living in Ein-el-Hilweh refugee camp.

buildings, courtyards and tents. MSF worked in Baalbek, Majdel Anjar (West Bekaa), and Aarsal and Hermel (North Bekaa), providing treatment for acute and chronic diseases, as well as reproductive healthcare. Patients included Syrian and Palestinian refugees, and Lebanese returnees.

As winter approached, MSF began distributing blankets, fuel vouchers, washing kits and stoves to the most vulnerable new arrivals.

Teams also helped refurbish public buildings in Aarsal in order to accommodate new arrivals. Five buildings were finished by the end of the year, two of which were already sheltering Syrian families.

Beirut

MSF works in the Shatila camp in Beirut, where many Palestinians from Syria have sought refuge, focusing on the basic and mental healthcare needs of children, pregnant women and patients suffering from chronic diseases. The team set up a system for supporting patients with emergency surgical needs, and refers them to two hospitals with which MSF has agreements.

A small team based itself in Southern Lebanon in February to provide basic healthcare for refugees. This project is ready to expand if there is another influx of refugees.

Malak

23 years old, Syrian refugee

My mother came yesterday with my two younger brothers from Qara. She had a very difficult journey because there was constant shelling on the way. It took them 18 days to get here. They moved from one neighbourhood to another until it was safe for them to cross the border. My husband and I took a van with our two children (four and two years old) 10 days ago. People were calling on each other in all Qara to leave. The situation was going to be very dangerous. The first couple of days we didn't move; we thought they were after young men for the army service. But then we understood that even women and children would be targeted. So we left.

No. staff end 2013: 127

Year MSF first worked in the country: 1976
msf.org/lebanon



A young Lebanese girl has her temperature taken at Bab el Tabbaneh dispensary in Tripoli.



These two Syrian families live in an unfinished building in the suburbs of Aarsal.

LESOTHO

KEY MEDICAL FIGURES:

- 1,300 patients on first-line ARV treatment
- 1,400 births assisted

There is also a shortage of skilled healthcare workers.

Médecins Sans Frontières (MSF) aims to close some of the gaps in care by providing integrated HIV and TB care in a programme focused on maternal and child health. Antenatal, postnatal and emergency obstetric care are offered at St Joseph’s district hospital in Roma, six basic healthcare clinics in the lowland area and three clinics in the more remote Semonkong area. An ambulance and maternity lodge provided by MSF, where women can come to give birth, have also improved emergency care.

Increased decentralisation of the HIV and TB component of the programme is providing people with the specialised care they need closer to their homes. In order to meet staffing needs, nurses have been trained to initiate and follow up HIV and TB treatment with the supervision of doctors, and village health workers and lay counsellors have been trained in key support roles.

Several advances in the programme were made during 2013. Beginning in April, all women who tested positive for HIV were put on antiretroviral treatment to prevent the transmission of HIV to their babies. A community adherence group was also piloted in one health centre. Here, patients get together to discuss concerns and pool resources so that only one of them, on a rotating basis, has to collect the medicines for the entire group. Technological improvements were made with the installation of CD4 testing machines (the CD4 count is an indicator of an HIV patient’s immunity level) in nine health centres, and the introduction of a rapid TB test (GeneXpert).

MSF was also granted permission to expand viral load monitoring within its programme ahead of changes in the national protocol. Measuring the amount of HIV virus in the blood is used to ascertain when first-line HIV treatment has failed and a patient needs an alternative drug regimen.

More than half of all maternal deaths in Lesotho are attributed to HIV and tuberculosis (TB).

Although basic healthcare is free, accessing it is not easy in this mountainous country, where many people live far from facilities.

Year MSF first worked in the country: 2006 | msf.org/lesotho



© Peter Casier / MSF

Ha Seng is one of the clinics supported by MSF, and women come for ante-, postnatal and emergency obstetric care.

LIBYA

Libya's health system is gradually recovering from the 2011 conflict, but the violence has had a lasting effect on many people's mental health.

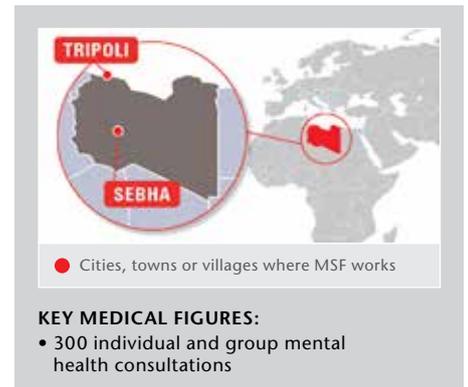
The World Health Organization estimates that more than a third of Libyans were directly and/or indirectly exposed to the conflict. The prevalence of severe post-traumatic stress disorder was estimated at 12.4 per cent and severe depression at 19.8 per cent in 2012.

In August 2013, Médecins Sans Frontières (MSF) opened a mental health centre in Tripoli, the country's capital, to help people suffering from physical and mental health problems related to violence. The centre treats people who have been affected by any form of violence, be it physical, psychological, sexual or conflict-related.

Designed to provide comprehensive care for a broad spectrum of mental disorders, the centre takes a multi-disciplinary approach across psychiatry, psychology and medical services. The team also trains doctors from the Ministry of Health and has established a referral system from basic healthcare facilities and from Libyan and international NGOs.

Emergency support

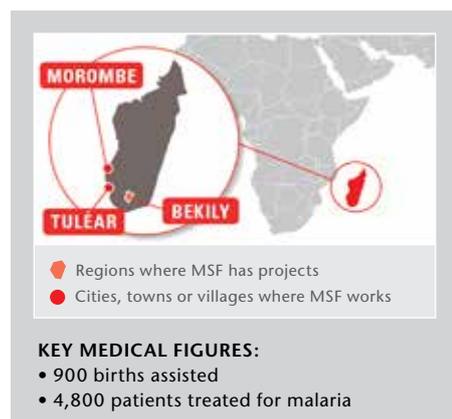
An outbreak of methanol poisoning in March killed approximately 90 people in Tripoli and resulted in the hospitalisation of around 1,000. MSF sent toxicology experts from Norway to offer technical assistance to the Libyan Ministry of Health and provided supplies of the antidote fomepizole, which acts by blocking the toxin produced by methanol poisoning. MSF toxicologists also carried out training for medical staff at Tripoli Medical Center and Tripoli Central Hospital to improve diagnosis and treatment in case of future outbreaks.



A team provided support to the Sebha Medical Center in the south of the country in September, when the facility treated a number of migrants suffering from burns as a result of a traffic accident. Medical supplies and materials needed for burn management were delivered, and staff received training in the appropriate clinical management of burn patients.

No. staff end 2013: 35 | Year MSF first worked in the country: 2011 | msf.org/libya

MADAGASCAR



Tropical cyclone Haruna struck the southwest coast of Madagascar on 22 February, causing extensive flooding and resulting in the displacement of more than 10,000 people.

People in the cities of Tuléar and Morombe were particularly affected by the cyclone. Several aid agencies responded, including a team from Médecins Sans Frontières (MSF) that ran mobile clinics and donated drugs to facilities in the cities and to health centres in the surrounding areas until mid-April. From February to May, a team also helped health authorities respond to a spike in malarial infections in Tuléar, Morombe and Betioky. A total of 5,761 consultations were carried out.

Governmental budget cuts to social services following the 2009 presidential coup have severely affected the country's health sector. A policy of free healthcare access for those in need was officially abolished in 2012. International donors also remain reluctant to release funds for non-emergency situations. Meanwhile, people in remote regions are unable to access the services they need because of the distances to health facilities.

Improving healthcare in Androy region

Since 2011, an MSF team has been improving patient care in the remote Androy region. Clinical care and drugs are dispensed through Bekily hospital's emergency room, inpatient department, and antenatal and maternity unit. Medicines, staff training and consultations are also provided in two health centres. Patients receive treatment for a range of health concerns such as malaria and tuberculosis, as well as for schistosomiasis (bilharzia), a curable parasitic disease endemic in Madagascar. In addition, MSF works with the Centre for the Testing and Treatment of Tuberculosis, testing, raising awareness and carrying out consultations. During 2013, 70 new patients were admitted for treatment.

No. staff end 2013: 118 | Year MSF first worked in the country: 1987 | msf.org/madagascar

MALAWI



KEY MEDICAL FIGURES:

- 75,100 patients on first-line ARV treatment
- 5,900 women enrolled on PMTCT treatment

Malawi is largely dependent on international aid for healthcare. Seventy per cent of general health services and 99 per cent of antiretroviral (ARV) coverage are donor-funded.

Malawi's HIV rates are among the 10 highest in the world: more than one in 10 people are estimated to be infected. The healthcare system is chronically underfunded and there is a severe shortage of skilled workers – a 61 per cent vacancy rate for clinical staff. Médecins Sans Frontières (MSF) has therefore been supporting the HIV response, improving care for patients, and also aiming to strengthen the existing health system through staff training and technical support, innovative and progressive treatment models, and by implementing operational research.

Chiradzulu programme

The HIV programme based in Chiradzulu district, and decentralised via 10 health centres, had more than 28,000 patients receiving ARV treatment this year. In mid-2013, the first point-of-care viral load test was installed in a rural health centre, thanks to a UNITAID grant. This test measures the amount of HIV virus in the blood, which increases when first-line treatment fails, so patients can be switched to a different drug regimen.

An MSF study in Chiradzulu showed that 65.8 per cent of people needing ARV treatment were receiving it, and a population-based survey revealed that there was also a very low level of new infections (0.4 per cent), suggesting that the large distribution of HIV treatment has played a role in reducing transmission.



Marita Saga's HIV status is classed as undetectable after she successfully adhered to her ARV treatment regimen.

Nsanje project

MSF started providing mentorship and improving health services in Nsanje and Chikhwawa districts in the far south of the country in 2010. In 2013, MSF withdrew from Chikhwawa and expanded its work in Nsanje, focusing on the needs of specific vulnerable groups. Early treatment through a 'test and treat approach' was implemented for sex workers, couples where only one partner had HIV, and HIV-positive breastfeeding women. Prevention of mother-to-child transmission of HIV was also fully integrated in all 14 health clinics. A total of 50 health workers were mentored in 14 sites and 88 per cent of them completed the mentorship programme.

Thyolo programme handover

The scheduled handover of first-line HIV treatment in Thyolo was completed, with the bulk of the HIV services now being delivered by the Ministry of Health. MSF remains in Thyolo to conduct operational research, to help expand community ARV treatment groups, and to provide technical and clinical services for people in need of advanced or specialised HIV care.

Developing capacity for hard-to-reach rural areas

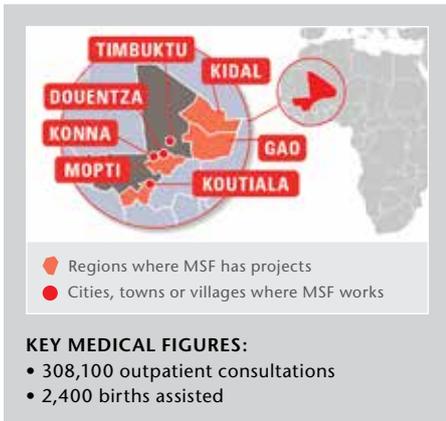
By the end of 2013, 49 students had enrolled in MSF's Rural Human Resources

for Health (HRH) Scholarship Programme. With this programme, MSF addresses the shortage of health workers in the understaffed, hard-to-reach areas of Thyolo, Nsanje and Chikhwawa districts by recruiting local students and paying for their training as mid-level health workers. In turn, the students agree to work for the health ministry in their home areas for at least five years.

David Chiradzulu

I have been on antiretroviral treatment since February 2002. Two months ago was the first time I got my viral load measured. Before, I only had my CD4 cells counted. So after more than 11 years, I am happy to know that my viral load is undetectable and that my treatment is working. I am also only taking one drug a day now and I feel very good!

MALI



Although the situation stabilised somewhat in Mali in the second half of the year, many people are still afraid to return home. The 2012 crisis has furthered weakened the healthcare system, particularly in the north.

Many health workers have fled the country and access to adequate medical care remains a significant issue throughout Mali, even in the south. Malnutrition and malaria are persistent health concerns.

Early in the year, sporadic attacks and fighting around Gao caused people to flee in fear of air strikes and reprisals. Some families left the country while others found shelter in small villages or withstood harsh living conditions in the bush. Médecins Sans Frontières (MSF) provided basic healthcare at several health clinics in the region. At the beginning of the year, teams were working in Chabaria, Wabaria and Sossokoira and services began at Bazi Haoussa health clinic in June. All these activities had been handed over to other NGOs and development agencies by the end of the year.

A team also worked in the 39-bed Ansongo hospital, south of Gao, vaccinating children and providing outpatient and inpatient services, reproductive healthcare and emergency surgery. More than 8,500 children were vaccinated against measles.

Healthcare in Timbuktu

Insecurity in and around Timbuktu contributed to a deteriorating food and

health situation. It is difficult for people to reach health facilities, particularly when they have to travel along roads targeted by armed gangs. MSF works in all departments of the 60-bed Timbuktu hospital, Niafunké hospital and five outlying health centres. A total of 91,975 consultations were conducted for patients mainly suffering from malaria, pregnancy complications, respiratory infections and chronic diseases.

Paediatric care

In the south, MSF continued a comprehensive paediatric programme in Koutiala, Sikasso state, in conjunction with the Ministry of Health. A free healthcare package is aimed at ensuring children's growth and development and reducing hospitalisation. MSF manages the paediatric unit in Koutiala hospital, where over 5,300 patients were admitted, including more than 5,000 children with severe or complicated malnutrition. Teams also provide basic healthcare in five peripheral health centres, where some 82,000 medical consultations were undertaken, more than a third involving malaria, and 3,460 children with severe malnutrition received treatment.

Preventive and curative paediatric care is also offered in the Konseguela health area, where children receive healthcare and preventive measures, including a

full package of vaccinations. Teams have observed a reduction in acute severe malnutrition and stunting in the children participating in the programme.

MSF implemented Seasonal Malaria Chemoprevention during the high transmission period between July and October. On average, around 163,000 children were given treatment at each of the four rounds and it is estimated that approximately 87 per cent of children received at least three of the four distributions. The number of children suffering from uncomplicated malaria in 2013 was 31 per cent less when compared to the previous year.

Severely malnourished children received medical care from MSF in Mopti region. The project, which had opened in 2012, was handed over to Save the Children in March. Before, during and after the fighting erupted in northern Mali, MSF worked in Mopti and Douentza districts, where the focus was on maternal and child health, basic healthcare and surgery. Teams worked in a referral centre in Douentza and in five basic healthcare centres: Konna, Boré, Douentza, Hombori and Boni. These activities had all been handed over to the Ministry of Health by late November.

No. staff end 2013: 610 | Year MSF first worked in the country: 1992 | msf.org/mali



Waiting to be seen at the MSF-supported health centre in Konna.

MAURITANIA

In January, another 15,000 refugees escaping violence in Mali crossed into Mauritania, joining those already settled in precarious conditions at Mbera camp.

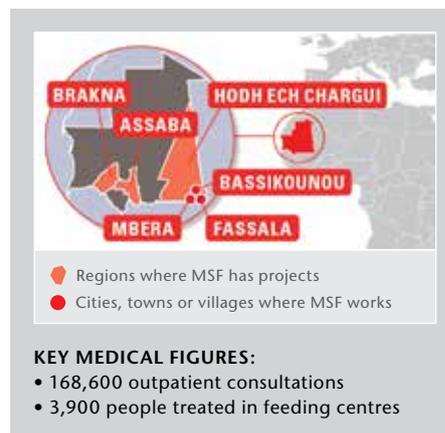
The presence of armed groups in Mali has instilled fear and pushed thousands of refugees into Mauritania. By early 2014, over 59,000 people had settled in the middle of the desert, and ethnic tensions in northern Mali have quashed any hopes of a swift return home.

Refugees receive healthcare through a health post at the border in Fassala – which also screens children aged from six months to five years for malnutrition – and through three health centres in Mbera camp, all supported by Médecins Sans Frontières (MSF). Teams carried out some 1,800 consultations each week in 2013.

The living conditions in the camp are very difficult and people rely on aid to survive. In April, MSF released *Stranded in the Desert*,

a report calling on aid organisations to meet the basic needs of refugees in Mbera. The majority of the diseases treated inside the camp are preventable, and are primarily caused by a lack of clean water and food. A comparative data analysis revealed that children developed malnutrition after six to eight weeks in the camp, and an average of 300 severely malnourished children were treated there every month.

MSF also supports Bassikounou health centre, where an operating theatre was set up to provide emergency surgery for refugees and the host population, and to stabilise patients for referral to the hospital in Néma. MSF carried out 160 interventions this year, the majority of them emergency responses.



KEY MEDICAL FIGURES:

- 168,600 outpatient consultations
- 3,900 people treated in feeding centres

Azarra*

40 years old, from Timbuktu

It took us two days to arrive in Fassala; we were tired but we were alive and safe. That was the most important thing. Now, we have to adapt to life in Mbera camp but it is very difficult for us ... I was poor in Mali but here it is even worse, I have absolutely nothing and I feel like a complete stranger, far from my own country. I want peace to return to the north so that I can finally go back home.

*Name has been changed.

No. staff end 2013: 307 | Year MSF first worked in the country: 1994 | msf.org/mauritania

MOROCCO



MSF handed over its migrant health projects in Morocco.

There is a steady flow of migrants from Africa – many of them coming from war-torn countries – making their way to European countries through Morocco. The reinforcement of European borders,

however, has meant that the country has become an unexpected and sometimes difficult final destination for many of them.

Médecins Sans Frontières (MSF) opened a programme in 2002 to address the poor access to healthcare and inhumane treatment that migrants experience, and has spoken out about their plight on several occasions, including in a report published in 2013, *Violence Vulnerability and Migration: Trapped at the Gates of Europe*.

In 2012, MSF started winding down a project in Rabat which supported trafficked people – mainly women, and many the victims of sexual violence – and the programmes facilitating access to healthcare for migrants in Oujda and Nador. The handover process to local health and human rights organisations was completed in February 2013. The decision

to close the Morocco programme was based on the fact that access to healthcare for sub-Saharan migrants has improved, and that local organisations have emerged to help ensure that migrants get the healthcare they need and that their rights are respected.

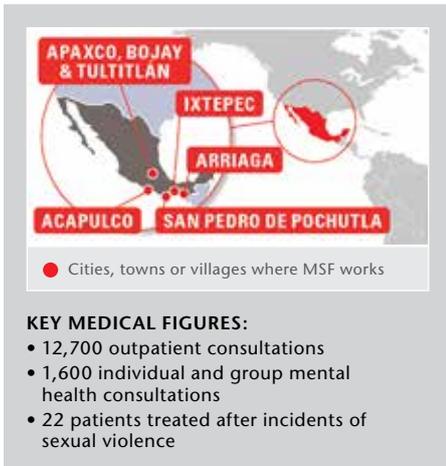
Beatrice

52 years old

They sent us to Médecins Sans Frontières, who told us we should do the tests for HIV. It's me who is a victim; my children are in good health. When I started to cry the doctor encouraged me. She told me that it's good to know, because now that we know they can help me with the treatment.

No. staff end 2013: 7 | Year MSF first worked in the country: 1997 | msf.org/morocco

MEXICO



Ongoing violence, mainly linked to criminal organisations involved in the drug trade, has serious health consequences for vulnerable populations, including economic migrants and people fleeing threats and attacks in their home countries.

The estimated¹ 91,000 migrants from Central America who journey across Mexico by freight train each year, hoping to reach the United States, are at particular risk. Many become victims of assault, abduction, torture, sexual violence and/or murder. People living in areas affected by violence also suffer from a lack of access to medical care, due in part to overwhelmed emergency services. Healthcare resources are generally scarce for victims of violence, particularly of sexual violence, and their mental health needs go largely unmet.

Teams from Médecins Sans Frontières (MSF) are addressing the medical and psychological needs of victims of direct and indirect violence. Programmes continued this year in Ixtepec (Oaxaca state), Bojay (Hidalgo state), and Apaxco and Tultitlán (México state). The activities included basic healthcare, reproductive and sexual health services, and mental healthcare – during the year there were 1,389 trauma consultations. Staff also made hospital referrals and ensured emergency cases were followed up. The programme in



Migrants from Central America travel across Mexico by train in a bid to reach the US.

Arriaga, Chiapas state, was closed in April, as healthcare services for migrants were handed over to the government.

Dengue emergency

Early in the year, the state of Guerrero and particularly the city of Acapulco saw a peak in the number of dengue cases, a viral infection spread by mosquitoes. Health programmes were put in place to combat the illness but were later suspended in some of the most vulnerable areas of Acapulco because of security incidents. In October, MSF worked with local institutions such as the church to promote dengue prevention and education, hiring and training 140 people from the area and fumigating 7,200 houses.

Chagas disease

Chagas, a parasitic disease that can be asymptomatic for years but may cause debilitating complications and death if left untreated, is now recognised as a healthcare priority by the government. An MSF Chagas project, designed in coordination with health authorities and integrated into the public healthcare network of San Pedro de Pochutla, Oaxaca state, was being set up at the end of the year.

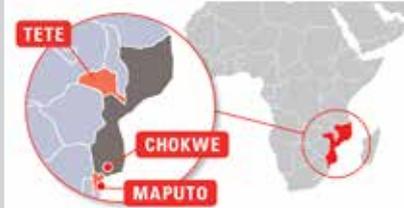
¹ *Migrantes en su paso por México: nuevas problemáticas, rutas, estrategias y redes.* Ana María Chávez Galindo and Antonio Landa Guevara.

A Guatemalan transmigrant*

I was kidnapped for 16 days near Tenosique ... They talked with my brother-in-law, as they forced us to give them the phone numbers of our family. They asked for US\$5,000 in order to let us go. Once the ransom was paid, they dumped us in Boca del Cerro without clothes and with bruises all over our bodies. I was on the hill all day and then I had to walk all night to reach a town. Some people helped me and took me to the nearest hospital ... I returned to Guatemala and, 15 days later, I was again crossing into Mexico.

*For security reasons, the person's name has been withheld.

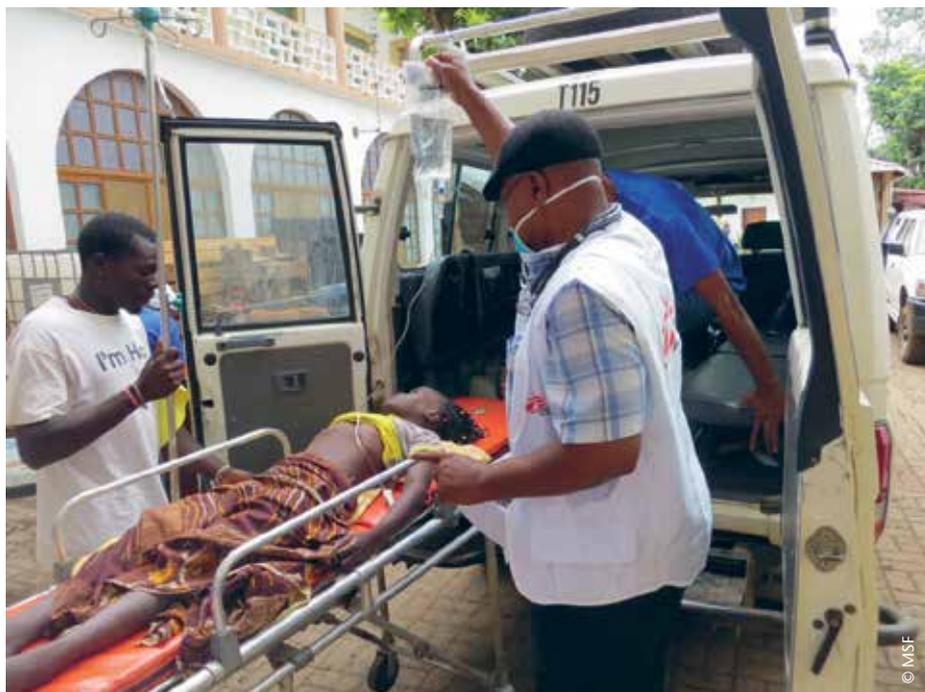
MOZAMBIQUE



- Regions where MSF has projects
- Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

- 55,100 patients on first-line ARV treatment
- 4,000 patients under treatment for TB
- 1,700 women screened for cervical cancer



There was extensive flooding at the beginning of the year in Gaza province and health facilities were disrupted. MSF supported the Ministry of Health with extra staff and medical supplies.

Médecins Sans Frontières (MSF) has been supporting the Ministry of Health to increase the number of people on antiretroviral (ARV) treatment for HIV.

Despite progress in Mozambique's national response to HIV/AIDS, the virus still accounts for 40 per cent of adult deaths and 14 per cent of child deaths in the country.

One significant barrier to people getting appropriate healthcare is a lack of skilled medical professionals. MSF has developed innovative solutions in the management of HIV to overcome this obstacle, by empowering patients as well as lower level healthcare workers.

Comprehensive treatment for HIV patients co-infected with tuberculosis (TB) was provided through programmes in Chamanculo and Mavalane districts in the capital city, Maputo, and in Tete. Specialised care was given to people with more complex conditions, such as drug-resistant TB (DR-TB), and those who had not responded to first-line ARV treatment, or had Kaposi's sarcoma or cervical cancer. Treatment for children was also included in the programmes. MSF is supporting implementation of a policy to provide all HIV-positive pregnant women, and children under five, with ARVs.

In Chamanculo, MSF worked in five health centres and in one referral centre for complex HIV/AIDS cases, all run by the Ministry of Health. MSF also supported the Mavalane project which registered patients on ARV treatment in four health centres and one health post; six per cent of the patients who registered were under 15. MSF has another team supporting the Primeiro de Maio health centre, which provides services specifically for adolescents. More than 600 young people were offered counselling, peer education, testing and linkage to care each month.

Viral load technology, considered the 'gold standard' for monitoring the amount of HIV virus in a patient's blood, was introduced in Maputo and Changara district in 2013. An MSF team provided staff training in support of the Ministry of Health's Acceleration Plan to make ARV treatment available to more people in need.

Flooding in Chokwe

At the beginning of the year, heavy rains caused extensive flooding. Gaza province and the city of Chokwe were particularly

affected, and health facilities, including the main hospital, were disrupted. MSF deployed an emergency team to support the health ministry with extra staff and medical supplies. During the two-month emergency programme the team carried out more than 23,000 medical consultations. Almost half of these related to HIV/AIDS and TB. The rest of the patients were mainly suffering from respiratory infections, diarrhoea and malaria.

Carla

Cured of multidrug-resistant TB in Maputo

I feel like I was born again. It was more than two years of treatment, which finally has ended. I thought about giving up the treatment and I even thought about suicide. Today I have hearing problems and I am forced to use a hearing aid to be able to listen. Besides that, my vision problem got worse. It was a big challenge for me, but now I am cured of drug-resistant TB and I can proceed with my dreams.

No. staff end 2013: 327 | Year MSF first worked in the country: 1984 | msf.org/mozambique

MYANMAR



KEY MEDICAL FIGURES:

- 519,100 outpatient consultations
- 33,200 patients on first-line ARV treatment
- 13,600 patients treated for malaria
- 3,300 patients under treatment for TB

There is an ongoing medical humanitarian crisis in Rakhine state, and there are concerns about the increasing challenges faced by those assisting people in need of healthcare.

While violence and segregation continue in Rakhine state, more than 100,000 people remain displaced, living in appalling conditions in camps, and almost entirely cut off from healthcare and other basic services including clean water. Communities living in isolated villages and townships, most in Northern Rakhine state, also face great difficulty in accessing medical services. As the minority Rohingya remain extremely vulnerable, Médecins Sans Frontières (MSF) is striving to overcome significant challenges and obstacles and provide free, high-quality medical assistance to those most in need.

Working closely with local communities, the team has offered basic healthcare, obstetric services, mental healthcare, treatment for HIV/AIDS and tuberculosis (TB), and supported emergency referrals. MSF also treated 10,816 malaria patients, 84 per cent of the nationwide total. Staff worked in 10 townships across the state, in fixed and mobile clinics in 24 camps for displaced people and in a number of isolated villages.

Throughout 2013, MSF continued to urge the government and the communities of Rakhine to work together with international



A drug-resistant TB patient receives treatment at MSF's clinic in Lashio, Shan state.

organisations to ensure that all patients in need of emergency medical services could access the necessary care, regardless of their background or ethnicity.

HIV and TB programmes

MSF is the largest provider of HIV/AIDS care in Myanmar, treating over 33,000 patients in a country where fewer than one in three people who need antiretrovirals receive them. People with HIV are more likely to have active TB, and multidrug-resistant TB (MDR-TB), which is harder to diagnose and requires two years of arduous treatment, is also an emerging health problem.

MSF runs projects treating HIV and TB patients in Kachin, Shan and Rakhine states, as well as in Yangon and in Dawei in Tanintharyi region. After three years of collaboration with the prison department in Yangon, MSF officially closed its HIV project in Insein prison in December. MSF had provided counselling and testing to 1,400 prisoners and conducted more than 15,000 outpatient consultations since the programme began in 2010.

In 2012, MSF started a programme in Yangon in conjunction with the Ministry of Health, which continued this year, treating 58 patients with MDR-TB.

Ko Min Naing Oo 37 years old, Yangon.

TB first came into my life in June 2000 and kept coming back over the next 13 years, getting harder and harder for the doctors to treat it. I took many different kinds of pills and injections over the years but nothing seemed to get the disease out of my body for good.

Before I started, I was able to carry out normal physical activities, but after I felt tired and exhausted. The side effects from the treatment were strong and it was really difficult to manage. I felt dizziness, pain in my buttocks from all the injections and had problems with my hearing. I felt nauseous when I smelled cooking, found myself easily getting angry, constantly weak and tired, always having diarrhoea, and experiencing hallucinations.

I tried to forget my emotional pain by realising that there are other people who were more socially, economically disadvantaged and with worse health than I was. I often reminded myself that I needed to get back my good health in order to save my family from a miserable situation.

From the MSF blog, 'TB & Me'

NIGER

KEY MEDICAL FIGURES:

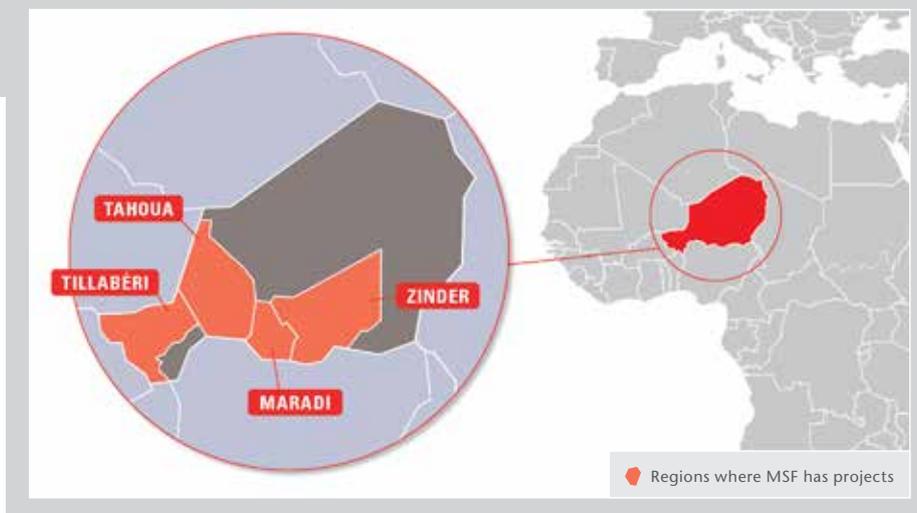
- 916,000 outpatient consultations
- 425,100 patients treated for malaria

Seasonal Malaria Chemoprevention (SMC) was used for the first time in Niger in 2013. Combined with malnutrition screening and treatment, this strategy aims to reduce suffering and child mortality.

During the months between harvests, there is a period known as the 'hunger gap', during which there is a steep rise in the number of children suffering from acute malnutrition. Children under five are particularly affected, as their young bodies have specific nutritional needs for proper growth and development and few reserves. The rainy season, which causes a proliferation of malaria-transmitting mosquitoes, also occurs during the hunger gap. This represents a dual threat to young children: malnutrition weakens their immune system, which makes it more difficult for them to cope with the malaria that causes anaemia, diarrhoea and vomiting, and that then leads to, or complicates, malnutrition. The combination of malaria and malnutrition is often fatal.

Aiming to shift from malaria treatment to prevention as much as possible, teams from Médecins Sans Frontières (MSF) widened the scope of prevention activities in 2013. SMC, a new strategy which has proven effective in Chad and Mali, was used in Niger for the first time. For four months during the rainy season, children received a course of antimalarial medicine in the districts of Guidan Roumdji and Madarounfa (Maradi region), Bouza and Madaoua (Tahoua region) and Magaria (Zinder region). On average, around 225,000 children received treatment at each of the four rounds and dependant on location coverage has been estimated at between 94 and 99 per cent.

While the usual methods of mosquito bite prevention, including the use of nets and sprays remain the basis of the programmes, SMC is proving useful to protect the health of children at risk from severe malaria where there is limited access to care.



Children waiting with their mothers for a course of antimalarial medication.

Teams involved in the SMC campaign undertook it alongside activities for children with malnutrition. MSF has ongoing nutrition programmes providing mobile screening and treatment, as well as hospitalisation for severely malnourished children, in all these regions.

Delivering essential healthcare closer to home is the goal of all MSF's malaria and nutrition programmes, a strategy known as PECADOM (Prise en Charge à Domicile). In Bouza and Madaoua districts, Tahoua region, MSF provided home-based malaria

diagnosis and treatment for pregnant women and children through community health workers based at 111 health posts. These staff are trained by doctors to detect and diagnose malaria, treat simple cases and refer complicated ones. They also examine children's nutritional and vaccination status. Following a measles outbreak in March in Madaoua and Sabon Guida, MSF launched a vaccination campaign in May which reached 84,460 children under the age of 14.

A new approach is also being adopted to help prevent severe acute malnutrition in

some villages in Tahoua region. The *mamans lumières* receive training from MSF teams on how to prepare food for maximal nutrition. The mothers, in turn, share what they learn with peers in their villages.

In Madarounfa district, Maradi region, where MSF provides paediatric care in conjunction with the Nigerien organisation FORSANI (Forum Santé Niger), a team also ran a malaria prevention programme for children under two years old in three of the five health areas. Nutritional supplements were provided, mosquito nets were distributed, and children received routine immunisations. Following heavy rains that destroyed homes and crops in Madarounfa in July, MSF distributed kits with mosquito nets, water cans, soap and blankets to 6,630 people.

In Magaria, Zinder region, MSF continued to focus on decentralising points of care, thus making treatment for malnourished children more accessible. Consultations were held at 'health huts' and in people's homes, eliminating their need to travel to

larger facilities and allowing some of the most vulnerable people to obtain care in their own communities. The development of intermediate treatment and observation at health centres in Magaria, Dungass and Bangaza enabled staff to improve triage and reduced the number of referrals to hospital. MSF has also supported an inpatient feeding centre at Zinder hospital for many years, and this was handed over to the Ministry of Health at the end of 2013. Teams remain ready to open an additional 450-bed treatment centre during peak periods of malnutrition.

Caring for Malian refugees

Armed conflict in Mali since 2012 has led to massive population displacement as people cross national borders in search of safety. MSF teams provided basic and specialist care, maternal healthcare and immunisations to Malian refugees and the host community in Tillabéri region. A total of 57,500 consultations were carried out. The team responded to a cholera outbreak

in May, treating 1,500 patients. Refugee healthcare was handed over to the Qatar Red Cross/UNHCR in September. MSF also worked in the Abala camp, about 250 kilometres north of Niamey, Niger's capital. Basic and specialist care was provided to 14,000 Malian refugees in the camp and some 33,000 local residents. Obstetric and surgical emergencies were referred to the district hospital.

Mariana Assoumane

26 years old, Tounfafi village, Madaoua

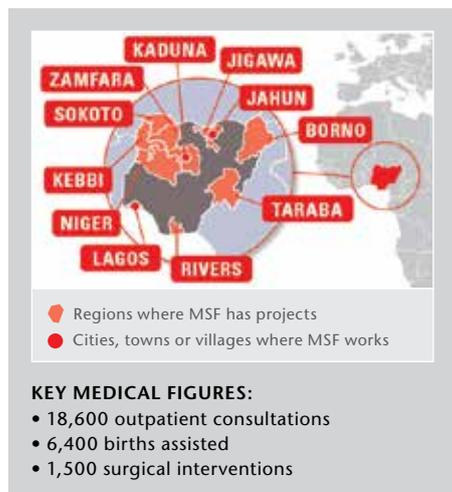
MSF community workers told us to come here for the malaria prevention medicine. We have now realised how important this treatment is and this is why so many people come here to take it. My children usually have malaria. Then their bodies burn with fever, causing seizures, vomiting and diarrhoea. This year ... there are fewer malaria cases.

No. staff end 2013: 1,879 | Year MSF first worked in the country: 1985 | msf.org/niger



In Bouza district, MSF is working to improve healthcare for children under five and pregnant women, focusing on early treatment and prevention, particularly in malnutrition and malaria.

NIGERIA



Health indicators for people living in northern Nigeria remain poor and there are frequent outbreaks of measles, meningitis and cholera.

An upsurge in violence in 2013 added to the difficulty of obtaining adequate healthcare. Threats posed by Ansaru and Boko Haram are affecting security for Nigerians as well as aid organisations.

Where possible, teams from Médecins Sans Frontières (MSF) continued to deliver specialist healthcare to vulnerable people and responded to outbreaks of disease.

Lead poisoning in Zamfara

The rising price of gold has led to renewed interest in mining in Zamfara state, where unsafe practices have resulted in a number of villages being contaminated with lead. The gold deposits contain unusually high concentrations of the metal, and as the rocks are ground into sand highly contaminated dust fills the air. Lead can enter the body through the lungs or digestive tract and is particularly harmful to children, potentially causing brain damage, kidney problems and death. MSF teams screened more than 1,570 children in 2013 and provided some 10,800 basic health consultations for children under five. Since the beginning of the project, 4,804 children have been screened and 4,306 treated. MSF continues to lobby at federal government level to remediate the

remaining villages – for example remove lead-contaminated soil and mining waste from villages, wells and ponds – and treat the children affected by lead poisoning who live there.

Providing maternity care and fistula surgery

Pregnant women in Jigawa state have limited access to maternity services, and deaths due to pregnancy and childbirth are high. It is also estimated that between 400,000 and one million Nigerian women live with obstetric fistula, a consequence of birth complications that causes not only pain but incontinence, which in turn often results in social stigma. MSF's programme in Jahun hospital cares for women with obstetric emergencies and offers surgical repair of fistulas. More than 8,390 women were admitted to the obstetrics unit and 370 women underwent surgery for fistulas.

A maternal and child health programme continued in Goronyo, Sokoto state, where many people suffer from malaria. The project closed in June due to insecurity.

Emergency care in Borno

The ongoing violence in the northeast caused population displacement to other states, including Abuja, and people also fled to countries such as Niger and Cameroon. MSF provided medical care to 3,750 people in Baga and Chibok. The team ended the intervention, which lasted for 10 weeks, in October because of insecurity.

Measles and cholera

A measles outbreak spread through Katsina state in January and MSF donated medicine to 300 public health clinics, thus providing treatment for 14,290 people. More than 217,490 children were vaccinated against measles in Bakori, Sabuwa, Funtua, Dandume and Faskari.

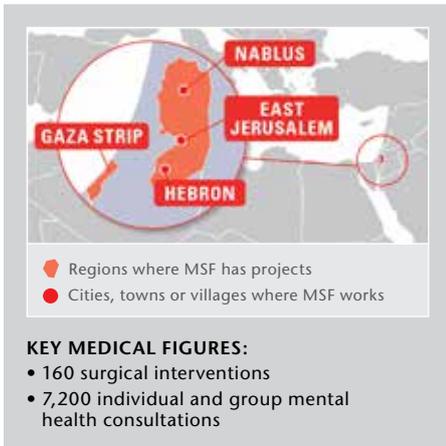
Between March and July a team responded to a measles outbreak in Kebbi, Sokoto and Zamfara states, treating 47,585 people and donating 3,600 treatment kits. Over 2,000 people received cholera treatment in Rini and Gusau between September and the end of December.

No. staff end 2013: 649 | Year MSF first worked in the country: 1971 | msf.org/nigeria



Obstetric fistula patients holding up their art projects on the grounds of Jahun hospital, where women with obstetric emergencies are cared for and surgical repair of fistulas is available.

PALESTINE



Unrelenting violence in Gaza and the West Bank continues to have medical, psychological and social consequences for Palestinians.

The Israel–Palestine conflict and inter-Palestinian violence has increased people’s need for medical and psychological care, and has reduced the availability of drugs, medical equipment and services to treat them. Médecins Sans Frontières (MSF) runs programmes in the Occupied Palestinian Territory aimed at meeting the needs not covered by the Palestinian health system.

In Gaza, MSF focuses on plastic surgery, reconstructive surgery and hand surgery for patients suffering from serious burns, trauma and other debilitating injuries. MSF specialist surgeons, anaesthetists and operating theatre nurses work alongside Palestinian colleagues in the two main public hospitals. Most patients are children with burns injuries caused by domestic accidents, as electricity shortages force people to find alternative means of cooking and heating their homes. MSF runs a clinic in Gaza City offering post-operative care, including physiotherapy and

dressings, to help patients rehabilitate from their surgery.

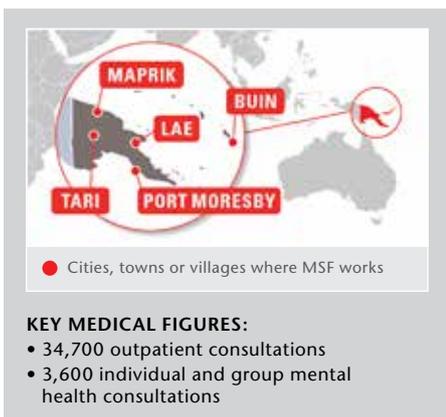
In 2013, MSF started supporting the Ministry of Health on intensive care, by implementing training programmes for medical and paramedical staff. An MSF medical team is working in close partnership with Nasser hospital medical staff, providing bedside clinical instruction, mentoring and technical support.

Mental health support

Exposure to conflict violence has a severe impact on people’s mental health. In Nablus, Hebron and East Jerusalem, MSF teams continue to provide psychological and social support to direct and indirect victims of violence. Almost half of the patients are under 18, and most are suffering from anxiety-related conditions. Depression, behavioural issues and post-traumatic stress disorder are common.

No. staff end 2013: 94 | Year MSF first worked in the country: 1989 | msf.org/palestine

PAPUA NEW GUINEA



Domestic and sexual violence is a medical-humanitarian emergency in Papua New Guinea (PNG), with consequences at individual, family and national level.

There are very high levels of sexual, domestic, social and tribal violence throughout PNG, and yet care for victims remains inadequate and, in many places, nonexistent. A durable model for prevention or treatment has yet to be identified, and survivors need access to free, quality, confidential and integrated medical care.

In June, MSF handed its project treating people suffering from high levels of intimate partner violence and sexual violence back to Angau Memorial General Hospital in Lae, but continued to provide technical support. The MSF team at Tari hospital in the southern highlands performed 830 major surgical procedures this year, and also continued to run a family support centre where 1,231 consultations were conducted. March marked the launch of the Port Moresby Regional Treatment and Training project, where staff were trained to provide the integrated care available in Lae. Five essential services are

covered during one appointment: emergency medical care for wounds, psychological first aid, preventative drugs for HIV and other sexually transmitted infections, emergency contraception and vaccinations to prevent hepatitis B and tetanus. The aim of the project is to help more people experiencing domestic and sexual violence to access the care they need through health centres and family support centres throughout the country.

Buin Health Centre

Access to healthcare in Buin district has improved significantly in recent years, and this combined with increased support from the provincial health services and AusAID (Australian Agency for International Development) means that MSF is starting to plan the closure of its project there. Teams carried out 3,894 antenatal consultations, 979 family planning consultations and assisted 870 births at the Buin Health Centre this year.



This patient at Tari hospital was attacked by her husband.

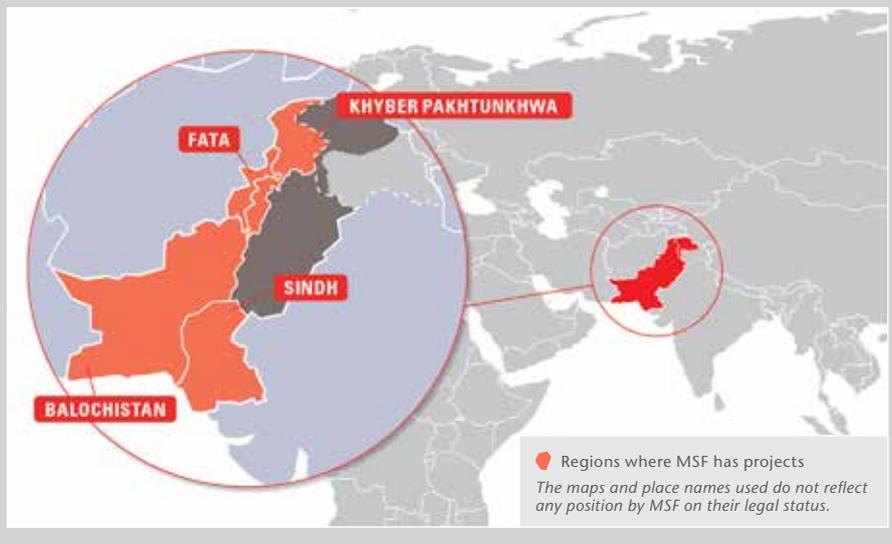
No. staff end 2013: 214 | Year MSF first worked in the country: 1992 | msf.org/png

PAKISTAN

KEY MEDICAL FIGURES:

- 252,500 outpatient consultations
- 3,900 surgical interventions
- 22,700 births assisted
- 8,400 individual and group mental health consultations

Providing comprehensive emergency healthcare to people in remote regions of Pakistan is a priority, yet accessibility and security are a constraint for both Médecins Sans Frontières (MSF) and the patients.



In addition to the general gaps in the healthcare system, people living in remote areas and those displaced or directly affected by conflict suffer from a critical lack of medical services, in particular emergency treatment and maternal and child care. MSF runs programmes to try to address these needs.

Khyber Pakhtunkhwa province

Hangu district borders three tribal agencies, North Waziristan, Orakzai and Kurram. These areas are among those most exposed to violence since military operations were launched by the government in response to an aggressive campaign by the Pakistani Taliban, which started in 2007. There are also sporadic clashes between the Sunni and Shia communities in the district. MSF teams manage the emergency and surgical services in the Hangu Tehsil Headquarters hospital. They admitted more than 25,000 patients to the emergency room and performed 1,407 surgical procedures in 2013. Within the hospital's maternity unit, MSF midwives support Ministry of Health staff, assisting with complicated deliveries, and providing training on obstetric procedures and hygiene protocols.

MSF runs a 32-bed private women's hospital in Peshawar, which opened in 2011. It offers free, emergency obstetric care, including surgery. A third of the 3,717 admissions this year were displaced or refugee women. A referral network has been developed among the district's rural health centres, communities and camps for displaced people or refugees, and is expanding to the neighbouring tribal agencies. A five-bed newborn unit opened, and a further 10 beds will be added in 2014.

In Lower Dir, there was a dramatic increase in patient numbers in the emergency and resuscitation rooms at Timurgara district hospital. More than 100,000 patients came to the emergency room, an increase of 33 per cent over 2012, and more than 22,000 patients were treated in the resuscitation room. MSF provides obstetric care with a focus on complicated deliveries, and assisted around 7,000 births in 2013. Teams also support the blood bank, improve sterilisation and waste management, and organise health education activities – some 56,000 health and hygiene education sessions were carried out. In addition, MSF conducted more than 5,300 mental health consultations and 26,900 mother and child sessions.

Federally Administered Tribal Areas (FATA)

Conflict in Kurram Agency has led to the isolation of local communities, closure of supply routes and the near-collapse of the state-sponsored healthcare system. Measles is very common in Kurram, highlighting gaps in basic health services such as vaccination. The area is hardly accessible to international staff, and local MSF personnel provide paediatric services at hospitals in the Sunni enclave of Sadda and the Shia community of Alizai. In 2013, a military offensive launched against the Tirah Valley in the neighbouring Khyber Agency led to the displacement of thousands of families to New Durrani camp, and around Sadda.

In Bajaur Agency, years of violence have left the population with limited access to basic healthcare. In March, a team of local MSF personnel began running mobile clinics to facilities in Talai, Kotkay and Derakai, providing basic healthcare and monitoring

for cases of infectious illnesses such as measles and diarrhoeal diseases.

Balochistan

Pakistan's largest province is remote and rural, and hosts many Afghan refugees. Healthcare indicators are among the country's worst, as delays in obtaining medical help are common and are accounted for by geography, insecurity in the region and a low density of medical services.

In Quetta, the paediatric inpatient medical care provided by government and private hospitals is insufficient to meet the population's needs and many people cannot afford the fees charged. MSF offers medical care in Quetta paediatric hospital, and treats malnourished children in ambulatory and inpatient feeding programmes. Neonatology services, and family and individual counselling sessions are also available.

An MSF team runs a mother and child health centre in nearby Kuchlak, offering outpatient treatment, including nutritional support, for children under five. There is a birthing unit, and a system to refer complicated emergency obstetric cases to Quetta. Other services include psychosocial support and counselling, and screening and treatment for cutaneous leishmaniasis.

Comprehensive emergency obstetric, neonatal and emergency care is provided at the Chaman District Headquarters hospital, where 17 per cent of patients treated in the emergency room in 2013 were victims of conflict. More than 2,500 measles vaccinations were given, in close collaboration with the Ministry of Health.

In the eastern districts of Jaffarabad and Nasirabad, MSF continued to focus on maternal and child health in programmes in Dera Murad Jamali hospital and four health centres. Conflict-related displacement has exacerbated malnutrition, and vaccination coverage is low. The team conducted a measles vaccination campaign with the Ministry of Health and reached 7,500 children. More than 9,600 children were treated in the therapeutic feeding programme at the Dera Murad Jamali hospital, and 6,000 antenatal consultations were carried out.

Healthcare in Karachi

On the outskirts of Karachi, the Machar Colony slum is home to many undocumented migrants who cannot access medical care. MSF runs a basic healthcare clinic with SINA Health Education and Welfare Trust, providing free basic, emergency and obstetric services

around the clock. Mental health support is also available. More than 35,000 basic healthcare consultations were conducted in 2013, 7,600 children were screened for malnutrition and over 80,000 people participated in health education sessions.

Emergency responses

Together with Ministry of Health staff, MSF treated 110 people for bomb blast injuries resulting from election-related violence in Khyber Pakhtunkhwa and FATA over four days in May. Non-combatants were the primary victims of the violence.

Between August and November, teams responded to outbreaks of both dengue fever and acute watery diarrhoea in Timurgara and Swat, a measles outbreak in Upper Dir in June and July, and an earthquake in the Mashkel district of Balochistan in April. MSF was ready to

provide assistance following the Awaran earthquake in September, in the same province, but the Pakistani government did not think it necessary for MSF to intervene.

Faiz Bibi

Kirani village, west of Quetta

My one-month-old baby boy has been sick with pneumonia. He had a high fever for two days and was wheezing and then became lethargic. My house is far away and when the baby was unwell during the night, in the morning I told my husband I would take the child somewhere – anywhere – for medical treatment. I asked a tuk-tuk [small taxi] driver and he said that at the MSF Quetta hospital, I could have the best treatment for my baby.

No. staff end 2013: 1,528 | Year MSF first worked in the country: 1986 | msf.org/pakistan



This unhappy patient is being treated in a clinic on the outskirts of Karachi.

PHILIPPINES

KEY MEDICAL FIGURES:

- 72,100 outpatient consultations
- 290 surgical interventions
- 29,100 relief kits distributed

The strongest typhoon ever recorded at landfall struck the storm-prone Philippines on 8 November, killing over 6,000 people and displacing more than four million others.

A massive local response had already begun as international aid flowed into the country, including a team from Médecins Sans Frontières (MSF) who arrived in Cebu on 9 November. Typhoon Haiyan destroyed hospitals and clinics and disrupted the public health system. Assistance was needed to treat the wounded and provide relief over a wide area. It was decided that MSF would fill gaps in emergency care and help rehabilitate hospitals and clinics so services would be available for ongoing healthcare needs.

Initially most aid activity was centred around Tacloban, on Leyte island, the main city in

the hard-hit Eastern Visayas, which still had a partially functioning airport and one partially functioning hospital. Damaged and blocked roads, fuel shortages and congested airports in the country posed logistical constraints and there were delays in getting supplies to people in need, particularly during the first 10 days. As many aid organisations were present around the city, MSF used trucks, boats, planes and helicopters to reach

outlying areas and assess people's needs. Teams set up medical activities and delivered relief supplies to typhoon survivors on the principal islands of Leyte, Samar and Panay, as well as smaller outlying islands, adapting aid to fill emerging healthcare gaps as the situation evolved.

Immediately after the typhoon, MSF provided surgery and wound dressings,



People affected by the typhoon on North Gigante island queue to receive shelter material and cooking and hygiene kits.



Typhoon Haiyan resulted in the death of thousands of people, displaced more than four million survivors and destroyed hospitals and homes.

and also treated patients presenting with infected wounds several weeks after the event. Healthcare for people undergoing treatment for chronic diseases such as diabetes, hypertension and kidney failure was also crucial. The psychological impact of the storm itself and of the loss of loved ones and homes meant that there were substantial needs for mental health support.

Leyte island

In the city of Tacloban, MSF erected a 60-bed inflatable hospital with an emergency room and outpatient department, and provided surgical, maternal and mental health services. Teams took mobile clinics around the city to reach people who could not visit the health centres. In Palo district, teams worked in the town of Tanauan, south of Tacloban and in Talosa, distributing essential relief items to 3,000 families

In the Burauen area of Leyte, a team supported the district hospital with staff and supplies and ensured that water and waste disposal were in place and meeting health standards. Staff distributed relief supplies such as tents, washing kits and mosquito nets, supplied clean drinking water and offered mental healthcare to people experiencing severe distress. More than 25,200 people received healthcare,

48,500 obtained relief supplies and 11,470 accessed mental health support.

Panay and offshore islands

Teams were based in Carles, Estancia and San Dionisio municipalities on Panay island and also delivered aid to people residing on 21 offshore islands. MSF rehabilitated 13 health facilities along the coastal areas of the Panay mainland and on the offshore islands, to render them functional and able to provide medical services to those in need. On the offshore islands, MSF vaccinated 4,650 children against polio, and 14,990 against measles. Staff distributed more than 11,000 relief kits and food for 11,000 families, as well as over 1.2 million litres of chlorinated water.

The typhoon caused an oil spill in the Estancia harbour and a team provided medical care, relief items and some 1,500 tents to people relocated to an evacuation centre, and also assisted vulnerable families in the surrounding area.

The Ministry of Health was able to take over Panay activities from MSF in January 2014. Teams had carried out 12,675 medical consultations and given mental health support to 3,290 people.

Eastern Samar

The Felipe Abrigo Memorial hospital in Guiuan, Samar island, was damaged beyond repair by the typhoon and so MSF set up a 60-bed tent hospital as a temporary replacement, equipped with an operating theatre, delivery room, maternity unit and isolation room. Teams carried out medical consultations in rural health centres on Samar and ran regular mobile clinics on the smaller islands south of Guiuan. Many people were suffering mental health distress and MSF teams offered psychosocial support to adults and children through group and individual therapy sessions. MSF's water and sanitation experts ensured that there was proper waste disposal, and supplied clean water for up to 20,000 people each day. Tents, cooking equipment and washing and shelter kits were distributed among isolated communities on the four nearby islands of Manicani, Homonhon, Sulangan and Victory, so people could begin to reconstruct their homes.

Many acute emergency activities were completed by January 2014, yet teams maintained a strong presence in areas where health services were severely diminished and not yet completely rehabilitated. MSF continued to work out of inflatable medical hospitals providing surgery, inpatient care and psychological support.

PARAGUAY



Medical services for the potentially fatal Chagas disease, caused by a parasitic infection transmitted by the triatomine bug, are particularly lacking in remote, rural areas such as the Paraguayan Chaco.

In Boquerón, Médecins Sans Frontières (MSF), in collaboration with the Ministry of Health, piloted an intervention strategy to bring diagnosis and treatment closer to Chaco's most isolated communities. Activities were integrated into Boquerón regional hospital, two smaller hospitals, and 15 health centres and health posts. Mobile teams also visited 120 remote communities that lacked a local health infrastructure.

The project was complemented by community education activities throughout the country and the training of medical

staff (through workshops and academic meetings) and those undertaking entomological surveillance of the bug. A Chagas School Guide was created in collaboration with groups of teachers, and 196 people were trained to use it as a tool in health education.

In total, over the course of the project, 15,330 people were tested for Chagas and 1,632 received treatment.

MSF continues to support Paraguayan health authorities from a distance in the development of a national protocol for Chagas diagnosis and treatment. MSF advocates the delivery of Chagas care within the basic healthcare system, integrated with community education and entomological surveillance and control.

No. staff end 2013: 55 | Year MSF first worked in the country: 2010 | msf.org/paraguay

In December, a three-year project helping to develop better awareness, diagnosis and treatment of Chagas disease came to an end.

RUSSIAN FEDERATION



Years of conflict in the North Caucasus have left gaps in many areas of the health system, resulting in a resurgence of TB, especially DR-TB. Poor diagnosis, interrupted treatment and the questionable quality of the TB drugs available on the open market are some of the factors contributing to high drug-resistance levels.

In 2013, MSF, together with the Chechen Ministry of Health, continued to implement a comprehensive TB diagnosis and treatment programme for patients with both TB and DR-TB. The programme promotes a patient-centred approach, and as the treatment is arduous and the management of side effects an important component, MSF health educators and adherence counsellors provide psychosocial support to all TB patients and their families.

medical services do not meet the needs of those with acute coronary syndromes and other cardiovascular emergencies. In Grozny, Chechnya's capital, MSF is improving the cardiac unit in the Republican Emergency Hospital through staff training and the purchase of medical equipment and medicines for specialised treatment. During 2013, the team conducted further training on fibrinolysis (the breakdown of fibrin, or clots) and improved laboratory procedures, as well as the quality of consultations pre- and post-admission.

Providing mental health support

An MSF team continued to offer counselling to patients in Grozny and communities in the mountainous districts of Chechnya, who are still experiencing the psychological effects of exposure to violence and death.

Expanding cardiac care

There is a high rate of heart disease in Chechnya, but the scale and quality of

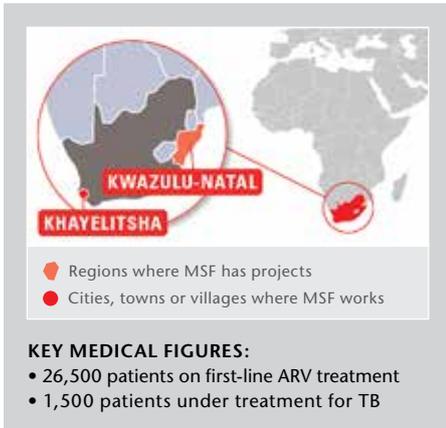
KEY MEDICAL FIGURES:

- 6,100 individual and group mental health consultations
- 430 patients under treatment for TB

Médecins Sans Frontières (MSF) is working with Russian health authorities to address tuberculosis (TB) and drug-resistant TB (DR-TB) in Chechnya.

No. staff end 2013: 153 | Year MSF first worked in the country: 1992 | msf.org/russianfederation

SOUTH AFRICA



These Community Health Agents are doing door-to-door HIV testing.

South Africa remains at the centre of the worldwide HIV/AIDS epidemic. More than six million people in the country live with HIV.

Innovative models of care have been introduced over the past decade and 90 per cent of patients with HIV now receive treatment through the public sector. The projects run by Médecins Sans Frontières (MSF) in 2013 continued to support the empowerment of people living with HIV, by giving them more flexibility in treatment approaches and enabling them to obtain drugs and support in their home communities.

Khayelitsha

Khayelitsha, a poor township on the outskirts of Cape Town, was the site of the first primary-level antiretroviral (ARV) treatment programme in South Africa in 1999, and subsequent innovations include the ARV adherence clubs, introduced by MSF in 2011. One-to-one appointments at the health centre are time consuming for patients who may not have the time to queue for hours to pick up their drugs, and are an added workload for health professionals in a country where medical facilities are chronically understaffed. As an alternative, MSF pioneered adherence clubs that offer people living with HIV the opportunity to combine peer support with check-ups and drug refills at bi-monthly meetings. The model quickly became popular and between

January 2011 and September 2013, 231 ARV clubs were established at 10 health facilities in Khayelitsha, enrolling a total of 7,733 patients.

Research by MSF has found that 97 per cent of adherence club members continued their treatment, compared with 85 per cent for patients who qualified for membership but remained in mainstream clinic care. Club patients were also 67 per cent less likely to experience treatment failure.

In September, the clubs were handed over to local health authorities and are being scaled up, thanks to a US\$15 million Global Fund grant. Community-based clubs are currently undergoing trials.

KwaZulu-Natal

KwaZulu-Natal has the highest tuberculosis (TB) incidence of all the provinces in South Africa and TB remains the leading cause of death for people with HIV. It is also the epicentre of the HIV epidemic in the country, with one in four adults infected. The Bending the Curves project that was introduced in 2013 seeks to implement multiple strategies to address the high co-incidence of HIV and TB, and reduce the number of incidences in line with the South Africa National Strategic

plan. These strategies include: the rapid expansion of community-based testing, greater continuity of ARV and TB treatment, faster TB diagnosis and treatment, and the aggressive promotion of prevention methods, including voluntary male circumcision and earlier treatment of HIV.

Integral to these goals are mobile one-stop shops, where people get rapid HIV testing and treatment in a single location, at the heart of the community. In 2013, teams started an outreach programme of testing and health promotion targeted at mobile populations on farms around Eshowe and Mbongolwane. A stronger focus was also placed on measuring patients' HIV viral load to monitor the effectiveness of ARV treatment, nurse-initiated management of ARV and the promotion of ARV adherence clubs.

Improving access to generic drugs

MSF is actively involved in the Fix the Patent Laws campaign in South Africa, which aims to tighten the law so that it only grants patents to drugs that are truly innovative. This in turn would facilitate the production and/or importation of generic drugs, thus making them more affordable to people seeking treatment.

Year MSF first worked in the country: 1999 | msf.org/southafrica

SOMALIA

KEY MEDICAL FIGURES:

- 318,400 outpatient consultations
- 6,150 births assisted
- 15,600 patients treated in feeding centres
- 28,600 routine vaccinations

In August, Médecins Sans Frontières (MSF) closed all of its projects in Somalia after 22 years of continuous operations.

Leaving Somalia was an extremely difficult decision to make. A series of violent attacks on MSF personnel took place with the tacit acceptance – or active complicity – of armed groups and civilian authorities. The minimal conditions necessary for operations were not respected, and hence MSF ceased supporting health facilities in Somalia by mid-September 2013, handing them over to government entities and humanitarian organisations where possible.

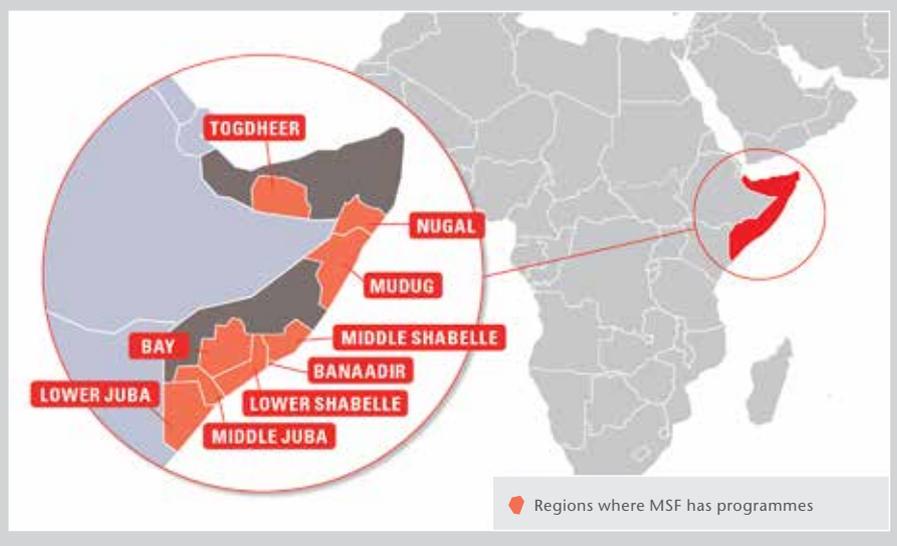
Although the humanitarian situation has improved since the nutritional crisis of 2011, the ongoing conflict in the south-central regions, together with natural disasters and seasonal outbreaks of disease, put huge strains on the weak healthcare system. In many parts of Somalia, access to healthcare is extremely limited and mortality rates for pregnant women and young children are among the highest in the world. Hundreds of thousands of Somalis remain displaced inside the country and in refugee camps across Somalia's borders, living a precarious existence exposed to many forms of violence and extortion.

MSF did not want to leave Somalia but was left with little choice, and continues to support Somali refugees in Ethiopia, Kenya and Yemen.

In and around Mogadishu

Nine kilometres northwest of Mogadishu, in Dayniile, MSF supported a 60-bed hospital with an emergency room, operating theatre, intensive care unit, paediatric unit, feeding centre and maternity facilities. The team performed 646 surgical procedures and over 8,272 consultations in 2013.

MSF's 40-bed hospital in the Jaziira district of Mogadishu, which mostly catered to displaced populations, carried out some 25,700 consultations and 2,200 hospital admissions this year, and treated over 330 severely malnourished children.



To improve access to quality basic and specialist healthcare for children, MSF ran the only paediatric hospital in Mogadishu, in Hamar Weyne. The hospital had isolation wards for children suffering from measles or acute watery diarrhoea and a nutrition centre that treated 3,800 children between January and August.

MSF also ran health clinics for displaced populations and residents in the Wadajir, Dharkenley and Yaaqshiid districts. These focused on maternal and child health and were able to respond to sudden outbreaks of disease such as cholera, treat peaks of malnutrition through feeding programmes, and participate in mass vaccinations against polio, which had made a resurgence in the country. Over 100,000 consultations were carried out at these health facilities prior to MSF's departure. All drugs and supplies

from these clinics were donated to other aid organisations in Mogadishu, and the Dharkenley clinic has continued operations.

Bay region

MSF began supporting Dinsor hospital in Bay region in 2002. It is the main referral hospital for the entire region, and is especially active in providing maternity services and treating malnutrition, tuberculosis (TB) and kala azar (visceral leishmaniasis). In 2013, the team at the 60-bed hospital performed 16,208 outpatient consultations, around 1,458 antenatal consultations, and treated more than 680 malnourished children.

Lower Shabelle region

The Afgooye district hospital serves displaced people and residents of the Afgooye Corridor with an outpatient



In many parts of Somalia, access to healthcare is extremely limited and mortality rates for pregnant women and young children are among the highest in the world.



© Muhammad Daoud/MSF

A child being tested for malnutrition in Hamar Weyne district.

and 30-bed inpatient department, emergency room, maternity facility and an outpatient feeding programme. Between January and September, the hospital conducted 11,408 medical consultations, admitted 738 patients to its wards and assisted the delivery of 953 babies. The Qatar Red Crescent Society assumed support of the hospital following MSF's withdrawal.

Middle Shabelle region

MSF provided outpatient care, maternal and child health services, vaccinations and nutritional support at the Jowhar maternity hospital and health centres in Kulmis, Bulu Sheik, Gololey, Balcad and Mahaday. The Mahaday and Gololey facilities also treated TB. Mahaday clinic closed in March 2013 due to insecurity and the other clinics were handed over to the International Medical Corps (IMC) in September. More than 60,000 consultations were performed, 1,040 deliveries assisted, and 8,447 women and children received vaccinations.

Mudug region

MSF ran projects in two referral hospitals in the divided city of Galkayo. In the Ministry of Health's referral hospital in Galkayo North, MSF offered paediatric outpatient and inpatient care, maternity services, feeding programmes and TB treatment. MSF teams carried out 33,824 consultations in 2013. In addition, MSF ran a satellite

programme for TB treatment in Burtinle in Nugal region.

In the hospital in Galkayo South, MSF provided surgery and paediatric care, maternity services, nutrition programmes, TB treatment and immunisations. Two mobile clinics also provided primary healthcare in Galmudug region. Some 44,071 people received assistance through the hospital and the clinics between January and September. Management of the hospital was passed to the Mudug Development Organisation, which now works in partnership with two international medical organisations to continue these vital services.

Middle Juba

MSF's hospital in the small rural town of Marere served as the referral hospital for the whole of Middle and Lower Juba and Gedo regions, providing basic and specialist healthcare, TB treatment, nutritional services and emergency obstetric care to a huge catchment population. In addition, mobile teams covered the towns of Ketoy and Osman Moto and delivered basic healthcare to children under 12 and nutritional care to malnourished children under five. A small fixed clinic in Jilib had facilities to treat malnutrition, measles and cholera. Over 68,000 medical interventions

were carried out through this programme between January and August.

Lower Juba

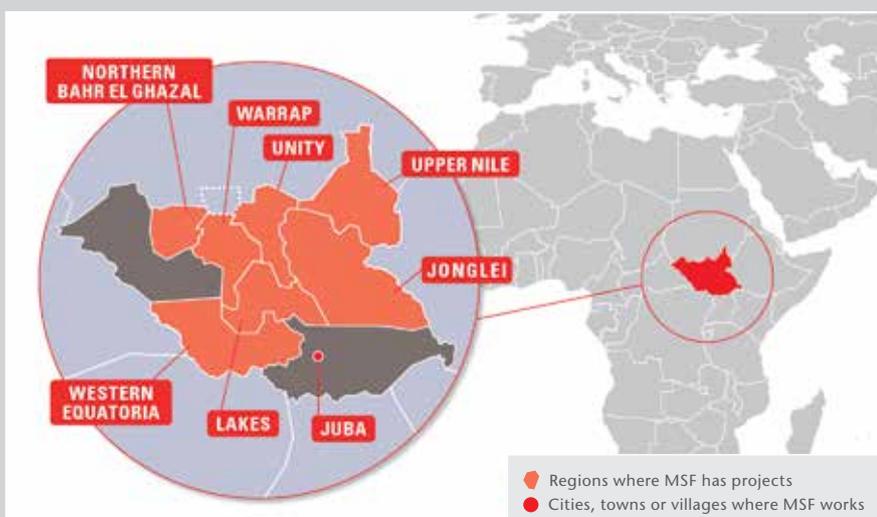
In the port city of Kismayo, MSF ran an inpatient nutrition programme for children under five, with special wards for those suffering from measles and cholera. This facility opened during the nutritional crisis of 2011 and saw a steady stream of children thereafter: 5,183 received treatment between January and September 2013. The International Committee of the Red Cross opened a similar structure at Kismayo hospital in October to compensate for MSF's withdrawal.

Somaliland

MSF had been supporting the inpatient, maternity and surgical facilities of the 160-bed Burao hospital in the Togdheer region of Somaliland since 2011. Prior to its withdrawal, MSF conducted 775 surgical interventions, admitted 1,602 people to the inpatient department and assisted in the birth of 720 babies.

MSF also intervened in three prisons in Somaliland, carrying out medical consultations, improving water and sanitation facilities and distributing relief supplies.

SOUTH SUDAN



KEY MEDICAL FIGURES:

- 981,500 outpatient consultations
- 4,700 surgical interventions
- 50,000 patients admitted to hospital
- 2,750 patients treated for kala azar

Escalating violence in South Sudan increased the need for emergency medical aid as the year progressed.

During clashes between the government and militia in Jonglei state in April, staff and patients at Pibor hospital were subjected to threats and intimidation and Médecins Sans Frontières (MSF) was forced to suspend activities. In May, the hospital was looted and severely damaged, and fighting in the area caused Pibor residents to flee into the bush or hide in malaria-infested swamps without access to safe water or food. As the MSF hospital was the only one in the county, 100,000 people were deprived of healthcare. Thousands of people emerged 40 kilometres away to attend MSF's small clinic in Gumuruk village, where teams carried out over 100 consultations per day for patients suffering from pneumonia, respiratory diseases, malaria, diarrhoea and malnutrition. During the first few weeks, a team set up a surgical unit at Gumuruk and performed 49 surgical procedures. To address the needs of the displaced people, a second clinic was opened in Dorein, south of Pibor town, and a helicopter was used to run mobile clinics in the bush in Pibor county. More than 26,500 consultations were provided across Pibor county over a six-month period. The team also conducted 1,468 antenatal consultations and offered mental health support through individual and group sessions.

On 15 December, fighting broke out in Juba between different army factions and violence spilled onto the streets. Some 40,000 people fearing for their lives sought refuge in two UN compounds, where MSF set up clinics and provided 1,890 health consultations. A high number of people were treated for acute diarrhoea, a direct result of poor water and sanitation. MSF also provided drugs and medical supplies to the Juba Teaching Hospital.

Fighting spread quickly through several states causing displacement, and 70,000

people, mostly women and children, fled the capital of Jonglei state, Bor, for Awerial, Lakes state.

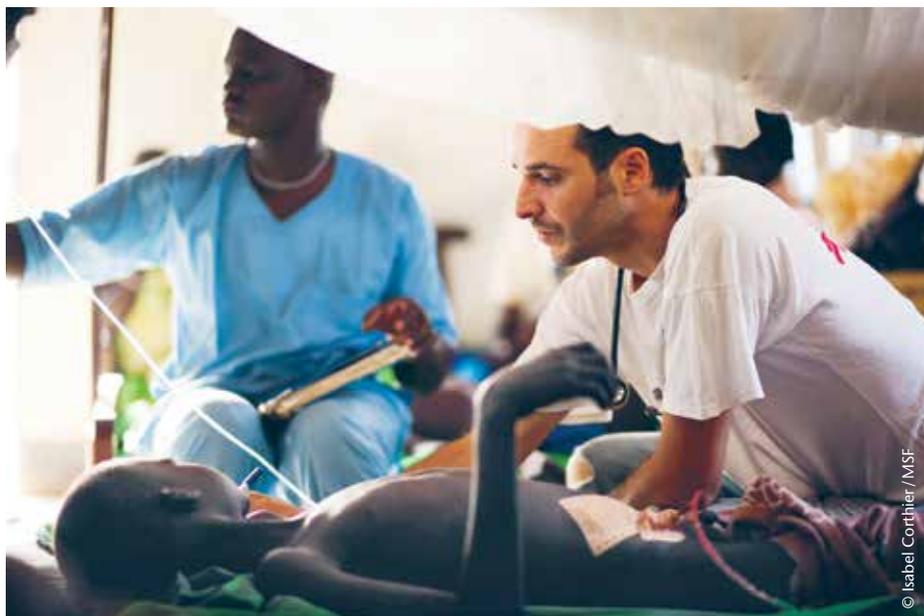
Refugee assistance

In Yida camp, Unity state, MSF provided basic and specialist healthcare, ran nutrition centres and helped ensure adequate water and sanitation for 70,000 Sudanese refugees. Teams delivered the same services to more than 110,000 refugees across four camps in Maban county, Upper Nile state. In cooperation with the Ministry of Health, MSF staff vaccinated 132,500 people against cholera in the camps and the surrounding area.

Teams began providing Sudanese refugees from South Kordofan with basic and specialist healthcare in Pamat, northern Bahr El Ghazal, in February. In October, staff in Upper Nile state offered medical and nutritional assistance to around 5,000 refugees in Fashoda, and carried out surgery and post-operative care at the hospital in Malakal.

Basic and specialist health services

MSF teams continued to offer a full range of services at clinics and hospitals throughout the country, including surgery, maternal and child healthcare, vaccinations, emergency obstetric services and treatment for malnutrition, kala azar, HIV and tuberculosis (TB). They also responded to outbreaks of disease.



In Gogrial town, Warrap state, MSF runs a small hospital that provides a full range of basic healthcare services.

In Jonglei state, more than 71,000 outpatient consultations were provided among a full spectrum of services at the Lankien hospital and an outreach clinic in Yuai. Further south, in Bor, 177 patients received emergency care from MSF at the Ministry of Health hospital during the violence that broke out in July and August.

The Nasir hospital, Upper Nile state, provided a full range of basic and specialist services including HIV and TB treatment, and cared for patients referred from surrounding counties and the border areas of Ethiopia.

In Bentiu, Unity state, MSF handed over a nutrition programme to the health ministry in February and opened a project to treat people with TB and HIV in the town and the surrounding area. In Leer, also in Unity state, MSF offered basic and specialist healthcare. More than 68,000 outpatient consultations took place; 13,394 of these

were for patients with malaria. MSF also performed 336 surgical interventions.

Health services are offered to residents, internally displaced people and nomads in Agok, 40 kilometres from the city of Abyei. MSF runs the only hospital in the area, providing comprehensive services including HIV and TB care. MSF constructed a new maternity ward in September to accommodate the high number of premature and low birth weight babies. Staff operated mobile clinics to ensure people in remote regions could access basic and maternal healthcare and referrals.

Around-the-clock care is available for children up to the age of 15 at Aweil civil hospital, Northern Bahr El Ghazal. Services include intensive care, surgery, treatment of burn victims, and neonatal, tetanus and isolation units. The hospital also has an inpatient maternity department. Staff

assisted more than 6,100 births and admitted over 4,600 children to hospital this year.

In November and December, MSF provided fistula surgery to 55 women. Fistulas, a consequence of birth complications, cause not only pain but incontinence, which in turn often leads to social exclusion and sometimes rejection by friends and family. The team also ran mobile clinics, treating large numbers of people with malaria, respiratory tract infections and diarrhoea.

At Yambio hospital, Western Equatoria state, MSF reinforced its support to the Ministry of Health's HIV programme by recruiting, training and deploying key technical staff to deliver comprehensive HIV care for HIV-exposed children and adults, including pregnant women.

In November and December, more than 41,000 children were vaccinated against measles in Lakes state.

No. staff end 2013: 2,854 | Year MSF first worked in the country: 1983 | msf.org/southsudan



This mother in Yida refugee camp has just had her daughter vaccinated. Infectious diseases related to the camp's poor hygiene conditions are further exacerbated once the rainy season starts.

SUDAN



KEY MEDICAL FIGURES:

- 130,000 outpatient consultations
- 470 patients treated for kala azar
- 319,200 measles vaccinations (outbreak)

In Sudan, Médecins Sans Frontières (MSF) focuses on providing medical assistance in remote regions with poor access to healthcare, and to people affected by conflict, outbreaks of disease and natural disasters.

In July, an MSF team started supporting the health centre in El Serif displaced person camp near Nyala in South Darfur.

In North Darfur, MSF continued working in Tawila but due to insecurity the project was limited to basic healthcare activities within the town and the implementation of a referral system to hospitals in El Fashir for specialist treatment. The focus in Dar Zaghawa was also on basic healthcare. Teams supported two health centres and two health posts, and carried out postnatal home visits. Projects in Kaguro, including vaccination campaigns, were under remote management, as no access was available to international staff. An emergency intervention in El Sireaf started in 2013 after tribal clashes displaced an estimated 65,000 people. Two mobile clinics provided outpatient consultations, therapeutic feeding programmes and reproductive healthcare. Referrals were made to the MSF-supported El Sireaf hospital. In July, two mobile clinics started providing care to people in two displacement camps in El Serif.

Aiming to improve access to emergency healthcare, MSF launched the North Darfur Emergency Response (NDER) programme



In Al-Gedaref state in eastern Sudan, an MSF doctor explains to a group of schoolchildren why they should be vaccinated against measles.

in 2013 in collaboration with the Ministry of Health.

Treating tuberculosis in Jebel Awlia

In February, MSF started diagnosing and treating tuberculosis (TB) in five health centres in Jebel Awlia, a large slum on the outskirts of the capital, Khartoum, where crowded living conditions increase people's risk of contracting the disease. The team is training Ministry of Health staff and working with patient groups in the community to develop counselling and support systems that will help patients adhere to treatment.

Reproductive healthcare in Tabarak Allah, Al-Gedaref state

MSF began supporting the Ministry of Health's reproductive health activities in July. The main objectives are to reduce maternal and neonatal mortality, and to ensure patients who need fistula repair and reconstructive surgery are appropriately referred. Comprehensive emergency obstetric services are offered, and women also receive follow-up services including postnatal consultations and family planning support. MSF renovated and equipped the maternity wing and refurbished the operating theatre in Quresha hospital. Children were also referred for vaccinations.

Vaccination campaigns

In January, MSF assisted the Sudanese health authorities in preventing a yellow fever epidemic. Over 750,000 adults and children were vaccinated over nine months in four localities in Central Darfur state. In West and Central Darfur, 256 patients suspected of having yellow fever were treated. From early March to May, MSF emergency teams carried out a measles vaccination campaign in five locations in Al-Gedaref state. A total of 306,400 people were vaccinated.

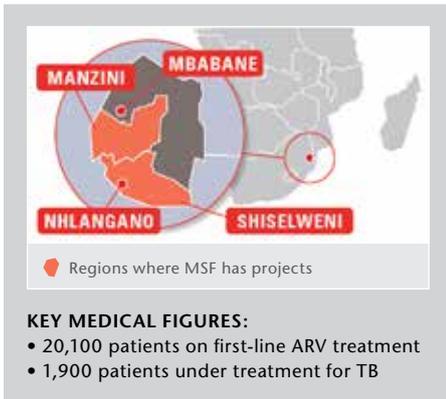
Emergency flood response

Heavy rains in August caused flooding which affected 150,000 people. Khartoum state was particularly hard hit, and MSF launched an emergency intervention, providing 228,600 litres of clean water and carrying out 654 mobile clinic consultations in the Sharag Alniel locality. Most patients had respiratory tract infections, gastritis or diarrhoea.

Kala azar

MSF continued its kala azar work in Tabarak Allah, Al Gedaref state, and treated 470 people in 2013. The Shangyl Tobaya basic healthcare programme was handed over to the Ministry of Health.

SWAZILAND



The decentralisation of medical services in Swaziland is helping people with HIV, tuberculosis (TB) and multidrug-resistant TB (MDR-TB) get the care they need.

Swaziland has high rates of HIV–TB co-infection and the number of people with drug-resistant forms of TB (DR-TB) is rising. Médecins Sans Frontières (MSF), in collaboration with the Ministry of Health, has been integrating HIV and TB services at basic health clinics and in the community. Further strategies have included advocating for the introduction of shorter, more tolerable treatment regimens for DR-TB and the promotion and implementation of outpatient DR-TB care.

One-stop, comprehensive care for HIV and TB is provided in Matsapha, Manzini region, an industrial town that attracts migrant workers. The clinic here offers HIV counselling and testing, diagnosis and treatment of TB, and sexual and reproductive healthcare services, including ante- and postnatal care. The clinic provides victims of violence with medical and psychosocial care, and consultations and treatment for common illnesses, as well as immunisations for children, are also available.

In Mankayane, MSF works closely with the Ministry of Health's HIV and TB department to improve diagnosis and treatment of patients suffering from HIV–DR-TB co-infection. Antiretroviral (ARV) treatment has been integrated with that for TB and DR-TB.



Treatment for drug-resistant TB involves swallowing 20 pills a day and receiving a painful daily injection that makes it difficult to sit or even lie down.

In 2013, the MSF team continued to improve infection control and provided psychosocial support for patients in Mankayane hospital and in community-based clinics. They also trained staff at the TB National Reference Laboratory in Mbabane, where MSF assists with TB cultures and drug-sensitivity testing.

Patient-centred HIV and TB care in Shiselweni

After five years of increasing the number of HIV and TB services, Shiselweni, formerly the most disadvantaged region for healthcare, now has multiple HIV and TB service points. MSF provides treatment and psychosocial support for HIV and TB patients in 22 basic health clinics and three specialist facilities. Teams also work on infection control and improving adherence to treatment.

In 2013, there was a strong focus on improving access to DR-TB diagnosis and care. Locating laboratories at points of care was an important component, and rapid diagnostic technology (GeneXpert) was distributed throughout the region; 20 primary clinics now have their own mini-labs. Furthermore, patients who cannot come to their nearest facility for daily injections during the intensive treatment phase are now visited by

community treatment supporters (CTS). This is a new approach and an analysis of the effectiveness of the CTS programme is currently underway.

A 'test early and treat early' effort began last year as a preventive measure against the transmission of HIV. It ultimately aims to put everyone testing positive for HIV on ARV treatment, regardless of how far the virus has progressed. The first phase, which started in January 2013, involved putting all HIV-positive women on treatment, and this work continues, along with routine viral load testing.

A voluntary door-to-door HIV-testing campaign was also conducted in August, which resulted in 6,452 people being screened.

SYRIA

KEY MEDICAL FIGURES:

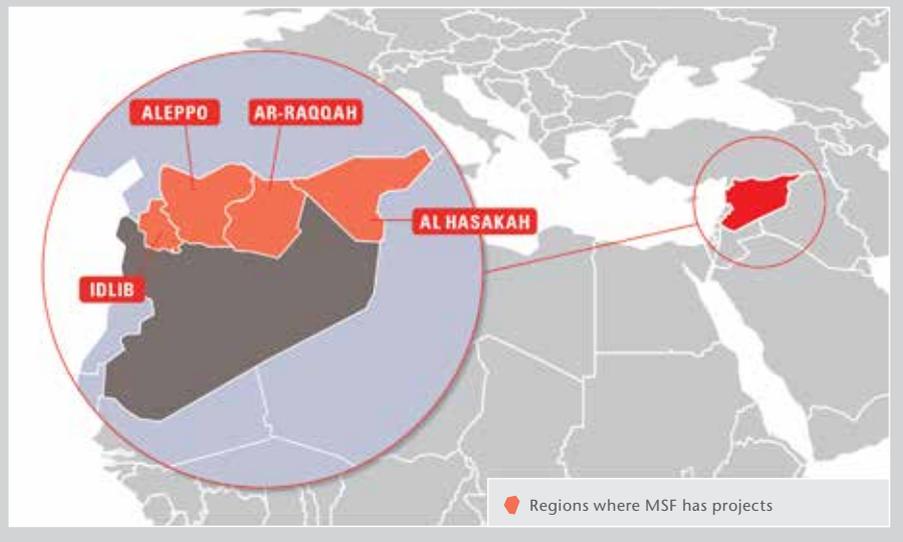
- 108,300 outpatient consultations
- 4,900 surgical interventions
- 1,800 births assisted
- 18,700 relief kits distributed

Against a backdrop of relentless violence, the Syrian people endured food shortages, disrupted power and water supplies, and the collapse of the healthcare system in 2013.

The conflict in Syria has decimated what was previously a well-functioning healthcare system. With regions of the country inaccessible to humanitarian organisations, the huge medical needs that are indirect consequences of the conflict remain largely unreported and unseen. The initial focus for Médecins Sans Frontières (MSF) was providing emergency and trauma surgical care in the north of the country. As the situation deteriorated, activities were extended to include basic and mental healthcare, maternal health services and measles vaccination campaigns. MSF also donated medical supplies and drugs to treat communicable diseases such as typhoid, chronic conditions such as asthma and diabetes, as well as cardiovascular and kidney diseases.

In Idlib governorate, MSF continued to run a trauma surgical unit set up in a house, where patients suffering from shrapnel wounds, bullet wounds and burns were treated. Physiotherapy and post-operative care were provided. Given the many people exhibiting psychological distress, mental health services were added in February.

More than 60,000 people have settled in displacement camps in the area around the hospital. MSF staff built 60 latrines and 40 showers to improve hygiene, and distributed supplies such as tents, blankets and plastic sheeting. The conflict has disrupted essential preventive care and between February and May, teams vaccinated children in the camps, immunising 3,137 against measles and more than 3,300 against polio. Routine childhood vaccinations started in November in partnership with two local NGOs, with an average of 1,000 children immunised per month. Seventy community health workers undertook outbreak surveillance and health education activities in the camps. Two outpatient clinics were also opened in November.



In late 2012, a field hospital in a cave was relocated to a converted farm in the mountainous region of Jabal Al-Akrad. More than 520 surgical procedures and 15,550 emergency consultations were performed there in 2013. When security allowed, MSF ran mobile clinics in the area, provided medical facilities with essential drugs and equipment, and distributed basic relief items. Over 30,600 consultations were carried out at mobile clinics and the hospital. Two additional basic healthcare clinics were opened in the area in June.

Aleppo governorate

The hospital MSF opened in 2012 in Aleppo governorate continued to treat children and the wounded. The team also performed surgical procedures, provided maternity and obstetric care, and treated patients with

acute and chronic diseases. Mental health services were launched in July.

With needs steadily rising, MSF opened another hospital in the governorate in May. Services include surgery for trauma, including burns, and obstetric care. Consultations are provided for adult and paediatric outpatients and there is also an inpatient department. Between May and December, staff performed more than 1,300 surgical procedures and carried out 14,300 consultations.

In July, MSF opened a third hospital on the outskirts of Aleppo city, providing care to patients with conflict-related injuries and those indirectly affected by the war. There is an emergency room, an outpatient department and a 12-bed ward.



A transit camp in Aleppo governorate, home to thousands of people.



© Robin Meldrum / MSF

In what used to be a chicken farm, MSF set up a makeshift hospital with an inflatable operating theatre – an efficient way to maintain a sterile environment.

Tens of thousands of displaced people live in camps in the Al Safira area and in October, MSF donated tents and medicines. When people fled north after violent attacks, a team supported Syrian volunteers treating displaced people at a health centre in Manbij. MSF also helped conduct a vaccination campaign and distributed winter tents and plastic sheeting to displaced people. Further support was provided to reopen the paediatric ward at Al-Bab hospital in Aleppo governorate.

Ar-Raqqa governorate

In May, a team opened a basic healthcare clinic in the Ministry of Health hospital in Tal Abyad, and since July there has been an MSF-supported paediatric ward in the facility. Donations were made to cover the treatment of dialysis patients, so that when the supply chain broke there was no interruption in care. Mobile teams provided emergency assistance to people living in empty school buildings, conducted more than 12,600 outpatient consultations and vaccinated 27,000 children against measles through several health centres. Non-medical items such as blankets, stoves and hygiene kits were distributed to vulnerable families.

Al Hasakah governorate

In July, MSF started to support the trauma ward in a hospital in Al Hasakah with skilled staff and drugs. The border with Iraq reopened in August and MSF set up a health post to assist those waiting to leave Syria. The border closed again at the end of September, leaving people in nearby villages, but the number of arrivals decreased. Approximately 3,110 consultations had been conducted by the end of the year in Al Hasakah. MSF also prepared for a possible large influx of casualties.

Donations and remote support

Restrictions on access and concerns about security are major obstacles to delivering medical-humanitarian assistance in Syria. Where MSF cannot send its own teams because of insecurity or being denied access by the government, drugs, medical equipment, and technical advice and support are offered. Throughout 2013, an average of three tons of medical and non-medical material were donated daily to a network of 40 hospitals and 60 health posts across seven governorates.

By the end of the year it was estimated that more than four million Syrians were

displaced inside the country, and two million had crossed into neighbouring countries. MSF also provided emergency medical aid to Syrians in Lebanon, Iraq, Jordan and Turkey.

A man who brought his sister to an MSF field hospital

We heard the sound of explosions ... I told my sister to move and find shelter, as it was close. She was behind me, about five metres. A bomb landed near her. She was covered in rubble. I shouted: "Are you hurt, sister?" She replied: "Yes, I am!" I ran towards her and saw that shrapnel had hit her face. Blood was coming out of her neck ... We shouted for a car. Thankfully there was one nearby. We took her to the hospital, where they stopped the bleeding. Her situation is stable now.

If there were no hospital, she'd have died. We need medical care. In my sister's case, she needs doctors, care, drugs. As you know, we have nothing here. We need support in medication, doctors, ambulances capable of transporting patients immediately, everything.

SIERRA LEONE



Regions where MSF has projects

KEY MEDICAL FIGURES:

- 73,300 outpatient consultations
- 2,200 births assisted

More than a decade has passed since the end of the civil war, but Sierra Leone is still recovering. Healthcare gaps are systemic and nationwide, and access to quality healthcare remains a major challenge for the population. Although the government initiative offering free healthcare to pregnant women and children is improving access, many people still die from treatable diseases such as malaria, measles, acute respiratory infection and Lassa fever, a viral haemorrhagic fever endemic in the country.

In Bo district, MSF runs the Gondama referral centre, a 220-bed hospital offering emergency paediatric and obstetric services. In 2013, ambulances transported patients from nine community health centres to the hospital, and an additional ambulance service took patients with Lassa fever to Kenema hospital for treatment. MSF also supports Gondama health centre, a nearby clinic run by the

Ministry of Health, with staff, medicines and medical materials.

MSF plans to build a 160-bed hospital closer to Bo town that will provide better access for patients, staff and supplies. The new, more spacious facility will also allow for better infection control protocols, and will include a proper isolation ward and a modern laboratory.

Médecins Sans Frontières (MSF) has begun reorienting its work to focus on improving medical care for children and its capacity for diagnosing Lassa fever.



A Clinical Health Officer examining a child at Gondama referral centre in Bo.

No. staff end 2013: 619 | Year MSF first worked in the country: 1986 | msf.org/sierraleone

TAJIKISTAN



Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

- 220 patients under treatment for TB, of which 28 for MDR-TB

In 2011, MSF started a paediatric TB programme to improve access and quality of care for children with drug-sensitive TB, drug-resistant TB (DR-TB) and multidrug-resistant TB (MDR-TB). The team continued to support the paediatric TB hospital in Dushanbe in 2013, offering diagnosis and comprehensive care to children who were admitted. Their family members were also tested and treated, and MSF worked with the Ministry of Health to diagnose and treat those who had come into close contact with the children.

MSF provided outpatient care for children and their families wherever possible, along with nutritional and psychosocial support to help them adhere to the difficult treatment. Hospitalised children took part in MSF-organised activities to aid their development, and teams also conducted activities to decrease the stigma surrounding the disease.

The diagnostic tools and treatment currently used are not adapted for children. MSF is hoping to find ways to better diagnose DR-TB and MDR-TB and produce paediatric formulations of the drugs, for example syrups.

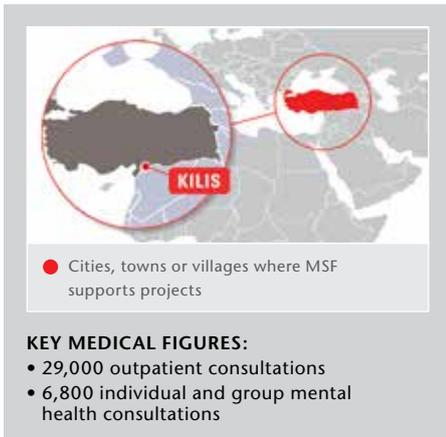
Kala azar

Following an outbreak of kala azar (visceral leishmaniasis), MSF trained 200 Ministry of Health staff and introduced a rapid test. Kala azar is a parasitic disease that is almost always fatal if left untreated, and the specialist facilities and expertise required for reliable diagnosis are often missing in areas where it is prevalent. At the request of the Tajik Ministry of Health, MSF developed treatment guidelines for the national kala azar programme.

Improving children's access to tuberculosis (TB) treatment continued to be the main focus of Médecins Sans Frontières (MSF) in Tajikistan in 2013.

No. staff end 2013: 64 | Year MSF first worked in the country: 1997 | msf.org/tajikistan

TURKEY



Over half a million Syrian war refugees were living in Turkey by the end of 2013.

The poor living conditions and lack of access to medical care endured by many of the predominantly Syrian refugees in Turkey remain concerning, and this year Médecins Sans Frontières (MSF) launched several humanitarian interventions to deliver assistance to those in need.

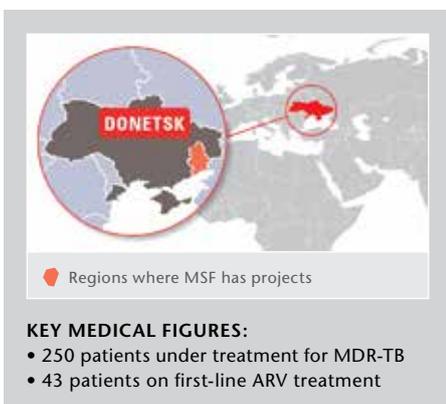
Many Syrians have settled in the southern province of Kilis, along the Syrian–Turkish border. The NGO Helsinki Citizens' Assembly (HCA), in collaboration with MSF, is running a clinic in Kilis aimed at providing quality healthcare, including mental health services, to this vulnerable population. The main goal of the mental health activities in Kilis is to help refugees cope and adjust to their new situation, regardless of whether they live inside or outside the camps. Unregistered refugees are a priority for MSF since they live

outside of the camps and may not have access to services or aid distribution.

A health needs assessment conducted by MSF among migrants revealed no access to healthcare, as well as financial barriers and poor living conditions. The response by humanitarian organisations was found to be inadequate. MSF provided support to an HCA psychosocial project assisting mixed migrant communities in Istanbul. Turkish psychologists, community health workers and interpreters supported referral activities in 10 municipalities. The project was closed at the end of the year, as MSF decided to focus its interventions on Syrian refugees in Turkey.

No. staff end 2013: 29 | Year MSF first worked in the country: 1999 | msf.org/turkey

UKRAINE



The dual drug-resistant tuberculosis (DR-TB) and HIV epidemics in the Ukrainian penitentiary system are an urgent public health issue.

Overcrowded prison environments and the inadequate healthcare provided to inmates exacerbate the spread of DR-TB. The diagnosis

and treatment of the disease in Ukrainian prisons is limited.

Since 2012, Médecins Sans Frontières (MSF) has provided DR-TB treatment to prisoners and ex-prisoners in eastern Ukraine's Donetsk region. DOTS (directly observed treatment, short course), the treatment recommended by the World Health Organization, is provided in a special prison TB hospital and in three pre-trial detention centres. Antiretroviral (ARV) therapy is given to DR-TB patients co-infected with HIV. After the prisoners are released, MSF works to ensure that they complete their DR-TB treatment.

The course of treatment for DR-TB takes up to two years and can result in a number of side effects, some of them severe, including vomiting, nausea, depression and loss of hearing. Counselling is an important part of the patient-centred programme, to help people cope with their diagnosis and adhere to treatment. Inmates often come from deprived environments, with difficult family histories and experiences of social marginalisation.

Some have psychological disorders, and many suffer from drug and alcohol addictions.

MSF provides laboratory services for rapid, accurate TB diagnosis, adverse effects diagnosis and management, and guarantees an uninterrupted quality-assured drugs supply is available. MSF also lobbies the State Penitentiary Service of Ukraine and the Ministry of Health, at regional and national levels, for the integration of TB and HIV services and multidisciplinary, patient-oriented TB case management in penal facilities.



MSF provides drug-resistant TB treatment to prisoners in Donetsk region.

No. staff end 2013: 62 | Year MSF first worked in the country: 1999 | msf.org/ukraine

UGANDA



KEY MEDICAL FIGURES:

- 52,900 outpatient consultations
- 6,500 patients on first-line ARV treatment
- 570 patients under treatment for TB

In Uganda, the rate of HIV infection is on the rise again, after decreasing for many years. The country has also had to host large numbers of refugees arriving from Democratic Republic of Congo (DRC) and South Sudan.

After several years of progress in the fight against HIV, and large increases in the number of people being tested and treated for the virus, the rate of new infections has risen since 2010. Test kits and condoms are difficult to obtain in several areas of the country; meanwhile it is estimated that one-third of women and half of men with HIV are not aware of their status. Specialised care, such as prevention of mother-to-child transmission (PMTCT) and the combined treatment of tuberculosis (TB) and severe malnutrition, is often unavailable.

In West Nile region, the prevalence of HIV among adults aged 15 to 49 is about five per cent and has almost doubled since 2005. Médecins Sans Frontières (MSF) has been working in the region to help improve access to care and reduce HIV-related mortality.

For several years, MSF teams have treated people with HIV and TB through a programme based at the Arua regional referral hospital. Care is provided to people living in the district as well as to a significant number of patients from neighbouring DRC. Activities include PMTCT and ensuring people infected with both HIV and TB receive the necessary integrated care.

After a 12-year presence in Arua, MSF has started to hand over medical activities to local authorities and their partner SUSTAIN, and will close the project in July 2014. This follows both an increase in the local ability to provide medical care for people with HIV and TB and a reorientation of MSF's work in the country.

Emergency care for refugees

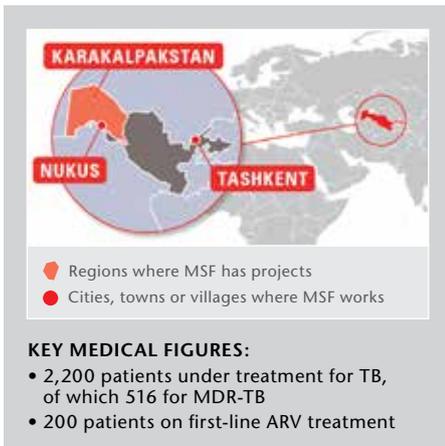
The conflict in North Kivu province, DRC, caused between 40,000 and 50,000 refugees to cross into western Uganda between May and the end of July. An estimated 22,000 people reached the Bubukwanga transit camp, near Bundibugyo. Originally designed for 12,500 people, the camp lacked sufficient shelters, latrines and drinking water for the increased numbers. MSF began providing medical care in July. Patients were suffering mainly from respiratory infections, malaria and diarrhoea. Teams also built latrines and trucked in water. Some refugees have since been transferred by the Ugandan authorities to the Kyangwali camp to ease pressure on resources. MSF provided healthcare to the 33,000 people in Kyangwali camp from September to the end of November. A total of 25,000 consultations were conducted and 1,500 people were admitted to hospital.

No. staff end 2013: 358 | Year MSF first worked in the country: 1986 | msf.org/uganda



Family and friends visiting patients at the health centre in Bubukwanga transit camp, near Bundibugyo.

UZBEKISTAN



A pilot project to shorten treatment time for people with multidrug-resistant tuberculosis (MDR-TB) was launched in 2013.

Uzbekistan is one of many countries in Central Asia with high levels of drug-resistant TB (DR-TB), a form of the disease that does not respond to the standard first-line drug regimen. Access to proper diagnosis and care is still limited and the vast majority of people with DR-TB remain undiagnosed and untreated.

In the Autonomous Republic of Karakalpakstan, Médecins Sans Frontières (MSF) has been running a TB programme in collaboration with the Ministry of Health since 1997. In 2013, 1,212 patients were enrolled for first-line TB treatment, as well as 677 for DR-TB. Many patients underwent treatment on an outpatient basis, so they avoided the additional stress of hospitalisation and could remain at home close to their families and social support network. Overall,

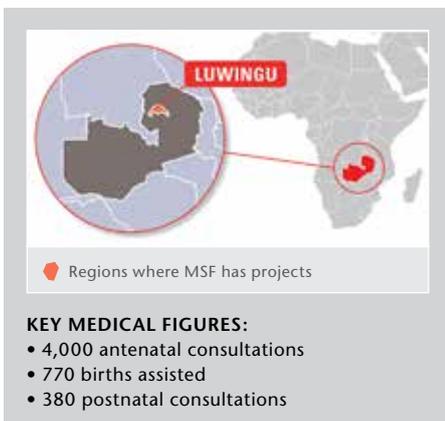
No. staff end 2013: 184 | Year MSF first worked in the country: 1997
msf.org/uzbekistan

nearly two-thirds of the DR-TB patients began ambulatory care. In September 2013, 16 MDR-TB patients were enrolled in a pilot project in which the often arduous treatment that usually takes up to two years was shortened to nine months.

The DR-TB project expanded this year into the districts of Chimbay, Shumanay and Kanlikul, while activities in the districts of Khodjeily, Takhiatash and Nukus region were handed over to local health authorities.

In Tashkent, Uzbekistan's capital city, an MSF team continued to work at the Republican AIDS Centre, and activities began at the Tashkent City AIDS Centre in September. Psychosocial activities such as counselling were also provided as an additional support for people living with HIV.

ZAMBIA



In September, a three-year project aimed at improving access to reproductive health services in Luwingu district came to an end.

Luwingu, a remote and rural area, was underserved in terms of health facilities when Médecins Sans Frontières (MSF) first

opened its programme in 2010. Residents had to travel long distances for appropriate health services and there were reports of high maternal mortality because of the poor availability of care. Although the HIV rate among pregnant women was low in the district, it was difficult for those with the disease to obtain antiretroviral treatment because of a lack of resources at the district hospital.

In close collaboration with Zambian health authorities, MSF established comprehensive sexual and reproductive health services in the Luwingu district hospital and several rural health centres. These included family planning, ante- and postnatal care, prevention of mother-to-child transmission of HIV and assisted births. Emergency obstetric referrals were also made from rural centres to the district hospital, and 56 women with obstetric fistulas were identified and referred to Chilonga district hospital for surgery.

Over the course of the project, MSF improved facilities, trained local staff and

donated medicines, medical equipment and an ambulance. More than 400 pregnant women referred from villages to health centres travelled by Zambulance, a covered trailer pulled by a bicycle – a viable means of transportation in this setting.

The decision to close the programme was based on the improvement of medical processes and came after a gradual handover to the Zambian Ministry of Health. Medical activities ended in June 2013, the project closed in mid-September and MSF withdrew from Zambia in October.



Patients waiting at Luwingu district hospital.

No. staff end 2013: 42 | Year MSF first worked in the country: 1999 | msf.org/zambia

ZIMBABWE

KEY MEDICAL FIGURES:

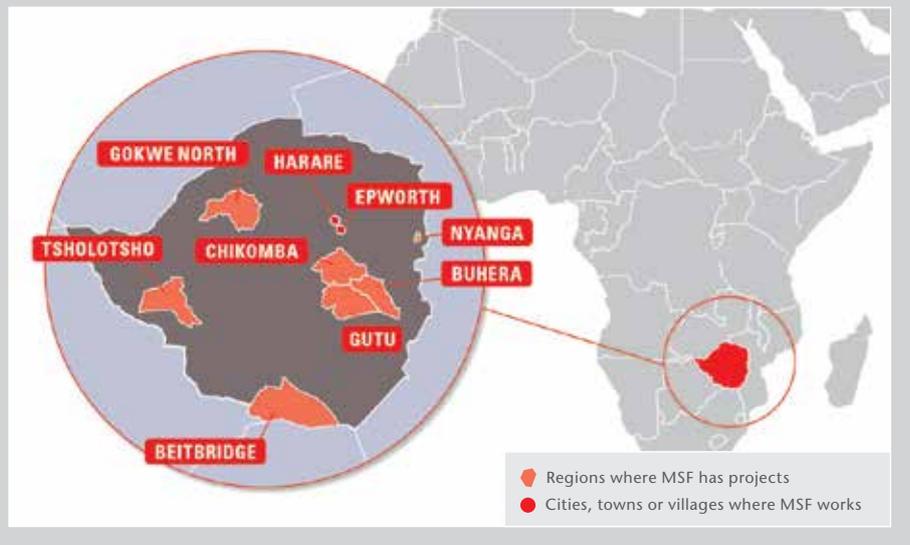
- 64,500 patients on first-line ARV treatment
- 3,200 patients under treatment for TB, of which 63 for MDR-TB

Although Zimbabwe has made significant progress, gaps in treatment for HIV/AIDS and tuberculosis (TB), including drug-resistant TB (DR-TB), remain. The needs of children and teenagers are particularly overlooked.

Treatment for HIV is reportedly widely available but there are still areas where coverage is extremely low. The main barriers include a lack of human resources, treatment fees, clinic hours and the long distances people must travel to reach facilities. Patients with multidrug-resistant TB (MDR-TB), where standard first-line drugs have failed, lack access to the best available treatment. Integration of TB and HIV care, ensuring treatment is available at a more local level, and moving tasks over from doctors to nurses are all key strategies being undertaken by Médecins Sans Frontières (MSF) in collaboration with the Ministry of Health. This streamlining enables more people to obtain the medical care they require.

MSF supported HIV and TB projects throughout the country in 2013: in Harare (Epworth and Caledonia Farm), Gokwe North, Tsholotsho, Beitbridge, Buhera, Gutu and Chikomba. A new project also opened in Nyanga district, after an assessment revealed that only five per cent of people were getting the antiretroviral (ARV) treatment they needed for HIV.

The emphasis in Nyanga is on paediatric ARV care. The strategy used aims to increase patient access to treatment by providing quality HIV and TB care using existing healthcare facilities and human resources. Services in Nyanga are being integrated into the district hospital and nine health clinics, with nurses undergoing training to initiate treatment. MSF supports the health team with the organisation of services, patient records and patient flow, so facilities can manage the additional workload. Community ARV treatment refill groups and the provision of a three-month drug supply for healthy patients reduce the number of visits to busy clinics.



The Gokwe North project made progress with its approach in 2013, increasing decentralisation of services through training and mentorship. Treatment for HIV and TB and for victims of sexual violence is being integrated into two rural hospitals and 16 rural health centres. Eleven facilities currently provide care for people with HIV, and four are treatment initiation sites. The Gutu/Chikomba programme has decentralised care to 28 facilities in Gutu and 31 in Chikomba. Support groups have also been established.

MSF pushed for seven health facilities within high-density suburbs in Harare, including the Caledonia Farm clinic, to be accredited as ARV treatment and follow-up sites. HIV and

TB training was provided for 16 nurses from Harare, thereby preparing for nurse-led treatment to be implemented in these facilities. The HIV and TB programme in Epworth was integrated into the Epworth polyclinic at the end of the year, with clinical responsibilities handed over to ministry of health staff.

The Tsholotsho project is also in the process of being handed over, having achieved 98.7 per cent coverage of all people in need of HIV treatment in the district. Provision of ARVs, treatment of opportunistic infections and prevention of mother-to-child transmission (PMTCT) of HIV continued at Nyamandhlovu hospital as part of the decentralisation of the project. The standard implementation of



A 14-year-old patient being shown his x-ray.

PMTCT is a key strategy in achieving an HIV-free generation in Zimbabwe.

At the end of December, MSF was forced to abruptly close the project in Beitbridge, on the border with South Africa, after the authorities decided not to allow the team to continue activities. Before leaving, MSF arranged a three-month drug buffer for patients to postpone interruption of their treatment, but remains concerned for the future healthcare of HIV patients in the area. Over the course of the project, 7,590 patients started ARV treatment. In 2013, 853 patients started TB treatment, five of these for DR-TB. Mental health specialists saw 16,300 people for counselling sessions over the course of the year.

Implementing newer technology

MSF is striving to implement modern technology that will improve HIV patient care in Zimbabwe. Routine yearly viral load (VL) monitoring – the gold standard for monitoring HIV patients – was already being used in Buhera and Gutu, and it

was introduced in January in Chikomba. Laboratory technicians and scientists were trained at three hospitals in Harare (Harare hospital, Parirenyatwa and Chitungwiza), and these were included as potential sites to send VL results. New diagnostic technology (GeneXpert) was introduced to improve the speed of diagnosis for TB and MDR-TB in most MSF-supported health facilities.

In May, MSF installed the NUCLEASE platform at the National Microbiology Reference Laboratory (NMRL) in Harare hospital. This project, funded by UNITAID and run in close collaboration with NMRL and the health ministry, aims to provide VL analysis throughout the country. Between September and December 11,500 samples were processed, paving the way for more to be dealt with in the country instead of being sent to a laboratory in South Africa.

Prison psychiatric care

A team of MSF mental health professionals continued to provide psychiatric support to inmates in 10 prisons, including Harare

maximum security prison, where 250 male and 30 female inmates receive care in a psychiatric wing. Occupational therapy was also available. The team treated 1,880 patients in individual and group counselling sessions.

Care for victims of sexual violence

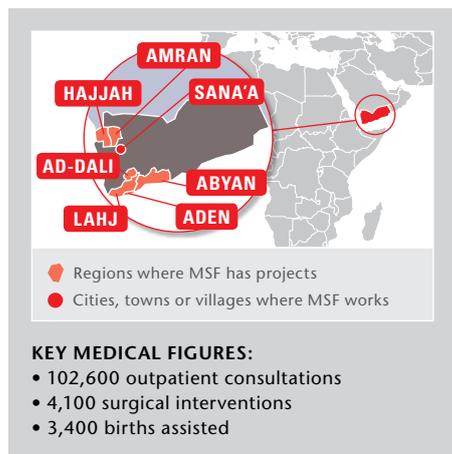
Free medical care, counselling and referrals for psychological, psychosocial and legal support were provided for victims of sexual violence in the high-density suburb of Mbare in Harare. Health promotion activities were conducted to raise awareness of sexual violence in the community, and the importance of seeking immediate medical care. A total of 1,220 new patients came to the centre in 2013 and the team saw more than 920 people for follow-up. A new building is under construction to accommodate the growing programme.

No. staff end 2013: 604 | Year MSF first worked in the country: 2000 | msf.org/zimbabwe



An MSF TB nurse injecting an MDR-TB patient in their home.

YEMEN



An MSF staff member talking to migrants living in the Sana'a detention centre.

There was a significant deterioration in living conditions in parts of Yemen in 2013, and insecurity towards the end of the year affected availability and accessibility of healthcare.

Insecurity affected programmes supported by Médecins Sans Frontières (MSF), further cutting people off from healthcare, and activities had to be suspended twice in Amran and once in Aden.

Over 150 Yemeni patients were sent from Yemen to MSF's reconstructive surgery programme in Amman, Jordan, which provides orthopaedic, maxillofacial and reconstructive plastic surgery (for more details, see the Jordan country report, p.56).

Ad-Dali

MSF continued to work in Ad-Dali governorate, but problems with security caused significant disruptions to the provision of healthcare there at the end of the year. Food shortages and maternal and child health are of great concern in the area.

Teams worked with local communities, both rural and urban, providing care for victims of violence and trauma. Emergency services, including surgery, were available at the Al Naser general hospital, Ad-Dali city, and patients received basic healthcare and lifesaving surgery in Al Azaraq and Qataba'a districts. More than 41,704 consultations were carried out.

Aden and the south

In Aden, more than 2,500 surgeries were performed and 860 patients received post-surgery follow-up and physiotherapy

at MSF's emergency surgical unit, which treated victims of violence from Aden as well as the nearby governorates of Lahj, Abyan, Shabwah and Ad-Dali. A weekly clinic was run for inmates at Aden central prison, and 80 patients were seen each month.

Staff support and supplies were provided to hospitals in Lawdar and Jaar in Abyan governorate. Teams also trained emergency room staff and sterilisation technicians.

Amran governorate

Access to healthcare decreases progressively in the rural areas of Amran governorate and ceases to exist for communities in the valleys. At Al-Salam hospital, Khamir, MSF is involved in the emergency, surgery, maternity, paediatric, inpatient and intensive care departments, and collaborates closely with the Ministry of Health to improve medical services. Support is also provided for the blood bank and laboratory. There was a dramatic rise in surgery patients towards the end of the year after violence intensified in the governorate. More than 1,940 surgical procedures were performed, and 4,080 people were admitted to hospital. Teams carried out 21,980 emergency consultations.

MSF resumed its support of the Huth health centre in March, after six months' suspension for security reasons. A team provided emergency, maternity and inpatient care. In September, Huth became

a stabilisation centre for managing large influxes of wounded people, providing emergency care and a referral system.

To assist the communities in remote areas with very limited access to healthcare, teams ran mobile clinics in the Osman and Akhraf valleys, carrying out 5,350 consultations and treating 427 patients for malaria.

Caring for migrants in Sana'a

MSF began providing HIV care to people in Sana'a in 2013. A mental health programme for migrants in detention also started in April.

Programme handovers

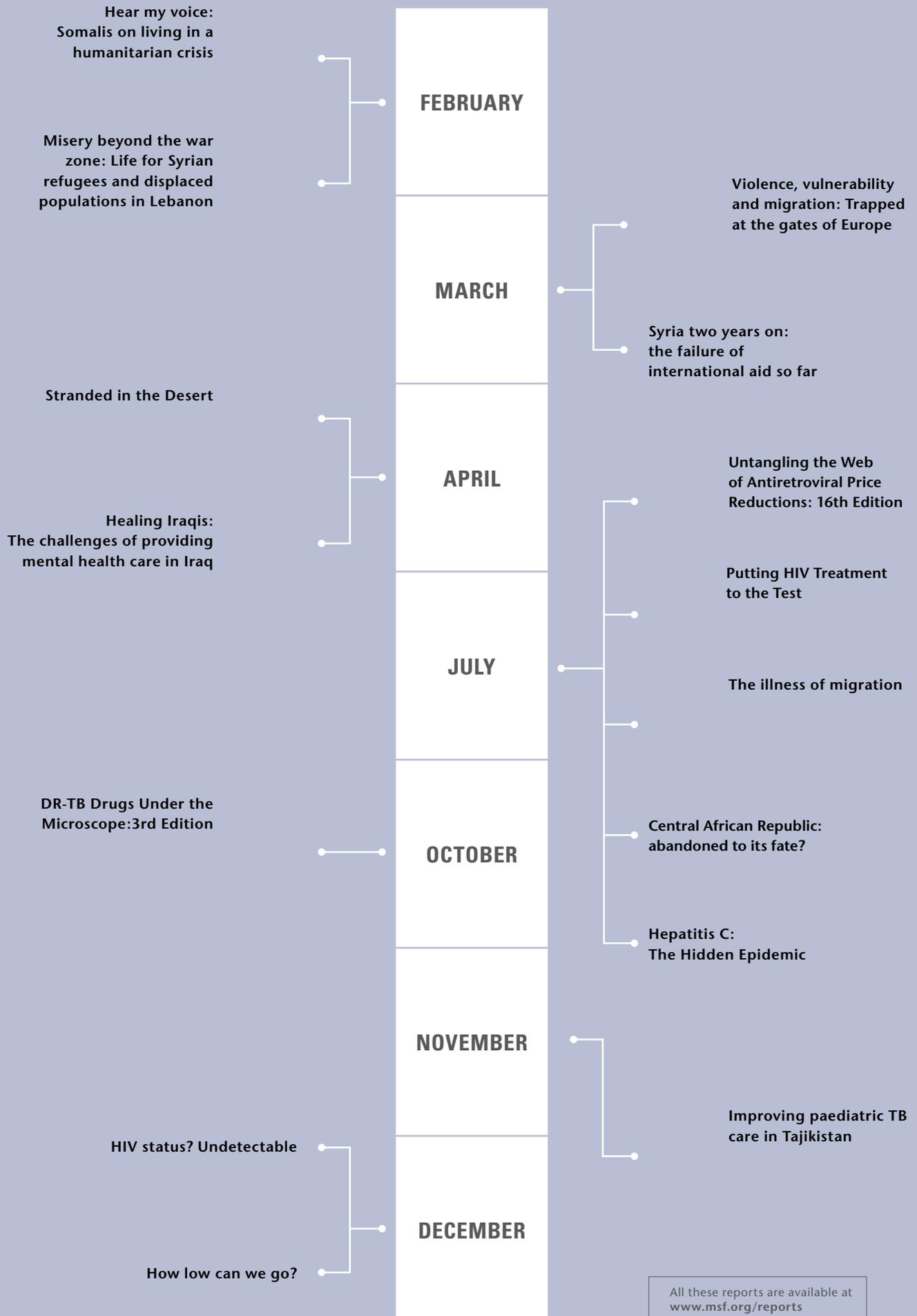
In February, MSF handed over activities at the Radfan hospital, Lahj governorate, to the Ministry of Health. A programme offering healthcare at Haradh, Hajjah governorate was closed in August.

Mohamed Shabwah

My nephew was shot during gunfire in Shabwah. There was no hospital ... nothing in the area. The only place we could bring him was here [MSF hospital in Aden]. We sincerely thank MSF for the unconditional medical care they offered to him and to everybody in this hospital.

No. staff end 2013: 459 | Year MSF first worked in the country: 1994 | msf.org/yemen

SPECIAL REPORTS 2013



FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, independent, private and non-profit organisation.

It is made up of 23 associations (2013): Australia, Austria, Belgium, Brazil, Canada, Denmark, East Africa, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Latin America, Luxembourg, Norway, Southern Africa, Spain, Sweden, Switzerland, UK and the USA. MSF's day-to-day activities are managed by 19 national offices and nine branch offices (see page 100 for contact details).

The search for efficiency has led MSF to create 10 specialised organisations, called 'satellites', which take charge of specific activities such as humanitarian

relief supplies, epidemiological and medical research, and research on humanitarian and social action. These satellites, considered as related parties to the national offices, include: MSF-Supply, MSF-Logistique, Epicentre, Fondation MSF, Etat d'Urgence Production, MSF Assistance, SCI MSF, SCI Sabin, Ärzte Ohne Grenzen Foundation and MSF Enterprises Limited. As these organisations are controlled by MSF, they are included in the scope of the MSF Financial Report and the figures presented here.

These figures describe MSF's finances on a combined international level. The 2013 combined international figures have been prepared in accordance with MSF international accounting standards, which comply with most of the requirements of the International Financial Reporting Standards (IFRS). The figures have been

jointly audited by the accounting firms of KPMG and Ernst & Young, in accordance with International Auditing Standards. A copy of the full 2013 Financial Report may be obtained at www.msf.org. In addition, each national office of MSF publishes annual, audited Financial Statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from the national offices.

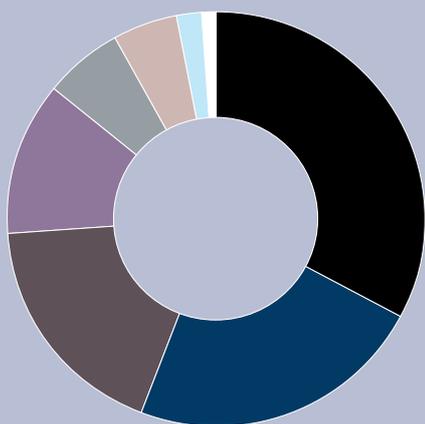
The figures presented here are for the 2013 calendar year. All amounts are presented in millions of euros.

Note: Figures in these tables are rounded, which may result in apparent inconsistencies in totals.

WHERE DID THE MONEY GO?

Programme expenses by nature

■ Locally hired staff	33%
■ International staff	23%
■ Medical and nutrition	18%
■ Transport, freight and storage	12%
■ Logistics and sanitation	6%
■ Operational running expenses	5%
■ Consultants and field support	2%
■ Training and local support	1%



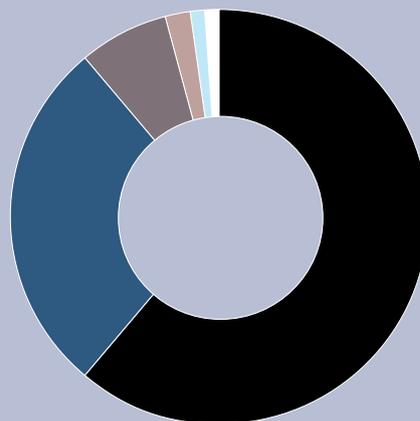
The biggest category of expenses is dedicated to staff working in the field: about 56 per cent of expenditure comprises all costs related to locally hired and international staff (including plane tickets, insurance, accommodation, etc).

The medical and nutrition category includes drugs and medical equipment, vaccines, hospitalisation fees and therapeutic food. The delivery of these supplies is included in the category of transport, freight and storage.

Logistics and sanitation comprise building materials and equipment for health centres, water and sanitation and logistical supplies.

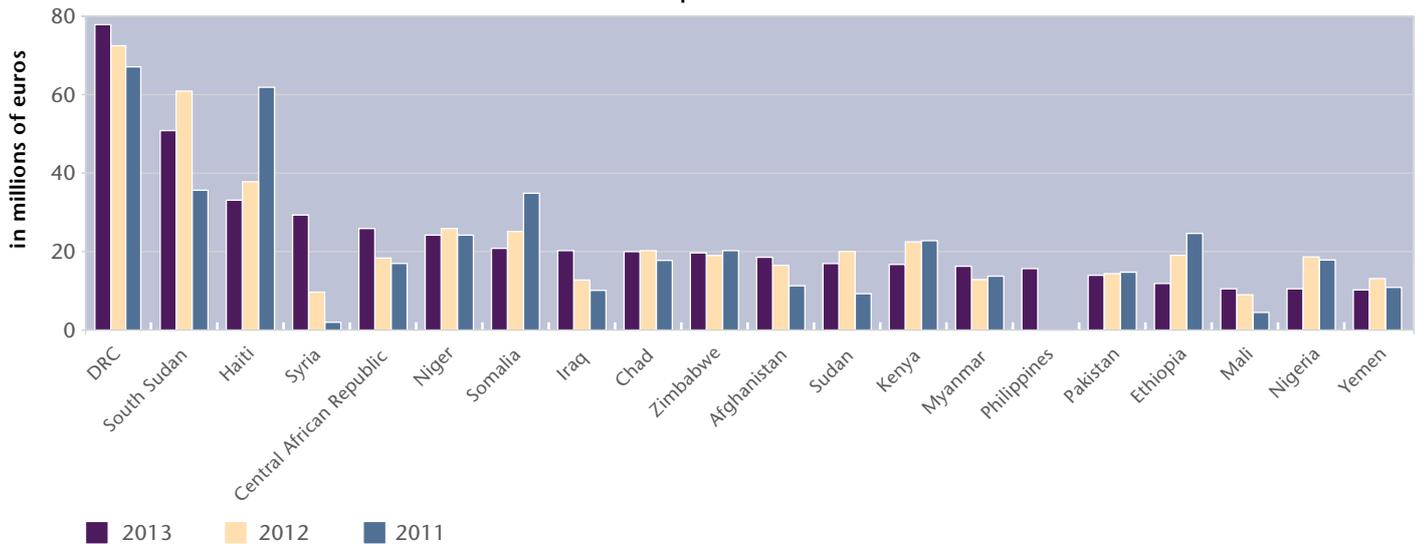
Programme expenses by continent

■ Africa	62%
■ Asia	28%
■ Americas	7%
■ Europe	2%
■ Oceania	1%
■ Unallocated	1%



COUNTRIES WHERE WE SPENT THE MOST

Countries where MSF expenditure is more than 10 million euros



AFRICA

	<i>in millions of €</i>
Democratic Republic of Congo	78.3
South Sudan	51.1
Central African Republic	26.0
Niger	24.4
Somalia	21.2
Chad	20.0
Zimbabwe	19.9
Sudan	17.1
Kenya	16.9
Ethiopia	12.0
Mali	10.6
Nigeria	10.5
Swaziland	9.9
Malawi	8.5
Mozambique	7.8
South Africa	7.3
Sierra Leone	6.6
Guinea	5.8
Uganda	5.0
Mauritania	4.1
Burundi	3.7
Cameroon	2.0
Egypt	2.0
Madagascar	1.5
Libya	1.5
Congo	1.4
Côte d'Ivoire	1.2
Zambia	1.0
Other countries*	1.8
Total	379.1

ASIA AND
THE MIDDLE EAST

	<i>in millions of €</i>
Syria	29.5
Iraq	20.4
Afghanistan	18.7
Myanmar	16.4
Philippines	15.8
Pakistan	14.2
Yemen	10.5
India	9.1
Lebanon	6.3
Uzbekistan	6.3
Palestine	3.5
Bangladesh	3.2
Kyrgyzstan	3.0
Jordan	2.8
Cambodia	2.5
Turkey	2.3
Armenia	2.2
Tajikistan	1.7
Laos	1.0
Iran	1.0
Other countries*	1.8
Total	172.4

THE AMERICAS

	<i>in millions of €</i>
Haiti	33.3
Colombia	5.5
Mexico	2.0
Paraguay	1.6
Honduras	1.4
Other countries*	0.2
Total	44.1

EUROPE

	<i>in millions of €</i>
Russian Federation	4.8
Ukraine	3.3
Other countries*	1.6
Total	9.8

OCEANIA

	<i>in millions of €</i>
Papua New Guinea	4.4
Total	4.4

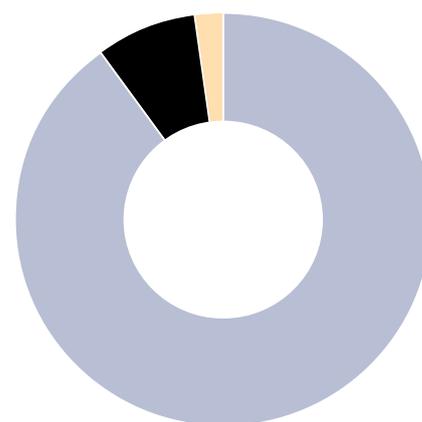
UNALLOCATED

	<i>in millions of €</i>
Other	3.2
Transversal activities	3.1
Total	6.3

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

WHERE DID THE MONEY COME FROM?

	2013		2012	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Private	899.7	89%	838.9	89%
Public institutional	93.0	9%	82.7	9%
Other	15.9	2%	16.1	2%
Income	1,008.5	100%	937.7	100%



Private income	89%
Public institutional income	9%
Other income	2%

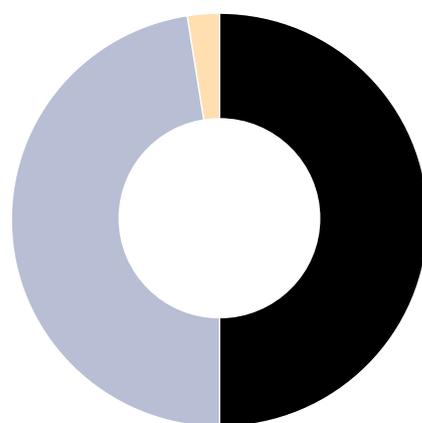
HOW WAS THE MONEY SPENT?

	2013		2012	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Programmes	615.4	65%	619.4	66%
Headquarters programme support	108.8	11%	103.9	11%
Témoignage/awareness-raising	30.2	3%	31.7	3%
Other humanitarian activities	9.3	1%	7.4	1%
Social mission	763.7	80%	762.4	81%
Fundraising	131.6	14%	124.8	13%
Management and general administration	57.1	6%	56.6	6%
Income tax	0	–	0.1	–
Other expenses	188.8	20%	181.5	19%
Expenditure	952.5	100%	943.9	100%
Net exchange gains/losses	-7.9		-4.8	
Surplus/deficit	48.1		-11.1	

5
MILLION
private donors

YEAR-END FINANCIAL POSITION

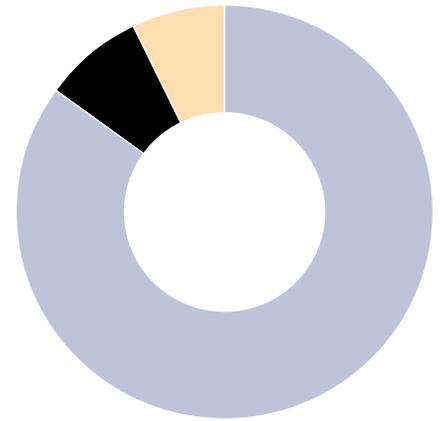
	2013		2012	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Cash and cash equivalents	616.3	81%	551.4	79%
Other current assets	87.3	11%	91.1	13%
Non-current assets	61.7	8%	57.4	8%
Assets	765.3	100%	699.9	100%
Permanently restricted funds	3.1	0%	3.4	–
Unrestricted funds	627.7	83%	580.2	83%
Other retained earnings and equities	3.4	0%	15.0	2%
Retained earnings and equities	634.2	83%	598.6	85%
Current liabilities	131.1	17%	101.3	15%
Liabilities and retained earnings	765.3	100%	699.9	100%



Income	1008.5
Expenditure	952.5
Surplus	48.1

HR STATISTICS

	2013		2012	
Medical pool	1,593	26%	1,548	26%
Nurses and other paramedical pool	1,892	30%	1,785	30%
Non-medical pool	2,714	44%	2,622	44%
International departures (full year)	6,199	100%	5,955	100%
	<i>no. staff</i>	<i>percentage</i>	<i>no. staff</i>	<i>percentage</i>
Locally hired staff	29,910	85%	29,228	86%
International staff	2,629	8%	2,592	7%
Field positions	32,539	93%	31,820	93%
Positions at headquarters	2,493	7%	2,326	7%
Staff	35,032	100%	34,146	100%



■ Locally hired staff 85%
■ International staff 8%
■ Headquarters staff 7%

The majority of MSF staff (85 per cent) are hired locally in the countries of intervention. Headquarters staff represent 7 per cent of total staff.

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 2013, 89 per cent of MSF's income came from private sources. More than 5 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF included, among others, the European Commission's Humanitarian Aid Department (ECHO) and the governments of Belgium, Canada, Denmark, France, Germany, Italy, Ireland, Luxembourg, Norway, Spain, Sweden, Switzerland and the UK.

Expenditure is allocated according to the main activities performed by MSF. All programme expenditure categories include salaries, direct costs and allocated overheads.

Social mission includes all costs related to operations in the field (direct costs) as well as all the medical and operational support from the headquarters directly allocated to the field (indirect costs). Social mission costs represent 80 per cent of the total costs for 2013.

Permanently restricted funds may be capital funds, where donors require the assets to be invested; funds retained for actual use, rather than expended; or the minimum level of retained earnings that is compulsory for certain sections of MSF.

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

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

MSF's retained earnings have been built up over the years by surpluses of income over expenses. At the end of 2013, the available portion (excluding permanently restricted funds and capital for foundations) represented 7.9 months of the preceding year's activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, a sudden drop in private and/or public institutional funding, the sustainability of long-term programmes (e.g. antiretroviral treatment programmes), and the pre-financing of operations to be funded by forthcoming public fundraising campaigns and/or public institutional funding.

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

CONTACT MSF

International Médecins Sans Frontières

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 84 | F +41 22 849 84 04
www.msf.org

Humanitarian Advocacy and Representation team

(UN, African Union, ASEAN, EU, Middle East)
T +41 22 849 84 84 | F +41 22 849 84 04

MSF Access Campaign

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 8405 | www.msfaccess.org

Australia Médecins Sans Frontières / Doctors Without Borders

Level 4 | 1-9 Glebe Point Road
Glebe NSW 2037 | Australia
T +61 28 570 2600 | F +61 28 570 2699
office@sydney.msf.org | www.msf.org.au

Austria Médecins Sans Frontières / Ärzte Ohne Grenzen

Taborstraße 10 | 1020 Vienna | Austria
T +43 1 409 7276 | F +43 1 409 7276/40
office@aerzte-ohne-grenzen.at
www.aerzte-ohne-grenzen.at

Belgium Médecins Sans Frontières / Artsen Zonder Grenzen

Rue Dupré 94 | Dupréstraat 94
1090 Brussels | Belgium
T +32 2 474 74 74 | F +32 2 474 75 75
www.msf-azg.be

Canada Médecins Sans Frontières / Doctors Without Borders

720 Spadina Avenue, Suite 402 | Toronto
Ontario M5S 2T9 | Canada
T +1 416 964 0619 | F +1 416 963 8707
msfcana@msf.ca | www.msf.ca

Denmark Médecins Sans Frontières / Læger uden Grænser

Dronningensgade 68, 3. | DK-1420 København K
Denmark
T +45 39 77 56 00 | F +45 39 77 56 01
info@msf.dk | http://msf.dk

France Médecins Sans Frontières

8 rue Saint Sabin | 75011 Paris | France
T +33 1 40 21 29 29 | F +33 1 48 06 68 68
office@paris.msf.org | www.msf.fr

Germany Médecins Sans Frontières / Ärzte Ohne Grenzen

Am Köllnischen Park 1 | 10179 Berlin | Germany
T +49 30 700 13 00 | F +49 30 700 13 03 40
office@berlin.msf.org
www.aerzte-ohne-grenzen.de

Greece Médecins Sans Frontières /

Γρατών Χωρίς Σύνορα
15 Xenias St. | 115 27 Athens | Greece
T + 30 210 5 200 500 | F + 30 210 5 200 503
info@msf.gr | www.msf.gr

Holland Médecins Sans Frontières / Artsen zonder Grenzen

Plantage Middenlaan 14 | 1018 DD Amsterdam
Netherlands
T +31 20 520 8700 | F +31 20 620 5170
office@amsterdam.msf.org
www.artsenzonderegrenzen.nl

Hong Kong Médecins Sans Frontières

無國界醫生 / 无国界医生
22/F Pacific Plaza | 410-418 Des Voeux
Road West | Sai Wan | Hong Kong
T +852 2959 4229 | F +852 2337 5442
office@msf.org.hk | www.msf.org.hk

Italy Médecins Sans Frontières / Medici Senza Frontiere

Via Magenta 5 | 00185 Rome | Italy
T +39 06 88 80 60 00 | F +39 06 88 80 60 20
msf@msf.it | www.medicisenzafrentiere.it

Japan Médecins Sans Frontières / 国境なき医師団日本

Waseda SIA Bldg 3F | 1-1 Babashita-cho
Shinjuku-ku | Tokyo 162-0045 | Japan
T +81 3 5286 6123 | F +81 3 5286 6124
office@tokyo.msf.org | www.msf.or.jp

Luxembourg Médecins Sans Frontières

68, rue de Gasperich | L-1617 Luxembourg
Luxembourg
T +352 33 25 15 | F +352 33 51 33
info@msf.lu | www.msf.lu

Norway Médecins Sans Frontières / Leger Uten Grenser

Hausmannsgate 6 | 0186 Oslo | Norway
T +47 23 31 66 00 | F +47 23 31 66 01
epost@legerutengrenser.no
www.legerutengrenser.no

Spain Médecins Sans Frontières / Médicos Sin Fronteras

Nou de la Rambla 26 | 08001 Barcelona | Spain
T +34 93 304 6100 | F +34 93 304 6102
oficina@barcelona.msf.org | www.msf.es

Sweden Médecins Sans Frontières / Läkare Utan Gränser

Fredsborgsgatan 24 | 4 trappor | Box 47021
100 74 Stockholm | Sweden
T +46 10 199 33 00 | F +46 10 199 32 01
info.sweden@msf.org
www.lakareutangranser.se

Switzerland Médecins Sans Frontières / Ärzte Ohne Grenzen

78 rue de Lausanne | Case Postale 116
1211 Geneva 21 | Switzerland
T +41 22 849 84 84 | F +41 22 849 84 88
office-gva@geneva.msf.org | www.msf.ch

UK Médecins Sans Frontières /

Doctors Without Borders
67-74 Saffron Hill | London EC1N 8QX | UK
T +44 20 7404 6600 | F +44 20 7404 4466
office-ldn@london.msf.org | www.msf.org.uk

USA Médecins Sans Frontières / Doctors Without Borders

333 7th Avenue | 2nd Floor | New York
NY 10001-5004 | USA
T +1 212 679 6800 | F +1 212 679 7016
info@doctorswithoutborders.org
www.doctorswithoutborders.org

Branch Offices

Argentina

Carlos Pellegrini 587 | 11th floor | C1009ABK
Ciudad de Buenos Aires | Argentina
T +54 11 5290 9991 | www.msf.org.ar

Brazil

Rua do Catete, 84 | Catete | Rio de Janeiro
CEP 22220-000 | Brazil
T +55 21 3527 3636 | F +55 21 3527 3641
www.msf.org.br

Czech Republic

Lékari bez hranic, o.p.s | Seifertova 555/47
130 00 Praha 3 – Žižkov | Czech Republic
T +420 257 090 150 | www.lekaribezhranic.cz

India

AISF Building | 1st & 2nd Floor | Amar Colony,
Lajpat Nagar IV | New Delhi 110024 | India
T +91 11 490 10 000 | F +91 11 465 08 020
www.msfindia.in

Ireland

9-11 Upper Baggot Street | Dublin 4 | Ireland
T +353 1 660 3337 | F + 353 1 660 6623
www.msf.ie

Mexico

Champlotón #11 | Col. Roma Sur
CP 06760 | Ciudad de México | Mexico
T +52 55 5256 4139 | F +52 55 5264 2557
www.msf.mx

South Africa

Orion Building | 3rd floor | 49 Jorissen Street
Braamfontein 2017 | Johannesburg | South Africa
T +27 11 403 44 40 | F +27 11 403 44 43
www.msf.org.za

South Korea

5 Floor Joy Tower B/D | 7 Teheran Road 37-gil
Gangnam-gu | Seoul 135-915 | South Korea
T +82 2 3703 3500 | F +82 2-3703 3502
www.msf.or.kr

United Arab Emirates

P.O. Box 65650 | Dubai | UAE
T +971 4457 9255 | F +971 4457 9155
www.msf-me.org

ABOUT THIS REPORT

Contributors

Corinne Baker, Igor G. Barbero, Aurélie Baumel, Niklas Bergstrand, Pierre Borelle, Talia Bouchouareb, Andrea Bussotti, Brigitte Breuillac, Amandine Colin, Lali Cambra, Giorgio Contessi, Stefan Dold, Silvia Fernández, Isabelle Ferry, Sarah-Eve Hammond, Solenn Honorine, Karem Issa, Nicole Johnston, Joanna Keenan, Aurélie Lachant, Sophie-Jane Madden, Samantha Maurin, Sally McMillan, Robin Meldrum, Isabelle Merny, Agustin Morales, Rebecca Murray, Heather Pagano, Nondas Paschos, Catrin Schulte-Hillen, Faith Schwieker-Miyandazi, François Servranckx, Sandra Smiley, Shumpei Tachi, Clara Tarrero, Fiona Terry, Frank Theunissen, Ann-Marie Wilcock, Pascale Zintzen.

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English Edition

Managing Editor Sara Chare and Linda Nagy

Editor and Writer Caroline Veldhuis

Editorial Support Robert Bartram

Photo Editor Bruno De Cock

Copyeditor Kristina Blagojevitch

French Edition

Editor Laure Bonnevie, Histoire de mots

Translator Translate 4 U sarl (Aliette Chaput, Emmanuel Pons)

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MSF is a non-profit organisation. It was founded in Paris, France in 1971. Today, MSF is a worldwide movement of 23 associations. Thousands of health professionals, logistical and administrative staff manage projects in 67 countries worldwide. MSF International is based in Geneva, Switzerland.

MSF International

78 rue de Lausanne, CP 116, CH-1211, Geneva 21, Switzerland
Tel: +41 (0)22 849 8400, Fax: +41 (0)22 849 8404

COVER PHOTO

Critically ill child being cared for by MSF at M'poko camp, Bangui airport.
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