MEDECINS SANS FRONTIERES

INTERNATIONAL ACTIVITY REPORT 2014

www.msf.org

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 2014. Staffing figures represent the total full-time equivalent positions per country in 2014.

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.92.

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.

CONTENTS

2 MSF PROGRAMMES AROUND THE WORLD

4 THE YEAR IN REVIEW
Dr Joanne Liu, International President
Jérôme Oberreit, Secretary General

8 OVERVIEW OF ACTIVITIES

10 GLOSSARY OF DISEASES AND ACTIVITIES

14 SYRIA: FOR EVERY PATIENT WE COULD SEE, THERE WERE THOUSANDS WE COULD NOT

16 SURVIVING EBOLA

18 OVER A DECADE OF OPERATIONAL RESEARCH IN MSF: FROM LUXURY TO NECESSITY?

20 MSF'S ACCESS CAMPAIGN IN 2014

21 ACTIVITIES BY COUNTRY

88 FACTS AND FIGURES

92 CONTACT MÉDECINS SANS FRONTIÈRES

4 The year in review

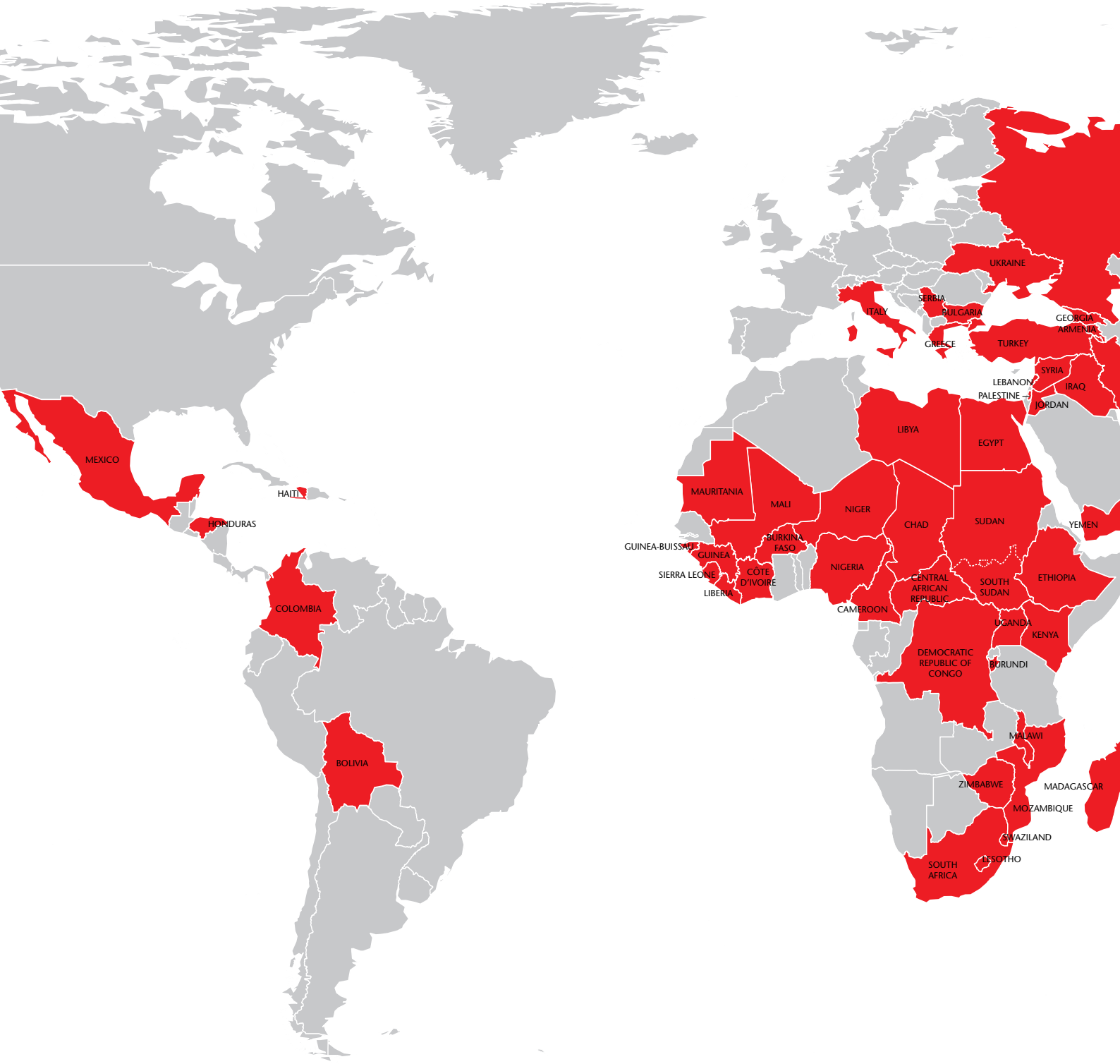
14 Syria: For every patient we could see, there were thousands we could not

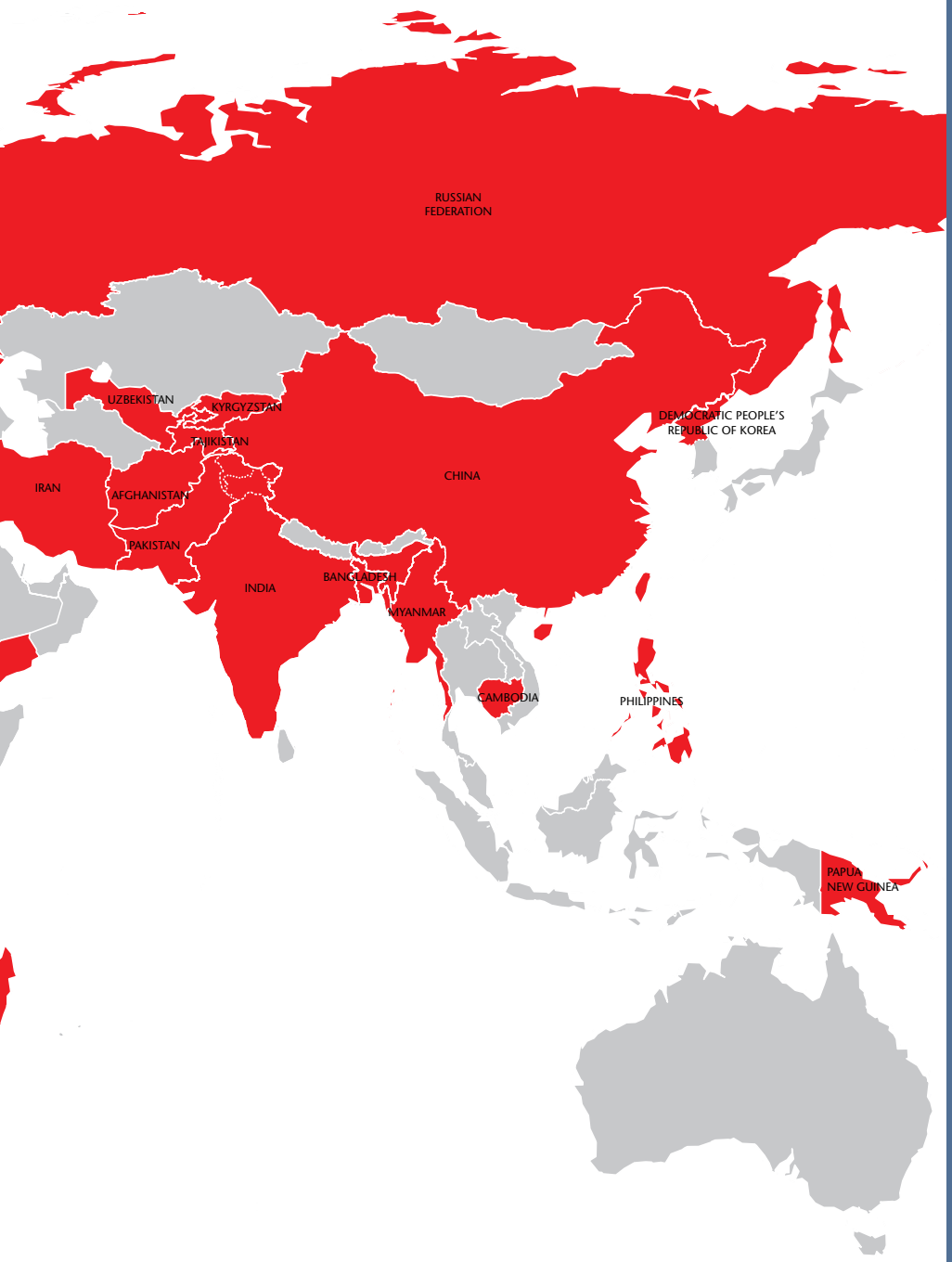
16 Surviving Ebola

18 Over a decade of operational research in MSF: From luxury to necessity?

21 Activities by country

MSF PROGRAMMES AROUND THE WORLD





22 AFGHANISTAN
24 ARMENIA
24 BOLIVIA
25 BANGLADESH
26 BULGARIA
26 BURKINA FASO
27 BURUNDI
27 CAMBODIA
28 CAMEROON
29 CHINA
29 CÔTE D'IVOIRE
30 CENTRAL AFRICAN REPUBLIC
32 CHAD
34 COLOMBIA
35 DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA
35 EGYPT
36 DEMOCRATIC REPUBLIC OF CONGO
38 ETHIOPIA
40 GEORGIA
40 GREECE
41 GUINEA-BUISSAU
41 HONDURAS
42 GUINEA
44 HAITI
46 INDIA
48 IRAQ
50 IRAN
50 ITALY
51 JORDAN
52 KENYA
54 LEBANON
56 KYRGYZSTAN
56 LESOTHO
57 LIBYA
57 MADAGASCAR
58 LIBERIA
60 MALAWI
61 MALI
62 MAURITANIA
62 MEXICO
63 MYANMAR
64 NIGER
66 NIGERIA
68 PAKISTAN
70 PALESTINE
71 PHILIPPINES
72 MOZAMBIQUE
72 PAPUA NEW GUINEA
73 RUSSIAN FEDERATION
73 SERBIA
74 SIERRA LEONE
76 SOUTH AFRICA
77 TAJIKISTAN
77 TURKEY
78 SOUTH SUDAN
80 SUDAN
81 SWAZILAND
82 SYRIA
84 UGANDA
84 UZBEKISTAN
85 UKRAINE
86 YEMEN
87 ZIMBABWE

THE YEAR IN REVIEW

Dr Joanne Liu, International President
Jérôme Oberreit, Secretary General

In 2014, the largest Ebola outbreak in history struck West Africa, the number of displaced people in the world exceeded 50 million and the war in Syria entered its fourth year.

Médecins Sans Frontières (MSF) deployed teams to work in simultaneous emergency situations across the globe, from Liberia to South Sudan, from Ukraine to Iraq. The common thread this year was one of abandonment: the sheer number of Ebola sufferers meant that at the height of the epidemic, many were left to die on their own, stripped of their dignity; in conflict zones the elderly, people with disabilities and the sick were often unable to escape to safety; and as high-income countries turned their attention ever inward, people in desperate need found themselves largely forgotten.

Fighting Ebola in West Africa

When the Ebola outbreak was officially declared on 22 March 2014 in Guinea, no one could have foreseen the extent of the suffering that would ensue. By the end of the year, the disease had claimed almost 8,000 lives in West Africa, including those of 13 MSF employees.

MSF and Ministry of Health staff were faced with the probability that at least 50 per cent of their patients would die from the disease, and that there was no treatment available. They worked daily with the fear of contracting Ebola themselves. As the number of cases grew, the time available to spend with each patient became increasingly limited and sometimes there were not enough staff members to care safely for the sick. Impossible compromises had to be made, such as turning people away at the gates. An MSF anthropologist in Liberia, Pierre Trbovic, told of turning away a father who had brought his sick daughter in the boot of his car: "He was an educated man,

© Sylvain Cherkaoui/Cosmos

The relief is palpable as an MSF nurse removes her personal protective equipment (PPE) in the undressing area of an Ebola management centre in Guinea.

These civilians in the Sinjar mountains are escaping after days under siege. Tens of thousands of people crossed into Syria in August, heading for the relative safety of northern Iraq.

and he pleaded with me to take his teenage daughter, saying that whilst he knew we couldn't save her life, at least we could save the rest of his family from her." People died alone, in the rain, at the side of the road, in front of the Ebola centre's gates. The horror that those living and working in West Africa have been through in the last year cannot be adequately put into words.

The cross-border geographical spread of this Ebola epidemic had never been seen before and, as the previous outbreaks had been much smaller, the number of people with experience of dealing with the disease was limited. The main problem, though, was that there was simply not enough political will to combat Ebola. It wasn't until 8 August – months too late – that the World Health Organization (WHO) at last declared the outbreak "a public health emergency of international concern" and that funding and manpower were unlocked. However, the aid provided was still insufficient and on 2 September, MSF appealed to the UN member states in New York for more help, including the deployment of civilian and military assets with expertise in biohazard containment.

Although MSF has learned a lot about the way Ebola behaves inside the body, much remains unknown about the virus. Before this outbreak it had never been considered a priority for research by big pharmaceutical companies as it was perceived as affecting only a limited number of economically disadvantaged patients in short-lived outbreaks in remote locations in Africa. In August, MSF made the decision to partner with research institutions, the WHO, ministries of health and pharmaceutical companies to trial experimental treatments and vaccines during the outbreak. The first trial began at MSF's centre in Guéckédou in Guinea on 17 December.

A practical plan to sustain research and development for vaccines, treatments and diagnostic tools must be developed. The events of the past year have shown how the world is failing vulnerable people in developing countries, many of whom will never have the money to buy the medicines they need. Effective research and development that is not driven by economic gain will be key to protecting people in remote areas from resurgences and future outbreaks of Ebola and other deadly diseases.

Late in 2014, the number of Ebola cases began to decline but the epidemic is not yet behind us. An outbreak is not over until there are zero cases in a region for a period of 42 days.

The conflicts in Syria and Iraq

Another major challenge for MSF this year was gaining access to people in need of medical care. Due to bureaucratic, political or security issues – or a combination of all three – in countries such as Libya, Nigeria, Sudan, Mali and Myanmar, we were forced to reduce or even in some cases end our programmes. As a consequence, we are now re-evaluating how we work in some contexts. Syria is a good case in point. On 2 January, five MSF staff members were taken hostage by ISIS (since renamed the Islamic State; IS) in northern Syria, despite agreements with local commanders that we would be allowed to work unhindered. Three staff members were released in April and a further two in May. The abduction led to MSF withdrawing from IS-controlled areas, and although local commanders have requested our return, we are unable to do so without guarantees from the leaders that our teams will not be harmed. Furthermore, we still do not have the government's permission to work in the areas that it controls, and we struggle to provide substantial direct medical support to civilians countrywide. Nevertheless, MSF

The hospital in Leer, South Sudan, after the building had been ransacked and set alight. It was the only specialist healthcare facility in Unity state.

still runs some health facilities in the country and supports networks of dedicated Syrian medical staff who often work in extremely hazardous conditions. This support, while valuable, is only possible in a few locations and falls far short of meeting the massive needs that medical teams inside Syria face.

Millions of people have fled the conflict in Syria, many going to Jordan and Lebanon where MSF has projects which treat the war-wounded and try to relieve some of the pressure on the host communities and infrastructure. A large number of Syrian refugees have also travelled to Iraq, which itself experienced an upsurge in violence as the conflict between the Iraqi army and armed opposition groups intensified. Over the course of the year nearly two million people left their homes in search of safety. Shelling, air strikes and fighting prevented humanitarian organisations from accessing people desperately in need of medical supplies, food and water.

At least half the people boarding unseaworthy boats bound for Europe are trying to escape conflict zones, and are searching for protection and a better life. As safe channels become scarcer and land borders are sealed, asylum seekers, migrants and refugees have little option but to take to the sea. It is estimated that at least 3,500 people drowned close to European shores in 2014, many of them from Syria, Eritrea or sub-Saharan Africa. MSF has been working with asylum seekers, migrants and refugees in countries such as Greece, Bulgaria, Italy, Serbia and Egypt, providing medical consultations and psychosocial support, and distributing relief kits.

Lack of respect for the medical mission

Once again this year we have had to consider the question of what to do when MSF employees, healthcare facilities and patients are threatened or attacked. In the Central African Republic (CAR), 19 people, including three Central African MSF staff members, were killed in April during an armed robbery in the grounds of an MSF hospital in Boguila. MSF doubled its medical assistance in CAR in 2014 and started running additional projects for Central African refugees in neighbouring countries. However, staff and patient safety in CAR has remained an issue. On several occasions armed groups entered hospitals and MSF staff had to physically protect patients, shielding them from attack.

This lack of respect for the medical mission was not limited to CAR. In South Sudan, for example, patients were shot in their beds, wards were burned to the ground, medical equipment was looted and, in one case, an entire hospital – in Leer – was completely destroyed. It will take months or even years to rebuild what took only hours to destroy. Hundreds of thousands of people are effectively being denied lifesaving assistance by acts such as these.

Our Congolese colleague, Chantal, was reunited with her family this year after being abducted by an armed group in July 2013, but Philippe, Richard and Romy are still missing and our thoughts go out to their families and friends.

Supporting hospitals in Palestine and Ukraine

When the conflict reignited between Israel and Palestine in mid-2014, MSF supported Al Shifa hospital with a full surgical team and emergency medical equipment, and made donations from its emergency stocks to the central pharmacy. Normally teams work on a fly-in/fly-out basis but a rise in the number of casualties led MSF to establish an emergency surgical team in Gaza between July and September to perform lifesaving operations. A permanent reconstructive surgery team was present until December.

Conflict also affected Europe this year, as the political protests that started in Ukraine in late 2013 gained momentum, leading to violent clashes between police and protestors, the removal of the president from power, and, in May, fighting between armed separatist groups and Ukrainian government forces. Medical supply lines were severely disrupted or cut completely, and health facilities' budgets were soon exhausted. As the conflict spread and intensified, MSF dramatically increased its support, and by the end of the year had provided enough supplies to treat more than 13,000 wounded patients in hospitals on both sides of the frontline.

Tackling illnesses such as malaria, tuberculosis (TB) and HIV

In addition to responding to emergencies this year, MSF teams continued to tackle diseases such as TB and HIV/AIDS in a number of countries, including Uzbekistan, South Africa, Cambodia and India. When cholera cases in Haiti spiked in October, MSF set up treatment centres, distributed disinfection kits and implemented awareness and education activities. In Niger, in collaboration with other organisations, teams worked to reduce under-five mortality, with a particular focus on children with severe malnutrition and malaria. Our programmes also looked at ways of improving treatment protocols and models of care, for example by supporting community adherence clubs and expanding viral load testing. From treating kala azar in South Sudan to providing comprehensive care for victims of sexual violence in Honduras, MSF worked in some of the most challenging environments around the world in 2014.

Looking forward

The Ebola crisis highlighted global failures in the humanitarian aid and health systems, which had been present for years but had never before been so evident. What struck MSF most strongly this year, however, were the lack of global leadership and the reticence of those in power to engage in the Ebola response. We were vocal about this, but ultimately MSF is a patient-focused organisation and our attention remains primarily on those in need of medical care and not on overhauling global systems. MSF concentrates on individuals and we are constantly striving to provide assistance to those who need it most. Our role is to save patients' lives, today, and we respond to crises with that at the forefront of our minds. We could not work in this way without our supporters and our teams around the world. We want to take this opportunity to thank you all.

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An MSF counsellor talks to a truck driver about HIV testing, as part of the new 'corridor project' rolled out in the high-transit cities of Tete and Beira, Mozambique.

OVERVIEW OF ACTIVITIES

Largest country programmes based on project expenditure

1. South Sudan
2. Democratic Republic of Congo
3. Central African Republic
4. Haiti
5. Sierra Leone
6. Afghanistan
7. Niger
8. Liberia
9. Ethiopia
10. Iraq

The total budget for our programmes in these 10 countries is 380.5 million euros, **54 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. South Sudan	3,996
2. Democratic Republic of Congo	2,999
3. Central African Republic	2,593
4. Haiti	2,159
5. Niger	1,866

Outpatient consultations

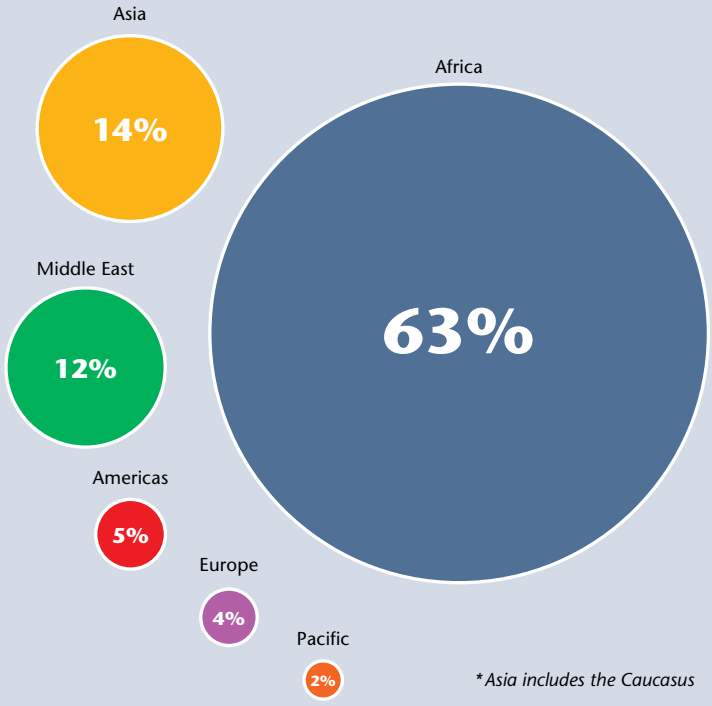
Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.

1. Democratic Republic of Congo	1,593,800
2. Central African Republic	1,401,800
3. South Sudan	936,200
4. Niger	508,300
5. Ethiopia	347,700
6. Kenya	333,400
7. Afghanistan	306,600
8. Pakistan	279,900
9. Chad	257,200
10. Sudan	246,900

Project locations

Number of projects

Africa	240	Americas	20
Asia*	55	Europe	16
Middle East	47	Pacific	6

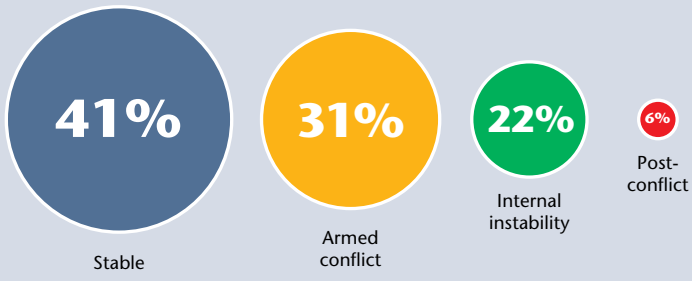


*Asia includes the Caucasus

Context of intervention

Number of projects

Stable	157
Armed conflict	120
Internal instability	86
Post-conflict	21



2014 ACTIVITY HIGHLIGHTS

8,250,700
outpatient consultations

511,800
patients admitted

2,114,900
cases of malaria treated

217,900
severely malnourished children admitted to inpatient or outpatient feeding programmes

229,900
HIV patients registered under care at the end of 2014

218,400
patients on first-line antiretroviral treatment at the end of 2014

8,100
patients on second-line antiretroviral treatment at the end of 2014 (first-line treatment failure)

194,400
women delivered babies, including caesarean sections

81,700
major surgical interventions, including obstetric surgery, under general or spinal anaesthesia

11,200
patients medically treated for sexual violence

21,500
patients on tuberculosis first-line treatment

1,800
patients on MDR tuberculosis treatment, second-line drugs

185,700
individual mental health consultations

32,700
group counselling or mental health sessions

46,900
people treated for cholera

1,513,700
people vaccinated against measles in response to an outbreak

33,700
people treated for measles

75,100
people vaccinated against meningitis in response to an outbreak

7,400
people admitted to Ebola management centres in the three main West African countries, of which **4,700** were confirmed as having Ebola

2,200
people recovered from Ebola and discharged from management centres

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. Symptoms are rare in the first, acute stage of the disease and if they do appear they are mild. 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 in 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 and in acute cases, 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.

Cholera

Cholera is a water-borne, acute gastrointestinal infection caused by the *Vibrio cholerae* bacterium. It is transmitted by contaminated water or food, or through direct contact with contaminated surfaces. In non-endemic areas, large outbreaks can occur suddenly and the infection can spread rapidly. Most people will not get sick or 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 46,900 people for cholera in 2014.

Ebola

Ebola is a virus that is transmitted through direct contact with blood, bodily secretions, organs and infected people. Ebola first appeared in 1976 and, although its origins are unknown, bats are considered the likely host. MSF has intervened in almost all reported Ebola outbreaks in recent years, but until 2014 these were usually geographically contained and involved more remote locations. Ebola has a mortality rate of between 25 and 80 per cent, and as there is currently no vaccine or treatment for the virus patient care is centred on hydration and treating the symptoms such as fever and nausea. Ebola starts with flu-like symptoms, followed by vomiting and diarrhoea and in some cases haemorrhaging and often death. Despite being so deadly, it is a fragile virus that can be killed easily with sunshine, heat, bleach, chlorine and even soap and water.

Preventing transmission is essential: patients are treated in Ebola management centres where strict infection control procedures are in force. Identifying people the patient was in contact with when they were ill becomes a priority, as do safe burials. Community health promotion is also undertaken to inform the community about the threat and how to try and keep themselves safe and what to do if they develop signs.

In 2014 MSF admitted 7,400 people to Ebola management centres in the three main West African countries, of which 4,700 were confirmed as having Ebola.

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, 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 – leading to acquired immunodeficiency syndrome, or AIDS. As the virus progresses, people begin to suffer from opportunistic infections. The most common opportunistic infection that (often) 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. 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, labour and breastfeeding, and to the infant just after birth.

MSF provided care for 229,900 people living with HIV/AIDS and antiretroviral treatment for 226,500 people in 2014.

A health worker washes their hands in chlorinated water, whilst removing protective clothing after an hour-long shift in the high risk area of MSF Ebola management centre in Paynesville, Liberia.

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 to detect 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 is toxic and 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 9,500 patients for kala azar in 2014.

Malaria

Malaria is transmitted by infected mosquitoes. Symptoms include fever, pain in the joints, headache, 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 an important means of controlling malaria. In endemic areas, MSF distributes nets to pregnant women and children under the age of five, who are the 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 or three to four months during the peak season for the disease.

MSF treated 2,114,900 people for malaria in 2014.

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.

continued overleaf ›

Glossary of diseases and activities continued ›

Global malnutrition in children is usually 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 stop their condition from deteriorating further.

MSF admitted 217,900 malnourished children to inpatient or outpatient feeding programmes in 2014.

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.

In high-income countries, most people infected with measles recover within two to three weeks, and mortality rates 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, severe respiratory infection or encephalitis (inflammation of the brain).

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 33,700 patients for measles and vaccinated 1,513,700 people in response to outbreaks in 2014.

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 vaccinated 75,100 people against meningitis in response to outbreaks in 2014.

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, which is a complementary approach.

MSF staff held 218,400 individual and group mental health sessions in 2014.

Relief items distribution

MSF's primary focus is on providing medical care but, in an emergency, teams often organise the distribution of relief items that are essential for survival. Such items include clothing, blankets, bedding, shelter, cleaning materials, cooking utensils and fuel. In many emergencies, relief items are distributed as kits. For example, 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 – such as 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 52,200 relief kits in 2014.

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 665,400 antenatal consultations in 2014.

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.

A patient co-infected with HIV and XDR-TB has her routine check-up at the MSF clinic in Mumbai, India.

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 11,200 patients for sexual violence-related injuries in 2014.

Sleeping sickness (human African trypanosomiasis)

Generally known as sleeping sickness, human African trypanosomiasis is a parasitic infection transmitted by tsetse flies which occurs in sub-Saharan Africa. In its latter stage, it attacks the central nervous system, causing severe neurological disorders and death if left untreated. 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 (NECT), developed by MSF, Drugs for Neglected Diseases initiative (DNDi) and Epicentre, is now the World Health Organization (WHO) 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 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 330 patients for sleeping sickness treatment in 2014.

Tuberculosis (TB)

One-third of the world's population is currently infected with the TB bacillus but they have a latent form of the disease and so have no symptoms and cannot transmit it. In some people, the latent TB infection progresses to acute TB, often due to a weak immune system. 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 (isoniazid and rifampicin), 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 very limited.

In 2014, MSF treated 21,500 patients for TB, of which 1,800 for MDR-TB.

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 organisations such as the WHO and MSF. Currently, these are DTP (diphtheria, tetanus, pertussis), measles, polio, hepatitis B, *Haemophilius influenzae* type b (Hib), pneumococcal conjugate, rotavirus, BCG (against TB), rubella, yellow fever and human papillomavirus – 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, less frequently, 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.

MSF undertook 376,100 routine vaccinations in 2014.

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.

SYRIA: FOR EVERY PATIENT WE COULD SEE, THERE WERE THOUSANDS WE COULD NOT

Sam Taylor

Inspired by the Arab Spring demonstrations that swept through North Africa and the Middle East, similar anti-government protests started in southern Syria in March 2011. The government responded to the protests with force and the situation deteriorated rapidly. Over the four years since then, the conflict has grown more complex, entrenched and divisive and the situation for those people living in Syria is critical.

With multiple, shifting fronts, besieged populations cut off from essential aid and a myriad of armed groups, Syria was one of the most difficult countries in which Médecins Sans Frontières (MSF) tried to work in 2014. Several projects were forced to close and international staff were withdrawn, subsequently making it even more difficult for MSF to reach patients. Syria has recently been referred to as the world's worst humanitarian crisis.

Working in northern Syria

By the start of 2014, MSF had a significant and well-established presence in the north of the country in areas not controlled by the government. It had not been easy to set up these facilities, but by working with networks of dedicated Syrians, MSF was able to gradually expand its operations. With six MSF-run hospitals, six clinics, several mobile clinics and around 60 international staff members working alongside hundreds of Syrian colleagues, teams were able to treat a substantial number of patients in Idlib and Aleppo governorates.

All this changed in January, however, when 13 of MSF's staff were abducted by the group who call themselves the Islamic State (IS). This occurred despite written and verbal security guarantees from local members. Eight Syrian staff were released shortly after being taken, but five international MSF colleagues were held for up to five months. This significantly altered the way MSF operated inside northern Syria and led to a considerable reduction in activities. Since security guarantees from high-level IS group leaders were not forthcoming, MSF made the difficult decision to stop all activities in IS-controlled areas, but continued to operate facilities in non-government areas outside the control of IS. MSF was unable to open any medical projects in areas under government control in 2014, but continued to operate three hospitals in the north, a specialist burns unit in Idlib and two other hospitals in Aleppo, all staffed by Syrians. In addition, MSF was able to run two facilities in the northeast of Syria.

Aleppo under barrel bombs

Aleppo is Syria's second-largest city but years of war have brought its health system to its knees, and thousands of medical workers have fled or been killed. Throughout 2014, the facilities in the city run by Syrian staff and managed at a distance by MSF international teams continued to provide a wide range of medical services to the trapped population amid a dramatically worsening humanitarian situation. These included treatment for the devastating injuries caused by barrel bombs: unguided high-explosive devices that are

In Idlib governorate, MSF runs the only burns unit in northern Syria where people can get the specialist care they need, such as wound cleaning (debridement) and dressing changes that are performed under anaesthesia.

A burn being tended to by an MSF staff member in a clinic in northern Syria.

filled with scrap metal and then dropped from helicopters or airplanes. As the bombs cannot accurately target military installations, civilians often fall victim to them.

The appalling toll on health is not just a result of traumatic injuries caused by the fighting, however, but also of the lack of access to basic healthcare and treatment for chronic diseases such as diabetes. Women are forced to give birth in deplorable conditions, and many people are suffering the severe mental health repercussions of living in a conflict zone for years.

As elsewhere in the country the needs of the population greatly outstripped what was offered by MSF and other humanitarian organisations working in the area. To make matters worse, in July, at least six hospitals in Aleppo – including one run by MSF – were bombed and either destroyed or damaged.

Essential medical support

Since the beginning of the conflict, MSF has donated equipment to support medical networks which continue to operate in extremely difficult situations throughout Syria; this can be as simple as gauze for wounds, or as complex as full kits of drugs and materials for operating theatres, including devices needed for orthopaedic surgery.

Over time this support work has expanded and now provides supplies to more than 100 field hospitals, health posts and clinics – facilities that without MSF help would struggle to offer essential medical services.

The support provided by MSF is particularly valuable in areas that are besieged by government forces – places where, for up to two years, there has been a blockade on certain goods. Although clearly useful this support falls far short of the needs that MSF knows exist.

Throughout 2014, MSF should have been running major projects in Syria, but with no security guarantees for staff and no access to areas controlled by the government, this simply was not possible. Increased and direct hands-on assistance will only be viable when the many armed groups, both government and opposition, show the political willingness to respect and allow independent medical humanitarian action. This willingness was not forthcoming in 2014, resulting in intolerable levels of suffering for the Syrian people.

For more on MSF's work in Syria in 2014, see pp.82–83.

STAFF STORY

DR S – a young surgeon working in an MSF-supported hospital in the east of Damascus

"Three years of non-stop surgery under tough circumstances – I have maxed out. I've had enough of scenes of misery. I was on the phone recently with my surgery professor and he said: 'Regardless of the operating conditions, your work during these three years matches my whole 30 years' experience as a doctor. You have reached retirement in just three years.' And indeed, every moment of every day I feel I have had enough, but we have no other choice. People here need us. They are in desperate need of all kinds of medical care, from the most simple to the most complicated. We cannot add another reason for the deterioration of this already disastrous situation. Today, I am almost certain that, when the war is over, I will quit medicine. Any human being would make that decision after living through what I have lived through. I look forward to the end of this war. It has to stop, one day. Then, I can choose what to do. Only then will we be truly alive again."

SURVIVING EBOLA

December 2013

6 December
Death of alleged "patient zero" of the epidemic, a two-year-old Guinean child

March 2014

22 March
Ebola outbreak is declared by the Guinean authorities

27 March
The first cases are officially reported in Conakry, Guinea's capital

31 March
Liberia reports two confirmed cases

May 2014

2 May
Despite a decrease in the number of new patients, MSF declares that "the epidemic is not over and we must remain vigilant"

26 May
World Health Organization (WHO) reports the first cases and deaths in Sierra Leone

June 2014

3 June
MSF raises the alarm about a "resurgence of the Ebola outbreak in West Africa"

17 June
Cases are reported in Monrovia, Liberia's capital

23 June
The outbreak has become the worst on record and MSF says it is "out of control" and calls for massive resources

July 2014

20 July
First confirmed case in Nigeria. The outbreak is declared over on 20 October.

28 July
First case is reported in Freetown, Sierra Leone's capital

In 2014, the Ebola virus coursed rapidly through Liberia, Guinea and Sierra Leone in a geographical spread never seen before.

An Ebola epidemic was declared on 22 March, and it soon became the largest in history. Médecins Sans Frontières (MSF) launched an unprecedented response to this exceptional outbreak, and deployed thousands of staff who treated one-third of all confirmed cases in West Africa.

The vulnerability of healthcare workers to Ebola is a double tragedy; the virus takes the lives of the very people meant to tackle it. Nearly 500 healthcare workers have died of Ebola while thousands of others have risked their lives to support patients and help control the outbreak. The Ebola epidemic took a heavy toll on MSF staff: 27 became infected and 13 tragically passed away in 2014.

MSF teams had never before responded to an outbreak of viral haemorrhagic fever on such a scale: the countries affected were Guinea, Liberia, Sierra Leone, Mali, Nigeria and Senegal, in addition to an unrelated Ebola outbreak in the Democratic Republic of Congo.

Despite sounding the alarm early on and calling for help, MSF teams battled Ebola for months in the face of a "global coalition of inaction". The virus spread wildly in the region, leading MSF to issue a rare call at the United Nations (UN) in September for the mobilisation of international civilian and military medical assets with biohazard capacity.

No one knows exactly how many people have died due to the epidemic: not only from Ebola but also from all the other diseases and ailments for which they were unable to obtain treatment due to the collapse of the health system.

By the end of the year, the number of cases in the region had begun to decline but the epidemic is still far from over. MSF teams continue to run Ebola management centres and are turning their attention to gaps in outreach activities, such as surveillance, contact tracing and social mobilisation.

For more on the Ebola intervention, see Guinea (p.42–43), Liberia (p.58–59) and Sierra Leone (p.76–77).

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A nurse gives medication to a suspected Ebola patient in the high-risk zone of the Kailahun management centre, Sierra Leone.

August 2014

2–5 August
Two international staff from Samaritan's Purse are infected and transferred to the US for treatment. Both are declared cured on 21 August.

8 August
WHO declares Ebola an "international public health emergency"

12 August
WHO gives its cautious approval to the use of experimental drugs and vaccines to treat Ebola

24 August
Democratic Republic of Congo declares an Ebola outbreak, believed to be separate from the West African epidemic. It is over by 21 November.

29 August
Senegal reports its first confirmed case. The country is declared Ebola free on 17 October.

September 2014

2 September
MSF's International President, Dr Joanne Liu, gives a speech to the UN member states. She warns that the world is "losing the battle against Ebola".

17 September
MSF confirms that a French nurse is infected with Ebola. After treatment in Paris, she is declared cured on 4 October.

18 September
Dr KP Jackson Naimah, an MSF doctor from Liberia, tells the UN Security Council that MSF has reached its limits and appeals for international aid. The council unanimously adopts Resolution 2177. The epidemic is declared "a threat to international peace and security".

25 September
In a speech to the UN, Dr Liu calls upon member states to take immediate action, not "outsourcing" their response but supplying the required human and logistical resources needed to tackle the outbreak

30 September
The Centers for Disease Control and Prevention in the US confirms that Liberian national Thomas Duncan has Ebola. He is the first patient to be diagnosed with the disease outside of West Africa. He dies on 8 October.

October 2014

3 October
MSF starts distributing family protection and disinfection kits in Monrovia, Liberia. The kits are designed to protect those who have been in contact with infected people and who cannot immediately be transferred to an Ebola management centre. MSF calls them "an imperfect response to an unprecedented epidemic situation".

23 October
MSF doctor Craig Spencer tests positive for Ebola. He is declared virus free on 10 November.

The first case is confirmed in Mali

25 October
In Monrovia, Liberia, MSF starts distributing anti-malarial treatments

November 2014

13 November
MSF announces that it will host trials for Ebola treatments in three of its management centres in West Africa

December 2014

10 December
Time magazine names "The Ebola Fighters" its Person of the Year

17 December
Favipiravir trial starts in Guéckédou, Guinea

By the end of December, WHO reports 20,206 confirmed cases of Ebola and 7,905 deaths

STAFF STORY

PATRICK TRYE – Medical Coordinator Assistant, Freetown, Sierra Leone

"I have been working with MSF since 2008, and when I felt ill in September 2014 I went straight to the staff clinic assuming I had malaria. When I did not respond to malaria treatment after 48 hours, the medical coordinator decided that I should be taken to the case management centre (CMC) in Bo for further tests. Within 24 hours I was told my viral status. Though it was a terrifying time, the system in place meant that there was no delay in initiating treatment before I started showing serious signs and symptoms of Ebola. It would have been worse if I had gone through the free-toll call system (117), as it could have taken more than 48 hours for the response team to arrive.

At the CMC, I was terrified to see people dying from a disease that I had just been diagnosed with but I helped those around me for as long as I could. Soon though my strength started to give in to the effects of the virus – vomiting, diarrhoea, sore throat and massive weakness – and I quickly realised I could no longer stand on my own. My first instinct was to think 'my turn to go has come, I am going to die'. I thought of my family … my committed wife who had always been by my side, my lovely children and my old mother.

I cannot overemphasise the terrible moments I went through at the centre, but what added to my agony is the memory of a female MSF colleague who was very hopeful she would survive the illness. She explained that she had recovered from Lassa fever some years back and that she knew she would recover from Ebola too. Unfortunately, she died two days after telling me this. It left me with a bitter taste.

For seven days my temperature remained high and at some points I refused my medication. But the clinicians at the CMC were relentless and courageous; they did not allow me to have my own way and coaxed me to comply. I was given antibiotics for my sore throat, and when I felt very weak and dehydrated intravenous fluids and oral anti-nausea drugs. My appetite was gone and I could not eat. Ten days after admission though, I started responding to the treatment, my throat improved and the diarrhoea and vomiting ceased. My appetite gradually returned, my body temperature normalised and I slowly regained my strength. On 23 October, I was finally pronounced Ebola free.

After six weeks of absolute rest, I realised I had an unfinished battle. I had seen many people die in agony and I knew that my contribution to the fight against Ebola was needed now more than ever. Complying with the medical coordinator's advice I started work on a half-day basis. I am delighted to have resumed my normal life."

PATIENT STORY

BENETTA COLEMAN, 25 year old Ebola survivor

"Ebola destroyed my future. I am lonely, helpless and hopeless. But I am grateful that I still have life despite the loss, grief, helplessness and hopelessness. I lost my son and my husband. I lost 22 other family members including my parents, siblings, nieces and nephews. I survived along with four nieces and nephews who I am now caring for.

My four year old niece caught the virus first and it quickly spread to the rest of the family – living in neighbouring buildings. It's still a mystery to me how she contracted Ebola.

Before this I was a happy woman living with a happy family. But Ebola stole my happiness and rendered me homeless. Today, I am a widow, an orphan and a grief stricken mother. I had not imagined that my life would turn out this way but this is the sad reality that I must confront. I must put the horrible past behind me. Recovering from Ebola has not been without after effects and I continue to feel pains in my legs.

Just before Ebola struck my family, I had passed into the 12th grade. I am not sure if I will return to school, as my husband and my parents were my main sponsors. I do not have the financial means to support myself and also care for the children … My dreams have been shattered."

OVER A DECADE OF OPERATIONAL RESEARCH IN MSF: FROM LUXURY TO NECESSITY?

Contributors: *Rony Zachariah, Tony Reid, Nathan Ford, Eric Goemaere, Marc Biot, Tom Ellman, Roger Teck, Wilma van den Boogaard, Engy Ali, Marcel Manzi, Rafael Van den Bergh, Petros Isaakidis, Mohammed Khogali, Walter Kizito, Tom Decroo, Laura Bianchi, Paul Delaunois, Bertrand Draquez*

How is operational research defined?

From a Médecins Sans Frontières (MSF) perspective, a pragmatic definition of operational research is "the search for knowledge on interventions, strategies and tools that can enhance the quality or performance of programmes". Broadly speaking, operational research is the 'science of doing better' and often it is about showing 'what works' and 'what does not work' in the contexts where we have projects in order to advocate for change in a scientifically credible manner.

What can operational research achieve?

There are many stories illustrating the start of operational research in MSF, but perhaps the most powerful are linked to our early struggles in sub-Saharan Africa with malaria and HIV/AIDS.

Malaria

In a hospital outpatient clinic in Mali in the 1990s, doctors treating malaria patients gave a prescription for chloroquine to a man who complained that he had already taken the drug several times in the past and it had not worked. He asked for an alternative. At the time though, MSF was applying national protocols based on WHO recommendations and chloroquine was the only medicine available. National and international authorities considered the available evidence of chloroquine resistance to be insufficient to justify the economic consequences of changing to more effective but costlier treatments. Evidence needed to be gathered to prove that chloroquine was not working.

MSF and one of its research arms – Epicentre – undertook efficacy studies in collaboration with health ministries in the early 2000s to evaluate national protocols. The patient was proved correct – chloroquine treatment had a failure rate of up to 91 per cent for *Plasmodium falciparum* malaria, which is one of the most common and the most deadly form of the disease. Now guidelines could be changed and alternatives implemented.

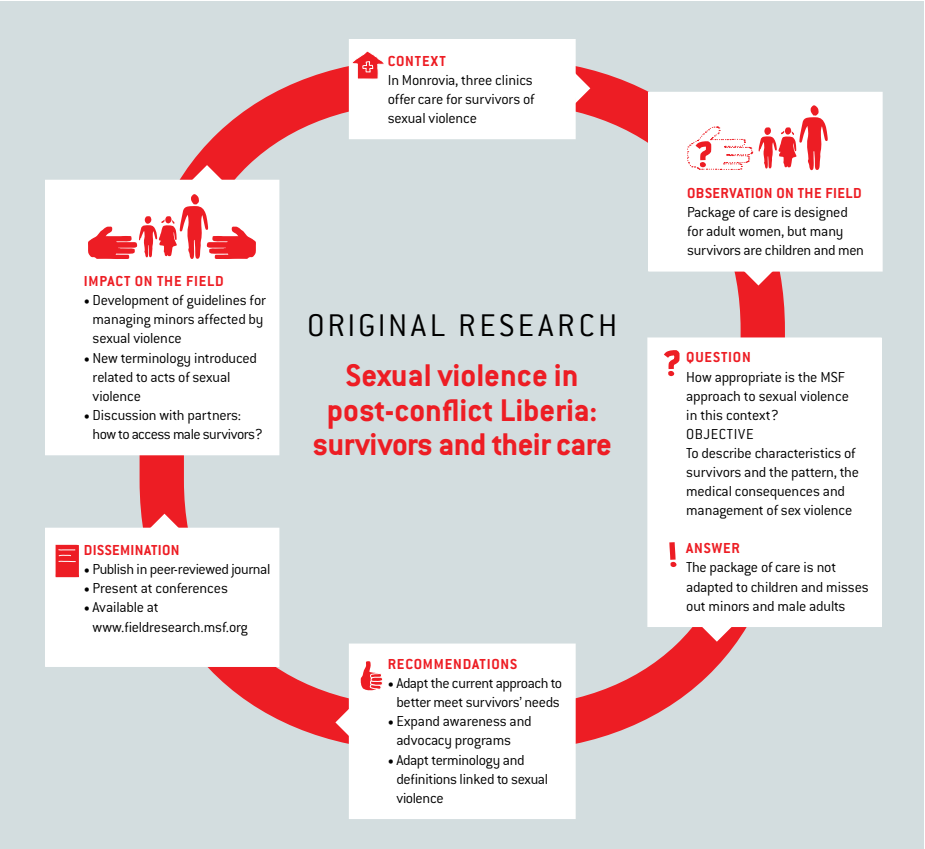
By giving this example, we are not seeking to blame clinicians, who do the best they can with limited resources. The story simply illustrates why operational research is a vital component in evaluating a programme, and why it should be a routine part of any project cycle. A culture of inquiry, combined with the application of scientific methods and peer-reviewed publications, is essential for advocacy, to show 'what works' and 'what does not work', and to find practical solutions.

An HIV-positive patient is given a month's supply of ARVs at the Thyolo district hospital, Malawi.

HIV/AIDS

In the late 1990s and early 2000s, MSF witnessed first hand the toll HIV and AIDS was taking on communities in lower-income countries, and there was much internal debate about whether or not MSF should get involved with potentially lifesaving antiretroviral (ARV) treatment provision. Western governments considered that ARVs were too complex and too expensive (US$10,000–15,000 per patient per year at the time) and that Africa should focus on other health priorities. This was at a time when more than 25 million people in sub-Saharan Africa were infected with HIV/AIDS, over 17 million had already died and many countries in the region had been brought to their knees due to HIV/AIDS-related illnesses and deaths.

The real problem for some, however, was perception. To give an extreme example, Andrew Natsios, the head of the United States Agency for International Development during the George W. Bush administration, argued against funding ARVs in Africa in an interview with the *Boston Globe* in June 2001. He said: "The problems extend to the Africans themselves. They do not know what watches and clocks are … they don't know what Western time is. You have to take these drugs at certain hours each day, or they don't work. And if you say, one o'clock in the afternoon, they don't know what you are talking about." Needless to say, his argument was roundly rejected and some called for his immediate resignation. The role of operational research in all this was to provide proof to people who thought as he did that they were wrong. Research conducted by MSF in Uganda, Kenya, South Africa, Malawi and Thailand played a historical role in demonstrating the feasibility and effectiveness of HIV treatment in resource-limited settings. It also showed that access to ARVs could transform HIV/AIDS from a death sentence into a manageable chronic disease.



MSF advocacy, in close collaboration with activist organisations for ARV price reductions (the price is now close to US$70 per patient per year), spearheaded by operational research, made pivotal contributions in steering the political momentum towards a global increase in ARV provision.

Why is operational research relevant for MSF?

Operational research allows MSF to improve programme performance, help patients, assess the feasibility of new strategies and/or interventions and advocate policy change.

It also makes MSF accountable to its patients, its donors and itself, and consequently challenges the 'business as usual' approach. Furthermore, operational research leads to improved medical/scientific visibility and credibility, raises awareness of the scientific literature among field staff and facilitates networking and partnerships with other organisations. It also brings synergistic improvements to data collection, monitoring and feedback, which is vital for credible medical *témoignage*. Operational research using project data acts thus as a scientific 'witness'.

To what extent has the MSF Movement embraced this science?

MSF has become an important international contributor to health research through the expansion of its research activities. This is reflected in the number of peer-reviewed publications in which MSF work has featured, which has increased from barely five, mainly focused on HIV/AIDS, in 2000, to more than 150 covering a range of subjects in 2014. Since 2010, the MSF Field Research website (www.fieldresearch.msf.org), which archives MSF-authored publications and makes them available for free, has had 430,000 downloads from around the world. The world seems to be increasingly interested in the operational research work done by MSF and we are clearly providing information that people are actively seeking.

MSF has created operational research fellowships, participated in international scientific conferences, established an Ethics Review Board, developed an institutional position on supporting open (free) access to publications, launched an innovation fund and set up research registries. MSF has also been a pioneering partner in developing a WHO-accredited course that is seen as a blueprint for increasing operational research in 70 low- and middle-income countries. This intervention should result in more relevant operational research being conducted, better implementation of health programmes and ultimately, more lives saved.

Integrating operational research into its operations has helped MSF to improve programme effectiveness, provided evidence for advocating on behalf of patients at risk and contributed to the growth of research capacity worldwide. Rather than a luxury, operational research undertaken by MSF units such as LuxOR (Luxembourg), SAMU (South Africa), the Manson Unit (United Kingdom), Epicentre (France) and BRAMU (Brazil) is a vital component of effective humanitarian aid.

Three examples of operational research studies published by MSF and their contributions to policy and practice:

Operational research study	Main findings	Effect on policy and practice
'Improving performance of medical interventions' Tayler-Smith K, Zachariah R, Hinderaker SG, Manzi M, De Plecker E, Van Wolvelaer P, et al. Sexual violence in post-conflict Liberia: survivors and their care. Trop Med Int Health. 2012; 17(11): 1356-60.	The care package focused only on women and was not adapted to the context where sexual violence also affected minors and men	Liberia's national guidelines and MSF's were revised
'Assessing feasibility of interventions in specific populations' O'Brien DP, Sauvageot D, Zachariah R, Humblet P. In resource-limited settings good early outcomes can be achieved in children using adult fixed-dose combination antiretroviral therapy. AIDS. 2006; 20(15): 1955-60.	Integrated ARV treatment can be offered in a conflict setting with good outcomes	Provided knowledge on how to implement an integrated HIV/AIDS programme in a rural conflict setting. Led to revision of the SPHERE guidelines* for displaced populations.
'Advocating for policy change' Guthmann JP, Checchi F, van den Broek I, Balkan S, van Herp M, Comte E, et al. Assessing antimalarial efficacy in a time of change to artemisinin-based combination therapies: the role of Médecins Sans Frontières. PLoS Med. 2008; 5(8): e169.	High levels of drug resistance in falciparum malaria and ineffective national regimens in 18 countries	Led to a shift in national and international policy on use of more effective antimalarial treatment

**Benchmark guidelines for offering health services for refugees and displaced populations.*

MSF'S ACCESS CAMPAIGN IN 2014

In 1999, Médecins Sans Frontières (MSF) launched the Access Campaign with the sole purpose of advocating for the accessibility and development of life-saving and life-prolonging medicines, diagnostics and vaccines for patients in MSF projects and beyond. Here are just some of the areas the Access Campaign worked on in 2014:

Vaccines

The Access Campaign drew attention to the challenges of delivering life-saving vaccines to children in developing countries, advocating for companies to reduce prices and to improve thermostability to enable the vaccines to be transported further into remote areas without the need for constant refrigeration.

Tuberculosis

Having survived extensively drug-resistant tuberculosis (XDR-TB) – the deadliest form of the disease – Phumeza Tisile, with her MSF doctor Jenny Hughes, wrote the 'Test Me, Treat Me' drug-resistant tuberculosis (DR-TB) manifesto to urge countries, companies, donors and researchers to support better DR-TB diagnosis and treatment. More than 55,000 people from around the world signed the petition, which was presented to global leaders at the UN's World Health Assembly in Geneva in May.

Protecting the 'pharmacy of the developing world'

India's vital role in providing affordable medicines to developing countries, as well as MSF programmes, is under threat from moves to roll back public health 'safeguards' in India's patent law, which protect against frivolous patent abuse and allow generic competition to flourish in the interest of access to affordable medicines. MSF urged the Indian government to stand firm in the face of pressure from the US government and multinational pharmaceutical companies.

Hepatitis C

As MSF was preparing to scale up treatment programmes for hepatitis C, a disease which affects 150 million people worldwide, the Access Campaign called on pharmaceutical firms to reduce the exorbitant prices of the drugs used to treat the disease. Highlighting the enormous gap between the prices being charged and the actual cost of production, MSF urged countries and companies to take all necessary measures to ensure affordable access to these life-saving drugs.

Ebola

An unprecedented outbreak of the deadly Ebola virus in West Africa prompted MSF to call on donors, researchers and pharmaceutical firms to collaborate to fast-track trials of new vaccines and treatments for the disease, and to run some trials at MSF treatment centres in West Africa. Affordable access to promising products should be prioritised for those in the most affected countries.

Trade agreements

Trade agreements currently being negotiated between developed and developing countries, including the Trans-Pacific Partnership Agreement, pose a serious threat to affordable medicines. MSF has urged countries not to accept harmful intellectual property provisions that extend monopoly periods for high-priced medicines while blocking price-lowering generic competition.

Priorities for 2015

In 2015, a major campaign on vaccines will be launched, advocating for a reduction in prices and for an increase in transparency regarding pricing. The Access Campaign will continue to push for affordable hepatitis C drugs, and for wider availability of new drugs to treat DR-TB.

Stay Connected

If you'd like to keep up-to-date with the work of MSF's Access Campaign, visit www.msfaccess.org and sign up to receive newsletter updates, and follow us on Twitter @MSF_Access.

ILLUSTRATIONS © Vivien Peng

Ismael (aged 4) has severe cholera and has been hospitalised in the MSF centre in the Delmas neighbourhood of Port-au-Prince, Haiti.

ACTIVITIES BY COUNTRY

22 AFGHANISTAN
24 ARMENIA
24 BOLIVIA
25 BANGLADESH
26 BULGARIA
26 BURKINA FASO
27 BURUNDI
27 CAMBODIA
28 CAMEROON
29 CHINA
29 CÔTE D'IVOIRE
30 CENTRAL AFRICAN REPUBLIC
32 CHAD
34 COLOMBIA
35 DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA
35 EGYPT
36 DEMOCRATIC REPUBLIC OF CONGO
38 ETHIOPIA
40 GEORGIA
40 GREECE
41 GUINEA-BUISSAU
41 HONDURAS
42 GUINEA
44 HAITI
46 INDIA
48 IRAQ
50 IRAN
50 ITALY
51 JORDAN
52 KENYA
54 LEBANON
56 KYRGYZSTAN
56 LESOTHO
57 LIBYA
57 MADAGASCAR
58 LIBERIA
60 MALAWI
61 MALI
62 MAURITANIA
62 MEXICO
63 MYANMAR
64 NIGER
66 NIGERIA
68 PAKISTAN
70 PALESTINE
71 PHILIPPINES
72 MOZAMBIQUE
72 PAPUA NEW GUINEA
73 RUSSIAN FEDERATION
73 SERBIA
74 SIERRA LEONE
76 SOUTH AFRICA
77 TAJIKISTAN
77 TURKEY
78 SOUTH SUDAN
80 SUDAN
81 SWAZILAND
82 SYRIA
84 UGANDA
84 UZBEKISTAN
85 UKRAINE
86 YEMEN
87 ZIMBABWE

AFGHANISTAN

No. staff in 2014: 1,738 | Expenditure: €24.8 million | Year MSF first worked in the country: 1980 | msf.org/afghanistan | blogs.msf.org/afghanistan

KEY MEDICAL FIGURES:

306,600 outpatient consultations

39,600 births assisted

7,800 surgical interventions

After more than a decade of international aid and investment, access to basic and emergency medical care in Afghanistan remains severely limited and ill-adapted to meet the growing needs created by the ongoing conflict.

In February 2014, Médecins Sans Frontières (MSF) published a report entitled *Between Rhetoric and Reality: The Ongoing Struggle to Access Healthcare in Afghanistan*, which revealed the serious and often deadly risks that people are forced to take to access medical care. It found that the majority of the 800 patients interviewed could not reach critical medical assistance due to insecurity, distance and cost. Of those who reached MSF hospitals, 40 per cent told us they had faced fighting, landmines, checkpoints or harassment on their journey. Their testimonies exposed a wide gap between what exists on paper in terms of healthcare and what is actually available.

Dasht-e-Barchi hospital, Kabul

At the end of November, MSF opened a maternity department in the district hospital of Dasht-e-Barchi, western Kabul.

Over the past decade, Kabul has become one of the world's fastest-growing cities but services have not kept pace with the rapid increase in population. The area of Dasht-e-Barchi has over one million inhabitants but only one public hospital and three public health centres. In a bid to reduce maternal and neonatal mortality, MSF opened a new obstetric department within the hospital, providing free, around-the-clock care for women presenting with complications in pregnancy or labour, and for seriously ill newborns. Just over a month after opening, the department was already functioning at maximum capacity, and there had been 627 deliveries by the end of December, including 33 caesarean sections.

The 46-bed facility includes a delivery room, an intensive care unit for women and newborns, an inpatient department and an operating theatre. Vaccinations, laboratory services and a blood bank are also available. There is even a 'kangaroo room', where mothers carry their newborns on their chest, skin to skin, so that their warmth acts as a natural incubator, regulating the baby's temperature.

Ahmad Shah Baba hospital, Kabul

In eastern Kabul, MSF continued to upgrade Ahmad Sha Baba hospital, by increasing bed capacity and training staff. Providing free and high-quality medical care, with a particular focus on emergency and maternity services, the hospital is now the most important maternal health facility in Bagrami and surrounding districts, with operating theatres and surgeons available at all times. This year, the team assisted 14,968 deliveries, performed 949 surgical procedures and carried out 10,094 antenatal consultations.

Trauma centre, Kunduz

In the northern province of Kunduz, the MSF trauma centre provides free surgical care to those

The Gulan camp in Khost province, eastern Afghanistan, is the temporary home of thousands of people who have crossed the border from Pakistan.

Midwives at the Khost maternity hospital monitor newborn twins. MSF staff assisted in the delivery of 15,204 babies here in 2014.

with conflict-related injuries, as well as to victims of general trauma such as traffic accidents, and people with moderate and severe head injuries. Construction and refurbishment work continued in 2014: the intensive care unit was expanded and the total bed capacity in the hospital was increased to 70.

The number of patients visiting the centre rose in 2014. Staff treated a total of 22,193 people and performed 5,962 surgical procedures. About 54 per cent of the patients admitted for more prolonged treatment had conflict-related injuries – from explosions, gunshots or rocket attacks. As it is the only trauma centre in the northern region, patients come from surrounding provinces such as Baghlan, Takhar and Badakhshan. During intense periods of fighting, people travelling to the trauma centre are at risk of being caught in crossfire and they are also delayed at checkpoints. For some patients, arriving within an hour of the incident can save their limbs or even their lives.

MSF's study published in February showed that in Kunduz more than one in five people had waited over 12 hours before going to hospital, either because they could not travel at night for security reasons, or because there was fighting or they simply could not find transport.

Khost maternity hospital

The hospital in Khost is the only specialised maternity hospital in the area, and it aims to provide a safe environment for women to give birth. It focuses on assisting with complicated deliveries and reducing the high number of maternal deaths in the province. Many patients travel long distances to access the free, high-quality care on offer. Staff assisted in the delivery of 15,204 babies; approximately one in three children born in Khost province was delivered in the MSF hospital this year.

Emergency assistance in Gulan refugee camp

At the beginning of the summer, tens of thousands of people fleeing a military offensive in the Pakistani region of North Waziristan crossed the border into Afghanistan, seeking refuge in Khost, Paktia and Paktika provinces. From July to September, MSF teams provided assistance with medical care and water and sanitation in Gulan refugee camp, 18 kilometres from Khost city. In view of the low vaccination coverage in North Waziristan, teams focused on measles vaccinations for children aged six months to 15 years – more than 2,900 were vaccinated. A clinic was also set up in the camp, where a medical team treated on average 100 patients per day. Once the basic services were up and running, MSF handed over the medical and sanitation activities to other humanitarian organisations who could provide longer-term support to the refugees.

Boost hospital, Lashkargah, Helmand province

An MSF team continued to support Boost hospital with surgery, internal medicine, emergency services and maternal, paediatric and intensive care. The 285-bed facility admitted around 2,480 patients and performed 300 surgical procedures each month. The maternity ward's capacity was expanded from 40 to 60 beds and 9,207 babies were delivered in 2014.

Helmand is one of the provinces most severely affected by the ongoing conflict. People have to deal with landmines, bombs and outbreaks of fighting on an almost daily basis. MSF's February report revealed that as a result of insecurity, some patients had waited more than a week before seeking medical help. These delays are particularly dangerous for children, many of whom are very sick by the time they arrive at the hospital. Malnutrition remains one of the main causes of child mortality in Helmand province and the hospital's therapeutic feeding centre treated 2,200 severely malnourished children this year.

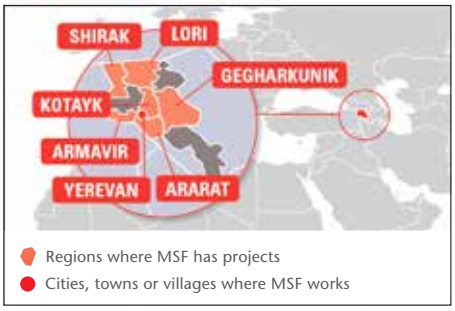
PATIENT STORY

FATIMA, 30 years old, Dasht-e-Barchi

"I feel very tired but so happy. It's my first baby. I have been pregnant four times before but never had a baby. I lost each of them, after three months, four months and five months. The last one after six months … When I got pregnant again, I went to a small private clinic for antenatal care. I never did before because we don't have money to spend for that. But this time, we really thought it was important and I went three times … My husband had to work a lot to pay for the medical care. Our neighbours told us to come [to the MSF clinic] once the baby came. They said I would be taken care of."

ARMENIA

No. staff in 2014: 91 | Expenditure: €2.2 million | Year MSF first worked in the country: 1988 | msf.org/armenia



KEY MEDICAL FIGURES:

120 patients under treatment for MDR-TB

Médecins Sans Frontières (MSF) supports the Armenian health ministry in improving drug-resistant tuberculosis (DR-TB) control activities in the country.

TB remains a significant public health concern in Armenia, as the country has one of the highest rates of the multidrug-resistant (MDR-TB) form of the disease in the world. According to the National Reference Laboratory, in 2012 MDR-TB was detected in 38 per cent of patients being re-treated and in 14 per cent of all new TB cases.

Since 2005, MSF has been working in Armenia to improve diagnosis and treatment of DR-TB, and to support patients to complete the arduous regimen. This has been achieved through patient education, counselling and social support. MSF has also helped implement infection control measures and practices.

Bedaquiline, a new TB drug, has been available to patients with MDR-TB and extensively drug-resistant tuberculosis (XDR-TB) since April 2013. Between April 2013 and September 2014, MSF and the health ministry provided bedaquiline to 46 patients. MSF supports the supply of the drug, as well as the day-to-day care and follow-up of patients taking it. Other antibiotics that are efficient in treating resistant forms of the disease are also made available.

Current treatments for MDR-TB and XDR-TB are long, taking up to two years. They are also painful and can have serious side effects, such as loss of hearing. Furthermore, they are not that effective: fewer than 50 per cent of patients are cured. Seasonal economic migration and the social stigma surrounding the disease further complicate the task of keeping patients under treatment. MSF works with the health ministry to offer support adapted to the individual patient, for example home-based care when needed and counselling.

The MSF team aims to enhance the national programme's capacity to implement DR-TB response plans in preparation for the handover of DR-TB management, which should happen in 2016.

BOLIVIA

No. staff in 2014: 12 | Expenditure: €0.5 million | Year MSF first worked in the country: 1986 | msf.org/bolivia

As many as one million people are estimated to be infected with Chagas disease in Bolivia.

People can live with this parasitic disease for years without symptoms. Complications develop in about a third of cases and can lead to death without treatment. Chagas is endemic across 60 per cent of Bolivia and is commonly transmitted by the vinchuca bug (*Triatoma infestans*), which lives in the cracks and roofs of rural adobe houses. Only four per cent of those people infected get treatment, owing to a lack of access to care. The government recognises this as a major health issue and has been working to address it; however, Chagas treatment is not guaranteed or integrated into basic healthcare.

Médecins Sans Frontières (MSF) has set up Chagas treatment programmes over the years it has been working in Bolivia, particularly in Narciso Campero province in Cochabamba department, where the disease is especially prevalent. The health ministry has managed that programme since 2013.

In 2014, MSF teams focused on another priority area: Chuquisaca department, Monteagudo municipality, in Hernando Siles province. Hardly any of the 61,900 residents of this region have access to treatment. In partnership with the health ministry, MSF is working on a model of prevention and treatment to be integrated into the basic healthcare system.

MSF also collaborated with the health ministry in partnership with Johns Hopkins University this year to prepare the launch of EMOCHA, an e-mobile surveillance application. Upon detection of a vinchuca infestation, a community volunteer will send a free SMS to a central information system, and a vector control team will be deployed.

BANGLADESH

No. staff in 2014: 324 | Expenditure: €3.1 million | Year MSF first worked in the country: 1985 | msf.org/bangladesh

KEY MEDICAL FIGURES:

96,900 outpatient consultations

4,200 individual and group mental health consultations

Médecins Sans Frontières (MSF) continued to provide essential care to vulnerable groups in Bangladesh: undocumented refugees, young women, and people living in remote areas and urban slums.

Many of the undocumented Rohingya who fled violence and persecution in Myanmar have been living in makeshift camps close to the Bangladeshi border for decades, yet they continue to suffer from discrimination and healthcare exclusion. In the Kutupalong makeshift camp in Cox's Bazar, MSF runs a clinic providing comprehensive basic and emergency healthcare to refugees and the host community, as well as inpatient and laboratory services and tuberculosis (TB) treatment. Some 80,000 outpatient and over 1,200 inpatient consultations were carried out during the year. More than 3,000 mental health consultations were undertaken. Approximately 6,000 women attended an initial antenatal consultation.

Poor living conditions in slums

In Kamrangirchar and Hazaribagh, teams visited factories and tanneries and conducted more than 4,450 outpatient consultations. MSF is looking for ways to increase access to healthcare for workers in these industries, many of whom work in hazardous conditions for long hours.

Teams also continued a sexual and reproductive health programme for adolescent girls aged 10 to 19 years. More than 7,700 consultations were carried out, 460 births assisted and 1,070 mental health consultations were conducted for social problems such as intimate partner violence. In addition, over 670 victims of sexual and domestic violence received medical care and short-term psychological assistance; almost 80 per cent of these attended further mental healthcare consultations.

MSF also monitored the vaccination status of children and administered more than 3,560 measles and 3,050 polio vaccines supplied by the health ministry.

Malaria emergency

MSF supported the health ministry's response to a major outbreak of malaria in the remote area of Bandabaran, Chittagong Hill Tracts, in August 2014. Teams travelled in boats and hiked through forests to reach communities in need of medical assistance. More than 2,280 people received treatment during the three-month intervention.

Kala azar research

In Fulbaria, Mymensingh district, MSF continued researching a treatment for post-kala azar dermal leishmaniasis. Results are expected in late 2015.

An MSF nurse and two local health workers travel by boat to reach a remote village in the Chittagong Hill Tracts and provide malaria treatment to the population.

BULGARIA

No. staff in 2014: 16 | Expenditure: €0.5 million | Year MSF first worked in the country: 1981 | msf.org/bulgaria

KEY MEDICAL FIGURES:

6,600 outpatient consultations

800 relief kits distributed

Bulgaria saw a large increase in the number of Syrians arriving via Turkey this year.

The Bulgarian government was underprepared for the surge of new arrivals and although makeshift camps were set up, the provision of food, shelter, and medical and psychological care was inadequate. People were sleeping in unheated tents, and up to 50 individuals were sharing one toilet.

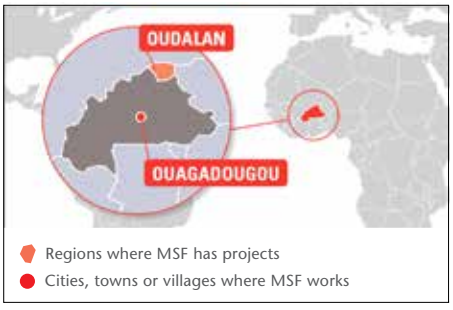
During the 2013–14 winter, after seeing the terrible living conditions in reception centres, Médecins Sans Frontières (MSF) started working in those worst affected: Vrezdevna and Voenna Rampa centres in Sofia, and also in the Harmanli camp close to the Turkish and Greek borders. MSF teams provided medical, antenatal and psychological care, distributed aid and made improvements to buildings and facilities. Over 5,500 outpatient consultations were carried out.

In May, after the authorities had increased their capacity and conditions had improved, MSF handed over the provision of medical and psychological healthcare services to the Bulgarian State Agency for Refugees and other humanitarian organisations.

For more on refugees and migrants arriving in Europe, see Italy (p.50), Greece (p. 40) and Serbia (p.73).

BURKINA FASO

No. staff in 2014: 63 | Expenditure: €1.3 million | Year MSF first worked in the country: 1995 | msf.org/burkinafaso



KEY MEDICAL FIGURES:

10,900 outpatient consultations

430 patients treated for malaria

370 births assisted

In September, Médecins Sans Frontières (MSF) closed its project providing healthcare to Malian refugees in Burkina Faso.

Malians began crossing the border into Oudalan province, fleeing violence and unrest in their home country, in February 2012. The following month, MSF opened a project providing basic healthcare to some 8,000 people in informal settlements around Gandafabou.

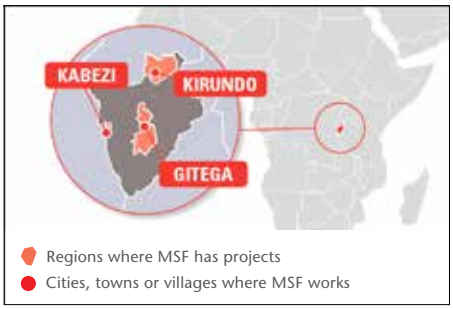
When the authorities moved the refugees to official camps in July 2013, MSF reoriented activities to assist those who had settled at Déou and Dibissi (2,000 and 4,000 people respectively). Staff ran mobile clinics three times per week offering medical care.

Basic healthcare was also provided to children up to the age of five in Déou health district. MSF screened children for malnutrition and ensured that those aged between six months and five years had received vaccinations.

Following a decrease in the number of Malian refugees in Oudalan province, MSF closed the project in September after having made donations to medical facilities in the region.

BURUNDI

No. staff in 2014: 122 | Expenditure: €2.3 million | Year MSF first worked in the country: 1992 | msf.org/burundi



KEY MEDICAL FIGURES:

2,700 patients treated for malaria

The use of injectable artesunate for severe malaria is now well integrated into the Burundian Ministry of Health's malaria treatment policy.

As a consequence, the Médecins Sans Frontières (MSF) programme focusing on reducing severe malaria-related mortality is being gradually handed over to the Ministry of Health. In July 2014, the Kirundo malaria project, which was supporting 34 clinics with diagnosis and treatment, was handed over and the project in Mukenke district is due to follow suit in early 2015. Injectable artesunate is easy to administer and the treatment is shorter and more effective than quinine, with fewer side effects.

Providing fistula care

An MSF team continued to provide obstetric fistula treatment at Urumuri health centre in Gitega, alongside health promotion, staff training and case-finding activities. MSF offers reconstructive surgery, physiotherapy and psychosocial support, and runs a hotline for those seeking help. Fistulas, a consequence of birth complications, cause not only pain but incontinence, which in turn often leads to social exclusion and sometimes rejection by family and friends.

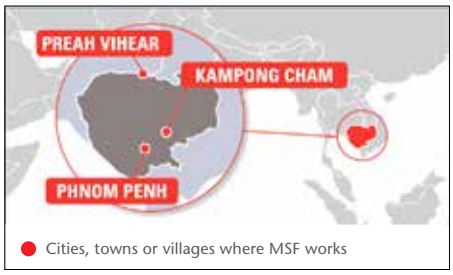
The number of new obstetric fistula cases has declined over the last few years, as much of the backlog that existed in the country when the project opened in 2010 has now been cleared. The project will be handed over to the Ministry of Health at the end of September 2015. The remaining cases will be managed by the Ministry of Health, as MSF has trained three Burundian doctors in fistula surgery.

Leaving Burundi

MSF has drawn up a preparedness plan in case of emergencies, but if no major MSF intervention is needed in the next year all programmes should close before the end of 2015.

CAMBODIA

No. staff in 2014: 155 | Expenditure: €2.3 million | Year MSF first worked in the country: 1979 | msf.org/cambodia



KEY MEDICAL FIGURES:

1,300 patients under treatment for TB

Médecins Sans Frontières (MSF) continues to provide treatment for malaria and tuberculosis (TB), two of the major health concerns in Cambodia.

Artemisinin-based medicines are currently the most effective antimalarial treatment and, in conjunction with other measures such as mosquito nets, have reduced the suffering and death caused by malaria. However, areas of artemisinin drug resistance have been identified, potentially creating a parasite pool that is more difficult to treat and eliminate. The areas that are most at risk of developing resistance are located in underdeveloped and remote border regions, where population movement and a lack of healthcare make this disease difficult to control. In September and October, MSF undertook a baseline survey of people with drug-resistant malaria in 23 villages in Chey Saen district, Preah Vihear province. In 2015, a project with a specific treatment protocol aiming to eliminate this strain of the disease will be developed. Active case detection was started in 2014, and health promotion teams were engaged to increase awareness in their communities.

The prevalence of TB in Cambodia remains among the highest in the world. An MSF programme of comprehensive TB care continued in Kampong Cham, the most populated province. The priority is early and active detection and testing of people at high risk of contracting the disease. In March, MSF completed the first phase of active case finding in Tboung Khmum district. All people older than 55 – a high-risk group – were screened, and 138 out of a total of 4,903 were found to have TB. Another round of active case finding began in October.

PATIENT STORY

THEA, 76 years old – was identified through case-finding activities in Kien Romiet village and admitted for treatment

"MSF came to see the village chief, who asked the people to go to see the MSF team about the screening. An MSF minivan came and took those who wanted to be screened to the hospital. When I arrived at the hospital the doctor saw me and after the process told me I had TB … I did not know I had TB, but MSF knew it."

CAMEROON

No. staff in 2014: 277 | Expenditure: €8.7 million | Year MSF first worked in the country: 1984 | msf.org/cameroon

KEY MEDICAL FIGURES:

110,200 outpatient consultations

25,600 patients treated for malaria

10,500 patients treated in feeding centres

3,300 patients admitted to hospital

Médecins Sans Frontières (MSF) opened an emergency programme in east Cameroon in response to an influx of refugees from Central African Republic (CAR).

Intercommunal conflict in CAR caused hundreds of thousands of people to seek refuge in Cameroon and other countries in 2014. Some 9,000 arrived in Cameroon during a 10-day period in February alone, and by the end of the year, an estimated 135,000 were in the country.

In January, MSF began to support the Ministry of Public Health by providing medical, nutritional and psychological support to refugees at sites in Garoua-Boulaï, Gado-Badzéré, Gbiti and Batouri. The majority of patients were suffering from malnutrition, malaria and respiratory infections. Medical care, primarily maternity services and healthcare for children up to the age of 15, was also offered to host communities and MSF helped with vaccination campaigns.

In Garoua-Boulaï, a small border city where many refugees crossed into Cameroon, MSF teams conducted medical consultations, distributed relief items and worked on sanitation and water supply at the Pont Bascule transit site. The water and sanitation activities were handed over to the NGO Solidarité Internationale in October. Another team continued to work at the district hospital and provided about 1,000 outpatient consultations per week last year. At the Protestant hospital, MSF supported a therapeutic feeding centre and in 2014 increased the bed capacity to 100 to accommodate more children with severe malnutrition.

From February to October, MSF ran a health centre at Gado-Badzéré camp, about 25 kilometres from Garoua-Boulaï. There was an outpatient feeding centre and a space designated for individual and group psychosocial counselling sessions. MSF also carried out water and sanitation activities in the camp, undertook epidemiological surveillance and implemented an early response to a cholera outbreak.

In March, MSF began working in Gbiti, another border town where more than 20,000 refugees have been registered.

MSF conducted more than 1,000 medical consultations per week, supplied water, and built latrines and showers at a makeshift camp. Two mobile teams provided medical care to small pockets of refugees in the area. Patients requiring more intensive care were referred by MSF to hospitals in Batouri or Bertoua. MSF also supported Batouri district hospital in the management of patients with severe, complicated malnutrition, and increased capacity to 150 beds.

Buruli ulcer project ends after 12 years

In June, MSF handed over the Buruli ulcer pavilion in Akonolinga to the Ministry of Health. This project had opened in response to the high number of people in the area affected by Buruli, a chronic and destructive infection that affects people's skin and tissue. Laboratory diagnosis, antibiotics, wound dressing, surgery and physiotherapy were provided. Some 1,400 patients have been treated since the project began in 2002, and around 43,000 people have benefited from awareness activities. The University Hospital of Geneva, Switzerland, will continue training Cameroonian medical students in chronic wound treatment and care, including for Buruli ulcer.

Refugees living in Gbiti camp, on the border with the Central African Republic.

CHINA

No. staff in 2014: 2 | Expenditure: €0.2 million | Year MSF first worked in the country: 1989 | msf.org/china

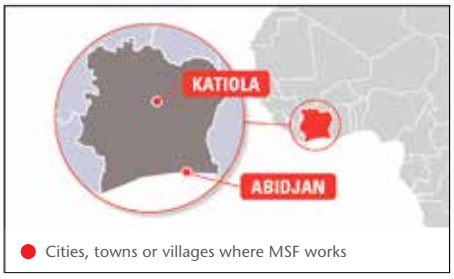
Médecins Sans Frontières (MSF) stopped working in China in 2014.

Although the prevalence of HIV/AIDS in China is low, people living with the disease face difficulties accessing the necessary care, and there is still widespread discrimination and stigma. 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. However, many people with the disease have not benefited from these measures.

A Chinese NGO, Aids Care China (ACC), is developing high-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, MSF started supporting a clinic near the border with Myanmar, 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 2013, an MSF team began providing technical assistance to ACC to improve the clinical management of HIV/AIDS patients. The aim was to demonstrate that a new model of comprehensive care, incorporating patient counselling, could deliver better treatment outcomes. MSF also supported the development of ACC by reinforcing its medical expertise in HIV/AIDS management. This collaboration came to an end in April 2014 due to a number of reasons, including changes in ACC's objectives and the fact that the health ministry started treating HIV patients suffering from hepatitis C.

COTE D'IVOIRE

No. staff in 2014: 152 | Expenditure: €2.3 million | Year MSF first worked in the country: 1990 | msf.org/cotedivoire



This year Katiola hospital's maternity unit started providing care for complicated deliveries and ante- and neonatal emergencies.

Mother and pre- and antenatal care is a priority for the Ministry of Health in Côte d'Ivoire, as maternal mortality has been increasing since 2005. Women generally deliver their babies at home with traditional birth attendants and without effective emergency obstetric care when there are complications.

With the Ministry of Health, Médecins Sans Frontières (MSF) opened a mother and child health programme in Katiola hospital in 2014. The 90-bed facility serves as the sole referral hospital for the whole region but until recently had very limited capacity to provide emergency obstetric and neonatal care. Only women who could afford to be transported by ambulance were referred to the larger Bouaké hospital to get the necessary medical assistance.

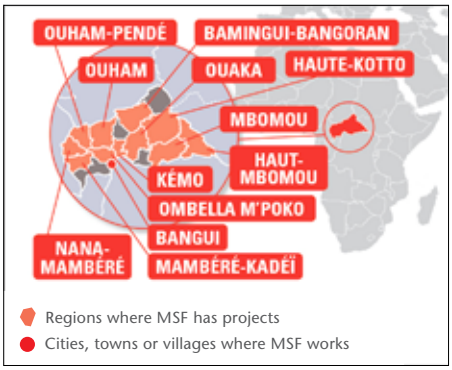
MSF renovated Katiola's maternity unit and the two operating theatres, built a water supply and sewage network in the hospital, and organised training for midwives. As a result, emergency obstetric care and complicated deliveries are now being managed by MSF, and between July and December over 1,000 births, more than 100 of them requiring caesarean sections, were assisted.

Ebola in neighbouring countries

As a consequence of the Ebola outbreak, the borders with Liberia and Guinea were closed in August. No suspected cases were reported in 2014, but an MSF team visited the area bordering Liberia to assess the preparedness of local staff and the authorities, as well as community awareness. MSF collaborated with the health authorities to build an Ebola management centre in Yopougon hospital in Abidjan (the country's largest city), as a contingency plan. MSF also supported the training of health staff and rapid investigation teams.

CENTRAL AFRICAN REPUBLIC

No. staff in 2014: 2,593 | Expenditure: €53 million | Year MSF first worked in the country: 1997 | msf.org/car | blogs.msf.org/car



KEY MEDICAL FIGURES:

1,401,800 outpatient consultations

749,100 patients treated for malaria

13,400 surgical interventions

© Andre Quillien/MSF

MSF staff working in the surgical emergency project at Bangui general hospital.

The health situation in Central African Republic (CAR) is catastrophic, and conflict and displacement prevent people from obtaining the medical services they desperately need.

At the beginning of 2014, most of the Muslim population in the western half of CAR left the country in the space of a few months to escape attacks. Several thousand people remained living in enclaves, fearful for their lives. Intercommunal violence and attacks by armed groups were not limited to the Muslim population though, and all communities in CAR were affected.

By December 2014, some 430,000 people were internally displaced in the country and hundreds of thousands of others had crossed the border into Chad and Cameroon. Although a transitional government was formed in January (elections are anticipated in 2015), many areas remain unsafe and people do not want to return home. Banditry and security incidents are common, and Médecins Sans Frontières (MSF) has been directly affected by armed attacks, harassment and robberies. On 26 April, 19 unarmed civilians, including three MSF national staff members, were killed by armed men at the MSF hospital in Boguila.

There is a severe shortage of skilled staff, and of vaccines in the country. Access to care is limited and expensive, and drug supplies are frequently interrupted. MSF remains the main healthcare provider in CAR, with many longstanding programmes offering comprehensive services, as well as emergency projects that are set up as needed. Malaria is rampant, and appalling living conditions are causing health issues such as intestinal infections and diarrhoeal or skin diseases.

Providing healthcare in Bangui

In Bangui, the capital city, MSF provides emergency surgery at the general hospital for victims of violence and trauma such as road accidents. From December 2013 to March 2014, MSF supported maternal health activities and surgery in the Castor health centre until the situation improved and people could access other health centres in the city. In June, some activities resumed and MSF started to carry out obstetric and other emergency surgery. A programme offering medical and psychological care for victims of sexual violence was opened in July.

Basic healthcare for children under 15 is available at Mamadou M'Baiki health centre in the city's PK5 district, and MSF ambulances transport emergency patients of all ages to hospital. Mobile clinics also began visiting displaced people several times a week at the Grand Mosque, Fatima's Church and St Joseph's Parish Centre this year. More than 39,900 consultations were carried out in PK5, nearly a third of them malaria-related.

There were approximately 100,000 displaced people living in and around M'poko airport in makeshift camps at the peak of the violence in 2014, but by the end of the year this number had dropped to 20,000. Two-thirds of patients travelled from Bangui to access the healthcare offered by MSF at the camps, as services were lacking in the city. People were treated for malaria, births were assisted and over 80 victims of sexual violence were helped.

When MSF started working in the general hospital in February, the emergency surgery activities at community hospital in the capital were handed over to the International Committee of the Red Cross. The project assisting displaced people at the Don Bosco centre closed in March once their number had significantly decreased.

Caring for the displaced

In January, MSF began activities at Berbérati regional university hospital, responding to the needs of displaced people, victims of violence, pregnant women and children. Weekly mobile clinics visited some 350 people living in the Berbérati area. In July, teams started outreach activities to support seven health centres providing healthcare in surrounding villages. Malnutrition, malaria, diarrhoea, respiratory tract infections and measles were the main health concerns. More than 41,900 outpatient consultations and 3,000 surgical interventions were performed. MSF also launched an

intervention from Berbérati to Nola, Sangha-Mbaéré prefecture, and 23,000 children were vaccinated there against measles.

From January to April, MSF responded to the health consequences of a spike in violence against enclaves of displaced people and the local population in Bouar, Nana-Mambéré, with mobile clinics and by supporting the emergency room and surgical activities at Bouar hospital.

Following the attack in Boguila, Ouham prefecture, in April, MSF's comprehensive healthcare services were reduced to a health centre with an outpatient unit, four health posts, maintenance of malaria testing and treatment sites ('palu points') and HIV treatment. The palu points were handed over to the NGO MENTOR Initiative in November. Another long-running project provided basic and specialist healthcare in Kabo. A series of security incidents resulted in a partial evacuation of the MSF team in February but the situation stabilised in the second half of the year. Staff treated more than 46,000 patients, most of whom had malaria.

MSF also supported the 165-bed Batangafo hospital and five local health centres. The village became part of the frontline in 2014 and there were security incidents during the year. More than 96,000 outpatient consultations were carried out and almost 5,000 patients were admitted. The emergency programme that had started in Bossangoa in 2013 for displaced people continued, although activities in the camps ceased in April when people were able to return home.

Following outbreaks of violence and population displacement in Ouaka prefecture, MSF opened projects in Bambari and Grimari in April. Mobile clinics travelled to villages and found many people still living in fear in the bush. MSF supported palu points and health centres and vaccinated 4,000 children in the prefecture against polio and measles in August. The Grimari project closed in October, and the focus was concentrated on Bambari.

In Kémo, MSF started supporting Dekoua parish clinic in May, following clashes that displaced civilians. Activities focused on outpatient consultations, assisting births and treating malnutrition. MSF also conducted mobile clinics. More than 5,500 consultations were undertaken, mostly for young children. The project closed in August when people left the area.

Teams offered a comprehensive package of healthcare in Carnot, Mambéré-Kadéï, in a longstanding project, carrying out over 49,000 consultations during the year. Approximately 500 Muslims from Carnot have taken refuge in a church in the city; more than 4,470 consultations were provided to them through a regular mobile clinic.

Access to general healthcare

MSF opened a hospital-based project in Bozoum, Ouham-Pendé, in January but closed it in March, as people felt safer visiting the nearer health centres. In Bocaranga, MSF ran a project between May and September to treat children under five during the annual malaria peak, and mobile clinics visited the northwest of the country. The comprehensive healthcare project in Paoua has been operating for many years and the team carried out some 71,400 consultations there in 2014.

In late February, MSF started working at the 80-bed referral hospital in Bangassou, the capital of Mbomou prefecture, where services had been severely disrupted. Basic and specialist healthcare, including internal medicine, maternity, paediatric and surgical services, were available. From May, MSF supported the 30-bed hospital in Ouango and rehabilitated its maternity, paediatric, internal medicine and surgery wards, as well as the operating theatre and the laboratory. The Ouango hospital was supported by MSF temporarily between May and October.

MSF also provided comprehensive healthcare to children under 15 in the refurbished hospital in Bria, Haute-Kotto, where there are high rates of malaria and malnutrition. More than 48,000 consultations were undertaken, and an average of 80 children were admitted to hospital each week.

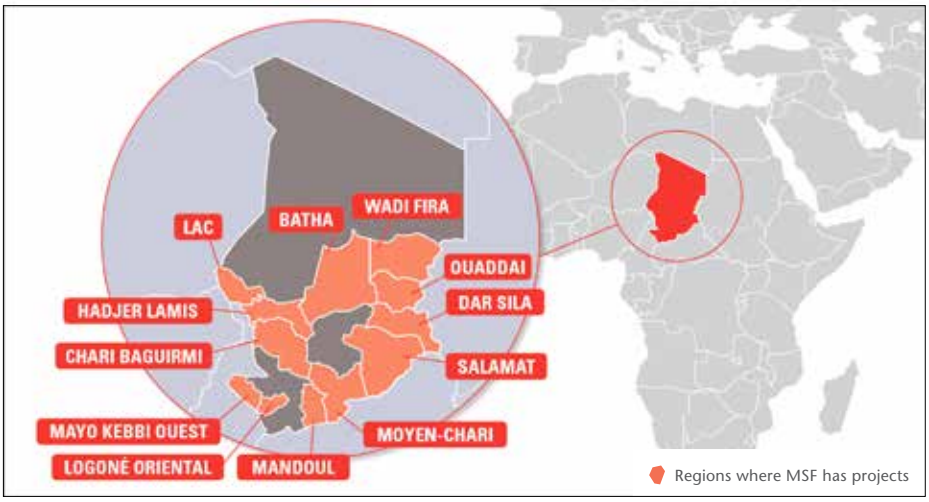
A programme of basic and specialist healthcare at Ndele hospital, Bamingui-Bangoran, and four nearby health centres continued. Staff saw a significant increase in patients with violence-related injuries.

MSF remained the main healthcare provider for those living in the east of the country in Haut Mbomou. Health facilities are scarce in this prefecture and people travel up to 200 kilometres to reach the main health centre in Zémio and four outlying health posts.

Muslims who have fled their homes for fear of violence are seen here sheltering in the Catholic church in Carnot.

CHAD

No. staff in 2014: 1,032 | Expenditure: €19.5 million | Year MSF first worked in the country: 1981 | msf.org/chad



KEY MEDICAL FIGURES:

257,200 outpatient consultations

158,200 measles vaccinations (outbreak)

156,700 patients treated for malaria

15,500 patients treated in feeding centres

Access to basic healthcare is limited in Chad, where malnutrition, malaria and outbreaks of disease are common. An influx of refugees from Central African Republic (CAR) in 2014 increased the need for medical aid.

Although improvements are being made to the health system, there are still critical gaps, which Médecins Sans Frontières (MSF) continues to address. These include implementing preventive measures and providing free medical care to children suffering from acute malnutrition and malaria, responding to disease outbreaks – including a major measles outbreak – with treatment and vaccinations, and meeting the acute healthcare needs of people displaced by conflict. Chad is home to the third largest number of refugees in Africa, and with ongoing violence in neighbouring Nigeria, CAR and Sudan, the refugee population is likely to increase.

Refugees from CAR

Since December 2013, more than 200,000 people fleeing violence in CAR have sought refuge in southern Chad. In January, MSF started providing health assistance, with projects in Bitoye until April, Goré until October and in Sido, which hosted the largest concentration of refugees (17,000). Altogether, teams carried out more than 35,000 consultations, mainly for malaria. Teams also supported the health ministry with a measles vaccination campaign for children aged six months to 10 years in Goré and surrounding areas, immunising around 7,000 children.

From May to October, MSF ran mobile clinics in three villages near Goré on the CAR border and provided seasonal malaria chemoprevention (SMC) for children under five, as 60 per cent of consultations were for malaria. More than 1,300 children were protected by this strategy of administering antimalarials as a prophylactic.

Responding to violence in Darfur

Since 2013, MSF has provided basic and specialist healthcare to the community in and around Tissi, a remote town that becomes inaccessible during the rainy season. Violence in neighbouring Darfur, Sudan, has caused large numbers of Sudanese refugees and Chadian returnees to cross the border. MSF ran a fixed clinic in Tissi, mobile clinics in Biere and Amsisi, and health posts at Um Doukhum and Ab Gadam. More than 47,300 general outpatient consultations were carried out in the Tissi programme overall. Increased stability in the region and the ensuing decrease in patient numbers as people travelled back to Darfur meant that MSF was able to hand over the Ab Gadam health post to the NGO Agence de Développement Economique et Social in June.

Malaria and malnutrition

Malaria is the main cause of death for children under five, especially during the peak season from July to October. MSF teams focus on the treatment of the most severely affected children in Moissala hospital's malaria unit in Mandoul region and provide support to health centres and community health workers in the districts of Moissala and Bouna. SMC was given to children under five and pregnant women to reduce the risk of severe malaria during the high season. Through these activities, 68,000 children were treated for malaria. In addition, standard vaccinations were administered to more than 27,200 children.

MSF also provides emergency paediatric care to children up to the age of 15 and specialised treatment for child malnutrition at the hospital in Massakory, the capital of Hadjer Lamis region, as well as basic healthcare in four surrounding health centres and a referral system for complicated cases. In 2014, there were more than 2,800 hospital admissions and 55,300 outpatient consultations. Over 23,900 children were treated during the peak malaria season. Between June and December, MSF ran an emergency care programme for acutely malnourished children in Bokoro, Hadjer Lamis. More than 4,760 children under five were enrolled on an MSF therapeutic feeding programme, and 574 were admitted to hospital for treatment.

Salamat region

MSF continued to support the government hospital in Am Timan and health centres in Salamat region. The focus was on specialist care for children up to the age of 15, including treatment for severe malnutrition, and reproductive healthcare for women – more than 5,200 antenatal consultations were carried out and 1,900 deliveries assisted. The team also offered treatment for HIV and tuberculosis and implemented an emergency malaria response for the general population. More than 20,600 outpatient consultations were carried out and 2,900 patients were admitted to hospital. In addition, MSF supported the hospital infrastructure by upgrading water and sanitation services.

Ouddaï region

MSF started supporting emergency services at Abeché hospital in Ouddaï region in June.

Since December 2013, more than 200,000 people fleeing violence in the Central African Republic have sought refuge in southern Chad.

Teams provided lifesaving care to all emergency surgical cases coming from Abeché or referred from Tissi. The main causes of trauma were road and domestic accidents. More than 900 major surgical procedures were carried out; one in five was related to violence.

Measles outbreak

In response to a measles outbreak early in the year, MSF collaborated with the health ministry at Liberty and Union hospitals in N'Djamena and seven basic health centres. More than 4,500 patients were treated in March and April. Teams also vaccinated over 69,600 children for measles in Massakory during the outbreak.

BLOG **Kim Comer, logistician**

CANOE KISS

"Today we did a canoe kiss. It sounds a lot more romantic than it is.

A kiss movement is a movement between two projects or locations where one vehicle from each project meets the other halfway to exchange cargo or passengers. It cuts down on the driver's time behind the wheel and the vehicle's time away from the field. It's called a kiss because the two Land Cruisers touch noses, like a kiss. In reality, they hardly ever touch noses. One, it's dangerous. Two, it's hard to load and unload when the cargo doors are on opposite sides, rather than the cars being side by side in some shady spot. But still the name remains, kiss."

To read more, visit blogs.msf.org/kim

COLOMBIA

No. staff in 2014: 139 | Expenditure: €3.9 million | Year MSF first worked in the country: 1985 | msf.org/colombia

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

KEY MEDICAL FIGURES:

12,300 outpatient consultations

6,800 individual and group mental health consultations

© Anna Surinyach/MSF

Decades of insecurity in Colombia have inflicted a devastating toll on people's mental health. Here an MSF psychologist is seen conducting a consultation with a patient.

People living in rural areas of Colombia and regions affected by conflict continue to face barriers to healthcare.

Up until recently, armed conflict was confined to rural areas; now, new armed groups are consolidating in urban centres and their peripheries and insecurity is exacerbating problems of access to medical services.

Médecins Sans Frontières (MSF) continued its programme in Cauca, Nariño and Caquetá, where poverty, social exclusion and violence have led to a high prevalence of preventable diseases and mental health problems. The health authorities have not guaranteed medical services in these areas. MSF teams run mobile clinics and offer services at health posts including basic, mental, sexual and reproductive healthcare, prenatal care, immunisations and a referral system for emergencies. A similar programme continued in Cauca Pacífico and a programme focused on mental health support for victims of violence, including sexual violence, operates in Cauca Cordillera.

People affected by conflict, sexual violence and psychiatric illnesses benefit when mental health services are integrated into basic healthcare. MSF is urging the government to recognise sexual violence as a medical emergency so victims can access the comprehensive care they need. The team opened a new programme offering mental health services to victims of violence, as well as comprehensive care (mental health and medical) to victims of sexual violence in Tumaco municipality in Nariño, and in Buenaventura.

Buenaventura tuberculosis (TB) project closed

MSF's TB programme in the port city of Buenaventura closed at the end of the year. Since its launch in 2010, a total of 147 patients were treated for drug-sensitive and drug-resistant TB in MSF-supported facilities. MSF also supported the national TB strategy. Some aspects of the programme have been transferred to the Municipal Program of TB Control and the Social Company of the State.

The programme in Caquetá was also closed at the end of the year.

PATIENT STORY

ANGELA PATRICIA –
Angela's brother and her sons' father were found murdered and dismembered in 2008

"My sons … still ask me what happened to their father. I tell them you need to forgive to feel good. But they are angry and ask why they did that to their father and uncle. The older one was very sad and missed him a lot. The MSF psychologist has helped us overcome the pain and she has guided me a lot because there are times when you don´t know how to explain things to children. With her you can open up."

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

No. staff in 2014: 3 | Expenditure: €0.5 million | Year MSF first worked in the country: 1995 | msf.org/dprk

Negotiations are underway to establish new medical projects in the Democratic People's Republic of Korea (DPRK).

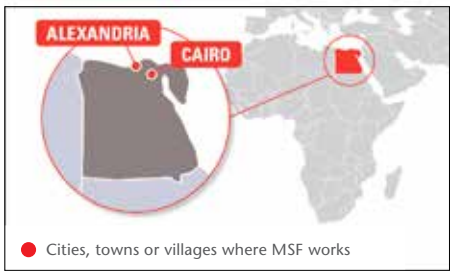
Health facilities are not regularly maintained in DPRK and they lack medical equipment and supplies. The population is also affected by food shortages. Only a handful of international NGOs are permitted to work in the country, and their activities are closely controlled.

In June 2014, Médecins Sans Frontières (MSF) completed a project in Anju district, South Pyongan province, aimed at increasing the capacity of medical services for the local population, primarily through staff training and donations of drugs and supplies. MSF's modular approach focused on mother and child healthcare, including specific training on management of diarrhoea, respiratory and neurological diseases, malnutrition among children, and life-saving obstetric procedures. As well as training medical personnel, the MSF team visited the paediatric and maternity wards of the local hospital, examining patients and assessing the implementation of training modules. MSF also supplied the medical equipment and drugs related to training topics, along with food for patients, caregivers and staff. Through the project MSF provided direct care for 250 patients and indirect support for 3,000 people.

At the end of October MSF began exploring the feasibility of activities in other locations. The team visited the county hospital in Sukchon in South Pyongan and Kim Man Yu hospital in Pyongyang and was negotiating with the government at year end to launch further programmes. In December, two Ministry of Health staff were invited by MSF to attend an Ebola training session offered in Geneva.

EGYPT

No. staff in 2014: 104 | Expenditure: €2.6 million | Year MSF first worked in the country: 2010 | msf.org/egypt



KEY MEDICAL FIGURES:

8,400 outpatient consultations

7,600 individual and group mental health consultations

430 people treated after incidents of sexual violence

A key transit and destination country for African and Middle Eastern refugees and migrants, Egypt has recorded a massive increase in arrivals and departures since 2011.

Regional instability continues to encourage the flow of refugees and migrants. In 2014, 177,000 people crossed the Mediterranean to Italy, most having set off from Libya and Egypt. At least half a million migrants are thought to reside in Egypt (of which 193,000 are recognised refugees), where they have few work opportunities, receive limited assistance and frequently suffer harassment. Many of those assisted have been victims of violence in their home country or during their journey. Médecins Sans Frontières (MSF) teams provide them with psychological support, and offer specialised medical assistance to those who have suffered sexual violence or torture.

In 2014, MSF expanded its services by opening a second clinic in Cairo. The new clinic in Maadi district and the existing one in Nasr City district carried out a total of 11,030 consultations. An MSF team also assisted 1,690 vulnerable individuals on the northern coast, providing over 1,000 medical consultations and distributing 1,435 hygiene kits.

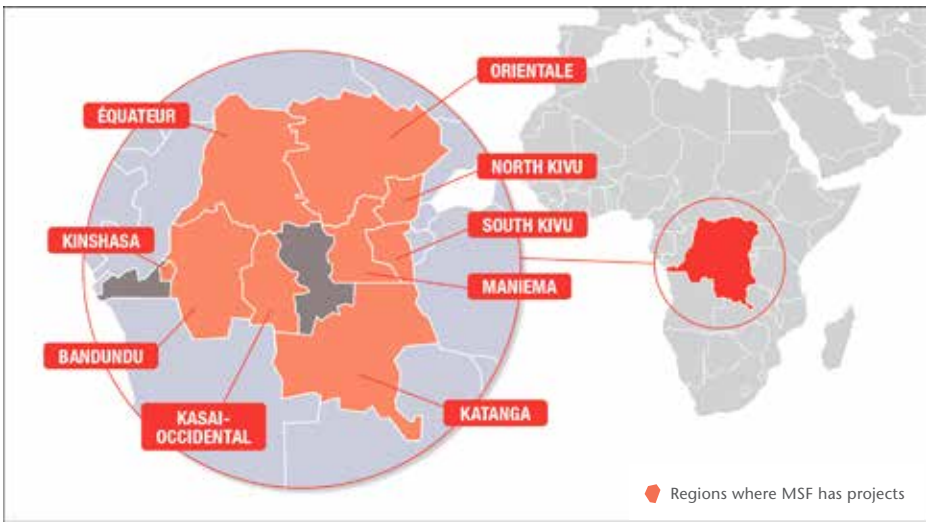
Viral hepatitis

MSF is collaborating with the health ministry to respond to hepatitis C in Egypt: an estimated 14 per cent of the population is infected which is the highest prevalence in the world. Access to treatment is limited by both cost and the centralised nature of care. A decentralised model of care is being developed, and a clinic integrated into an existing healthcare structure is expected to launch in rural Fayoum governorate in 2015.

The Abu Elian mother and child health clinic was closed in June, and patients were directed to existing health facilities nearby where the relevant services were available and accessible. About 40,000 consultations had been provided since 2012.

DEMOCRATIC REPUBLIC OF CONGO

No. staff in 2014: 2,999 | Expenditure: €70.1 million | Year MSF first worked in the country: 1981 | msf.org/drc



KEY MEDICAL FIGURES:

1,593,800 outpatient consultations

499,400 patients treated for malaria

116,300 patients admitted to hospital

In 2014, Médecins Sans Frontières (MSF) continued to respond to the humanitarian consequences of conflict in the eastern provinces of the Democratic Republic of Congo (DRC), as well as to outbreaks of disease across the country.

DRC's successive wars have had a severe impact on the health infrastructure and government-funded services. Violence, fear and displacement have not abated in the eastern provinces, despite a discourse of stability linked to the large peacekeeping force. MSF works closely with the health ministry to provide comprehensive healthcare in some of the country's most remote areas, where people cannot obtain or afford the medical care they need. MSF's basic and specialist services typically cover outpatient and inpatient consultations, surgery, reproductive and mental healthcare, paediatric care including vaccinations, treatment for malnutrition, HIV and tuberculosis, and aftercare for victims of violence – notably sexual violence. Teams continually work at preventing and limiting the frequent, life-threatening outbreaks of malaria, cholera and measles.

Four Congolese MSF staff members were abducted in 2013 in North Kivu. This year, one of them, Chantal, was reunited with her family and she decided to start working with MSF again. Efforts are ongoing to locate Philippe, Richard and Romy.

North Kivu

The MSF-supported 300-bed general reference hospital in Rutshuru remains the only place where the host population and displaced people can obtain specialist healthcare in Rutshuru territory. More than 28,800 patients were admitted this year, a 31 per cent increase over 2013. Teams also work in Masisi hospital, an outpatient centre in Masisi town, and Nyabiondo health centre, west of Masisi. Mobile clinics visit camps for displaced people and remote villages in the area. A vaccination campaign in an extremely remote mountainous area south of Masisi immunised over 4,000 children and pregnant women against a wide range of diseases.

MSF provides basic and specialist healthcare in Mweso and Walikale hospitals and associated health centres, and runs malaria-

A mother and child in the paediatric ward of Baraka hospital, South Kivu.

An MSF team en route to the village of Lukweti in Masisi, in the east of the DRC, to conduct a mobile clinic – the route is inaccessible by car.

focused mobile clinics in Walikale health zone, where the disease is rife. Over 16,200 patients were treated for malaria in 2014.

As mortality rates had decreased, MSF withdrew from Mugunga III camp, Goma, after providing 21,100 consultations in 2014. Activities in Bulengo were handed over to other organisations in December. A small cholera treatment centre on the outskirts of Goma and its surrounding camps continued to treat a small but steady stream of patients. In Birambizo health zone, MSF supported paediatric care in Kabizo health centre until May and a cholera outbreak was brought under control in July in Kibirizi.

South Kivu

MSF continues to support Shabunda general hospital, the smaller Matili hospital, and seven health centres. Basic and specialist care was also provided to displaced people and host communities in Minova and Kalonge through the local hospitals and health centres. The Kalonge project was handed over to the health ministry in April.

In Fizi territory, MSF treated more than 101,200 patients for malaria in its Baraka project, assisted 8,500 births and cared for 2,035 cholera patients. A full range of healthcare was available at Lulimba hospital in Kimbi Lulenge health zone. MSF saw an increase in patient numbers in 2014, as other aid organisations providing healthcare left the region – staff conducted more than 76,100 outpatient consultations and treated 42,800 patients for malaria. A sexual and reproductive health clinic was opened in October in Misisi, offering ante- and postnatal care, treatment for sexually transmitted infections, care for victims of sexual violence, and family planning services.

Katanga

MSF continued to develop preventive measures with other partners to combat the recurrent outbreaks of cholera in Kalemie town. These included improving water supply, distributing residential water filters in Kataki health area and vaccinating 51,400 people against the disease in July. Some 700 people received treatment from MSF during a cholera outbreak in July and August. In Kongolo, MSF treated more than 12,300 children under five for malaria and admitted over 1,350 children with severe or complicated malaria to Kongolo hospital between March and June. Teams also worked at six health centres, treating respiratory and parasitic infections and diarrhoeal diseases. In the provincial capital Lubumbashi, MSF responded to a spike in measles cases by providing clinical care in two health facilities. Following a cholera outbreak in the city, MSF distributed water, disinfected family homes and rehabilitated wells.

MSF supported Shamwana hospital and six health centres in the conflict- and displacement-affected health zones of Kiambi, Mitwaba and Kilwa with basic and specialist healthcare. Some 67,000 outpatient consultations were carried out. A community-based malaria programme with nine fixed sites along the Mpiana–Kishale axis was set up, providing treatment for simple malaria in villages in the area. A motorbike referral system was expanded to transport patients to hospital and road rehabilitation work was undertaken to improve access to healthcare.

More than 37,000 people were treated for malaria during a 14-week emergency intervention in Kinkondja.

Orientale

Violent clashes between the Congolese army and armed opposition groups continued to take a toll on people in Gety health zone. An MSF programme here focuses on healthcare for women and children under five. MSF also manages Gety hospital's emergency and intensive care wards, paediatric and maternity services, blood transfusions and laboratory. A neonatal ward was opened in September. To relieve pressure on health centres in the area, MSF donated medicines and treated more than 96,800 patients. When large numbers of people were displaced by extreme violence in Nia Nia, Mambassa and Bafwasende health zones, MSF provided medical care, including urgently needed support for victims of sexual violence, from June to November. In October, teams offered health consultations in Ituri district following an influx of 25,000 people escaping conflict in North Kivu.

The project screening and treating patients with sleeping sickness (human African trypanosomiasis) in Ganga-Dingila, Ango and Zobia was closed due to low prevalence but activities were ongoing in Doruma. MSF continued to manage Dingila hospital's intensive care and emergency wards until December when the project was closed.

Kinshasa

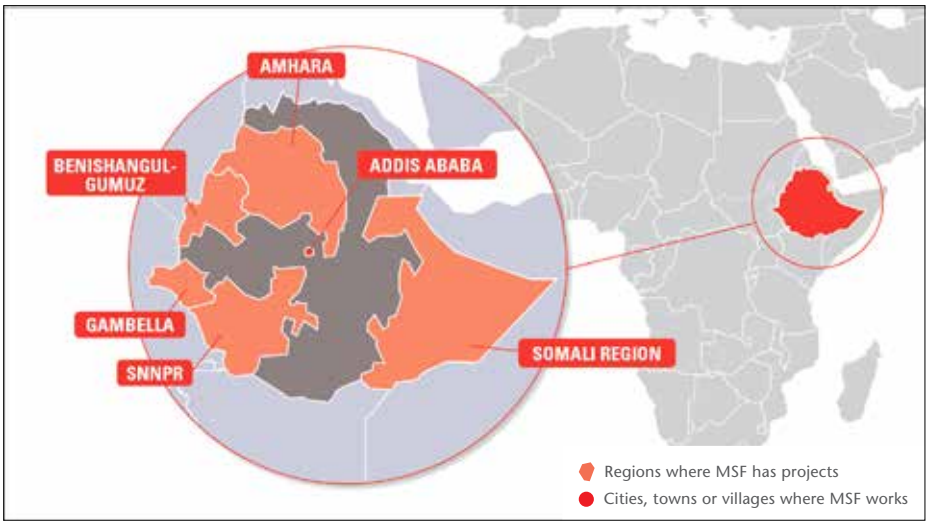
For many years now HIV treatment has been increasingly decentralised in Kinshasa and a community-based programme manages the distribution of antiretroviral medication to stabilised patients. The MSF HIV programme is now focused on providing comprehensive and high-quality care to people living in the Massina neighbourhood and this includes proactive testing, especially for high-risk groups, the introduction of community ARV groups and the implementation of viral load monitoring.

Ensuring rapid response to emergencies

MSF's emergency response teams monitor, investigate and respond to disease across DRC as needed, and interventions were launched following outbreaks of measles, typhoid, Ebola and suspected yellow fever. MSF's emergency teams also responded to the needs of displaced people and victims of violence. When the first Ebola cases were confirmed in August, MSF set up two treatment centres and worked with the health ministry to manage and control the outbreak. Of 25 Ebola patients treated at these centres, 13 recovered. The outbreak was over by November.

ETHIOPIA

No. staff in 2014: 1,416 | Expenditure: €21.3 million | Year MSF first worked in the country: 1984 | msf.org/ethiopia



KEY MEDICAL FIGURES:

347,700 outpatient consultations

6,800 routine vaccinations

2,800 births assisted

Some 200,000 refugees from the civil war in South Sudan arrived in Gambella region, western Ethiopia, between December 2013 and October 2014.

The long journey on foot, with inadequate food and water, had taken a toll on people's health and many arrived in Ethiopia sick and malnourished. From February, Médecins Sans Frontières (MSF) provided medical consultations and care at entry points close to the border. Teams worked at a health post in Pagak and Tiergol, ran mobile clinics in Pamdong and Burbiey, and conducted outpatient consultations at a health post in the Matar transit camps.

MSF also started a programme in Leitchuor camp. The 100-bed hospital offered outpatient consultations, emergency services, maternal healthcare and treatment for malnutrition. Outreach workers engaged in health promotion activities and identified people needing medical attention. The camp is located in an area prone to flooding and was inundated during the rainy season, causing the eventual relocation of the refugees to other camps in nearby villages and on higher ground.

MSF ran inpatient and outpatient services for refugees and the host population at a 118-bed health centre in Itang, close to Kule and Tierkidi camps, where more than 100,000 people had settled by April. When the Itang health centre flooded in August, MSF moved activities to the staff compound and had to reduce the number of beds. MSF provided decentralised medical care through two health posts in Tierkidi camp and three in Kule, and ran a 120-bed hospital in Kule. The hospital has an isolation unit for hepatitis E patients and between July and the end of the year, 541 people with suspected hepatitis E received medical care.

To address the lack of clean water and sanitation facilities in Kule and Tierkidi camps, MSF set up a water treatment plant that produced 56.4 million litres of safe water before it was handed over to Oxfam in July. Teams also constructed more than 2,500 showers, 1,200 latrines and 180 hand-washing points in the camps.

MSF launched a preventative vaccination campaign against cholera in Gambella region in July, targeting 155,000 refugees and members of the host community who each received two doses of the vaccine. In November, some 23,000 children aged six weeks to five years were immunised against pneumococcus and common childhood diseases.

Southern Nations, Nationalities and People's Region (SNNPR)

A programme focused on health services for mothers and children under five continued in the Aroressa and Chire *woredas* (districts) of Sidama, SNNPR. Teams worked in health centres in Mejo and Chire and conducted outreach activities in 13 locations. During the course of the project, which was handed over to the Ministry of Health in October, two maternity waiting houses were constructed

A vaccination campaign underway in one of the refugee camps in Gambella region.

A child being examined in Chire health centre, Sidama, where MSF runs a programme focused on the health of mothers and children under five.

to enable women with high-risk pregnancies who lived far from health facilities to deliver safely. MSF also supported referrals of paediatric emergencies and women presenting with complications during labour to hospitals in Hawassa, Yirga Alem or Addis Ababa.

MSF started a new project in SNNPR in October, together with the Regional Health Bureau. Its purpose is to strengthen the emergency preparedness, surveillance system and response capacity of the public health management team in six selected zones of the SNNPR. These zones are Sidama, Wollayta, Gamogofa, Segen, South Omo and Bench Maji.

Somali region

Underdevelopment and conflict between the government and armed opposition groups pose barriers to healthcare in Somali region, and 200–500 refugees from Somalia arrive in the Liben zone each month. The population of Buramino and Hiloweyn refugee camps, Liben zone, has reached 77,000. MSF continued to assist with the provision of basic healthcare at the reception centre and in the camps. A team also provided medical care for Somali refugees and the host community in Dolo Ado, Liben zone. In the hospital, MSF supported the paediatric inpatient department, stabilisation centre, emergency room and laboratory, as well as emergency obstetric surgery and maternity services. Between January and March teams vaccinated 12,100 children against measles and carried out several rounds of polio vaccinations in collaboration with the Regional Bureau of Health.

MSF supported the regional hospital in Degehabur, providing inpatient care for children under five, tuberculosis (TB) treatment, nutritional support, and emergency room and intensive care services. It also supported three health centres and nine health posts in Degehabur, Ararso and Birqod *woredas*, and conducted outreach activities. The focus in 2014 was on mother and infant health – there were 2,578 antenatal consultations – as well as nutrition and vaccination activities.

In September, MSF started supporting Fiq hospital, Nogob zone, and provided an emergency referral system, outpatient services, nutritional support, paediatric inpatient care, obstetrics and gynaecology, and pharmacy and laboratory services. A network of community health workers was also established.

In Danod, MSF offered basic healthcare in the 24-hour health centre and ran weekly mobile clinics in four villages in the district. The team conducted more than 12,000 consultations in 2014. In addition, MSF helped build local healthcare capacity by donating medical supplies, and coaching and supervising staff. Maternity services and treatment for malnutrition are a focus of this programme. MSF continued to address gaps in healthcare provision around Wardher, running mobile clinics in five villages in the district, and visiting Yucub health centre three times a week to support and supervise the staff and to donate medical supplies. An ambulance service also operated, covering 18 villages in Wardher and Danod districts, transferring patients with life-threatening conditions to Wardher hospital. MSF supported the hospital's paediatric, TB and maternity departments, as well as a stabilisation unit for severely malnourished children and was involved in the set-up of an operating theatre run by the Ministry of Health, which provides emergency obstetric surgery. A measles vaccination campaign was carried out in collaboration with local health authorities in March, reaching 4,300 children, and eight rounds of polio vaccinations were completed in Wardher and the surrounding area. In September, MSF handed over routine vaccinations, care for chronic conditions and triage to national health authorities.

Kala azar and malnutrition in Amhara

The parasitic disease kala azar (visceral leishmaniasis), endemic in this area, is usually fatal if left untreated. MSF continued its programme for patients with kala azar in Abdurafi, Amhara region, including those co-infected with HIV/AIDS or TB. Nutritional support is available to patients in the programme. More than 1,200 people were screened for kala azar in 2014. MSF also filled gaps in emergency services, provided inpatient care for children under five with malnutrition and transported patients to hospitals in Humera and Gondar.

Project closures

In Raad, Gambella region, an emergency project that started in July 2013 came to an end in January following the closure of the transit camp for South Sudanese refugees. Another project providing assistance to refugees in the western region of Benishangul-Gumuz, also came to an end in May.

GEORGIA

No. staff in 2014: 28 | Expenditure: €0.8 million | Year MSF first worked in the country: 1993 | msf.org/georgia

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

KEY MEDICAL FIGURES:

18 patients under treatment for MDR-TB

Médecins Sans Frontières (MSF) handed over its multidrug-resistant tuberculosis (MDR-TB) activities in Abkhazia in August 2014, and focused on patients with extensively drug-resistant forms of the disease in the capital Tbilisi.

Despite a very significant decrease in the number of TB cases in Georgia over the last 20 years, prevalence remains high. Every year around 500 patients are found to have MDR-TB and are offered treatment; approximately 10 per cent of these prove to have the extensively drug-resistant form of the disease (XDR-TB). Treatment is not successful in more than 60 per cent of patients diagnosed with XDR-TB and a significant number of them subsequently die. These statistics from the Georgia Ministry of Health clearly show the need for improved treatment regimens. Two new drugs – bedaquiline and delamanid – have recently become available to some patients who have no other treatment options left. These are authorised by the manufacturers on a case-by-case basis.

In September 2014, MSF started supporting the National Center for Tuberculosis and Lung Diseases in Tbilisi. Training and technical support were provided to hospital staff to improve detection and clinical care of XDR-TB patients, and to facilitate their early access to new drugs. As of December, 18 XDR-TB patients were benefiting from bedaquiline. Clinical trials for new and improved treatments for MDR-TB should start taking place at the hospital in 2016. The trials will aim to identify new treatment plans combining old and new TB drugs, and will include assessments of their toxicity and effectiveness. A grant for activities in Tbilisi was under discussion with UNITAID at the end of 2014.

Handing over activities in Abkhazia

In August, MSF handed over its access to care programme for elderly and vulnerable people, as well as its TB and MDR-TB activities in Abkhazia, to a local NGO set up by former MSF staff. Support for patients with chronic diseases included home-based care, ophthalmologic consultations and provision of equipment such as wheelchairs. MSF continues to facilitate the transportation of sputum samples from Abkhazia to the culture laboratory in Tbilisi.

GREECE

No. staff in 2014: 10 | Expenditure: €0.5 million | Year MSF first worked in the country: 1991 | msf.org/greece

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

KEY MEDICAL FIGURES:

2,500 outpatient consultations

490 individual and group mental health consultations

Thousands of migrants and asylum seekers arrived in Greece in 2014, many on their way to northern Europe.

Undocumented migrants and asylum seekers continued to be detained with limited access to healthcare or basic services. Living conditions in detention centres remained extremely poor. Overcrowding, substandard hygiene, and inadequate heating, hot water and ventilation led to the outbreak and spread of respiratory, gastrointestinal and dermatological diseases. In April, Médecins Sans Frontières (MSF) released a report, *Invisible Suffering*, documenting the massive impact of detention on the physical and mental health of migrants and asylum seekers. Many of those detained have no or limited access to the outdoors. The report also highlighted the gaps in healthcare provision and the absence of medical assessments, as well as the detrimental effects of prolonged detention on the health of migrants and asylum seekers due to lack of necessary care or interruption of treatment.

In Evros region, MSF provided medical consultations and psychosocial support to people being held at detention centres in Komotini and Filakio, and in the police stations of Feres and Soufli. Nearly 600 relief kits were distributed to help people maintain a basic level of hygiene, health and dignity. In March, these activities were handed over to EKEPI.

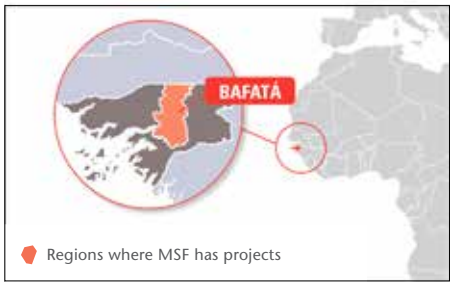
In 2014, more than 42,000 people – almost 80 per cent of them from Syria – crossed the Aegean Sea from Turkey to the Dodecanese Islands. Many were forced to sleep outside or in overcrowded police cells while waiting to be transferred to the Greek mainland, as there were not enough suitable facilities to host them. Towards the end of the year, MSF launched two emergency interventions, providing medical care and distributing more than 2,000 kits containing sleeping bags and hygiene items such as soap.

In September, in collaboration with two Greek organisations, MSF opened a project in Athens offering medical rehabilitation, including physiotherapy, for asylum seekers and migrants who have been victims of torture.

For more on refugees and migrants arriving in Europe, see Bulgaria (p.26), Italy (p.50) and Serbia (p.73).

GUINEA-BUISSAU

No. staff in 2014: 8 | Expenditure: €0.9 million | Year MSF first worked in the country: 1998 | msf.org/guineabuissau



KEY MEDICAL FIGURES:

1,000 outpatient consultations

There is a shortage of good-quality healthcare in Guinea-Bissau, particularly in rural areas.

A rudimentary health system is in place, but its poorly functioning facilities lack resources and a referral system, and access to them is unequal.

In the central Bafatá region, public healthcare is limited, the population is scattered and distances to the nearest health facilities are considerable. Mortality rates are therefore very high, and the average life expectancy is 48 years. Child and maternal mortality rates are particularly concerning. As an initial response to the high incidence of illness and death among young children, Médecins Sans Frontières (MSF) opened a project in Bafatá in November. Free basic paediatric care is offered at the health centres in the rural area of Tantan Cossé, Contuboel, and a team provides basic and specialist healthcare for children in the paediatric outpatient area and the paediatric ward of the regional hospital. Furthermore, the project aims to develop decentralised, community-based healthcare for young children, involving community health workers. This would help to address the identified barriers to access, and implement simpler diagnostic algorithms for children presenting with fever.

HONDURAS

No. staff in 2014: 44 | Expenditure: €1.2 million | Year MSF first worked in the country: 1974 | msf.org/honduras

KEY MEDICAL FIGURES:

1,800 individual and group mental health consultations

560 people treated after incidents of sexual violence

Médecins Sans Frontières (MSF) provides treatment to people affected by violence, with a particular focus on victims of sexual violence.

Honduras has experienced years of political, economic and social instability and as a consequence has become overrun with criminal activity. Tegucigalpa, the capital, is one of the world's most violent cities, and murder, abduction and rape are day-to-day realities for many inhabitants.

MSF developed a *servicio prioritario* or priority service in collaboration with the health ministry in Tegucigalpa, offering emergency medical and psychological attention to victims of violence, including sexual violence. Comprehensive healthcare services are lacking for those who are able to overcome fear of retaliation and seek help. The priority service, where everything is provided in one place and is confidential and free, is offered at two health centres and in Tegucigalpa's main hospital. As many people, especially young women and girls, do not know that this help exists, MSF's health promotion teams focus on sensitisation and outreach activities to spread the word, and consequently the number of victims of sexual violence seeking assistance within 72 hours increased this year.

In 2014, MSF treated 700 victims of violence, including 560 victims of sexual violence, and carried out 1,770 mental health consultations. Medical treatment for rape includes post-exposure prophylaxis to prevent HIV infection and provide protection against other sexually transmitted infections, hepatitis B and tetanus. The mental healthcare includes counselling and psychological first aid. The emergency contraceptive pill, however, has been banned in Honduras since 2009. A debate was initiated in 2014 in the Honduran Congress to change the policy on emergency contraception, and it continues today. MSF has taken part in the discussions and has highlighted the psychological and medical consequences of pregnancy as a result of sexual assault.

As there are currently no guidelines in place for the treatment of victims of sexual violence in Honduras, MSF is pushing for the health ministry to implement a national protocol.

PATIENT STORY

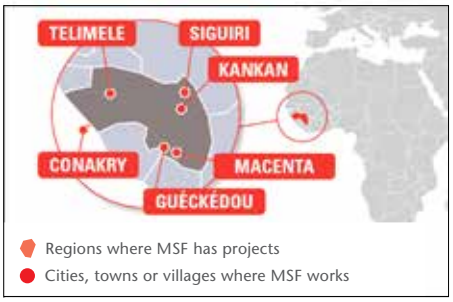
AURELIA* – an MSF patient in Tegucigalpa, who was raped at gunpoint by strangers

"Before the (MSF) doctors took care of me, I wanted to die … I felt dirty; I felt as if I had lost a part of my life; I didn't want to exist anymore. But I had therapy and counselling and, thanks to this, I've been able to overcome a lot. It has changed my life."

** Name has been changed*

GUINEA

No. staff in 2014: 545 | Expenditure: €18.7 million | Year MSF first worked in the country: 1984 | msf.org/guinea | blogs.msf.org/ebola



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

KEY MEDICAL FIGURES:

3,100 patients admitted to Ebola management centres, of which **1,700** were confirmed as having Ebola

800 patients recovered from Ebola and discharged

On 22 March, what was to become the largest recorded outbreak of Ebola was officially declared in Guinea.

It is believed that the outbreak originated in the Guinée Forestière region in December 2013. Previous outbreaks of Ebola had mostly erupted in remote villages in central and eastern Africa, where they could be more easily contained. This time, however, Ebola broke out at the junction of Guinea, Liberia and Sierra Leone, where people regularly move across the porous borders. The deficiencies of the public health system in Guinea and the fact that early symptoms of Ebola are similar to malaria – a salient health threat in the country – led to misdiagnosis of infections early in the epidemic and allowed for the spread of the disease.

Médecins Sans Frontières (MSF) was collaborating with the Guinean health ministry on a malaria-focused project in the hospital in Guéckédou and 20 community locations in Guinée Forestière when Ebola was suspected. On 18 March a reinforcement team with viral haemorrhagic fever specialists arrived in Guéckédou and started an exploratory intervention, supporting the health ministry in collecting samples for analysis. Once the Ebola epidemic was declared, the malaria programme was put on hold as staff were reassigned to help the MSF emergency team build the first Ebola management centre (EMC) in Guéckédou. The malaria programme closed in August.

The EMC in Guéckédou opened on 23 March and served as the main centre for Ebola cases in the region, caring for patients, carrying out health promotion and outreach activities, and training medical and sanitation staff. A psychosocial team also worked at the EMC to support patients, and spent time with

An MSF staff member wearing personal protective equipment (PPE), which includes a protective suit, goggles, a face mask, gloves, an apron and rubber boots. No skin should be exposed.

Sia Bintou, pictured here being discharged, spent more than 10 days in the Guéckédou management centre before successfully beating Ebola.

families and communities, helping address their fears and cope with the loss of family and community members. By the end of the year, 1,076 Ebola cases had been confirmed, and 430 patients had recovered and been discharged from the facility.

To reinforce the activities of the EMC, MSF opened a transit centre in Macenta, Nzérékoré region, facilitating detection, triage and referral of patients coming from the southeast of Guinea. Psychological support was also provided. Between March and November, 520 patients were transferred to Guéckédou EMC. At the end of the year, the transit centre was converted into an EMC and handed over to the French Red Cross.

On 25 March, MSF opened an EMC within Donka hospital in Conakry, Guinea's capital city. The team conducted health promotion, educational and outreach activities, including identification of possible patients with Ebola, provided psychosocial support and trained medical and sanitation staff. By the end of the year, 1,463 patients had been admitted; 594 of these were confirmed to have Ebola and 290 recovered.

Telimele district, 270 kilometres north of Conakry, was relatively far from the country's Ebola epicentre in the southeastern forest region, but Ebola cases were reported in May. MSF teams were quick to respond, transforming one of the local health centre's wings into an isolation area and building an EMC nearby which opened within days. By the end of July, Telimele was declared Ebola free.

Researching Ebola treatment

In the absence of specific human treatments for Ebola, MSF partnered with the French National Institute of Health and Medical Research (INSERM) to trial an experimental treatment in the midst of an outbreak. The drug tested in Guéckédou for efficacy against Ebola was favipiravir, an antiviral used in Japan to combat resistant flu in adults. Soon other sites, not managed by MSF, were also included in the favipiravir trial. More trials for treatments, vaccines and diagnostic tools were planned to start in the region early in 2015.

Ongoing challenges

In order to bring the Ebola outbreak under control, critical components of the response – such as surveillance, contact tracing, community mobilisation and infection control protocols – needed to be strengthened, and MSF continually asked for more support in 2014. Many Guineans remain reticent to accept messages about Ebola, as the general level of knowledge about it is low. Health workers, patients, contacts and survivors are often stigmatised and this prevents people from seeking medical help – such as those suffering from malaria, which has not receded as a health issue during the Ebola crisis.

Measles vaccinations in Conakry

In February 2014, MSF vaccinated more than 370,000 children aged between six months and 10 years against measles in the Conakry neighbourhoods of Matam, Ratoma and Matoto. At the end of the intervention the vaccination coverage was just over 87 per cent. Staff treated 2,948 cases of measles, 241 of which were severe.

HAITI

No. staff in 2014: 2,159 | Expenditure: €35.2 million | Year MSF first worked in the country: 1991 | msf.org/haiti

● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

14,600 surgical interventions

9,500 births assisted

Five years after Haiti's massive earthquake, the health system is only partially reconstructed and specialist services remain out of reach for many people.

Médecins Sans Frontières (MSF) has continued to fill gaps in the Haitian healthcare system (gaps it has been filling since before the catastrophic earthquake in 2010) and has been helping to build local capacity by training national staff. Haitians need better access to emergency services, including obstetrics, neonatology, surgery and trauma care. Cholera is an ongoing health threat but there is a lack of available finances to tackle it and no effective response plan in place. MSF is regularly stepping in to treat patients and prevent major cholera outbreaks and loss of life.

Drouillard burns unit

Domestic accidents and poor living conditions are the main causes of burns in Haiti, and victims are predominantly women and children. MSF continued to run the only facility treating burns patients in the country, in Drouillard hospital, close to the Cité Soleil slum in Port-au-Prince. Equipped with three operating theatres, the hospital increased capacity from 30 to 35 beds. To focus on the treatment of burns patients, MSF closed the trauma unit it was running inside the hospital. There were 481 patients hospitalised for burns in 2014.

Emergency services in Port-au-Prince

Responding to more than 45,000 emergencies in 2014, the Martissant emergency and stabilisation centre is a free, around-the-clock resource for people experiencing any kind of medical emergency, caused by violence, accidents, burns or obstetric complications. There are eight beds where patients can remain under observation and an ambulance service for referrals to appropriate hospitals. MSF's specialists provide care in paediatrics and internal medicine. Staff treated more than 25,000 patients with accidental trauma, 13,250 with violent trauma and more than 3,700 people with cholera.

MSF provides emergency services including surgery and trauma-related care around the clock at the 121-bed Nap Kenbe centre in Tabarre, eastern Port-au-Prince. The centre has three operating theatres, an intensive care unit and an outpatient department that is open six days a week. Since mid-2014, MSF has been running an orthopaedic surgery training programme at the centre.

To ensure a high standard of care, MSF has installed onsite technical services, including an X-ray machine, a laboratory and a blood bank, sterilisation facilities and a pharmacy. Social and mental health support and rehabilitation through post-operative care and physiotherapy are all available to patients to maximise their recovery after emergency treatment. Teams responded to more than 9,880 emergencies and performed more than 4,200 surgical procedures in 2014.

Specialist care for obstetric emergencies

Located in the central Delmas 33 neighbourhood of Port-au-Prince, MSF's 140-bed Centre de Référence en Urgence Obstétricale (CRUO) continued to provide 24-hour, free obstetric care to pregnant women experiencing serious and life-threatening complications such as pre-eclampsia, eclampsia, obstetric haemorrhage, prolonged and obstructed labour and uterine rupture. CRUO offers a range of reproductive healthcare services, including ante- and postnatal care, family planning and prevention of mother-to-child transmission of HIV, as well as neonatal care and mental health support. There is also a 10-bed 'Cholernity' ward for pregnant women with cholera. There was an average of 17 births a day in the CRUO in 2014. Some 10,400 patients were admitted to the facility.

Chatuley hospital

Following the January 2010 earthquake, MSF constructed a temporary container

A mother and child in the Drouillard burns unit are seen here talking to an MSF staff member.

The number of people contracting cholera spiked in October. In response, MSF set up cholera treatment centres in Port-au-Prince neighbourhoods such as Martissant. Cholera is transmitted by contaminated water or food, or through direct contact with contaminated surfaces.

hospital to conduct surgery in Léôgane, an area that was 80 per cent destroyed by the disaster. The programme has evolved to handle emergencies, focusing mainly on complications in pregnancy and road accident victims. Basic medical care is also provided to pregnant women as well as children under five.

In keeping with the plan to shut the hospital in 2015, MSF has been progressively reducing activities at Chatuley since 2013. In February, a cholera treatment unit that had been running since 2010 was closed. As of November, only emergency services for pregnant women, newborn babies and children under five were being provided. There will be no formal handover of the hospital to the Haitian authorities, and so teams have been reinforcing the capacity of other medical facilities in the area in preparation for the closure.

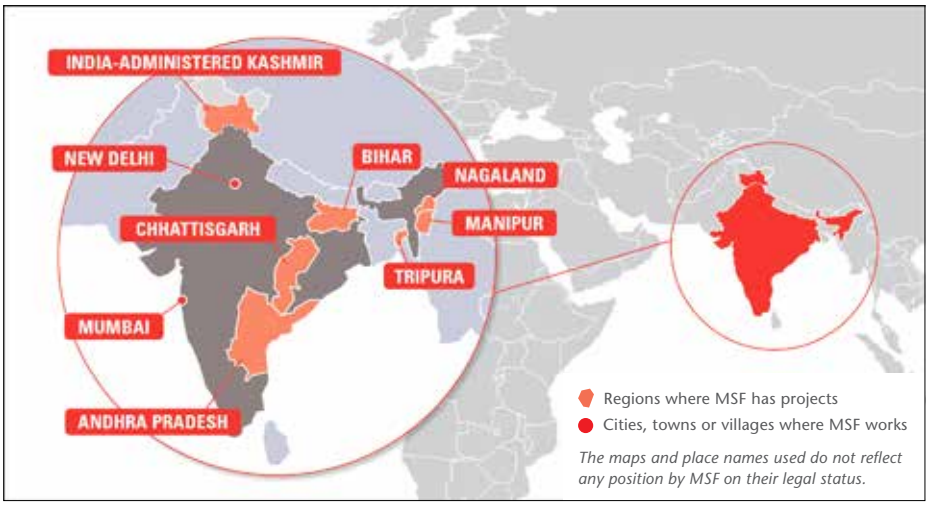
In 2014, MSF admitted 6,782 patients to Chatuley hospital, carried out 2,617 consultations for children under five, provided 6,162 antenatal consultations and assisted 3,298 births.

Cholera response

Four years after cholera's first appearance in the country, the Haitian health system is still facing a shortage of funds, human resources and drugs. Many Haitians continue to lack access to clean water and adequate latrines, resulting in regular outbreaks of cholera, a potentially deadly communicable disease. Outbreaks today can mostly be predicted, yet the authorities remain unprepared. There are insufficient public cholera treatment centres (CTCs) in Haiti and reduced international funding has limited the delivery of medical care and the provision of clean water and sanitation services. When the number of people contracting cholera spiked in October, MSF set up CTCs in the Martissant, Delmas and Carrefour neighbourhoods of the capital. Teams also focused on preventive measures, including distribution of disinfection kits (chlorine, buckets, etc), and awareness and education activities. More than 224,600 people were reached via these activities and 1,640 disinfection kits were distributed. Overall, more than 5,600 people received MSF-supported cholera treatment.

INDIA

No. staff in 2014: 657 | Expenditure: €10 million | Year MSF first worked in the country: 1999 | msf.org/india



KEY MEDICAL FIGURES:

92,200 outpatient consultations

4,400 patients treated in feeding centres

2,700 individual and group mental health consultations

1,500 patients on first-line ARV treatment

Many people in India cannot access medical care because of poverty, social exclusion and an under-resourced healthcare system.

High-quality services are available for those with means, but a significant portion of the population cannot obtain even basic healthcare. Treatment for diseases such as HIV, tuberculosis (TB) and kala azar (visceral leishmaniasis) is not universal. Médecins Sans Frontières (MSF) aims to fill some of these gaps and build capacity so more people can get the medical care they need.

Malnutrition

Child malnutrition is an underreported health emergency and MSF has been working with health authorities to increase access to treatment for malnourished children in Darbhanga district, Bihar state. Most children are from impoverished families and live in villages where health services are often inadequate. The MSF programme provides weekly outpatient treatment for severely malnourished children aged six months to five years, through 12 basic health centres. More than 3,500 patients were enrolled for outpatient treatment and over 300 children with minor complications were referred to MSF's stabilisation centre for inpatient care in 2014.

The malnutrition intensive care unit, built inside Darbhanga Medical College Hospital and run by MSF, is the first of its kind in India. It opened in March to treat severely malnourished children up to five years of age with serious medical complications, and admitted more than 250 patients over the course of the year. MSF continues to work with the health authorities to integrate nutritional care within the public health system.

Kala azar

Kala azar is endemic in the Vaishali district of Bihar. Transmitted by the bite of an infected sandfly, this parasitic disease is almost always fatal if left untreated. Although MSF's kala azar programme saw more than 1,000 patients in 2014, the number of recorded cases has decreased across India in the last four years.

In order to achieve the goal of eliminating kala azar in India by 2015, the government adopted single-dose liposomal amphotericin B as the first-line treatment in October. This policy change was made following sustained advocacy by MSF, which included a presentation of the data collected from a pilot project, aimed at demonstrating the safety and effectiveness of new treatment models. MSF also supported the authorities by training doctors and nurses in areas where kala azar is widespread.

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

An MSF nurse takes a blood sample to check for malaria; one of the services offered at the mobile clinic in Chhattisgarh.

Mobile clinics

Ongoing, low-intensity conflict between the government and Maoist groups makes it difficult for people in Chhattisgarh, Andhra Pradesh and Telangana to obtain medical care. MSF continued to offer healthcare through weekly mobile clinics in villages in southern Chhattisgarh, and to displaced people in Andhra Pradesh and Telangana.

In Chhattisgarh, the MSF health centre in Bijapur district focused on mother and child health, providing obstetric, neonatal and paediatric care. Teams also ran mobile clinics to bring basic and specialist medical services to the surrounding population. More than 63,200 consultations were carried out, and 14,657 patients were treated for malaria.

Extending care for HIV and TB

In Mumbai, MSF runs a clinic that provides psychosocial and medical care to patients with drug-resistant TB, HIV and hepatitis B or C, and those who are co-infected with any of these diseases. These patients require specialised diagnostics, care and treatment which are not available through the public health system. Teams actively share knowledge with local organisations and professionals to build capacity.

MSF continued to run clinics providing HIV and TB diagnosis and treatment in Churanchandpur and Chandel districts in the northeastern state of Manipur, which has some of the highest rates of HIV in the country. MSF started cooperating with a local NGO to offer inpatient care for HIV patients, and offered additional support for opioid substitution therapy for intravenous drug users. After screening patients for hepatitis C, MSF confirmed that more than 25 per cent of HIV patients were co-infected.

Mental healthcare in Kashmir

MSF has been running mental health programmes in Kashmir since 2001. There are currently programmes in Srinagar, Baramulla, Pattan and Sopore, and normally patients come to the projects to see counsellors and clinical psychologists after referrals from hospital psychiatrists. To increase local awareness and the visibility of mental health issues, MSF worked with a Kashmiri production company to produce a 13-episode TV soap opera, *Aalav Baya Aalav*. The first episode was broadcast on 18 December, and immediately triggered 80 phone calls to the MSF clinic information line with questions and reactions. People subsequently visited the MSF clinics for more information and for counselling.

Floods in the Kashmir valley in September forced MSF to close mental health clinics in Kashmir for more than a month, but counselling services were later extended with the opening of clinics in Pulwama, Kakapora and Bandipora. In the immediate aftermath of the flooding, teams distributed relief items including water, food, blankets and wash kits.

Malaria emergency

By mid-year, more than 50,000 cases of malaria had been recorded in a four-month period in different areas of Tripura state. MSF trained community health workers to detect and treat simple malaria and refer complicated cases for intensive care. More than 5,200 rapid diagnostic tests were carried out and MSF treated over 2,300 patients in some of the hardest-to-reach areas of the state.

Nagaland project handover

MSF played a key role in revitalising the Mon district hospital in the northeastern state of Nagaland with equipment upgrades and staff training. The four-year project was successfully handed back to the Ministry of Health by mid-year, once the hospital was fully functional.

IRAQ

No. staff in 2014: 627 | Expenditure: €20.4 million | Year MSF first worked in the country: 2003 | msf.org/iraq

KEY MEDICAL FIGURES:

219,800 outpatient consultations

17,700 individual and group mental health consultations

7,300 relief kits distributed

A rapid escalation in conflict in Iraq caused massive internal displacement in 2014. Nearly two million people have fled their homes in search of safety.

Continual fighting hampered the delivery of humanitarian assistance to displaced people in northern and central Iraq. Médecins Sans Frontières (MSF) launched emergency interventions and found that most of the health problems were related to poor sanitary conditions, particularly the lack of latrines and clean water. Staff routinely treated people with respiratory and urinary tract infections, gastrointestinal problems, and skin and chronic diseases.

Emergency relief for displaced people

The Islamic State (IS) group and allies launched major offensives in Samarra and Mosul in June, and around Sinjar, near the border with Syria, in August. During this period people fled for safety, mainly into Iraqi Kurdistan. MSF responded by launching emergency interventions to provide basic medical care and relief for displaced families in several locations.

In June, four mobile clinics started to operate across Dohuk governorate, providing basic medical care and distributing relief items to displaced people. Teams supplied over 1,000 wash kits (soap, shampoo) and undertook water and sanitation activities, including the construction of latrines and showers in Dabin to help maintain a basic standard of hygiene.

In Kirkuk city and the surrounding areas, two teams ran mobile clinics in five locations providing basic healthcare, focusing on chronic diseases, maternal and paediatric care. More than 20,000 blankets and 2,200 wash kits were given to displaced families. Mobile clinics reached displaced people in several locations between Mosul and Erbil from June to August and MSF was the first healthcare provider to arrive and set up a basic health clinic at Bharka camp, where displaced people were gathering. The clinic was handed over to the International Medical Corps several weeks later.

In October, MSF began offering basic healthcare in a clinic in Diyala governorate, focusing on the needs of people displaced by the conflict in the region. Teams conducted more than 4,700 medical consultations. As winter was approaching, they distributed relief items, including blankets, tents and shelter construction kits to more than 400 families living in makeshift camps and informal settlements in northern Diyala.

Between November 2014 and January 2015, MSF assisted displaced people coming from the north of the country and from Najaf, Karbala, Babil, Wassit and Al-Qadisiyyah governorates, by running mobile clinics and health promotion activities, and by providing relief supplies. More than 14,000 kits containing blankets, cooking utensils and hygiene items were distributed, and 1,387 consultations took place.

As fighting intensified in Anbar, Ninewa, Salah ad-Din, Diyala and Kirkuk governorates towards the end of the year, people trying to leave unsafe areas were finding themselves trapped. MSF has repeatedly asserted that protection, access to humanitarian aid and the right to reach safer areas must be guaranteed for all communities.

The consequences of conflict

In June, the day after MSF had completed its basic healthcare clinic in Tikrit, the structure was destroyed by an explosion, and international and Iraqi medical staff were evacuated from the area. The IS group took control of the city and MSF has not been able to return since.

Teams had been working in the general hospital of Hawijah, supporting the emergency services, since 2010. In August, MSF offices in the hospital compound were severely damaged during fighting and this prompted the closure of the project. Also in August, staff had to flee the Sinjar hospital when IS forces seized the town; some staff members later joined the MSF teams in

Displaced people from Sinjar are living in Dohuk governorate, in unfinished buildings and informal settlements.

Patients are seen here at an MSF mobile clinic in Dohuk governorate, collecting medication after their consultation.

Dohuk and are still working to provide medical services to their communities.

In December, MSF withdrew from Heet hospital after the IS group took the city. Most of the members of the medical team left, and thousands of people from Al-Anbar who had already fled their homes were forced to move on once again.

Assisting Syrian refugees in Iraqi Kurdistan

In addition to the newly displaced Iraqis needing assistance in the region, more than 200,000 Syrian refugees have been living in Iraqi Kurdistan, many in Erbil governorate, and have ongoing healthcare needs. MSF was the main provider of basic healthcare to Syrians in Darashakran and Kawargosk refugee camps, until activities could be handed over to the International Medical Corps in November and December, respectively. MSF had carried out more than 64,000 outpatient consultations. There is still a great need for psychological support among camp residents who have fled violence and are living with fear and uncertainty. MSF has continued to provide a programme of mental health support in these camps and the team carried out more than 1,100 consultations during the year.

MSF remains the main healthcare provider in Domiz camp, Dohuk governorate, home to some 60,000 Syrian refugees. Services include sexual and reproductive healthcare, management of chronic diseases and mental health support. MSF also ensures emergency services and referrals to Dohuk hospital around the clock. In August, MSF opened a maternity unit and had assisted 571 deliveries by the end of the year.

Reconstructive surgery in Jordan

Many victims of war are unable to access reconstructive surgery in Iraq because of the cost and the security situation, and post-operative care such as physiotherapy is lacking. MSF offers wounded Iraqis reconstructive surgery, psychosocial support and physiotherapy through its project in Amman, Jordan. A network of eight medical liaison officers refers patients, and more than 150 Iraqi victims of violence needing these specialist services were referred in 2014.

Programme closures

In February, MSF ended its support of the neonatal unit in Kirkuk general hospital. MSF also completed a programme of training and support in Al-Zahra hospital, Najaf governorate, in October.

IRAN

No. staff in 2014: 31 | Expenditure: €0.7 million | Year MSF first worked in the country: 1990 | msf.org/iran

KEY MEDICAL FIGURES:

5,000 outpatient consultations

1,900 individual and group mental health consultations

Drug users, sex workers and impoverished refugees from Afghanistan are among the vulnerable groups in Iran who face barriers when seeking medical care.

Despite improvements in the health system and greater recognition of addictions and stigmatised diseases such as HIV, healthcare gaps remain. A Médecins Sans Frontières (MSF) team continued to provide medical and psychological care, as well as voluntary counselling, social support and testing for HIV and hepatitis, to some of Iran's most vulnerable residents in Darvazeh Ghar, southern Tehran. A team of community workers and peer educators also worked with MSF to reach those in need.

The health clinic, which opened in 2012, offers care to drug addicts and those excluded from regular medical services, primarily women, including sex workers, and children under 15.

Specific attention is given to the most-at-risk populations for sexually transmitted infections and infectious diseases such as HIV, hepatitis C and tuberculosis. Patients include drug users (including children) and their family members, sex workers and child labourers.

In 2015, MSF will develop a specific approach to the management of hepatitis C and HIV, will undertake activities to try and reduce the risks of infection and hopes to start working with male drug users.

ITALY

No. staff in 2014: 22 | Expenditure: €0.9 million | Year MSF first worked in the country: 1999 | msf.org/italy

KEY MEDICAL FIGURES:

42,100 outpatient consultations

136 patients admitted to hospital

An unprecedented number of migrants, refugees and asylum seekers landed on Italian shores in 2014, many of them fleeing wars in their home countries.

Arriving via the Mediterranean remains the main option for many migrants and asylum seekers trying to reach Europe and claim international protection. Exploitation, violence and the risks of the crossing are not deterrents for people already facing life-threatening situations.

Médecins Sans Frontières (MSF) teams saw an increase in the number of vulnerable people disembarking in Italy, including victims of violence and torture, those with disabilities, children and pregnant women. Figures from the UN's Refugee Agency showed the most common nationalities of arrivals were Syrian and Eritrean. Collaborating with the health ministry, teams conducted health screenings in Pozzallo, Sicily, and provided psychological care to people living in reception centres in Ragusa province. Many patients presented with scabies, respiratory tract infections, suspected tuberculosis and psychological suffering. A temporary tented clinic was also set up in the port of Augusta to offer medical care to new arrivals and make urgent referrals to hospital. The Augusta project was handed over to the health ministry and the Italian Red Cross in December, once the number of new arrivals had decreased.

Between March and September, an MSF team managed a 23-bed inpatient service in Milan to provide medical care to homeless people discharged from hospital. The project was located in a shelter with a capacity for 150 people, and was run in cooperation with local organisations, offering free inpatient and outpatient care, including nursing. Many patients suffered from chronic diseases or illnesses resulting from the harsh living conditions, such as respiratory tract infections. The project was handed over to the health ministry in September.

The MSF Chagas disease project, which included education and screening, ended in June.

For more on refugees and migrants arriving in Europe, see Bulgaria (p.26), Greece (p.40) and Serbia (p.73).

JORDAN

No. staff in 2014: 209 | Expenditure: €8.4 million | Year MSF first worked in the country: 2006 | msf.org/jordan

● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

1,500 individual and group mental health consultations

1,500 patients treated after incidents of violence

1,300 surgical interventions

Rayya is a Syrian refugee from Daraa governorate, where in January 2012 she was injured by a grenade. The shrapnel shattered her lower arm. She has since undergone a number of operations in Jordan, conducted by MSF staff.

More than 600,000 Syrians fleeing war have sought safety in Jordan, mainly in urban areas. As a result, the need for basic services such as healthcare has vastly increased.

The majority of refugees are living outside of camps, where they share space, resources and services with their Jordanian hosts. This has stretched the capacity of all public services – from health and education to waste collection and disposal. In November, the Jordanian authorities announced that Syrian refugees would have to pay for health services at public facilities.

Médecins Sans Frontières (MSF) runs a maternity hospital in Irbid, northern Jordan, providing free healthcare to help meet the needs of a large number of Syrian refugees and vulnerable Jordanians. Ante- and postnatal outpatient consultations and basic emergency obstetric and neonatal care are available. Over 2,000 births were assisted in 2014. MSF extended services by opening a paediatric outpatient department in January, which conducted nearly 14,000 consultations throughout the year. In October, MSF launched a mental health programme for children showing signs of distress from war and displacement and there were 351 consultations by the end of the year. A team also started a pilot project in mid-December, offering free medical care to Syrian refugees and underprivileged Jordanians with chronic diseases, mostly diabetes and hypertension, at a government clinic in Irbid. The aim is to ease the demand on local medical resources.

Trauma surgery in Ar Ramtha

Just a few kilometres from the border with Syria's Daraa governorate, MSF provides emergency surgery for wounded Syrians in Ar Ramtha hospital. More than 1,300 major surgical interventions, many of them lifesaving, were performed on 538 patients. General inpatient care and physical therapy were also available, and more than 1,160 mental health consultations took place.

In March, MSF opened a post-operative care facility in Zaatari refugee camp. This 40-bed facility is for war-wounded patients transferred from Ar Ramtha and other hospitals in Jordan. Among the more than 460 patients admitted were 244 patients needing follow-up care for pain management and wound treatment. Mental health support and physical therapy are also offered.

Reconstructive surgery in Amman

MSF's reconstructive surgery programme in Amman provides a critical service for victims – many of them children – of conflict in Syria, Iraq and Yemen. Patients are referred through a network of doctors in the region and surgeons carry out orthopaedic, maxillofacial and plastic reconstructive surgery free of charge to help patients recover from devastating injuries. The team performed 1,369 surgical procedures in 2014, and Syrians accounted for 45 per cent of all admissions. An outpatient department also provides consultations for Syrians who have undergone operations elsewhere and need post-operative care. Mental health professionals ran a total of 8,000 sessions with patients in this project.

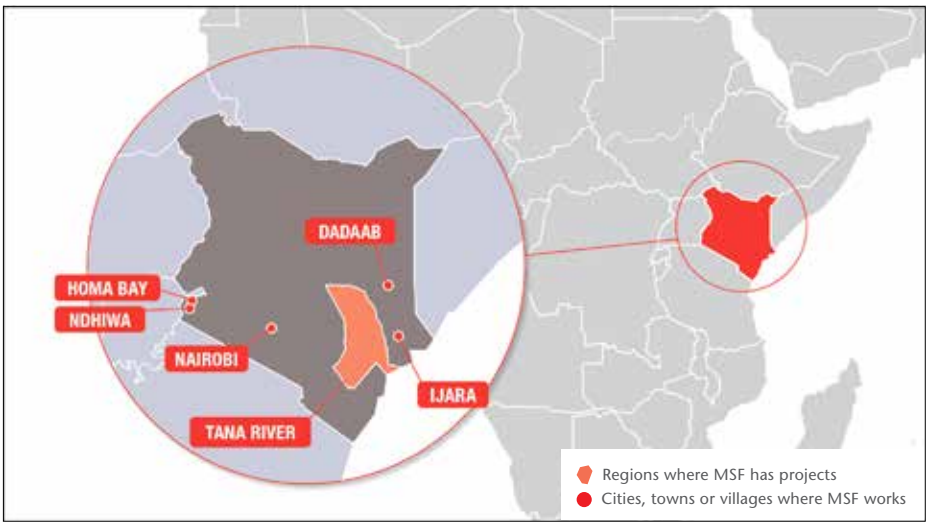
PATIENT STORY

AHMED – Ahmed's nine year old son and a friend were injured while playing with something they found: unexploded ordnance. Ahmed brought his son to Ar Ramtha for emergency treatment.

"In Daraa they told me they could not treat the kind of injuries my son had. They did not have the right kind of equipment, and there was only one doctor. We were lucky. It only took 15 minutes to get to the border and we managed to get to the hospital within 25 minutes. His whole body was full of shrapnel; the largest injuries were on his leg. So far he has had seven surgeries, and we hope that his treatment is nearly finished."

KENYA

No. staff in 2014: 603 | Expenditure: €17.4 million | Year MSF first worked in the country: 1987 | msf.org/kenya



KEY MEDICAL FIGURES:

333,400 outpatient consultations

10,500 patients on first-line ARV treatment

2,800 patients treated after incidents of sexual violence

Médecins Sans Frontières (MSF) continues to respond to the medical needs of some of Kenya's most vulnerable people: inhabitants of slum settlements and refugee camps, patients with HIV/AIDS and tuberculosis (TB), and victims of sexual violence.

Over 350,000 people, mostly Somalis, live in precarious conditions in Dadaab, the world's largest long-term refugee settlement. Following a tripartite agreement on voluntary return (signed by the UN Refugee Agency and the governments of Kenya and Somalia in 2014), the refugees can either go back to a war-torn country or stay in closed camps where they receive minimal assistance. The threat of kidnappings, robberies and sexual assault puts significant pressure on the people living in the camps and insecurity severely limits the capacity of humanitarian organisations to provide services.

MSF has not had a permanent international staff presence in Dagahaley camp, 80 kilometres from the border with Somalia, since 2011 due to increased insecurity, but continues to manage a 100-bed hospital and an inpatient feeding centre through the work of national staff and remote management. Outpatient and inpatient services for children and adults are provided, including maternity care, emergency surgery and treatment for HIV/AIDS and TB. Four health posts in Dagahaley offer basic healthcare consultations and outreach activities including mental health support. Each month, teams carried out around 15,000 outpatient consultations and 1,000 antenatal consultations, and admitted an average of 1,000 patients to hospital. MSF issued a briefing paper in March 2014, drawing attention to the inadequate and insecure conditions in Dagahaley and calling for more government and donor support for the Dadaab camps.

HIV/AIDS

MSF's programme in Homa Bay has provided antiretroviral (ARV) treatment to people living with HIV since 2001. Homa Bay was the first public hospital in Kenya to offer it free of charge. The programme is in the process of being handed over to the health ministry. More than 7,400 people were on ARVs in 2014. A new programme was started in Ndhiwa, where MSF has found adult HIV prevalence as high as 24 per cent and a worrying rate of new infections at two per cent per year. In order to reduce this, an integrated and simplified model of care will be introduced in health ministry facilities and in the communities in order to diagnose and care for people living with HIV

Patients with TB wait to be seen at the Green House clinic in Mathare, Nairobi.

MSF midwives talk to a new mother in the Kibera South clinic in Nairobi, and examine baby John.

and decrease their viral load. Support will be given to health authorities to improve access to HIV testing, voluntary medical male circumcision, and prevention of mother-to-child transmission of the virus. MSF will also focus on follow-up and treatment adherence, and on improving the quality of care in Ndhiwa and Homa Bay hospitals' inpatient wards where mortality rates among HIV patients remain high.

Healthcare in Nairobi slum settlements

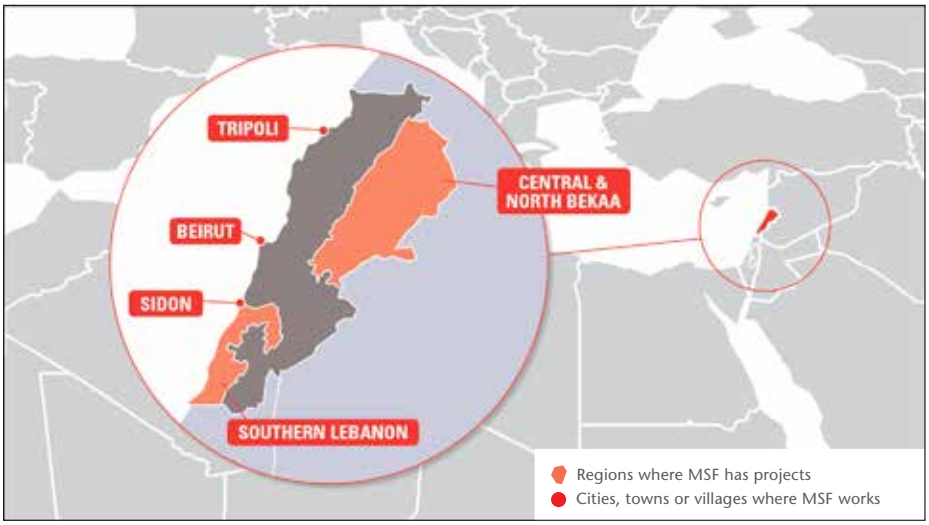
In the Eastlands slums, poverty, drug use, crime and impunity contribute to high levels of violence, including sexual assaults. Victims, however, have very limited access to emergency medical care in this part of the city. MSF has been working to fill this gap with its programme at the Lavender House clinic in Mathare, which offers comprehensive care to victims of sexual and gender-based violence, including access to a 24-hour hotline and pick-up by ambulance. Patients receive medical consultations, treatment to prevent transmission of HIV and sexually transmitted infections, a pregnancy test when relevant, swabs for legal purposes, psychological counselling, and referrals for social and legal support. In 2014, more than 200 patients received aftercare each month; half of these were minors, and a quarter were under the age of 12. A trauma room at Lavender House was also established to manage ambulant medical emergencies, and stabilise and refer patients to other facilities when needed. Some 300 patients received care in the trauma room each month, the majority for physical assault.

After evaluating the health needs in the area, MSF decided to address the population's lack of access to hospitals and specialist healthcare. A dispatch centre was set up and two ambulances were made available to the residents of Mathare and Eastleigh. During the first six weeks of the project, 141 calls were received. MSF also started supporting the accident and emergency department of Mama Lucy Kibaki hospital – the only hospital accessible for Eastlands's two million residents – with additional staff, equipment, training and supervision. A programme focusing on detection and treatment of people with drug-resistant TB continued at Green House, Mathare, and MSF started the first patient diagnosed with extremely drug-resistant TB on a regimen that includes the new anti-TB drug bedaquiline.

The only free basic healthcare for people in the Kibera slum is provided through two MSF clinics. Treatment for HIV/AIDS, TB and chronic diseases is available, and the team runs a comprehensive aftercare programme for victims of sexual violence. MSF opened a new clinic in Kibera South, offering basic healthcare and maternity services. There is an inpatient maternity ward and an ambulance service for obstetric and other emergencies. Integrated management for diseases such as HIV, diabetes and asthma make it a one-stop service, improving patient access to medical care and facilitating early diagnosis, treatment and follow-up. Health education sessions, counselling and social support are also available. 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 overcrowding, as well as poor hygiene and sanitation in the slum.

LEBANON

No. staff in 2014: 284 | Expenditure: €15.6 million | Year MSF first worked in the country: 1976 | msf.org/lebanon



KEY MEDICAL FIGURES:

245,200 outpatient consultations

7,200 individual and group mental health consultations

An estimated 1.2 million Syrian refugees, Palestinian refugees from Syria, and Lebanese returnees have sought refuge in Lebanon since the Syrian conflict began in 2011. Lebanon, a tiny country with a population of only four million, is struggling to cope.

With few employment opportunities and dwindling financial resources, the refugees and returnees are largely reliant on humanitarian assistance for survival. As no official refugee camps have been established in response to the Syrian conflict, a very large number of people live in informal settlements, collective shelters, farms, garages, unfinished buildings and old schools, with inadequate access to shelter, food and water. Overcrowding and exposure to extreme weather conditions have a negative impact on their health.

The lack of healthcare is one of the main problems. Thousands of people who had previously received regular medical treatment in Syria for chronic diseases such as hypertension, asthma and diabetes have had to interrupt their treatment – sometimes with severe consequences – because they cannot access or afford it. Many women receive no monitoring during their pregnancies and specialised care is completely out of reach for most people.

Médecins Sans Frontières (MSF) continues to respond with free medical care for people in need, regardless of nationality and refugee registration status.

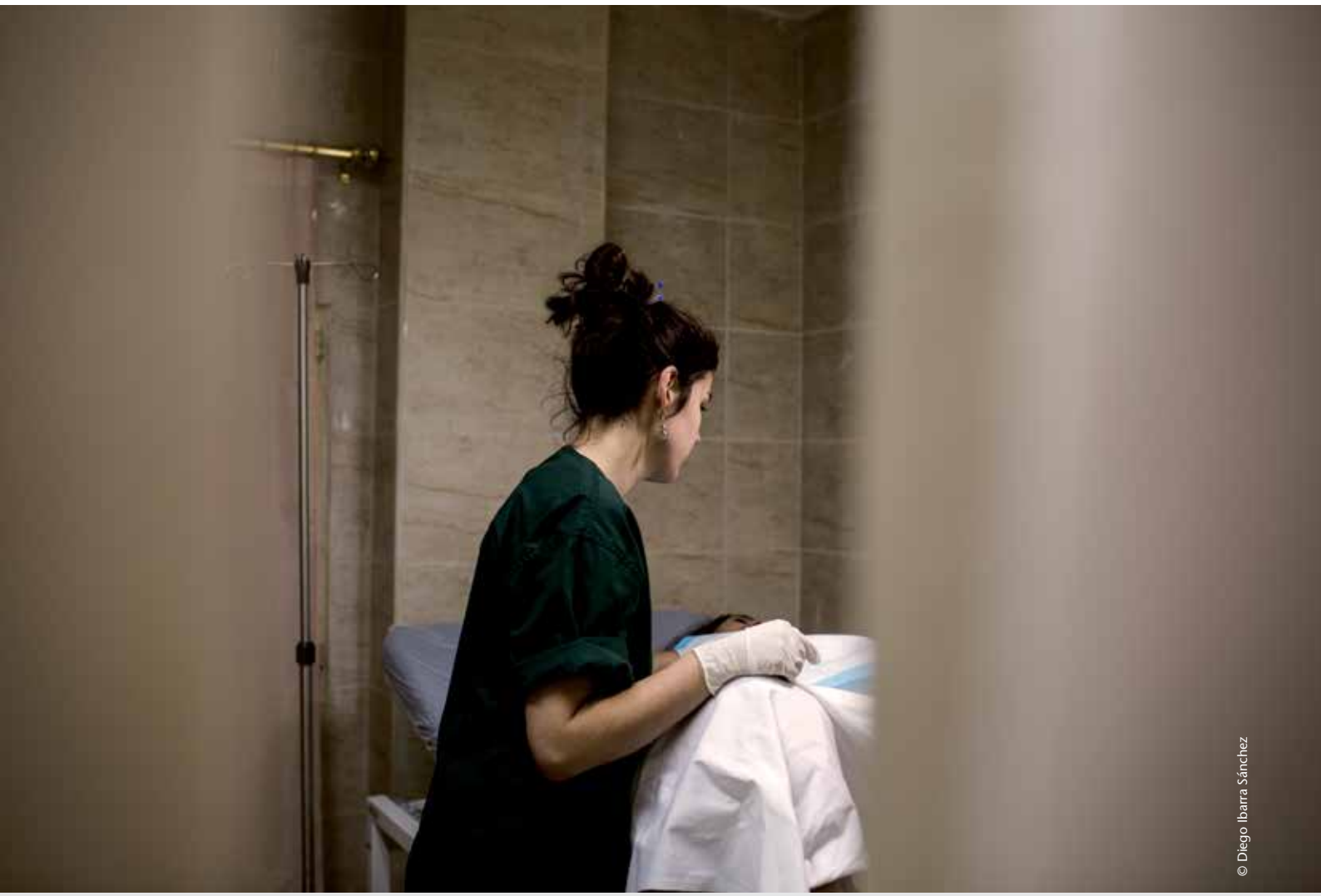
Bekaa Valley

Many people who have crossed into Lebanon have stayed close to the border, in areas such as Bekaa Valley, where there is insufficient healthcare infrastructure to meet the current needs. MSF provides basic and reproductive healthcare, treatment for chronic diseases, counselling, and health promotion activities to Syrian refugees and vulnerable Lebanese. Teams work at clinics in the towns of Baalbek and Majdal Anjar (West Bekaa), Aarsal (North Bekaa), and in Hermel. Across the Bekaa Valley, 113,000 consultations were carried out during the year.

Beirut

MSF continues to work in Shatila camp in southern Beirut, a Palestinian refugee settlement dating back to 1949, where more recent Palestinian refugees from Syria and Syrian refugees are also living. The focus is on unregistered refugees who are not eligible for official assistance and

A Syrian refugee with diabetes is shown by an MSF nurse how to exercise daily in order to stimulate his blood circulation.



An MSF midwife assisting a delivery in Shatila camp, southern Beirut.

registered refugees with medical needs falling outside the UN Refugee Agency's eligibility criteria. Basic healthcare for children under 15, treatment for chronic diseases and mental health support services are available. A referral system is in place for patients requiring specialist medical intervention, such as caesarean sections for women with high-risk pregnancies and birth complications.

Tripoli

In the coastal city of Tripoli in northern Lebanon a team works in Dar al Zahraa hospital in the Abou Samra neighbourhood. Medical services, including treatment for acute and chronic illnesses, reproductive healthcare, counselling and routine vaccinations, are provided to vulnerable Lebanese and Syrian refugees, regardless of their status. Similar services have been offered in Abdie since April. MSF also offers reproductive healthcare, counselling and care for acute diseases in Jabal Mohsen and Bab el Tabbaneh dispensaries.

Southern Lebanon

A small team based in southern Lebanon offers basic healthcare to refugees. MSF supports three health centres, with activities focused on children under 15, chronic diseases, mental healthcare and reproductive and maternal health services. There is also a referral system for patients in need of specialist healthcare. In 2014, MSF extended its healthcare programme from Ein-el-Hilweh camp to assist the Palestinian refugee community, Syrian refugees and vulnerable residents across the Sidon area. More than 4,800 mental health consultations were conducted; nearly double the number that took place in 2013.

STAFF STORY

SAMAR ISMAIL – MSF counsellor, Shatila camp, Beirut

"Many of the people I see come from parts of Syria that have been bombed. Some have lost children or other family members ... The first thing I try to do is understand what happened to them and where the negative feelings are coming from. We work on stress management, after we understand the problems. Most people have difficulty understanding why people have treated them the way they have."

KYRGYZSTAN

No. staff in 2014: 108 | Expenditure: €2.1 million | Year MSF first worked in the country: 2005 | msf.org/kyrgyzstan

KEY MEDICAL FIGURES:

620 patients under treatment for TB

One in four patients newly diagnosed with tuberculosis (TB) in Kyrgyzstan has a multidrug-resistant strain of the disease.

This means they do not respond to standard first-line drugs and need longer, more complex and more intensive treatment. In addition, medical services for TB have been centralised and are largely focused on treatment in hospitals only. Consequently people have difficulty accessing medical care, particularly in rural areas.

Médecins Sans Frontières (MSF) is the only international organisation actively engaged in the direct clinical implementation of drug-resistant TB (DR-TB) programmes in Kyrgyzstan. In Kara-Suu district, Osh province, where TB rates are among the highest in the country, MSF focuses on outpatient care to limit the amount of time a patient spends in hospital and to improve their adherence to treatment. The programme aims to influence health policy and has succeeded in introducing this decentralised approach to DR-TB treatment as a key strategy for the Kyrgyzstan Ministry of Health in the coming years.

For patients with severe TB, MSF continued to diagnose and treat patients in Kara-Suu hospital, which has 80 beds, including an isolation ward for those with multidrug-resistant TB (MDR-TB). MSF provides support in the pharmacy and laboratory, and also assists with the management of the hospital's waste, water and infection control.

Many patients have received prior treatment for TB, and more than two-thirds of them have developed drug resistance because treatment has been interrupted or they have had difficulty in adhering to it. As part of its comprehensive package of care, MSF provides psychosocial support to help people sustain and complete their arduous drug regimens.

Prison project handover

In 2006, MSF began to develop a programme providing TB diagnosis and treatment for inmates at a prison in Bishkek due to the high prevalence of the disease. The project was handed over to the International Committee of the Red Cross, the health ministry and prison authorities in 2014. MSF had enrolled and treated more than 3,000 patients over the eight years.

PATIENT STORY

SHAKIR – suffering from MDR-TB

"While on treatment, I had no idea that I would need psychological help. But when you take the drugs, you get side effects. I became nervous and apathetic. The psychosocial support that I received from MSF during my entire treatment was tremendously helpful. After six months of outpatient treatment, the doctor came to my house with the results of my last sputum tests: 'Shakirake, I have good news for you, the test results are great. You have been cured!'"

LESOTHO

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

KEY MEDICAL FIGURES:

6,600 family planning consultations

5,900 patients received first-line ARV treatment

1,900 births assisted

Women in Lesotho face numerous obstacles to obtaining maternal care, and this poses severe risks to their health.

The country is mountainous and has few roads. Many people in remote rural communities cannot afford transportation costs to health facilities. There is also a shortage of skilled health workers. Consequently, about 50 per cent of women deliver their babies at home. Another challenge is the high prevalence of HIV in Lesotho – it is 27 per cent among pregnant women. HIV, along with tuberculosis (TB) co-infection, contributes to high rates of maternal death. Médecins Sans Frontières (MSF) continues to focus on improving access to maternal medical care and family planning, as well as to treatment for people with HIV.

Family planning services, ante- and postnatal care and emergency services are offered at the MSF-supported St Joseph's district hospital in Roma, six health clinics in the lowlands and three clinics in remote Semonkong. An average of 133 babies were delivered each month at St Joseph's and more than 230 women were accommodated at the nearby maternity lodge, where they can come to give birth. MSF also has an ambulance to transport patients to the hospital for emergency treatment.

MSF trains and mentors local staff at these facilities to provide integrated care for patients co-infected with HIV and TB. Local counsellors and community health workers initiate and follow up antiretroviral (ARV) treatment. More than 1,550 people were started on ARVs in 2014. Viral load monitoring – an important laboratory measure of HIV in the blood that can indicate treatment success or failure – was also expanded.

LIBYA

No. staff in 2014: 71 | Expenditure: €2.2 million | Year MSF first worked in the country: 2011 | msf.org/libya

KEY MEDICAL FIGURES:

390 outpatient consultations

Renewed fighting erupted in the spring of 2014, forcing thousands of people from their homes. Chaos and insecurity severely hampered assessments and the delivery of aid throughout the year.

Médecins Sans Frontières (MSF) opened a mental health centre in Tripoli in 2013 to provide medical and psychological support to people suffering from physical and mental health problems related to previous conflicts. MSF's team in Tripoli was temporarily evacuated in July due to the volatile situation in the city. Staff returned in October but due to the deterioration of the security situation, MSF was unable to continue the project and it was closed in December.

Violence and unrest were still widespread at the end of the year. Many health workers fled and health facilities experienced shortages of supplies and drugs. Insecurity prevented access to many areas, particularly in the east, where there were high numbers of casualties.

MSF provided assistance to Tripoli, Zawiyah, Yefren, Zuwara and Jaddu through donations of drugs and medical materials, including kits to treat war-wounded.

The crisis in Libya has funnelled thousands of people through to Europe, with 90 per cent departing from its coast. People working in Libya or using its coastline as a jumping-off point to reach Europe are especially vulnerable to its instability. In Zuwara and the surrounding area on the northern coast, where the majority of boats heading for Europe leave from, MSF donated hygiene materials such as chlorine, masks and protective gloves to the local crisis committee to help cope with the number of bodies washing up on the shore.

MADAGASCAR

No. staff in 2014: 40 | Expenditure: €0.4 million | Year MSF first worked in the country: 1987 | msf.org/madagascar

KEY MEDICAL FIGURES:

670 patients treated for malaria

290 births assisted

In June, Médecins Sans Frontières (MSF) handed over its project in the south of Madagascar to the Ministry of Health.

Following the political crisis of 2009, people in Madagascar faced a deteriorating economic and health situation and MSF conducted several needs assessments before opening a project in Bekily, Androy region, in 2011. Based at Bekily hospital, and providing support at two health centres, the project's activities focused on medical care for women experiencing complications and emergencies in pregnancy, malnourished children, and patients with tuberculosis (TB), schistosomiasis (a curable parasitic disease) and malaria.

Over the course of the project, 20,000 patients received emergency consultations, 42 per cent of them were children aged five or under. One in four patients suffered from malaria. Teams carried out 12,000 antenatal consultations and admitted 1,460 children to hospital. A total of 130 TB patients were diagnosed and treated.

LIBERIA

No. staff in 2014: 373 | Expenditure: €23 million | Year MSF first worked in the country: 1990 | msf.org/liberia | blogs.msf.org/ebola

KEY MEDICAL FIGURES:

2,500 patients admitted to Ebola management centres, of which **1,600** were confirmed as having Ebola

670 patients recovered from Ebola and discharged

Construction teams building what will become one of the wards at ELWA 3, MSF's EMC on the outskirts of Monrovia.

On 31 March, the first cases of Ebola were confirmed in Liberia. By the end of July, the number of sick had risen to overwhelming numbers and people were dying in the streets.

Liberia's healthcare infrastructure had suffered as a result of the long civil war, and when the Ebola outbreak occurred there were already significant gaps in care. As there were few confirmed Ebola patients in March and April, and none between the end of April and the beginning of June, the country and the aid organisations present were lulled into a false sense of security. The national health system was unprepared to cope with the explosion of cases when the situation rapidly worsened at the end of July. In the space of two months, the number of cases went from fewer than 10 in June to more than 1,000. The epidemic peaked between August and October.

Margibi and Lofa counties

In April, following reports of suspected cases of Ebola in Liberia, MSF sent a small team to Lofa and Margibi counties. In Margibi, east of Monrovia, a small isolation unit was built by a local company and MSF supported it with technical expertise and organised training for local health staff.

In Foya, close to the Guinean and Sierra Leonean borders, MSF built an Ebola management centre (EMC), and also trained local health staff and made sure that alert systems were in place to refer suspected cases. After the NGO Samaritan's Purse suspended operations in Liberia when two of its international staff became infected, MSF took over the management of the centre and increased the bed capacity to 100. It soon became clear that a comprehensive approach to tackling Ebola was essential if the virus was to be contained in this area. A package of medical care, outreach activities, psychosocial support, health promotion and contact tracing was put into place. Nearly 700 patients were admitted to the centre, 394 of whom were confirmed as having Ebola. There were 154 survivors. The centre was closed in December.

Monrovia

In the capital Monrovia, MSF started by supporting the authorities and training medical staff in JFK and Elwa hospitals. An isolation unit was also constructed in JFK hospital. In August, the Elwa 3 EMC opened with a capacity of 120 beds, but this gradually increased as the outbreak worsened. The centre had 250 beds by the end of September, making it the largest EMC ever built. At this point, teams were admitting on average 152 patients per week and were being forced to turn away up to 30 people per day because there simply wasn't enough space.

An MSF rapid response team ran mobile clinics and trained local health staff in triage and infection control. To mitigate the risk of contagion and restore public confidence in the health system, MSF supported 13 health centres with infection prevention and control – this later increased to 22 facilities, as new cases presented in different areas. MSF also began constructing a new free-of-charge paediatric hospital in the city. An ambulance service was also set up in December to transport suspected Ebola cases to an EMC.

Redemption hospital, the only facility in the capital providing free medical care to a population of approximately 90,000, closed entirely in October. To enable the hospital to start offering inpatient services again, MSF opened a 10-bed transit centre for the triage of those suspected of having Ebola. Psychosocial support was also offered to the families of Ebola sufferers.

River Cess county

Following a visit to River Cess county by the Liberian county health team, the World Health Organization and the Centers for Disease Control and Prevention in November, MSF was asked to establish a transit centre in Gozohn. This centre tested people suspected of having Ebola and referred patients to Monrovia for care.

By 8 December, the transit centre was empty but contact tracing and health promotion activities, as well as the construction of triage areas and training of health workers on infection control procedures, continued in six health centres in the region. On 15 December, the organisation Partners in Health and the county health team took over the activities.

Grand Bassa county

On 22 November, one case was confirmed in Grand Bassa county but just eight days later there were nine severely ill people. MSF deployed a team of 16 to establish a base in Quewein. At the end of December, the charity Concern Worldwide and the Liberian county health team took over the epidemiological surveillance and contact tracing. The decommissioning of the EMC and departure of the MSF team was planned for early January 2015.

Distribution of antimalarials

MSF distributed antimalarials to 522,000 people in Monrovia not only to protect them from the disease but also to reduce the number of patients presenting at EMCs wrongly thinking they had Ebola. Two rounds of distribution took place in five districts (New Kru Town, Clara Town, Gardnersville, West Point and Logan Town) between late October and December.

Looking forward

The number of Ebola cases declined sharply towards the end of the year, and by December Liberia was reporting the lowest incidence of the three main affected countries. However, contact tracing and cross-border communication remain essential in identifying and dealing with any new cases. Now that the peak of the Ebola crisis looks to be over in Liberia, non-Ebola health needs must be addressed as an urgent priority to ensure people do not continue to die of treatable diseases such as malaria and diarrhoea. Many hospitals have shut, health workers have died or fled, and few people have access to the level of care they need.

PATIENT STORY

ALEXANDER KOLLIE – his son was MSF's 1,000th Ebola survivor

© Katy Athersuch/MSF

"I noticed my son looking more tired than usual. I was worried about him. He didn't have any symptoms like vomiting or diarrhoea, but he just looked tired. I called the Ebola hotline and MSF brought him to their Ebola care centre here in Foya to be tested … When the test came back positive, it was a night of agony for me … After some time, my son started doing much better. He was moving around. I prayed that he would be free of Ebola and test negative, but I was worried that his eyes were still red. I just wanted us to be together again. Then something amazing happened, something I could not actually believe until I saw it. Until that moment I saw him coming outside, I could not truly believe that it would happen. I've seen people with Ebola start to look strong and then the next day, they're just gone. So I was also thinking, maybe Kollie will be one of those who will be gone the next day. When finally I saw him come out, I felt so very, very happy. I looked at him and he said to me, "Pa, I am well."

© Martin Zinggl/MSF

Deddeh, who had recovered from Ebola, stayed in the confirmed area to take care of three-month-old Elijah. He had tested positive for the virus, which killed his mother.

MALAWI

No. staff in 2014: 586 | Expenditure: €7.1 million | Year MSF first worked in the country: 1986 | msf.org/malawi

KEY MEDICAL FIGURES:

43,300 patients on first-line ARV treatment

400 patients under treatment for TB

A man being examined by a doctor at Thyolo health centre, a three-hour walk from his village.

A major limitation to healthcare provision in Malawi is the shortage of skilled healthcare workers – the vacancy rate for clinical staff is around 60 per cent.

For many years Médecins Sans Frontières (MSF) has been supporting the national health system to strengthen its HIV response through staff training and technical support and trying out innovative treatment models to reach more people with the virus.

In August, MSF and the health authorities in Chiradzulu district began a four-year handover process of a programme that opened in 1997. MSF continues to simplify HIV treatment: since September almost 50 per cent of people taking antiretrovirals (ARVs) in Chiradzulu have been on a six-month appointment schedule, which reduces the patient load and waiting times in the health centres. In addition, MSF is implementing a UNITAID-funded project using point-of-care tests to measure CD4 count (the CD4 count is an indicator of an HIV patient's immunity level) and viral loads (rather than sending samples away to be tested) in Chiradzulu. By the end of the year, five health centres were testing for CD4 and four for viral load.

In Nsanje, MSF is supervising the implementation of a policy to put all HIV-positive pregnant and breastfeeding women on ARVs, regardless of their clinical status, to prevent transmission of the virus to their babies. The team is also developing a programme to treat tuberculosis (TB) in 14 health centres as a step towards integrated HIV–TB treatment. In addition, MSF is working to improve counselling, testing and treatment services for sex workers, couples in which only one person has HIV, adolescents, and people with advanced HIV.

The handover to the Ministry of Health of first-line HIV treatment in Thyolo was completed in December 2013, but MSF teams continue to mentor local staff who provide second-line treatments and viral load testing to patients. It is planned for the project to be handed over completely in 2015. During 2014, the combined MSF and Ministry of Health community team enrolled 4,200 people into community ARV groups, whereby people living with HIV take it in turns to collect medication on behalf of the group. More than 22,864 laboratory tests for viral load were carried out for patients in Nsanje and Thyolo.

Twelve students graduated from MSF's Rural Human Resources for Health Scholarship Programme in 2014. They will work in the understaffed and hard-to-reach areas of Thyolo, Nsanje and Chikhawa.

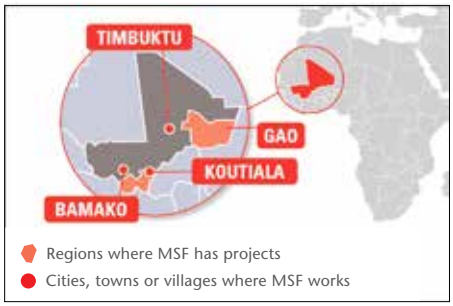
Prison project

MSF started a new project in two prisons: Maula in Lilongwe and Chichiri in Blantyre. Some 4,400 inmates and staff were screened for HIV, TB, hepatitis B and sexually transmitted infections (STIs). Treatment was provided for HIV, TB and the STIs, and people were vaccinated against hepatitis B. MSF undertook other activities to improve and expand prison health services, including providing training scholarships to four prison staff, constructing consultation rooms, pharmacies and laboratories, as well as supporting general outpatient services.

In 2014, a project offering testing for HIV and STIs to truck drivers and commercial sex workers began in Mwanza and Zalewa, near the border with Mozambique. More than 300 sex workers and 50 truck drivers were tested.

MALI

No. staff in 2014: 883 | Expenditure: €9.5. million | Year MSF first worked in the country: 1992 | msf.org/mali



KEY MEDICAL FIGURES:

173,500 outpatient consultations

75,700 patients treated for malaria

15,000 routine vaccinations

Access to basic healthcare was severely restricted in parts of northern Mali in 2014, as the security situation deteriorated. Jihadist attacks continued against military targets and peace talks did not lead to an agreement.

Northern Mali

Civilians were unable to seek medical assistance in areas controlled by certain factions or where there were violent clashes between armed groups. Meanwhile, there is still a shortage of health workers and the authorities lack the means to respond to health crises such as epidemics. Médecins Sans Frontières (MSF) programmes aimed to fill critical gaps between needs and available medical services.

The MSF programme supporting several health centres in Gao region carried out more than 47,750 consultations in 2014. Some areas near the town of Ansongo, south of Gao, were difficult to access. A team continued to provide free healthcare and medicine to patients in Ansongo reference hospital, where there are currently insufficient government health staff to cover the needs of the population. MSF also supported the health ministry during a measles outbreak at the beginning of the year, and transferred 124 patients to Gao hospital for treatment.

MSF collaborated with other organisations to ensure screening for child malnutrition and seasonal malaria chemoprevention (SMC) in Gao region. More than 40,000 children between the ages of three months and five years received antimalarials to guard against the disease through its seasonal four-month peak. Teams managed to reach a scattered population in a very insecure environment.

MSF supported the 65-bed Timbuktu regional hospital, focusing on medical and surgical emergencies. There were on average 700 inpatient admissions and 150 assisted deliveries every month. Teams also provided consultations for patients with chronic illnesses at the Centre de Santé de Référence (CSREF), to treat diseases such as diabetes or hypertension and combat complications.

In the Timbuktu region, over 40 per cent of people live more than 15 kilometres from the nearest health centre. Mobile teams continued to support staff in five peripheral health centres offering basic care, vaccinations and malnutrition screening, but insecurity severely hampered supervision of these facilities in 2014 and danger on the roads hindered patient travel to Timbuktu for referrals and hospitalisation.

Southern Mali

In the relatively peaceful south of the country, MSF focused on children's health, primarily treating malaria (37,400 children were treated) – the main cause of child mortality – and severe acute malnutrition in Koutiala, Sikasso region. MSF supports the paediatric unit within Koutiala health centre, and basic healthcare in five district health areas. MSF doubled the number of beds to 400 in the paediatric unit during the seasonal malaria peak. MSF has been running an SMC programme in this area for three years, and in 2014 treated 183,970 children. Teams also trained local paramedics and medical students. A pilot preventive paediatric care project, including vaccinations and bed net distribution, continued in the Konséguéla health area.

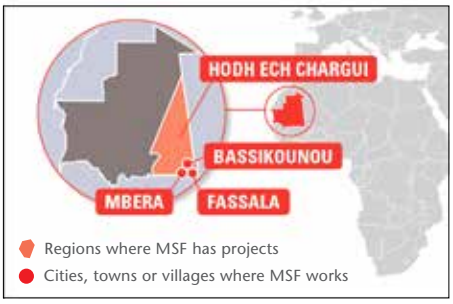
Ebola response

Following confirmed cases of Ebola in October, two emergency teams were dispatched to Kayes and Bamako to set up and run Ebola management centres (EMCs). MSF reinforced the health ministry's capacity to detect and respond to alerts, trained rapid response teams, participated in the elaboration of country protocols, and treated patients in the EMCs to prevent further infections. In addition, MSF set up an early warning system on 1 December for suspected cases in Sikasso. A team provided comprehensive Ebola training to 95 health workers in Sélingué and Yanfolila.

A young girl receives her antimalarials from a community leader as part of the SMC campaign in Gao region.

MAURITANIA

No. staff in 2014: 346 | Expenditure: €4.4 million | Year MSF first worked in the country: 1994 | msf.org/mauritania



KEY MEDICAL FIGURES:

175,800 outpatient consultations

1,800 births assisted

260 surgical interventions

More than 51,000 Malian refugees in Mauritania's Mbera refugee camp are almost entirely dependent on international aid for survival and many don't have adequate food or shelter.

The political and security crisis in Mali in 2013 forced thousands of Malians to flee across the border to Mauritania. Despite the initiation of a peace process in 2014, northern Mali remained so insecure that government services were largely absent from the region. Armed groups splintered while violent attacks and banditry dissuaded refugees from returning home.

Médecins Sans Frontières (MSF) provides basic and emergency healthcare, and gynaecological and obstetric services for the refugees in Mbera camp and for the host communities in nearby Bassikounou and Fassala. By supporting the government clinics and hospitals, MSF has ensured that everyone in the economically marginalised area has access to free medical care for the first time. In 2014, the majority of the life-saving surgical procedures were caesarean sections and visceral and orthopaedic surgery.

MEXICO

No. staff in 2014: 84 | Expenditure: €2.9 million | Year MSF first worked in the country: 1985 | msf.org/mexico

KEY MEDICAL FIGURES:

21,200 outpatient consultations

2,000 individual and group mental health consultations

200 patients treated after incidents of sexual violence

The urban population, and migrants passing through Mexico en route to the United States, are at risk of kidnapping, extortion, physical and mental abuse, and death.

In 2014, Médecins Sans Frontières (MSF) continued to provide migrants with basic and mental healthcare, hospital referrals and follow-up of emergency cases. Many people have experienced violence at some point on their journey, but there are few resources available for victims of sexual violence, and no mental health services. Teams carried out more than 10,000 medical consultations and 1,000 mental health consultations in Ixtepec, Apaxco, Lechería, Huehuetoca, Bojay and Tierra Blanca.

MSF also started offering mental health support to people subjected to extreme violence in Colonia Jardín, Acapulco; the city with the highest homicide rate in Mexico.

Improving emergency care in Tamaulipas state

People living in Tamaulipas state have been exposed to extreme, drug-related violence for more than a decade. The general hospital in Nuevo Laredo – the only place in the city where free, good-quality medical care is available to the vulnerable population – is overwhelmed by the number of patients. MSF worked with health authorities to improve emergency care by implementing 24-hour triage, expanding the emergency room, training staff, donating equipment and drugs, and standardising treatments. There were significant improvements in patient care and in October MSF replicated the project in Reynosa, Río Bravo and Valle Hermoso. Mental health and sexual violence care were introduced in Nuevo Laredo and Reynosa in late 2014.

Integrating Chagas treatment

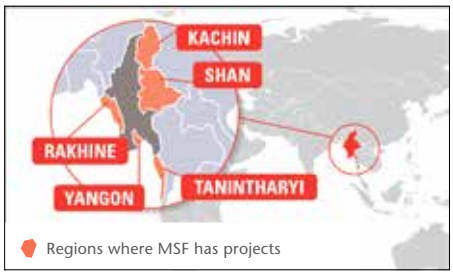
This year MSF collaborated with health authorities to implement a comprehensive response to Chagas disease – a parasitic disease that is prevalent but neglected in Mexico – in the healthcare facility in San Pedro de Pochutla municipality, Oaxaca state. Education, preventive measures (including 3,145 rapid diagnostic tests), and treatment were all available, with MSF providing technical support and training. Five health centres in the area have been trained to provide treatment for Chagas disease, which can be asymptomatic for years but may cause debilitating complications and death if left untreated.

The missing in Guerrero state

Since October, MSF has been offering psychosocial and therapeutic support to nearly 400 relatives and classmates of the 43 students who went missing in Iguala on 26 September.

MYANMAR

No. staff in 2014: 1,146 | Expenditure: €14 million | Year MSF first worked in the country: 1992 | msf.org/myanmar



KEY MEDICAL FIGURES:

51,600 outpatient consultations

34,700 patients on first-line ARV treatment

1,300 patients under treatment for TB

A patient who is undergoing treatment for MDR-TB at MSF's clinic in Insein Township, Yangon. It is the largest HIV/AIDS and TB clinic in Myanmar.

The Médecins Sans Frontières (MSF) project in Myanmar's Rakhine state was suspended for most of 2014, but by the end of the year it was again providing essential healthcare to thousands of people caught up in a medical humanitarian crisis.

A long-established MSF project providing basic healthcare to highly vulnerable communities in northern and eastern Rakhine state was suspended by the authorities in February and resumed only in mid-December. Prior to the suspension, MSF provided medical services in 24 camps for displaced people and in isolated villages across Rakhine.

From June, MSF was able to provide medical staff to facilities managed by the Ministry of Health in Rakhine, and supplied resources such as vehicles and medical equipment to the Ministry of Health Rapid Response Teams in Sittwe and Pauktaw townships. HIV patients previously under MSF care were also supported. After the official resumption of activities, MSF teams carried out more than 3,400 consultations in less than a month, mainly for people with skin diseases and respiratory tract infections; 550 were for pregnant women.

Not all of MSF's project activities had restarted by the end of 2014.

HIV and tuberculosis (TB)

Working in collaboration with the Ministry of Health, MSF remains a key provider of HIV/AIDS and TB care in Myanmar, supplying antiretrovirals (ARVs) to more than half of the 70,000 people undergoing treatment. MSF treats patients co-infected with TB and HIV through integrated programmes in Shan and Kachin states, as well as in Yangon and Dawei in Tanintharyi region. These programmes also offer treatment for sexually transmitted infections, health education, psychological and social support and prevention of mother-to-child transmission of HIV. In November, MSF inaugurated its newly renovated clinic in Insein Township in Yangon. The largest HIV/AIDS and TB clinic in Myanmar, it is currently treating approximately 10,000 HIV/TB patients.

In late 2014, MSF also started supporting three HIV testing and counselling centres in Dawei and the surrounding area, focusing particularly on harder-to-reach groups, such as sex workers, migrant workers and men who have sex with men. MSF counsellors also conduct support groups within these communities.

A landmark development occurred in 2014 for the treatment of cytomegalovirus (CMV) retinitis, an HIV-related infection that causes blindness. Approximately one in four severely ill HIV/AIDs patients in Myanmar develops CMV. Following many years of price negotiations with a pharmaceutical company, MSF began providing its patients in Dawei with valganciclovir, a single daily pill taken orally. Although it has been available in high-income countries since 2001, this is the first time MSF has been able to use the drug; patients previously had to endure uncomfortable injections directly into the eye.

Emergency mobile clinics

When active fighting resumed in northern Shan and Kachin states in April, MSF began to operate mobile clinics to bring healthcare to displaced people.

PATIENT STORY

MA* – diagnosed with advanced HIV and CMV and was the first MSF patient to take valganciclovir

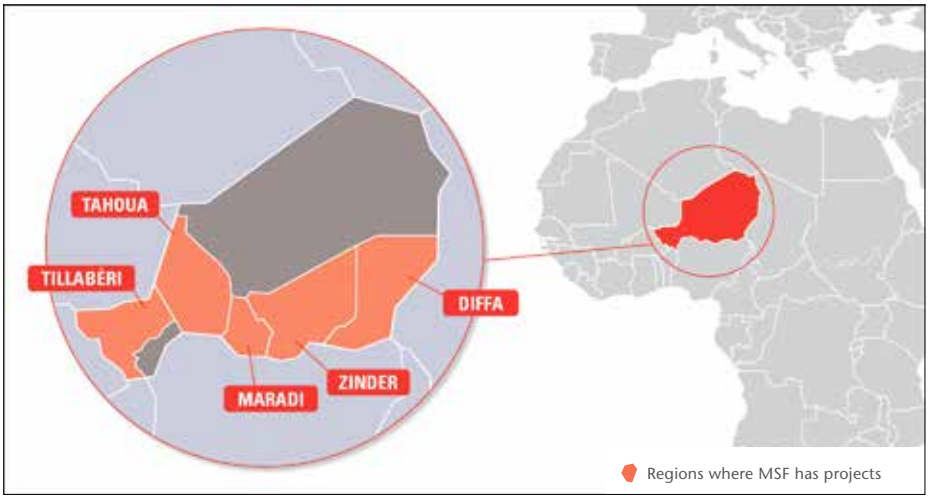
"If I had not [attended] the clinic in Dawei, I would probably be dead. For the CMV, the doctor said that when he looked into my eyes, he could see a lot of lesions in my retina through the lens. But after four months of treatment, that has improved. I have not felt any side effects and I am feeling better now. Before, it was not like that, and I had to lie down all the time. Now I can go everywhere by myself. I even got my vision back and can read the text messages on my mobile phone.

If I hadn't got the treatment on time, I might have lost my vision within three months. I feel very lucky that I got the chance to take this oral treatment."

** Name has been changed*

NIGER

No. staff in 2014: 1,866 | Expenditure: €23.5 million | Year MSF first worked in the country: 1985 | msf.org/niger



KEY MEDICAL FIGURES:

508,300 outpatient consultations

185,100 patients treated for malaria

85,700 patients treated in feeding centres

Médecins Sans Frontières (MSF) continued to improve and expand integrated health programmes to reduce child suffering and death in Niger.

Niger is affected by child malnutrition of epidemic proportions which peaks during the 'hunger gap', a period between harvests in May and September when household food stocks become depleted and are insufficient to meet nutritional needs. The hunger gap coincides with the rainy season and a proliferation of malaria-transmitting mosquitoes, a lethal combination for young children: a malnourished child is more vulnerable to diseases such as malaria and a sick child is more likely to become malnourished.

MSF collaborates with national authorities and NGOs (FORSANI, Befem/Alima) to reduce under-five mortality in several regions of the country, with a particular focus on the management of children with severe malnutrition and malaria. In 2014, MSF supported six inpatient and several outpatient centres in Madarounfa and Guidan Roumdjii (Maradi region), Bouza and Madaoua (Tahoua region), and Magaria (Zinder region).

Aiming to complement treatment with prevention, MSF also conducted a seasonal malaria chemoprevention (SMC) campaign in the Sahel region (Tahoua, Zinder and Maradi) for the second year running, reaching a total of 447,500 people. SMC involves the administration of antimalarial treatment. It is used alongside common methods of mosquito bite prevention such as nets and has been proven to significantly reduce the incidence of malaria in children under the age of five.

Zinder region

In 2014, MSF continued a programme of medical and nutritional care for children under the age of five in Magaria, Zinder. The programme focused on the paediatric unit of Magaria hospital, as well as seven health centres and 21 health posts during the peak in malnutrition. In 2014, more than 65,000 children were targeted for Plumpy'Doz (supplementary food) distributions.

Maradi region

In Madarounfa, MSF runs two outpatient and one inpatient feeding centre to treat children with severe acute malnutrition and supervises four outpatient facilities managed by the national NGO Niger Health Forum (FORSANI). Over 137,000 children were screened for malnutrition and 14,500 were admitted for treatment. MSF also supports the Ministry of Health in Madarounfa hospital's paediatric unit and provided additional support to 11 health centres during the annual malaria peak in 2014. Preventive activities included SMC, providing 54,400 vaccinations and distributing

Thousands of people fled their homes in the Lake Chad region, as a result of violence by Boko Haram. Many sought refuge in the Diffa region of southeast Niger.

A child is checked for malnutrition during a SMC campaign, which involves the administration of antimalarial treatment.

7,850 mosquito nets. A temporary respite care unit in Dan Issa relieves the pressure on the Madarounfa centres during the malnutrition peak and cares for the most severely ill children.

MSF supports five health centres in Guidan Roumdji, where outpatient consultations and vaccinations are available for children up to the age of five. Those that are severely malnourished are screened and treated in ambulatory therapeutic feeding centres, and the ones with medical complications or associated diseases are admitted to the paediatric ward of the MSF-supported district hospital. In 2014, over 125,800 children were treated in the outpatient facilities and approximately 10,000 were hospitalised. During the period of high malaria transmission from June to December, MSF supports six additional health centres by providing drugs, training staff and supervising medical activities. Nearly 9,300 paediatric cases of malaria were treated and SMC was provided to over 67,000 children aged between three and 59 months.

Tahoua region

In Madaoua district, MSF supports six integrated health centres to provide treatment of childhood illnesses and severe acute malnutrition throughout the year. More than 4,800 children with acute malnutrition were admitted to inpatient programmes and over 13,660 received treatment as outpatients in 2014. Psychosocial activities are also being implemented to ensure healthy development and recovery from malnutrition. A visiting MSF psychologist carried out more than 2,000 consultations, supporting mothers and children by introducing developmental activities to help with psychosocial and psychomotor (the relationship between cognitive function and physical movement) development, and conducting group and individual counselling sessions.

In Bouza district, MSF provides paediatric and nutritional care for children under five in the hospital in Bouza town and the area's six health centres. There is also a programme that decentralises essential healthcare in three of the project's health areas; children and pregnant women can be treated at the health posts and only need to attend the hospital if referred.

MSF is also beginning to work with children with HIV and tuberculosis in Madaoua and Bouza. In Bouza, basic training of hospital staff on HIV was undertaken with the aim of reducing stigmatisation.

MSF expanded its SMC campaign in the two districts, covering all the health areas and treating 237,000 children aged between three and 59 months.

Aiding refugees from Nigeria

The violent activity of Boko Haram in Borno state, Nigeria, caused people to flee their villages and cross into neighbouring countries, including the Diffa region of southeast Niger. Responding to the influx of refugees, mainly women, children and elderly people, MSF began supporting health centres in N'Garwa and Gueskerou at the beginning of December, providing free access to healthcare and distributing relief kits to new arrivals. MSF also responded to a cholera outbreak among refugees and the host population in Diffa, after cases were recognised in Diffa city and Chatimari. Teams set up cholera treatment sites and oral rehydration points. MSF also trained local health centre staff to chlorinate water at the rehydration points.

Cholera outbreak

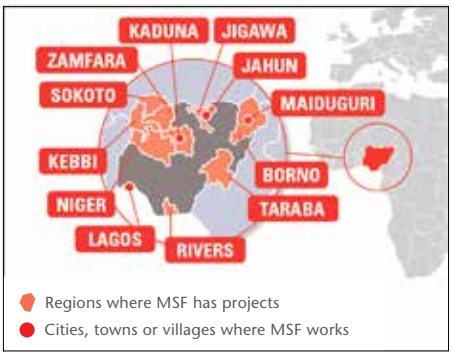
In September, MSF worked with the Ministry of Health to respond to an outbreak of cholera affecting Tamaske, Madaoua, Bouza, Tahoua, Maradi and Madarounfa. Emergency teams treated some 1,000 patients within a few weeks. This was one of the interventions carried by EMUSa, an MSF emergency medical response team for the Sahel, which is based in Niger and aims to create better surveillance and respond more rapidly to emergencies.

Tillabéri project handover

The healthcare programme for Malian refugees and the host community in Abala, Tillabéri region, was handed over to the Qatari Red Crescent in June. A total of 20,777 consultations had been provided.

NIGERIA

No. staff in 2014: 508 | Expenditure: €9.8 million | Year MSF first worked in the country: 1971 | msf.org/nigeria



KEY MEDICAL FIGURES:

28,300 outpatient consultations

26,800 patients treated for cholera

13,000 patients admitted to hospital

10,000 patients treated for malaria

The security situation deteriorated in many areas of Nigeria in 2014. Violence and displacement took their toll on people's health and reduced their access to medical services.

Médecins Sans Frontières (MSF) continued to try and provide healthcare to communities in need, but some clinics experienced temporary closures due to insecurity.

Healthcare for the displaced

Political instability, numerous attacks by Boko Haram and security operations by the Nigerian army forced thousands of people to flee their homes. Up to 400,000 internally displaced people settled in and around Maiduguri, the capital city of Borno state, with host families or in camps that were set up in July. Medical supplies and physicians remain extremely limited.

In August, MSF began providing care to displaced people in two of the largest camps. Weekly mobile clinics screened for malnutrition and offered antenatal care to pregnant women. By the end of the year, 10,000 consultations had been carried out across the camps. A health surveillance system was also established to respond to disease outbreaks and launch vaccination campaigns, if necessary.

Water being treated with chlorine during a cholera outbreak in northeastern Nigeria.

There was a cholera outbreak at the end of September and in the space of a month 4,500 cases and 70 deaths from cholera were reported in Maiduguri. MSF set up a cholera treatment centre with 120 beds and five posts for oral rehydration. By December, MSF had supported the care of 6,833 patients, 40 per cent of whom were displaced people living in camps.

Focus on obstetrics

At Jahun hospital, Jigawa state, where maternal mortality rates have been among the highest in the country, MSF continued to support the emergency obstetrics programme, which admitted a total of 7,980 women, an 11 per cent increase over 2013. More than 5,700 births were assisted. 'Kangaroo care', a technique in which women spend time holding their babies skin to skin, was implemented after more space was created in the new neonatal unit. Kangaroo care was originally used in low-resource settings that had no incubators for premature babies and has been shown to support infant development and wellbeing.

Jahun hospital also treats fistula, with MSF support. Obstetric fistulas are injuries to the birth canal, usually caused by complicated

or prolonged labour resulting in pain, incontinence and often social stigma. MSF offers reparative surgery, as well as psychosocial support, helping women to reintegrate into their communities. A total of 264 women benefited from fistula surgery in 2014.

Paediatric care

From the Noma children's hospital in Sokoto, MSF provided care to children suffering from noma, a rapid-onset gangrene infection that causes facial disfigurement. It is most common in children under the age of six. The exact cause of the disease is unknown but malnutrition, poor hygiene and unsafe drinking water are among the risk factors. Psychosocial counsellors carried out 90 group sessions and 12 individual consultations, and 50 children were admitted to hospital for treatment. Nutritional and psychological support was offered and corrective surgery is planned for 2015. Without medical treatment, noma has a mortality rate of around 90 per cent. Approximately 140,000 new cases are reported each year, predominantly from sub-Saharan Africa.[1]

Teams also continued to treat children with lead poisoning in eight villages in Zamfara state. Lead poisoning can cause brain damage, kidney problems and even death. As patient numbers decreased over the year, MSF closed three outreach clinics but continued to lobby the Nigerian government to assist local villagers. Staff also screened children for measles, meningitis and yellow fever, treated over 3,560 for malaria and carried out more than 7,680 outpatient consultations.

Responding to disease outbreaks

The MSF-run Nigeria Emergency Response Unit (NERU) provides early warning and rapid response to seasonal outbreaks of infectious diseases in the northwestern states of Zamfara, Kebbi, Sokoto and Niger. From June to December, NERU treated over 6,000 people for cholera in Goronyo (Sokoto state), Aliero (Kebbi state), and Mada, Anka and Shagari (Zamfara state). Some 330 people were also treated for meningitis in Aliero. Banditry and attacks on villages, mostly in Zamfara, limited the movement of the emergency team for short periods from time to time.

Ebola containment

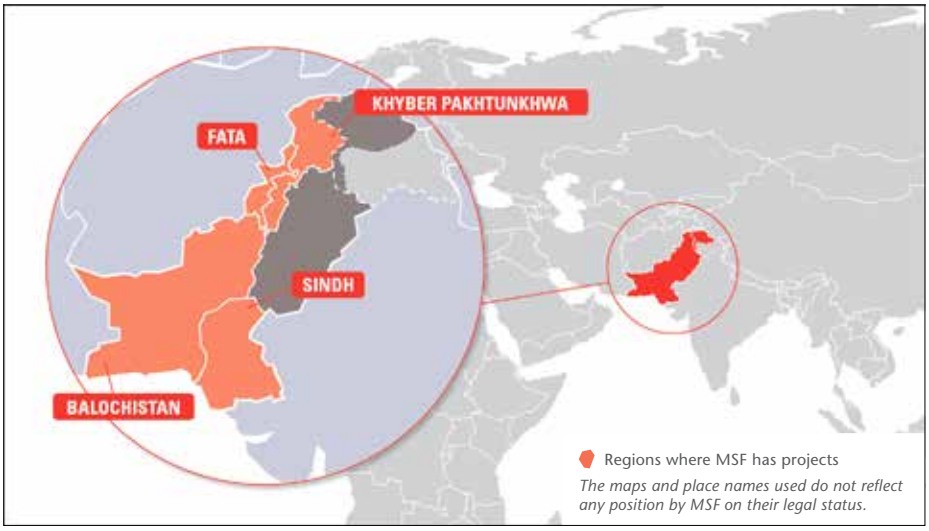
MSF provided Ebola-related technical support to health authorities in Lagos and Port Harcourt from July to October, assisting with isolation and contact tracing, and providing training and public education. There were 20 confirmed cases in Lagos and Port Harcourt and eight patients died. The outbreak in Nigeria was declared over by 20 October.

[1] 'Visor flap for total upper and lower lip reconstruction: a case report', Peter Nthumba and Louis Carter, *Journal of Medical Case Reports* 2009, 3:7312

Patients in an MSF cholera treatment centre. Severe cases require hospitalisation for intravenous rehydration.

PAKISTAN

No. staff in 2014: 1,558 | Expenditure: €17.8 million | Year MSF first worked in the country: 1986 | msf.org/pakistan | blogs.msf.org/pakistan



KEY MEDICAL FIGURES:

279,900 outpatient consultations

25,200 births assisted

10,900 individual and group mental health consultations

3,600 surgical interventions

Women and children in particular suffer from the lack of access to healthcare in Pakistan and there is an overwhelming need for neonatal care. Mother and child health remains a focus for Médecins Sans Frontières (MSF).

Teams also respond to the medical needs of vulnerable communities largely excluded from medical care, including people displaced by conflict, and marginalised, low-income groups.

Government restrictions, bureaucratic processes and a climate of insecurity and sporadic violence pose operational challenges in Pakistan. The presence of armed militant groups and ongoing counter-terrorism operations hamper humanitarian access and there is a general distrust of aid workers. MSF's activities in Pakistan are funded solely by donations from individuals, with no institutional or government contributions.

Balochistan

MSF continued to provide basic healthcare with a focus on women and children in Quetta and Kuchlak, Balochistan – Pakistan's most underdeveloped province and home to thousands of Afghan refugees. Staff regularly see malnourished patients and provide nutritional support to severely underweight infants, young children, pregnant women and lactating mothers. A total of 3,361 individual and group psychosocial sessions were undertaken with both women and men in 2014 and additional psychosocial support services, such as children's play groups, were available.

Teams also admitted 697 people suffering from cutaneous leishmaniasis, a parasitic disease prevalent in this region, and provided treatment and supportive care. The disease is transmitted by the bite of a sandfly and can cause debilitating skin lesions.

Overall, MSF conducted almost 59,690 consultations and assisted 3,598 births in Quetta and Kuchlak.

North of Quetta, at Chaman district hospital, MSF supports medical services for women and children, including reproductive healthcare and specialist neonatal and paediatric care. There are also inpatient and outpatient feeding programmes, and treatment and support services for trauma patients. Teams carried out 6,978 outpatient consultations and assisted 4,048 births. Over 5,795 women attended a prenatal consultation. MSF also supervises the women's outpatient department, which is mainly run by health ministry staff using MSF protocols.

In eastern Balochistan, MSF works closely with the health ministry and focuses on malnutrition and on providing specialist care to newborns, infants and children suffering from acute medical complications

An MSF doctor examines a malnourished child in Dera Murad Jamali district, eastern Balochistan.

Aminah is being reassured by the MSF doctor that her baby is safe and well.

at the District Headquarters Hospital in Dera Murad Jamali district. There are high rates of malnutrition throughout this region, which worsen during the May to October 'hunger gap' between harvests. An outpatient feeding programme, which runs all year, was increased during these months to cover eight locations in Jaffarabad and Nasirabad districts, in which more than 8,800 people received nutritional support.

The obstetric and maternity components in Nasirabad and Jaffarabad were handed back to the Ministry of Health at the end of October. MSF also handed over Sohbat Pur and Mir Hassan Basic Health Units to the ministry at the end of May and the sexual and reproductive health components in October.

Federally Administered Tribal Areas (FATA)

MSF provides medical care to displaced and vulnerable communities in Bajaur Agency, the northernmost tribal agency. Medical staff support two basic health centres in Talai and Bilot, and are improving services in the outpatient departments and antenatal care units. Children are screened for malnutrition and receive vaccinations. MSF teams also work at Nawagai civil hospital, in the outpatient department, emergency room, and mother and child health department. Paediatric services include vaccinations and therapeutic feeding for malnourished children. For complicated cases, MSF ensures timely referral of patients to Khar, Timurgara or Peshawar.

In the Sunni enclave of Sadda, Kurram Agency, MSF runs a paediatric outpatient department for children up to the age of five, inside Tehsil Headquarters Hospital. There is also a therapeutic feeding programme for this age group. Newborns and children under 12 needing hospitalisation are treated on the MSF-supported paediatric ward, and referrrals are organised. MSF staff also assisted the ante- and postnatal departments. In addition, some 160 patients received treatment for cutaneous leishmaniasis at a general health centre established by MSF.

In Alizai, a Shia community in Kurram, MSF operates a paediatric outpatient department for children under 12 years of age. More than half (59 per cent) of patients in 2014 were under the age of five.

Khyber Pakhtunkhwa

In Peshawar, the province's capital, MSF runs a 35-bed maternity hospital receiving patients from health units, government-run hospitals and other health partners in the district and FATA. Over 3,700 patients were admitted and 3,268 babies were delivered.

Mother and child health is the focus at the government-operated Hangu hospital too, where MSF runs a round-the-clock emergency room, an operating theatre and surgical wards, and provides technical and referral support to the delivery room. MSF also supports the health ministry's blood bank and X-ray departments.

MSF continues to work in the District Headquarters Hospital in Timurgara, Lower Dir, providing medical expertise in the emergency room (where 114,957 patients were triaged), resuscitation room (where 27,576 patients were seen and treated) and in the observation room. Comprehensive obstetric care is available, including surgery for complicated deliveries, and 7,369 deliveries were assisted in 2014. In May, MSF opened a neonatal unit for premature and low birth weight babies. In addition, MSF supports the hospital's blood bank, sterilisation and waste management systems.

Isolation wards were established in Timurgara following outbreaks of acute watery diarrhoea and measles. MSF also ran dengue fever prevention and awareness activities in communities and schools in the area. More than 8,000 students and teachers attended health promotion sessions.

Karachi

The Machar Colony slum is situated on the edge of Karachi's Fish Harbour; it is crowded and polluted and has no proper sanitation. MSF opened a clinic in 2012 with local partner SINA Health, Education and Welfare Trust, providing basic and emergency healthcare, including outpatient consultations, triage, stabilisation and referrals for emergencies. Labour and delivery support for pregnant women is also available. Health promotion teams run health and hygiene education sessions for parents and children, and staff conduct mental health consultations. Demand continues to increase as the community learns about the clinic's services from the health promotion teams and MSF's commitment to provide free, high-quality care.

PATIENT STORY

GUL BIBI* – brought her eight-month-old granddaughter to the MSF-supported hospital in Sadda for treatment. Gul Bibi and her family fled their village after militants took control and destroyed their homes and way of life. They now live in a camp for displaced people.

"We lived in peace. We lived good lives … then three years ago everything changed. They came to the area and nothing was the same again … There was fear everywhere. We went from living in a happy and peaceful place where everyone knew everyone to not knowing whom we could trust or who was living among us … I still see our village burning when I close my eyes and try to sleep."

** Name has been changed*

PALESTINE

No. staff in 2014: 121 | Expenditure: €4.3 million | Year MSF first worked in the country: 1989 | msf.org/palestine

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

KEY MEDICAL FIGURES:

9,100 individual and group mental health consultations

3,400 outpatient consultations

1,600 patients treated after incidents of violence

400 surgical interventions

© Samantha Maurin/MSF

An MSF anaesthetist in a hospital in Gaza is seen here caring for a child who suffered severe burns after a missile fell on his family's house.

Violence increased across the Occupied Palestinian Territory in 2014, and the year was marked by a 50-day war with Israel. Médecins Sans Frontières (MSF) doubled its capacity to help meet medical and psychological needs.

Tensions mounted between Israel and Palestine in June, and Operation Protective Edge was launched in the Gaza Strip on 8 July, leaving 2,286 Palestinians dead (25 per cent of which were children), over 11,000 injured and 3,000 with permanent disabilities. A ceasefire was declared on 26 August, but of the 500,000 people displaced, 54,000 have still not been able to return home.

Access to healthcare across the occupied territories remains severely limited by the West Bank wall, the Gaza blockade and other measures. There is a shortage of technical equipment and training for specialist care, including surgery and mental healthcare, in Gaza. Living conditions continue to deteriorate and people's coping mechanisms are stretched. In the West Bank, including East Jerusalem, daily violence, collective punishment, and humiliation at checkpoints are common and have taken a psychological toll.

West Bank

A mental health programme was started by MSF in Hebron, Nablus and Qalqilya governorates in the West Bank in 2000, extending to east Jerusalem in 2011. The programme focuses on adults and children who have experienced or witnessed violence (Israeli–Palestinian or inter-Palestinian), and whose psychological suffering impedes their normal life. It aims mostly to help those served evacuation orders, whose homes are demolished, and those under regular attack from settlers and Israel Defense Forces search and arrest operations. More than 5,500 patients received psychological support during the year.

Gaza Strip

The demand for reconstructive surgery in Gaza dramatically increased because of the acute conflict. Normally teams work on a fly-in/fly-out basis to perform hand surgery, post-burn surgery and correct defects, but a rise in the number of casualties led MSF to establish an emergency surgical team in Gaza between July and September to perform lifesaving operations. A permanent reconstructive surgery team was present until December. Over 320 surgical procedures were carried out in 2014.

Two MSF clinics, in Gaza City and in an inflatable tent at Nasser hospital, provided post-operative care, including wound dressings (12,700), physiotherapy (11,800 sessions) and occupational therapy. More than 1,000 patients received rehabilitative care and 350 patients were being treated at the close of the year.

After one and a half years, MSF's support to the intensive care unit at Nasser hospital was suspended after results were not as good as expected. Training sessions with doctors and nurses are now planned.

A Gaza mental health programme suspended in 2011 by local authorities resumed in October, responding to a rise in needs following Operation Protective Edge. Mental health consultations were integrated into post-operative care. MSF plans to launch a dedicated paediatric mental health programme within Ministry of Health structures in the coming months.

BLOG **Hazem Abu Malouh, doctor**

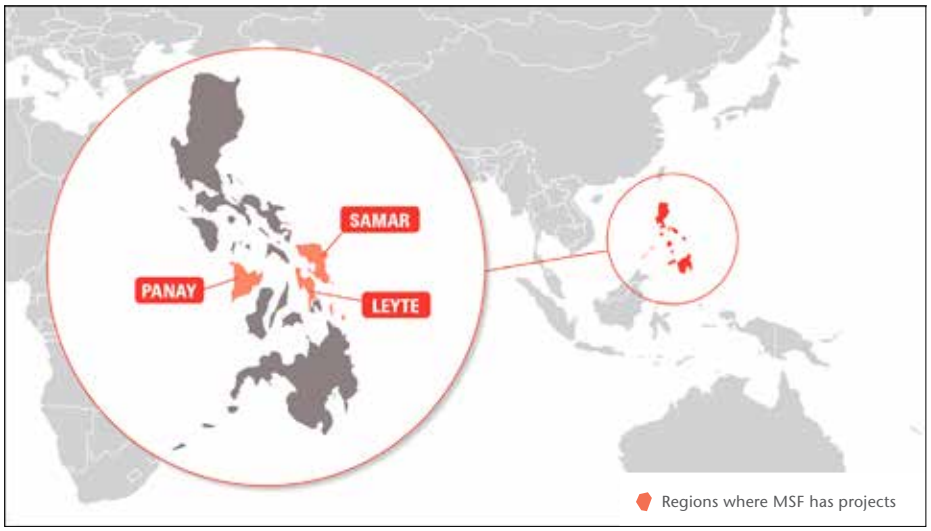
"It's very hard because we have no news from patients who used to come regularly for care. Or we see patients that tell us terrible stories like this little girl of seven who has burns to her face, caused by an explosion. She came for treatment. But when I asked her where her father and mother were, she said they died. There is also this 32-year-old woman who was slightly injured by shrapnel and was pretty good physically. But she was very shaken by the loss of her four brothers. Two of them just got married and all died in recent weeks. We listen to patients, they need to talk but they do not understand what happened to them.

We really go through a lot of emotions. Sometimes incredible things happen also. A patient we follow up for a while is in a wheelchair … When I learned that the city of Shujahia where he lives was under heavy shelling and that everybody was fleeing, I wondered how he would do. How to escape in a wheelchair? And then one night I was watching television that showed refugee families in a school and I saw him on TV! He was alive. It was great."

To read more, visit blogs.msf.org/hazem

PHILIPPINES

No. staff in 2014: 114 | Expenditure: €6.9 million | Year MSF first worked in the country: 1987 | msf.org/philippines | blogs.msf.org/philippines



KEY MEDICAL FIGURES:

5,900 outpatient consultations

2,700 births assisted

840 surgical interventions

Médecins Sans Frontières (MSF) continued to support communities in the Philippines affected by Typhoon Haiyan with response and recovery activities.

On Leyte island, local services are now capable of meeting medical needs and MSF therefore closed the 25-bed tented hospital in Tanauan in Palo district in March and the inflatable 60-bed hospital in the city of Tacloban in April. Overall these facilities had provided over 45,600 consultations and had facilitated 475 major and 5,400 minor surgical procedures.

A mental health programme that began immediately after the typhoon continued with individual and group sessions in Tacloban, and in schools in Palo and Tanauan, where teams helped identify children who were still suffering from trauma as a result of the typhoon. More than 7,400 patients took advantage of these services.

An MSF assessment showed, however, that gaps persisted between needs and available obstetric services in Palo. In May, MSF began supporting the maternity ward and surgical team at Leyte provincial hospital. The project focused on human resources support in surgery, maternity and neonatology, renovation of the wards, and ensuring an adequate supply of drugs and medical supplies. Teams also repaired the damaged sections of the hospital, installed new facilities and donated equipment.

MSF worked on rehabilitating Abuyog general hospital on Leyte, and two facilities in Eastern Samar province: Albino Duran memorial hospital in Balangiga and General MacArthur municipal hospital in General MacArthur. All renovation activities are expected to be completed in 2015.

In Guiuan, Samar island, where the typhoon had essentially destroyed Felipe Abrigo Memorial hospital, MSF continued to treat patients in a tent hospital until construction of a permanent hospital was completed in June. Around 80 consultations were carried out daily, mostly for respiratory tract infections and diseases such as dengue fever. The volume and nature of medical needs have returned to their pre-typhoon levels.

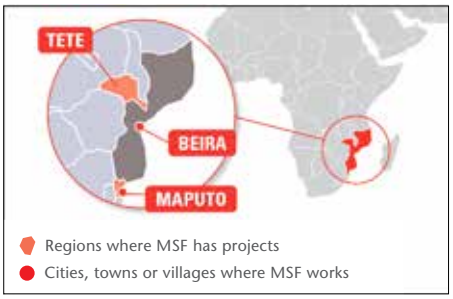
MSF facilitated the movement of patients into the new structure and handed it over to the provincial health office. Hospital equipment and a six-month supply of drugs and medical supplies were donated to make sure there were adequate stocks. A small number of MSF staff stayed until the end of October to ensure that the hospital services were running smoothly before completing the handover.

The new hospital withstood the December 2014 typhoon Hagupit. It is made out of innovative durable and recyclable composite materials adapted to the hot, humid conditions in the Philippines.

Patients wait to be seen at the outpatient department of the hospital in Guiuan, where there are around 80 consultations a day.

MOZAMBIQUE

No. staff in 2014: 370 | Expenditure: €7.8 million | Year MSF first worked in the country: 1984 | msf.org/mozambique



KEY MEDICAL FIGURES:

38,300 antenatal consultations

31,400 patients on first-line ARV treatment

3,600 women screened for cervical cancer

Médecins Sans Frontières (MSF) continues to fill some of the most critical gaps in treatment for HIV/AIDS and tuberculosis (TB) in Mozambique.

The national response has made progress in recent years, but HIV remains the leading cause of adult death in Mozambique, and the Ministry of Health estimates that 1.6 million people are infected. The country also has the world's fifth-highest rate of HIV–TB co-infection, which is resulting in an emerging multidrug-resistant TB (MDR-TB) problem.

Since 2001, MSF has supported the Ministry of Health to ensure access to comprehensive healthcare for HIV/AIDS and TB patients in the health districts of Kampfumo and Nlhamankulo (both formerly Chamanculo). The aim for the next few years is to provide specialised care for complicated cases and address emerging problems such as patients presenting late with HIV, those with HIV who fail first-line antiretroviral (ARV) treatment and those co-infected with opportunistic infections such as MDR-TB and Kaposi's sarcoma, a cancer that causes patches of abnormal tissue to grow under the skin. In Primeiro de Maio health centre the MSF project focuses primarily on the needs of adolescents, and supports urban community ARV groups.

Viral load testing was rolled out in the public health centres of Maputo city and Changara district, as part of a pilot project aiming to improve patient monitoring. In Tete province, MSF works with community ARV groups, whose members meet regularly to support each other and take turns to pick up medicines from health centres. By the end of 2014, over 10,500 people had joined groups. A new 'corridor project' has started in the high-transit cities of Tete and Beira, targeting hard-to-reach populations such as sex workers, truck drivers and seasonal workers. More than 2,000 people were tested and treated for HIV and other sexually transmitted infections.

PAPUA NEW GUINEA

No. staff in 2014: 219 | Expenditure: €5.3 million | Year MSF first worked in the country: 1992 | msf.org/png

KEY MEDICAL FIGURES:

21,900 outpatient consultations

Médecins Sans Frontières (MSF) opened a project for the diagnosis and treatment of tuberculosis (TB) in July in Gulf province.

MSF started supporting Kerema general hospital this year to improve detection rates for TB. The hospital, including the laboratory, was renovated and a consultation room for suspected TB cases was set up. Over 290 people were diagnosed and treated, and patient education and counselling activities were organised. Teams also began to offer diagnosis and treatment to people living in remote areas, some only accessible by boat. MSF and the US technology company Matternet successfully trialled the use of unmanned aerial vehicles for the transportation of sputum samples and results between distant health centres and Kerema hospital.

Sexual, domestic, social and tribal violence

Domestic and sexual violence remains a medical humanitarian emergency in Papua New Guinea, with consequences at individual, family and national level. MSF is working with the health authorities to provide access to free, good-quality, confidential and integrated medical care for victims.

At the Port Moresby Regional Treatment and Training project, 50,000 people attended awareness sessions outlining the care available to the victims of sexual violence. Over 900 people were seen as outpatients, and there were 265 first consultations for rape. In Southern Highlands province, the MSF team at Tari hospital performed 1,190 major surgical interventions, and also continued to provide medical and psychosocial care for victims of violence. In June, MSF handed over its maternal and child health project in Buin to the provincial health authorities.

Emergency intervention in the Solomon Islands

In April, the Solomon Islands were hit by flash floods and landslides. Approximately 10,000 people in the capital Honiara were made homeless, and bridges, roads and some health centres were destroyed. MSF set up mobile clinics in the temporary shelters, and carried out 1,443 medical consultations. The teams also offered mental health sessions, training in psychological first aid and monitored potential disease outbreaks. MSF implemented a programme raising awareness of sexual violence, which had been planned before the floods occurred. The provision of relevant services in Honiara and Guadalcanal province were also increased.

RUSSIAN FEDERATION

No. staff in 2014: 132 | Expenditure: €4.9 million | Year MSF first worked in the country: 1992 | msf.org/russianfederation

KEY MEDICAL FIGURES:

5,300 individual and group mental health consultations

300 patients under treatment for TB

Médecins Sans Frontières (MSF) continues to address gaps in cardiac care, tuberculosis (TB) and mental healthcare in Chechnya.

The rate of heart disease in Chechnya is high, but the quality and scale of medical services do not meet the needs of people with coronary syndromes and cardiovascular emergencies. In Grozny, MSF continued to improve patient services at the cardio-resuscitation unit of the Republican Emergency Hospital, donating medicines and medical equipment and training staff on coronarography (an imaging technique to visualise the inside of coronary arteries) and angioplasty (an endovascular procedure to widen narrowed or obstructed coronary arteries). Training for ambulance staff who administer first aid was also initiated.

Drug-resistant TB is a life-threatening issue in Chechnya, resulting from years of poor TB diagnosis and interrupted treatment. A comprehensive programme, including diagnosis, treatment and counselling for TB and multidrug-resistant TB (MDR-TB), is integrated in health ministry facilities. Extensively drug-resistant TB (XDR-TB), a form of the disease that does not respond to second-line drugs administered for MDR-TB, is also on the rise. MSF procured appropriate medicines to provide treatment for people with XDR-TB. The TB programme also includes laboratory support, health promotion and psychosocial assistance for patients and their families.

MSF runs a mental healthcare programme in Grozny and the mountainous districts of Chechnya still affected by violent clashes. People's symptoms of trauma and anxiety are related to direct or indirect violence or abuse experienced in detention.

In August, an MSF project started in Moscow and provided over 700 outpatient consultations to migrants from former Soviet Union countries with limited or no other access to healthcare services. A limited number of referrals were also arranged for specialist care in state medical facilities.

PATIENT STORY

ASLAMBEK, 54 year old heart patient

"When I was admitted to the hospital for myocardial infarction [heart attack], I had an injection of a thrombolytic to restart my heart. But after being discharged, I still had pain. Then I was offered a new operation with [MSF] doctors who were coming soon. I accepted. The operation consisted of placing two stents. Since [the operation] I feel different, I can walk without any problem."

SERBIA

Year MSF first worked in the country: 1991 | msf.org/serbia

In late 2014, a Médecins Sans Frontiéres (MSF) team arrived in Serbia aware that thousands of migrants and asylum seekers were travelling through the country on their way to northern Europe.

The cold winter months posed a great risk to those people forced to sleep outside. MSF found that the undocumented migrants and asylum seekers were not being adequately registered and assisted due to their high numbers. Working with the authorities, MSF repaired, renovated and built toilet and shower facilities at two temporary asylum centres located in Sjenica and Tutin.

In December 2014, teams also began to provide medical assistance to migrants and asylum seekers in the village of Bogovadja, which is about 80 kilometres from the capital Belgrade, as well as in Subotica near the Hungarian border. An MSF team ran mobile clinics and distributed specially designed transit kits containing essential relief items to hundreds of people. The kits contained hygiene, food and survival items ranging from toothpaste to cooking pots and were designed to address the needs of people in transit. The most common health problems encountered by the team were respiratory and skin diseases – mostly due to the cold weather and poor sanitary conditions – and musculoskeletal injuries. There were also patients suffering from chronic illnesses such as hypertension and diabetes who were without the necessary medication; MSF gave them a supply to tide them over until they reached their next destination.

For more on refugees and migrants arriving in Europe, see Bulgaria (p.26), Italy (p.50) and Greece (p.40).

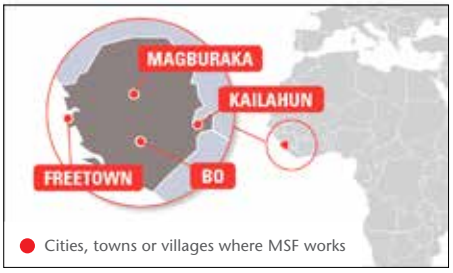
PATIENT STORY

AFGHAN MAN, 27 years old

"I had to cross many countries to come here: first Iran, then Turkey and finally Bulgaria. The border between Iran and Afghanistan was the most dangerous … I was also detained for two and a half months in Bulgaria. I have been here [Subotica] for four days, and every day I try to cross the border [to Hungary] but so far I have not succeeded. Each time I fail I have no choice but to come back here, there is nowhere else to go. It is very cold and I can barely sleep at night."

SIERRA LEONE

No. staff in 2014: 959 | Expenditure: €26 million | Year MSF first worked in the country: 1986 | msf.org/sierraleone | blogs.msf.org/ebola



KEY MEDICAL FIGURES:

1,800 people admitted to Ebola management centres, of which **1,400** were confirmed as having Ebola

770 people recovered from Ebola and discharged

Cases of Ebola were first confirmed in the east of Sierra Leone, near the border with Guinea, at the end of May.

Even before the Ebola outbreak, people in Sierra Leone had limited access to medical care and the health system was both under-resourced and overburdened. Médecins Sans Frontières (MSF) was working in the country at Gondama, near the city of Bo, running an emergency paediatric and maternity hospital as well as a midwifery clinic in response to the devastating levels of maternal and infant mortality in the country.

When the first cases of Ebola were confirmed in Sierra Leone, the Ministry of Health asked MSF to intervene. Teams opened an Ebola management centre (EMC) on the outskirts of Kailahun town on 26 June, where testing and care was available for those people suspected of having the virus. MSF teams also launched outreach, health promotion and disease surveillance activities, and trained local health staff. Community health workers were trained to deliver messages about how people could protect themselves from Ebola and what to do if they showed signs or symptoms of the disease. An MSF psychologist provided support to patients and to families who had lost loved ones. As the virus quickly spread across the country, patients arrived by ambulance from locations up to 10 hours away. The EMC had a maximum capacity of 100 beds. In addition, MSF constructed a small maternity unit in October where pregnant Ebola patients could receive specialised care within the high-risk zone.

Bo, Southern Province

In September, MSF opened a second EMC five kilometres outside Bo, which was more easily accessible from most parts of the country. The centre was extended to accommodate 104 beds. MSF teams carried out outreach, health promotion and surveillance activities, trained local health staff and offered support to the Ministry of Health's activities.

Also in Bo, MSF launched a third Ebola project focused on offering specific, structured and targeted training for other organisations to enable them to run EMCs safely. The training sessions took place in MSF facilities or in those of the other NGOs to help them start activities. In total six other organisations were trained.

Freetown

In early December, as health facilities in the country's capital, Freetown, became overwhelmed, MSF opened an EMC in the

A member of MSF's hygiene team hangs disinfected scrubs and goggles on a clothesline at the Ebola management centre in Freetown.

A clinical health officer hands medication for a patient to an MSF staff member who is already inside the high-risk zone.

centrally located Prince of Wales secondary school. There were 30 individual rooms for suspected Ebola cases and 70 beds. A new design was used which meant that the intensive care ward could be viewed through Plexiglas and patients could therefore be better monitored by staff who did not have to wear protective gear.

MSF started conducting outreach, health promotion and surveillance activities in nine sub-districts of Freetown to support the government coordination body, National Ebola Response Centre (NERC), in mapping and following up on Ebola contacts. Epidemiologists visited the areas and had daily meetings with staff from the World Health Organization, the Ministry of Health and the NERC to support the response system and help where possible. Teams also provided training on disinfecting houses.

Magburaka, Northern Province

On 15 December, MSF opened a fourth EMC in Magburaka, Tonkolili district, again, with critical complementary activities including outreach, health promotion, surveillance and training of local health staff. A rapid response team was established in Magburaka to be deployed quickly wherever new cases appeared in the country.

Infection control issues, and antimalarial distributions

Many Sierra Leonean health staff on the frontline of the outbreak were infected as a result of caring for patients, because they lacked the necessary protective gear and knowledge about the transmission of the disease. Up to 10 per cent of local health workers are estimated to have died, leaving government health facilities with even fewer staff than before the epidemic and unable to cope.

In October, MSF suspended its obstetric and paediatric projects in Gondama. Due to the strain on resources as a result of responding to the Ebola outbreak, MSF could not guarantee the extremely high quality of medical care needed to treat patients or the protection of its staff from Ebola infection.

Meanwhile, women suffering complications in childbirth and people sick with malaria and other diseases were reluctant to seek care at government hospitals for fear of contracting Ebola, and untold numbers of people are thought to have died from non-Ebola-related diseases in 2014. In December, to address the threat of malaria and to avoid confusion with Ebola due the similarity of initial symptoms, MSF recruited and trained some 6,000 volunteers to carry out a four-day, door-to-door distribution of antimalarial treatments in partnership with the Ministry of Health. Some 1.5 million people in the Freetown area were reached. Another distribution campaign was carried out in January 2015.

BLOG **Patricia Carrick, nurse**

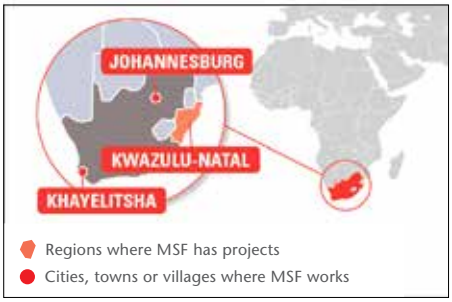
"The woman's upper body was curved around one middle bed leg, her legs wedged around the opposite middle bed leg, her lower legs and feet protruding from under one side of the bed, her face from the other, staring up into a blank nothing, her mouth stretched wide, the desperate death-mask I am coming to recognise. She was still breathing but could not respond, even to moan.

Despite training in Brussels, briefing in Freetown and Bo and Kailahun, an ever-increasing pile of tales of misery, and my own past experience, I admit I was dumbfounded. I began to reach toward her and realised there was nothing, nothing to be done. I turned to Konneh stupidly and, bless him, even from within the depths of my PPE (personal protective equipment) and his, he had the compassion to say it to me in words – 'We cannot do anything for her, Patricia.' We could not move her, lift her – we could not even wrest her from under the bed. We had no proper equipment, we had limited time and energy; we had come for other tasks, the discharge of survivors."

To read more, visit blogs.msf.org/patricia

SOUTH AFRICA

No. staff in 2014: 198 | Expenditure: €6.7 million | Year MSF first worked in the country: 1999 | msf.org/southafrica



KEY MEDICAL FIGURES:

15,600 patients on first-line ARV treatment

1,400 patients under treatment for TB

© Chantuigi Guercia/AFP Photo

A mobile HIV-testing clinic on the outskirts of Eshowe, KwaZulu-Natal. The programme also focuses on prevention activities such as promoting safe sex.

South Africa runs the world's largest programme of antiretroviral (ARV) treatment for HIV.

Despite a tremendous increase in testing and treatment and improved prognosis for people with HIV, there are still many new infections and HIV-related deaths each year. Rates of co-infection with tuberculosis (TB) are also high. More needs to be done to reduce HIV transmission and initiate and keep people on ARV treatment, such as carrying out interventions tailored to children and adolescents, and for hard-to-reach communities.

Médecins Sans Frontières (MSF) continues to pilot new strategies to scale up testing and access to treatment for HIV and TB.

Khayelitsha, Cape Town

Each month some 1,000 people learn that they are HIV positive in Khayelitsha township, on the outskirts of Cape Town, where rates of HIV and TB co-infection have reached 70 per cent. MSF provides testing and treatment for HIV and TB, including drug-resistant TB, which requires a longer, more intensive, toxic and less effective drug regimen. Adherence clubs are a key element in the HIV programme: instead of monthly one-to-one appointments at the health centre, club members attend bi-monthly meetings where, as well as receiving a check-up and a drug refill, they can ask questions and offer mutual support.

The programme also addresses the needs of children and adolescents. A pilot project providing diagnosis and treatment for newborns began in 2014. Children are involved in family clubs and there are now nine clubs that are youth-focused, for those aged between 12 and 25 years. Overall the project supports 18 community adherence clubs.

An MSF-initiated pilot project at community 'wellness hubs', offering family planning and testing for pregnancy and sexually transmitted infections, significantly improved access to HIV screening for young women. More than 15,000 patients attended two wellness hubs before the facilities were handed over to the Western Cape Department of Health. MSF also supported two human papillomavirus vaccination campaigns in Khayelitsha, vaccinating more than 3,800 girls.

KwaZulu-Natal

MSF continued an HIV–TB programme covering Mbongolwane Health Service Area and Eshowe municipality in KwaZulu-Natal. In 2014, more than 50,000 people underwent HIV testing, and three times as many viral load tests were carried out compared to 2013. This enabled staff to identify patients who could benefit from a change in their drug regimen. The programme also focuses on prevention activities such as promoting safe sex. A million condoms were distributed and more than 3,000 men underwent voluntary circumcision, which is shown to decrease the risk of HIV transmission.

Stop Stock Outs project

Drug stock outs cause a major bottleneck in South Africa's HIV–TB programming and threaten the health of patients. MSF and several partners launched the Stop Stock Outs project in 2013, asking patients and healthcare workers to become 'sentinel surveyors': to anonymously gather reports on stock levels in the facilities they attend or work at, map reported cases and track specific issues. The overall goal is to understand the causes of shortages and stock outs and draw attention to a struggling health system.

PATIENT STORY

THULILE, 29 years old

"I first heard about MSF early last year, and joined my first club towards the end of 2013. Before clubs, you would first have to queue to get your file, then queue to get your blood pressure and weight measured, and then queue to see your nurse to get your treatment. If the clinic was full, you could be there from 7am to 1pm. When your month's supply of ARVs came to an end, you started dreading the clinic visit. You put it off. But with clubs, you actually look forward to the visit! It only takes an hour and we get two months' supply of ARVs."

© Kate Ribet/MSF

TAJIKISTAN

No. staff in 2014: 67 | Expenditure: €1.4 million | Year MSF first worked in the country: 1997 | msf.org/tajikistan

● Cities, towns or villages where MSF works

KEY MEDICAL FIGURES:

160 patients under treatment for TB, of which **30** for MDR-TB

The first patient ever treated for extensively drug-resistant tuberculosis (XDR-TB) in Tajikistan was declared cured in December.

The 17-year-old received treatment through the paediatric TB programme supported by Médecins Sans Frontières (MSF) at Dushanbe hospital. The programme provides TB diagnosis and treatment for young people aged 18 or under. Before MSF began the project, children undergoing standard TB treatment had to withstand long, isolated periods in hospital, while those with multidrug-resistant TB (MDR-TB) or XDR-TB (for whom first- and second-line antibiotics, respectively, have failed) went untreated.

Children with TB now receive appropriate treatment on an outpatient basis whenever possible, with nutritional and psychosocial support to help them adhere to their arduous regimens. In 2014, drug compounding (combining drugs to create a formulation particular to a patient's needs) was introduced to make paediatric formulations of drugs for MDR-TB.

The health ministry, in partnership with MSF, diagnoses and treats patients' family members and MSF searches for individual solutions for people who live far from the hospital. MSF is also working to eliminate the stigma of TB and to facilitate children's return to school.

Until now, only MSF was providing XDR-TB treatment in Tajikistan, but discussions with the Global Fund and the United Nations Development Programme have been successful and treatment provision is beginning to expand. The Paediatric TB Protocol developed by MSF has been adopted as the national guideline.

Kala azar

In May, MSF completed a response to the 2013 outbreak of kala azar (visceral leishmaniasis) in Tajikistan. MSF trained health ministry professionals including doctors, nurses, epidemiologists and laboratory technicians in seven locations, and worked on national guidelines for disease management.

TURKEY

No. staff in 2014: 8 | Expenditure: €0.8 million | Year MSF first worked in the country: 1999 | msf.org/turkey

● Cities, towns or villages where MSF supports projects

Over 1.8 million Syrian war refugees were living in Turkey at the end of 2014.

The poor living conditions and limited access to medical care endured by many predominantly urban and unregistered refugees in Turkey remain concerning. This year Médecins Sans Frontières (MSF) launched several interventions to support Turkish Civil Society Organisations (CSOs) in delivering assistance to those in need.

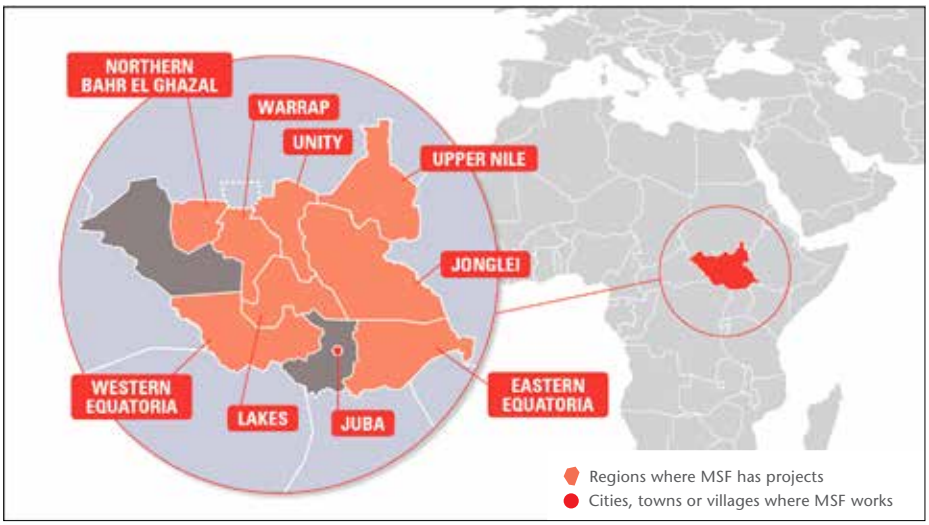
A number of Syrians have settled in the southern provinces of Kilis and Sanliurfa, along the Syrian–Turkish border. MSF is providing financial and technical support to a number of organisations, including the Helsinki Citizens' Assembly (hCa) which is running a clinic in Kilis aimed at offering high-quality basic healthcare, such as 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.

MSF also offers financial and technical support to the humanitarian agency Support to Life and the International Blue Crescent Relief and Development Foundation in Sanliurfa, where there is a mental health intervention for refugees and activities are underway to improve water supply, hygiene and sanitation conditions – something that is much needed in the temporary refugee settlements in the governorate. The CSOs supported by MSF responded immediately to influxes of Syrian refugees by distributing shelter materials and non-food aid items such as soap, blankets and plastic sheeting.

If MSF's request for legal registration is granted by the Turkish authorities, activities directly supporting the growing number of refugees may be increased.

SOUTH SUDAN

No. staff in 2014: 3,996 | Expenditure: €83.3 million | Year MSF first worked in the country: 1983 | msf.org/southsudan | blogs.msf.org/southsudan



KEY MEDICAL FIGURES:

936,200 outpatient consultations

22,700 patients treated in feeding centres

6,900 surgical interventions

6,800 patients treated for kala azar

6,800 patients treated for cholera

Throughout 2014, Médecins Sans Frontiéres (MSF) responded to emergency medical needs arising from conflict while striving to maintain its pre-existing, essential healthcare programmes in South Sudan.

When fighting broke out in the capital Juba at the end of 2013 and rapidly spread throughout the country, MSF started dispatching medical supplies and staff to critically affected locations. The number of projects had soon increased from 13 to more than 20 across nine states. Many people fled their homes and thousands hid in the bush. An estimated 1.5 million people remained internally displaced by the end of 2014.

Since the beginning of the crisis in South Sudan, MSF has called on all parties to respect the integrity of medical facilities, and to allow aid organisations to access affected communities. In January 2014, there was heavy fighting in the town of Leer, southern Unity state, and the MSF-supported hospital was looted and set alight. The provision of outpatient and inpatient care for children and adults, surgery, maternity services, treatment for HIV and tuberculosis (TB) and intensive care was interrupted for several months.

Medical care has come under attack time and again in South Sudan, with patients shot in their beds, wards burned to the ground and medical equipment stolen. Hundreds of thousands of people have been denied lifesaving assistance because of these acts. MSF staff witnessed the gruesome aftermath of armed attacks and clashes in Malakal in Upper Nile state, when they discovered patients murdered inside the town's teaching hospital. After fighting in Bentiu in April, people who had been seeking shelter inside the hospital were killed on the grounds.

Juba

To escape the violence in Juba, tens of thousands of people sought refuge in UN compounds, where Protection of Civilians (PoC) sites were designated. MSF set up medical facilities in the Tomping and Juba House PoC sites, but spoke out about the deplorable living conditions there, and in other PoC sites in the country, throughout the year. With the gradual stabilisation of medical needs, and as other organisations increased their activities, MSF's medical projects in the Juba PoC sites were handed over to the International Medical Corps, South Sudan Red Cross and Health Link South Sudan in August.

Unity state

The rapidly worsening security situation in January forced the evacuation of international staff from Bentiu. In April MSF was forced to stop providing TB and HIV care in the hospital because of increased violence. The town's residents fled to the nearby UN compound, where the population swelled from 6,000 people to more than 22,000 in a matter of days.

Bentiu's residents sought shelter from violence in a UN compound; by the end of the year 40,000 people were living there in a makeshift camp. In July, when the first rains came, much of the camp was flooded.

By the end of the year, the number had increased to 40,000. At the PoC site, MSF maintained a 24-hour emergency room and provided more than 10,000 outpatient consultations, treated nearly 1,000 children for severe malnutrition and performed 300 emergency surgical interventions, 83 per cent of which were conflict-related – mostly gunshot wounds. Tens of thousands of children were vaccinated against measles inside and outside the PoC. MSF ran mobile clinics and set up both a general and an antenatal clinic for people outside the site. Another team maintained a programme of comprehensive medical services for some 70,000 Sudanese refugees at Yida camp, and undertook a pneumococcal vaccination campaign – the first ever in a refugee setting. Some 10,000 children under the age of two were vaccinated.

In Leer, the international MSF team was evacuated in January due to increased insecurity. Shortly afterwards, 240 South Sudanese MSF hospital staff were forced to escape into the bush with their families and some of the most severely injured patients. By mid-April, the local population had begun to return to the town and in May medical activities resumed. By this time malnutrition in the area had reached crisis levels, and during May and June MSF treated more patients for malnutrition than in all of 2013.

Jonglei state

Some 70,000 people fled the town of Bor as a result of violence and the state hospital was ransacked. In April, an MSF team helped the health ministry repair the hospital and resume basic medical activities. A team also treated people wounded during an attack at Bor airport. MSF had long supported Lankien hospital, and in 2014 began emergency surgery to treat the increasing number of war wounded. Of the 910 major surgical interventions performed at the hospital, 76 per cent were violence-related. There was also a massive outbreak of kala azar (visceral leishmaniasis) and more than 6,000 patients were treated.

Insecurity in Pibor in 2013 caused MSF to withdraw from a fixed health centre and operate instead through mobile clinics. By July 2014, the situation had stabilised and MSF resumed activities in Pibor town, including basic health consultations, inpatient services and maternity care. Teams also offered healthcare in nearby Gumuruk, Lekwongole and Old Fangak, areas regularly affected by the war.

Upper Nile state

In a pre-existing project at Nasir hospital, a monthly average of 4,100 consultations were carried out until heavy fighting broke out nearby. The town's population fled and the hospital was evacuated in May. MSF staff visiting in June found the hospital completely looted and the town deserted. They had no way of knowing the whereabouts or the health status of those who had fled.

In the hospital in Agok, an MSF surgeon and his team change the dressing and remove damaged tissue from a child's gunshot wound.

Due to mounting insecurity, MSF had to stop working in the Malakal public hospital in April and rapidly opened a clinic in the PoC where 20,000 people were sheltering. In Melut, teams provided medical care to those people displaced by violence, which included treating them for kala azar and TB. As the health situation in the refugee camps stabilised over the year, MSF reduced its number of outpatient clinics.

Lakes state

MSF provided basic and specialist healthcare, including vaccinations, in Minkamman camp, Awerial.

Around 95,000 displaced people live in the camp, and more have settled in the surrounding areas. Teams carried out more than 52,000 outpatient consultations and 2,700 mental health consultations and also launched vaccination campaigns against measles, polio, cholera and meningitis.

Following a measles outbreak in Cueibet county in late March, MSF provided support to the health ministry and organised a vaccination campaign against measles and polio which reached 32,700 children under five.

Northern Bahr El Ghazal state

In Pamat, close to the border with Sudan, MSF continued to offer basic and specialist medical care to people displaced by conflict. Staff distributed relief items and provided health consultations to new arrivals in December. Since 2008, MSF has supported Aweil civil hospital, with around-the-clock paediatric and maternity services, including high-risk and emergency obstetric care – more than 7,100 women were admitted to the maternity ward and over 1,500 complicated deliveries were assisted during the year. In addition, MSF treated more than 30,000 people for malaria in 2014 – three times as many as the previous year.

MSF has also supported Yambio state hospital in Western Equatoria state since 2008, with specialist paediatric and antenatal care, surgery and treatment for HIV. There are more than 3,000 patients in the treatment programme. In Warrap state, MSF runs a small hospital in Gogrial town providing basic and specialist care, including an operating theatre for emergency surgery.

Agok

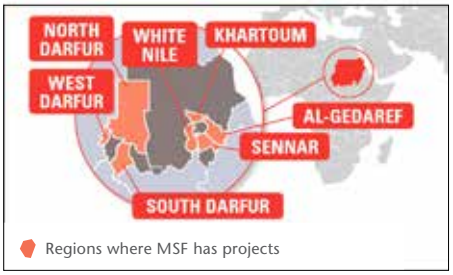
MSF continued to work in Agok, 40 kilometres south of Abyei, an area contested by Sudan and South Sudan. In the only hospital providing specialist services in the region, teams offered inpatient care, emergency surgery, maternity services and an inpatient therapeutic feeding centre. Early in the year a triage area and emergency room were also opened. Over 1,550 deliveries were assisted and 6,600 people were admitted to hospital. In February, the mobile clinics run by MSF ceased due to security concerns, and in March outpatient services were handed over to the NGO GOAL.

Cholera emergency response

On 15 May, the health ministry declared a cholera outbreak in Juba. MSF opened and ran five cholera treatment centres and three oral rehydration points, and provided technical assistance at Juba teaching hospital. MSF also responded to small outbreaks in Torit, Eastern Equatoria state, and in Malakal and Wau Shilluk, Upper Nile state.

SUDAN

No. staff in 2014: 589 | Expenditure: €11.8 million | Year MSF first worked in the country: 1979 | msf.org/sudan



KEY MEDICAL FIGURES:

246,900 outpatient consultations

400 patients treated for kala azar

© MSF

A health clinic was opened in February in White Nile state to provide basic healthcare to some 30,000 South Sudanese refugees, many of them women, children and elderly people.

Conflict continues to inflict a heavy toll on the health of people in Sudan's Darfur, South Kordofan and Blue Nile states.

Médecins Sans Frontières (MSF) aims to respond to emergency health needs in the country, but in 2014 various restrictions hindered its access to conflict-affected areas. An MSF-operated hospital in South Kordofan was bombed in January. Thousands of people are cut off from humanitarian assistance and are in dire need of medical care.

North Darfur

Clashes took place between resident Zaghawa and nomadic Arab tribes in Tawila, where an MSF hospital-based project offers outpatient and inpatient care, focusing on the needs of mothers and children. The team carried out more than 34,900 outpatient consultations and 5,400 antenatal consultations, and treated 1,300 children for malnutrition. Another MSF team, again concentrating on basic medical care for mothers and children, works in four health centres in Dar Zaghawa. Postnatal care is available at three peripheral health posts. More than 46,800 outpatient consultations were conducted in 2014.

MSF continued to assist displaced people in El Sireaf, providing water and sanitation, relief items and medical care, including surgery. More than 17,700 outpatient consultations were carried out and 1,100 people were treated for malaria.

North Darfur Emergency Response (NDER), a project with the North Darfur health ministry, conducts rapid health assessments and interventions. Activities included relief item distribution in Tawisha, Usban and El Fasher; a hepatitis E intervention in Um Kadada; malnutrition screening in Shangil Tobaya; supporting the campaign against dengue fever in El Fasher with such things as case management, vector control and active surveillance; and emergency response training.

South Darfur

In March and April, there were 4,000 new arrivals at El Sereif displaced people camp near Nyala. Their villages southwest of the city had been destroyed and they had fled in fear. MSF was already working in the camp, improving the water supply (which was far short of emergency standards) and treating residents whose health was suffering due to the poor living conditions.

West Darfur

Towards the end of 2014, MSF began to support four health centres in Kerenek locality, West Darfur, offering basic medical care. A team also worked with the health ministry on Ebola preparedness, training more than 100 staff and strengthening surveillance.

Assisting South Sudanese refugees

A health clinic was opened in February in White Nile state to provide basic healthcare to some 30,000 South Sudanese refugees, many of them women, children and elderly people who had walked long distances to safety. An average of 4,300 consultations were carried out each month.

Neglected diseases

MSF conducted training on kala azar (visceral leishmaniasis) for 590 health professionals in Sennar state and treated 400 kala azar patients in Tabarak Allah hospital, Al Gedaref state. MSF also supported reproductive healthcare services in the hospital.

MSF supported tuberculosis diagnosis and treatment in five health centres in Jebel Awila, a large slum area on the outskirts of Khartoum, where crowded living conditions increase the risk of contracting the disease.

SWAZILAND

No. staff in 2014: 406 | Expenditure: €8.4 million | Year MSF first worked in the country: 2007 | msf.org/swaziland

KEY MEDICAL FIGURES:

16,500 patients on first-line ARV treatment

1,700 patients under treatment for TB

© Giorgos Moutafis

A mother and child attending a clinic in Shiselweni region.

Decentralised care and innovative treatments are helping people with HIV live longer, healthier lives.

The co-infection rates of HIV and tuberculosis (TB), including drug-resistant TB (DR-TB), are extremely concerning, and 10 per cent of people with TB are diagnosed with a drug-resistant form of the disease. Médecins Sans Frontières (MSF) began collaborating with the health ministry to address the HIV–TB epidemic in Shiselweni in 2007 and in Manzini in 2010.

Shiselweni region

MSF continued to support integrated HIV and TB care in Shiselweni region this year, with projects in Nhlangano, Hlatikulu and Matsanjeni. Since 2010, the programme has trained local workers and community members living with HIV, and has helped expand diagnosis and treatment of HIV and TB in this rural southern region. Patients are now able to access treatment and psychosocial support through 22 health clinics and three specialised facilities. A five-year evaluation on the decentralisation of care demonstrated that simplifying it and bringing it closer to home is sustainable, leads to increased access to antiretrovirals (ARVs) and helps patients adhere to their drug regimens.

Central to the programme are the HIV-positive community members trained by MSF and the health ministry, Expert Clients, who carried out more than 3,200 health education sessions in 2014. Through these, some 137,100 people in Shiselweni were made aware of HIV-related issues. Door-to-door HIV testing has also been integrated into the programme, increasing the detection of HIV-positive people. Additionally, routine viral load measuring has been implemented to monitor health status, which allows for the identification of patients whose viral load is "undetectable", meaning that the virus is under control and that the risk of transmission is markedly lower.

The first phase of the Treatment as Prevention strategy targeted pregnant women. It was implemented as a national strategy in 2014 after proving effective in a pilot project in Nhlangano. The second phase, Early Access to Antiretrovirals for All (EAAA), was launched in Nhlangano in October, providing all HIV-positive patients with ARV treatment whatever their clinical or immunological status.

Manzini region

The migrant workers and residents of Matsapha can be tested and treated for HIV and TB at MSF's one-stop comprehensive family health clinic. Basic healthcare services, including maternity care, immunisations for children under five, family planning, home-based care services, and medical and psychosocial treatment for victims of sexual violence are available.

Comprehensive care is also offered for people co-infected with HIV and TB at Mankayane hospital and community-based clinics. Whenever possible, patients with DR-TB are treated as outpatients, which helps minimise the isolation and discomfort of long hospital stays and increases adherence to treatment.

When standard first-line TB drugs do not work, the patient is said to have multidrug-resistant TB (MDR-TB). As the conventional treatment for this form of the disease takes a minimum of 20 months and has many painful side effects, MSF began an observational trial to study the effectiveness and safety of a nine-month MDR-TB regimen in Matsapha and Mankayane in 2014.

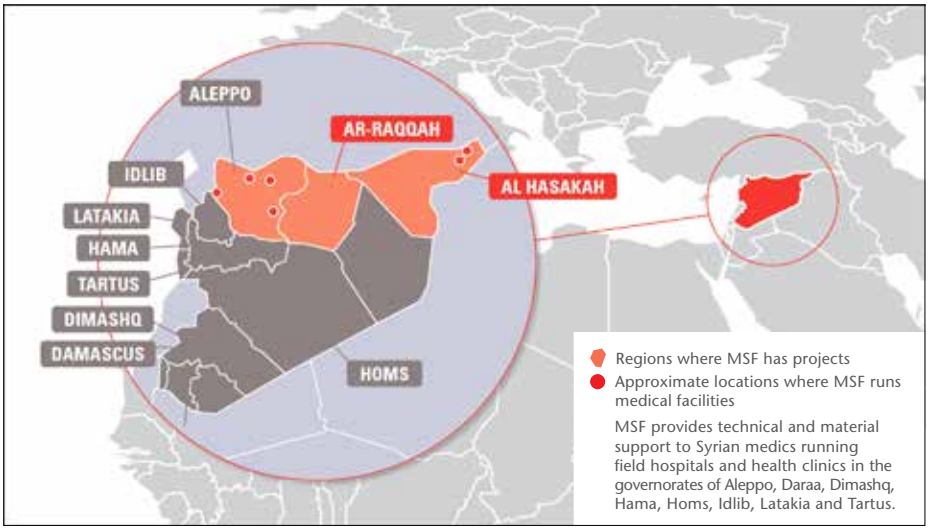
PATIENT STORY

SPHIWE – started on ARVs at Mashobeni clinic as part of the EEAA strategy

"I am a rural health motivator (RHM); one of the people who has been trained by the Ministry of Health to conduct health promotion and home-based care at community level. As an RHM I talk about these things. Even at our support group we talk about it and encourage people to know their status and adhere to their medication. Being a part of these groups has helped me to accept my status and use my story to encourage other people in my community."

SYRIA

No. staff in 2014: 729 | Expenditure: €16.6 million | Year MSF first worked in the country: 2009 | msf.org/syria | blogs.msf.org/syria



KEY MEDICAL FIGURES:

135,600 outpatient consultations

4,900 relief kits distributed

4,400 surgical interventions

1,400 births assisted

With millions of people in need of assistance, Médecins Sans Frontières (MSF) should be running some of the largest medical programmes in its 44-year history, but it is prevented from doing so.

Violence and insecurity, attacks on health facilities and medical workers, the absence of government authorisation and the reneging by armed groups on guarantees of safety for our teams have been some of the main obstacles to a more extensive programme of medical humanitarian aid.

The war entered its fourth year in 2014, and continued to be defined by brutal violence that does not distinguish between civilians and combatants. An estimated 200,000 people have been killed, and half the population is displaced either within Syria or in neighbouring countries. Entire communities are besieged and cut off from any outside assistance and people are trapped between the ever-shifting frontlines. Thousands of doctors, nurses, pharmacists and paramedics have been killed, kidnapped, or displaced by violence, leaving a massive gap in medical expertise and experience.

On 2 January 2014, ISIS (later renamed Islamic State; IS) abducted 13 MSF staff members. Among them were eight Syrian colleagues who were released after a few hours. The remaining five international staff members were held captive for up to five months. The abduction led to the withdrawal of MSF's international teams and the closure of health facilities in IS-held areas. MSF closed its field hospital in the mountainous region of Jabal Al-Akrad, in the west of Syria's Idlib governorate, as well as the two health centres it was running nearby.

Aleppo governorate

MSF runs three health facilities within Aleppo governorate, which has seen some of the most intense fighting, and is one of the main corridors for Syrians attempting to flee the country. One of the hospitals has 28 beds, and offers emergency, maternity and outpatient care. Vaccinations, orthopaedic services and treatment for some chronic diseases are also provided. The team stabilises patients at this hospital before transferring them to other facilities when necessary. From this base, MSF donated drugs and medical supplies to 10 field hospitals, nine first-aid points and three health centres.

A second MSF hospital in the Aleppo area had to be closed in August for security reasons. It provided access to healthcare for adults and children, including surgery for war wounded, trauma cases and burns patients, as well as emergency services, maternity, ante-and postnatal care and outpatient consultations.

On the outskirts of Aleppo, a third MSF hospital has a capacity of 12 beds. At this location teams carried out some 22,000 outpatient consultations, more than 12,300 emergency room consultations, over 500 surgical interventions, and admitted 1,200 patients. Vaccinations, antenatal care and mental health support were available and the hospital has a referral system in place for people who need additional services.

A young girl having a medical consultation at a mobile clinic in Al Hasakah governorate.

Bab Al Hawa camp, where some of the Syrian people forced from their homes by the violence are now living in terrible conditions.

Idlib governorate

There are extreme shortages due to the war, and the poor-quality fuel that families have to use for stoves and heaters frequently causes explosions, resulting in severe burns. In Idlib governorate MSF runs the only burns unit in northern Syria where people can get the specialist care they need, such as wound cleaning (debridement), dressing changes performed in the operating theatre under anaesthesia, skin grafts and physiotherapy. The 15-bed hospital has an emergency room, and a team offers psychological support to patients. More than 1,800 burns patients came to the facility in 2014 and over 5,800 patients were treated in the emergency room. The team performed more than 3,800 surgical interventions.

In response to reports of several measles cases in a community of some 100,000 internally displaced people along the border with Turkey, MSF conducted a vaccination campaign. More than 11,000 children were vaccinated against measles in camps and villages in August. MSF is continuing routine vaccinations for children under three years old. The absence of routine vaccination schedules as a result of the war has led to a rise in preventable childhood illnesses.

Ar-Raqqah governorate

The health centres and hospitals that are still operational in Ar-Raqqah governorate are struggling to maintain supplies, staff numbers and to ensure drugs are stored at the correct temperatures. It is estimated that up to 40,000 people across the governorate have been forced to leave their homes, and this has put additional pressure on local communities who are sheltering them in their houses, in schools and in former health centres. MSF continued to run a basic healthcare clinic in the Tal Abyad referral hospital, and supported a paediatric ward in the facility. Mobile teams provided emergency assistance to the displaced in multiple locations, and also supported routine vaccination activities by health workers in the region. More than 5,200 outpatient consultations were conducted, and 7,000 children were vaccinated against measles before these activities were handed over to the Ministry of Health and the local authorities in May.

Al Hasakah governorate

In northeast Syria, acute shortages of drugs, medical supplies and skilled personnel are having a devastating impact on healthcare. MSF provided staff and supplies to support pre- and post-operative care in a hospital's trauma ward. A team also assisted in the maternity ward, which MSF rehabilitated and furnished with new equipment. MSF started to run two clinics offering outpatient consultations and mother and child healthcare.

MSF has been running mobile clinics in the region bordering Iraq since 2013. Basic healthcare, with a focus on the health needs of mothers and children, is provided to displaced people and to the host communities on the Syrian side of the border. MSF also conducts routine polio vaccinations campaigns in the area – in October 2013, the first case of polio in Syria in 14 years was reported.

The border with Iraq, which had been closed since September 2013, reopened in one direction in June – allowing people to travel from Iraq to Syria. In August, tens of thousands of Iraqis crossed the border, fleeing violence in Iraq's Ninewa governorate. MSF teams working on both sides of the border responded to the increase in needs by running mobile clinics and setting up health facilities in transit camps and in camps for displaced people.

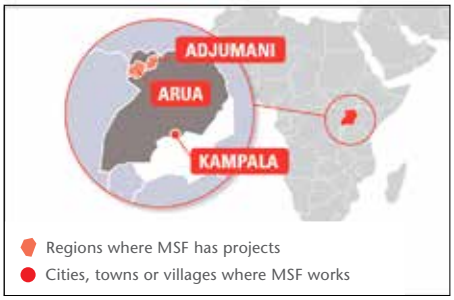
Support programmes for Syrian doctors

Despite the increasing access restrictions, MSF doctor-to-doctor networks continued to provide clandestine support to medical facilities run by Syrian doctors in both government- and opposition-controlled areas. These support programmes allow dedicated Syrian medical staff to work, often in extremely hazardous conditions, and bring a minimum level of healthcare to people trapped by the conflict.

MSF has developed a programme of large-scale support to over 100 underground and improvised healthcare facilities at two locations along Syria's borders and across six governorates, almost half of which are dedicated to besieged areas in the Damascus governorate. The facilities are in both government-held areas and opposition-controlled zones – all locations where it is not possible for MSF teams to be physically present. These programmes are increasingly focused on areas under siege, and supply essential drugs and medical items, distance training and technical support, as well as tailored support such as ambulances in some areas.

UGANDA

No. staff in 2014: 568 | Expenditure: €6 million | Year MSF first worked in the country: 1986 | msf.org/uganda



KEY MEDICAL FIGURES:

129,300 outpatient consultations

4,000 patients admitted to hospital

More than 128,000 South Sudanese people fleeing violence had crossed into Uganda by the end of October.

The majority of the refugees, some 81,000 of them, settled in northern Uganda's Adjumani district. After being registered through Numanzi transit centre, they were dispersed to camps. Médecins Sans Frontières (MSF) launched an emergency programme to provide basic healthcare for refugees at the transit centre and in the four camps. Teams screened children for malnutrition, and set up outpatient and inpatient departments, maternity wards and an intensive therapeutic feeding centre. Water and sanitation activities were also undertaken to ensure minimum hygiene standards were being met. As the number of arrivals dropped and other agencies began to cover some of the needs, MSF shifted it's focus to the two largest camps in the south, Ayilo 1 and Ayilo 2, and health screening and consultations at the transit centre. More than 124,000 consultations were carried out and over 4,000 patients were admitted to hospital.

A significant number of refugee children seen by MSF had respiratory infections, which can spread quickly in crowded environments. From July to September, MSF conducted three rounds of vaccination against pneumococcal disease and *Haemophilus influenzae* type B, the two main causes of respiratory infections in children. More than 2,700 children under two, living in the refugee camps or in the surrounding villages, were fully immunised against pneumococcus. This was the first vaccination campaign using the pneumococcal conjugate vaccine ever run in Uganda, and one of the first in a refugee setting.

Arua HIV/tuberculosis (TB) programme closes

The HIV/TB programme that MSF started in 2001, based at Arua regional referral hospital, was handed over to the Ministry of Health and SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally), a Ugandan–American NGO, in July. The project included clinical care, the management of a laboratory for HIV, TB and drug-resistant TB testing and the provision of antiretrovirals. MSF also handed over the management centre for multidrug-resistant TB that it built and had been running.

MSF is continuing to work on improving access to viral load testing, including for infants, with the UNITAID-funded Treatment Success Project. An MSF team is also assessing specific medical needs related to HIV in particularly vulnerable groups, such as children, adolescents and mobile populations.

Marburg emergency preparedness

In October, one case of Marburg haemorrhagic fever was confirmed in Kampala, triggering a joint response by the Ministry of Health, MSF and the US Centers for Disease Control and Prevention. MSF set up five transit centres and one Ebola treatment centre within Kampala hospitals and trained staff working at these sites and in other provinces. No further cases were reported.

UZBEKISTAN

No. staff in 2014: 246 | Expenditure: €5.9 million | Year MSF first worked in the country: 1997 | msf.org/uzbekistan

KEY MEDICAL FIGURES:

2,000 patients under treatment for TB

570 patients on first-line ARV treatment

Médecins Sans Frontières (MSF) continues to work to improve the quality and availability of treatment for tuberculosis (TB).

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 diagnosis and good-quality care is still limited and the vast majority of people with DR-TB remain undiagnosed and untreated.

MSF believes that introducing new approaches to diagnosis and treatment of TB – such as ambulatory care, rapid diagnostic tests and a comprehensive patient support programme including education, psychological support, transportation, food packages and financial aid – will help increase adherence to treatment and control the spread of the disease.

TB programme in Karakalpakstan

In the Autonomous Republic of Karakalpakstan, MSF runs a TB programme in collaboration with the Ministry of Health, helping patients manage the side effects of their drugs and providing psychosocial support to improve treatment adherence. In 2014, over 2,000 patients were enrolled for first-line TB treatment and 607 for DR-TB. Many patients underwent treatment on an outpatient basis, so they avoided the additional stress of hospitalisation. During 2014, MSF continued to enrol multidrug-resistant TB patients on a shorter, nine-month regimen instead of the usual two years. The first people who started the regimen in 2013 finished their treatment, and MSF will continue to monitor them for 12 months to check that the TB does not return.

Treating HIV in Tashkent

MSF is also seeking to address the developing HIV epidemic in Tashkent, Uzbekistan's capital city. Teams continued to work at the Tashkent City AIDS Centre, and a total of 671 people were started on antiretroviral treatment. Psychosocial activities such as counselling were also provided.

UKRAINE

No. staff in 2014: 71 | Expenditure: €5.5 million | Year MSF first worked in the country: 1999 | msf.org/ukraine

Regions where MSF has projects

KEY MEDICAL FIGURES:

1,200 individual and group mental health consultations

280 patients under treatment for TB

Over 600,000 people were displaced and 10,000 wounded during the intense conflict in eastern Ukraine in 2014.

The political protests that started in late 2013 gained momentum in 2014, leading to violent clashes between police and protestors and the removal of the Ukrainian president from power in February. Médecins Sans Frontières (MSF) provided medicines and supplies to health facilities receiving the injured in the capital Kiev. Following protests in the east of the country, fighting broke out in May between armed separatist groups and Ukrainian government forces.

© MSF

MSF teams delivering medical supplies to a hospital just outside Donetsk.

Medical supply lines were severely disrupted or cut completely, and health facilities' budgets for the year were quickly exhausted. While local doctors were able to cope with treating the wounded, they faced an acute shortage of medical supplies, so MSF donated medicines and materials for treating war-wounded patients to hospitals in Donetsk and Luhansk regions.

As the conflict spread and intensified, MSF dramatically increased this support, and by the end of the year had provided enough supplies to treat more than 13,000 wounded patients in hospitals on both sides of the frontline.

Throughout the conflict, hospitals were damaged by shelling, depriving people of medical care just when they needed it the most. This demonstrated a lack of respect for the health staff who continued to offer care at great risk to themselves, even though many of them had not been paid for months on end.

Despite a ceasefire in September, the fighting dragged on and medicines became increasingly difficult to obtain. Following a Ukrainian government decision to withdraw all support for state services from rebel-controlled areas, pension payments were cut, leaving disabled and elderly people particularly vulnerable, and all banking services were blocked. People began to delay going to see a doctor simply because they could not afford transport or medication. In response to the difficulties people were facing to access basic healthcare, MSF started to expand its medical support to include those patients with chronic diseases such as diabetes.

MSF teams also distributed more than 2,600 hygiene kits, including soap, dental supplies and towels, to people in Donetsk region who had fled their homes. In preparation for the harsh winter, MSF donated 15,000 blankets to hospitals and displaced people around Donetsk and Luhansk.

Treating the psychological effects of war

In March, MSF began to work with Ukrainian psychologists in Kiev, conducting training sessions and workshops on psychological problems such as depression and post-traumatic stress, and treating patients on both sides of the conflict. From August, MSF psychologists started to run individual, group and family mental health sessions in several cities on both sides of the frontline in the east, educating people about emotional reactions following traumatic events, and teaching them practical tools to help cope with fear, anxiety and nightmares. In addition, MSF psychologists trained local medical and mental health staff to improve their skills and avoid burnout.

Tuberculosis (TB) programme

MSF has been running a programme for people with drug-resistant TB within the regional penitentiary system in Donetsk since 2011. Throughout the conflict, MSF has made every effort to keep this project running and support patients to avoid treatment interruption. When heavy shelling made it too dangerous for the teams to reach the penitentiaries, they ensured the drugs were still available by delivering them to a safer location to be picked up by prison staff.

PATIENT STORY

SVETLANA – a patient receiving counselling from an MSF psychologist

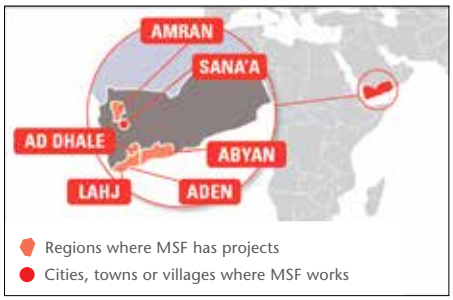
© Julie Remy/MSF

"I was in the yard with my husband when the shelling came. We had heard shelling before, but never this close. An artillery shell hit very close by. My husband was very badly wounded. Some shrapnel went into my legs and my chest. I still have a piece of metal lodged between my ribs. I called for an ambulance, but they said it was too dangerous … My husband died in the yard.

I've been staying at this hospital in Svitlodarsk for two months with my five-year-old daughter because we have nowhere else to go. I'm too afraid to go back to Debaltsevo … Now I hear explosions when there aren't any. When my daughter hears an explosion, she asks 'Is that a grad or a shell?' Is that normal for a five-year-old?"

YEMEN

No. staff in 2014: 562 | Expenditure: €9.9 million | Year MSF first worked in the country: 1994 | msf.org/yemen | blogs.msf.org/yemen



KEY MEDICAL FIGURES:

91,000 outpatient consultations

4,300 surgical interventions

720 patients on first-line ARV treatment

High levels of poverty and unemployment combined with continuous insecurity make it difficult for Yemenis to access healthcare.

Basic healthcare and lifesaving surgical care is provided by Médecins Sans Frontières (MSF) in Al Azaraq and Qataba'a districts of Ad Dhale governorate. More than 47,000 outpatient consultations took place in 2014. Emergency surgery for victims of violence is available in Al Naser general hospital, Ad Dhale city. The team performed around 300 surgical procedures here between June and September, when they were evacuated because of insecurity.

Amran

MSF teams in Amran continued to support Al-Salam hospital, providing emergency, maternity, inpatient and outpatient services and assisting in the laboratory and blood bank. More than 2,300 surgical interventions and 25,300 emergency consultations were carried out, 5,200 patients were admitted to hospital and over 2,500 babies were delivered during the year. To assist the communities in the remote Osman and Akhraf valleys, MSF supported the reopening of Heithah health unit in April, but insecurity caused the suspension and then complete cessation of activity in November.

Hundreds of thousands of Yemenis were forced to leave their homes due to conflict in 2014.

Aden

MSF's emergency surgical unit in Aden re-established networks of medical referrals from Abyan, Ad Dhale, Lahj and Shabwah – places frequently affected by violence and increased surgical needs. More than 2,000 emergency consultations, 1,600 surgical procedures and 5,600 physiotherapy sessions were completed. A weekly clinic in Aden central prison recorded more than 1,600 consultations. Support to Lawdar and Jaar hospitals in Abyan was stopped because MSF was seeing fewer victims of violence from these areas, and the networks were re-established and strengthened so patients could be referred to the MSF emergency hospital in Aden.

Rapid emergency response

MSF set up a team to provide rapid medical aid following violence and other emergencies. Medical supplies were donated to clinics and hospitals, relief items were distributed to people forced to leave their homes by conflict and direct care was offered to victims of violence and the displaced. Medical items were donated to 38 health facilities in five governorates, including the capital Sana'a, and hundreds of displaced people received direct emergency support.

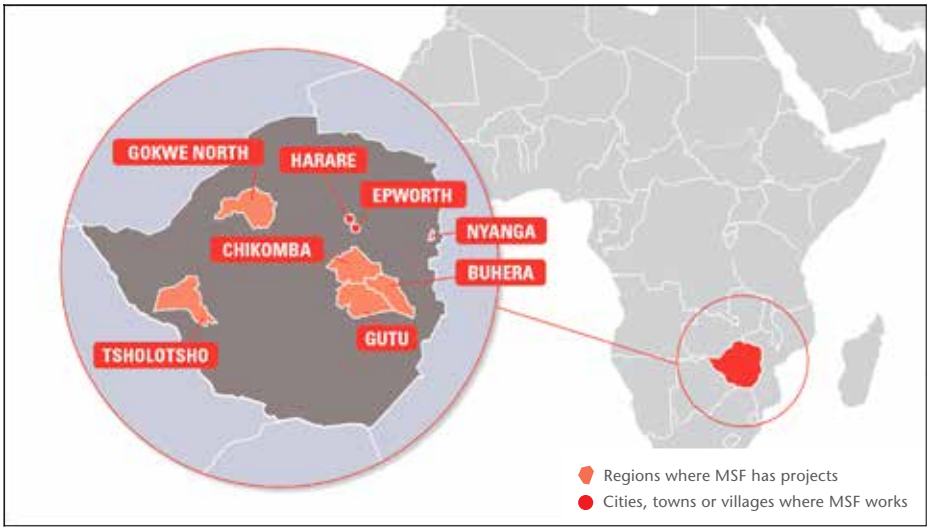
Reducing HIV stigma

Lack of knowledge about HIV/AIDS among healthcare providers has been the main cause of stigma and discrimination in Yemen. MSF trained staff in seven hospitals as part of its work with the National AIDS Programme and its advocacy resulted in a dramatic increase in the number of people getting tested for HIV, including pregnant women, and in the number of HIV-positive patients admitted to Al Gumhuri hospital in Sana'a.

MSF closed the mental health programme for migrants in detention that had opened in 2013. The number of new arrivals had stabilised, and there were organisations ready to take over running the project.

ZIMBABWE

No. staff in 2014: 362 | Expenditure: €13.6 million | Year MSF first worked in the country: 2000 | msf.org/zimbabwe



KEY MEDICAL FIGURES:

6,000 patients on first-line ARV treatment

1,400 patients under treatment for TB

Access to treatment for HIV/AIDS in Zimbabwe has improved in recent years, but remains limited for certain vulnerable groups.

Children with HIV have particular difficulty in obtaining appropriate care. Staff shortages, restricted clinic hours, high fees and long distances to facilities are some of the barriers that patients face. Médecins Sans Frontières (MSF) has worked with the health authorities to develop integrated care in government health facilities, decentralising diagnosis and treatment to help meet people's needs close to home.

In Epworth, Harare, MSF focuses on paediatric and adolescent HIV and tuberculosis (TB), and on providing treatment to patients whose standard HIV or TB treatment has failed. More than 2,660 patients under 20 were tested for HIV and more than 200 were started on treatment. Routine HIV and TB management was handed over to the health ministry in 2014 after more than a year of building up the necessary staff capacity.

MSF's HIV–TB programmes in Buhera, Gutu and Chikomba concentrated on staff training and mentoring, and provided technical and material support to local health centres to implement new World Health Organization guidelines and increase access to routine viral load monitoring. Testing and antiretroviral (ARV) treatment is now available to everyone and has been decentralised to all clinics in the three supported districts. MSF continued to implement patient-friendly models of care to relieve the pressure on health centres. By the end of the year there were 72 community ARV groups in Gutu, with a total of 477 members, who take turns in picking up drug refills for each other. New strategies were also tried in Gutu to increase the number of people taking HIV tests, including weekly night clinics and testing and counselling campaigns directed at young people or linked with sporting events.

MSF also continued to support viral load testing at the central hospital in Harare, which enables the monitoring of patients on ARVs. UNITAID financed the viral load testing machine and covered its running costs, whilst MSF piloted the implementation. A total of 35,439 tests were conducted in 2014.

In Nyanga district, HIV and TB care was decentralised to 18 out of a total of 21 clinics in 2014.

Psychiatric care in prisons

MSF provides diagnosis and treatment of male and female inmates with mental illness at Chikurubi maximum security prison, Harare. Staff in 10 prisons are also receiving training on the appropriate diagnosis and management of mental illness. MSF ensures that diagnosis and treatment for HIV and TB is available in the prisons via the Ministry of Health.

Sexual violence programme

Sexual violence is a critical issue in Zimbabwe, which MSF continues to address. In Mbare, Harare, MSF's clinic for victims of sexual violence offers free medical care, and counselling and referrals for further psychological, social and legal support.

Programme handovers

MSF's project in the rural district of Gokwe North decentralised and improved medical care for people with HIV and TB and victims of sexual violence through two hospitals and 18 healthcare facilities. After three years, during which time 12 facilities obtained accreditation as ARV initiation sites and another six as ARV follow-up sites, the project was handed over to the Ministry of Health and Child Care, as the initial objectives had been achieved. In Harare, MSF has also supported the ministry to decentralise these services, which are now available at six health centres. The team's recent focus had been on improving care for children with HIV and more complicated cases of HIV and TB. The project was handed over to the ministry in October, as they had the capacity to offer the necessary medical care.

After more than nine years working on HIV in Tsholotsho, the HIV project was handed over to local health authorities in November. The programme had achieved its overall goal of treating HIV/AIDS and reducing transmission and related morbidity and mortality. By the end of August, more than 10,400 people were on ARVs, 85 per cent of all people in need of HIV treatment in the district.

Before the introduction of community ARV groups, Bej Murevi had a monthly 20-kilometre round-trip to pick up her medication.

FACTS AND FIGURES

Médecins Sans Frontières (MSF) is an international, independent, private and non-profit organisation.

It comprises 21 main national offices in Australia, Austria, Belgium, Brazil, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, South Africa, Spain, Sweden, Switzerland, the United Kingdom and the United States. There are also offices in Argentina, the Czech Republic and Ireland. MSF International is based in Geneva.

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, Fondation MSF Belgique, 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 2014 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 2014 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.

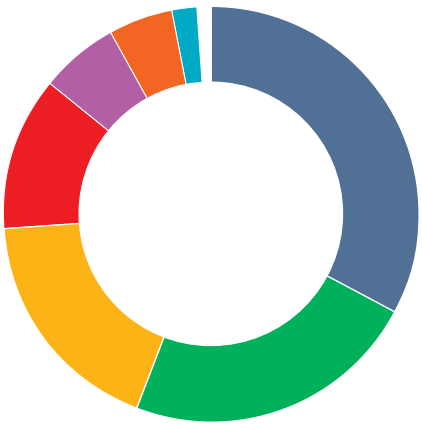
The figures presented here are for the 2014 calendar year. All amounts are presented in millions of euros.

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	31%
International staff	21%
Medical and nutrition	18%
Transport, freight, storage	14%
Logistics and sanitation	7%
Operational running expenses	6%
Consultants and field support	2%
Training and local support	1%



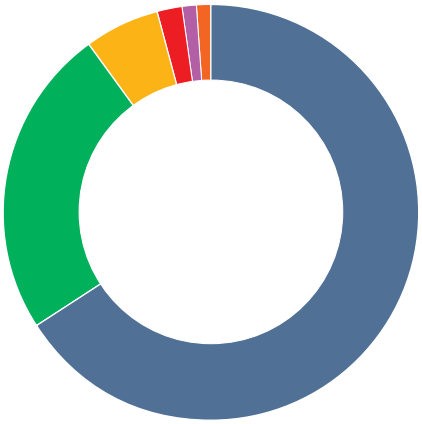
The biggest category of expenses is dedicated to staff working in the field: about 52 per cent of expenditure comprises all costs related to locally hired and international staff (including plane tickets, insurance, accommodation, etc).

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.

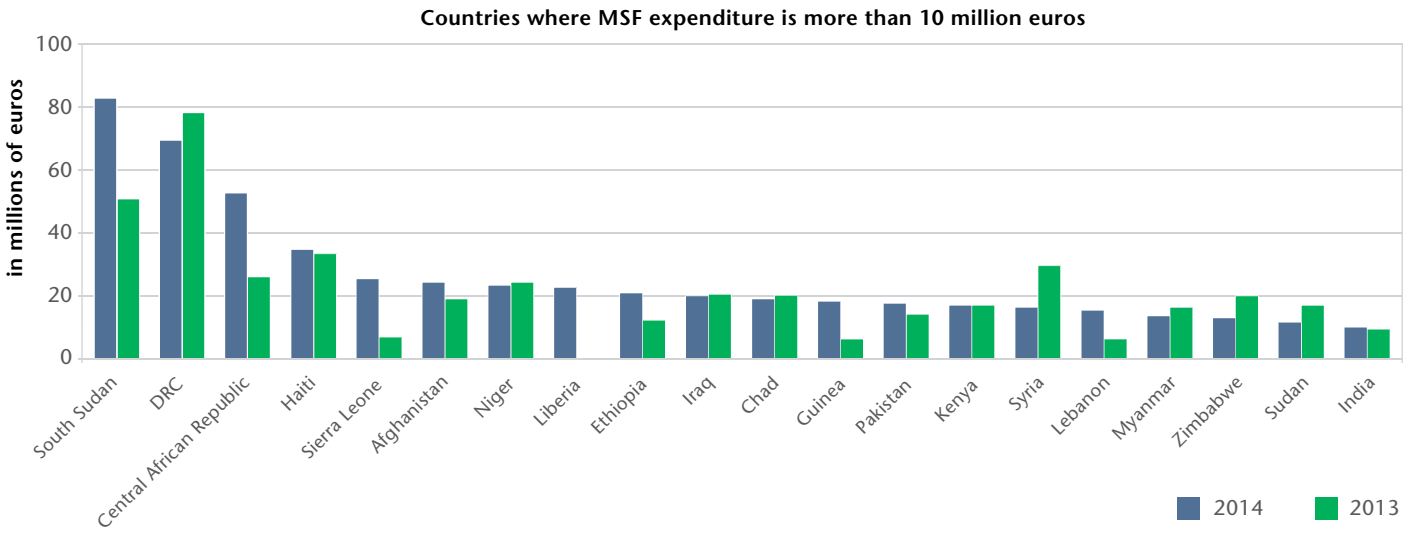
Logistics and sanitation comprise building materials and equipment for health centres, water and sanitation and logistical supplies.

Programme expenses by continent

Africa	66%
Asia	24%
Americas	6%
Europe	2%
Oceania	1%
Unallocated	1%



COUNTRIES WHERE WE SPENT THE MOST



AFRICA

	in millions of €
South Sudan	83.3
Democratic Republic of Congo	70.1
Central African Republic	53.0
Sierra Leone	26.0
Niger	23.5
Liberia	23.0
Ethiopia	21.3
Chad	19.5
Guinea	18.7
Kenya	17.4
Zimbabwe	13.6
Sudan	11.8
Nigeria	9.8
Mali	9.5
Cameroon	8.7
Swaziland	8.4
Mozambique	7.8
Malawi	7.1
South Africa	6.7
Uganda	6.0
Mauritania	4.4
Egypt	2.6
Côte d'Ivoire	2.3
Burundi	2.3
Libya	2.2
Other countries*	1.9
Total Africa	**462.2**

ASIA AND THE MIDDLE EAST

	in millions of €
Afghanistan	24.8
Iraq	20.4
Pakistan	17.8
Syria	16.6
Lebanon	15.6
Myanmar	14.0
India	10.0
Yemen	9.9
Jordan	8.4
Philippines	6.9
Uzbekistan	5.9
Palestine	4.3
Bangladesh	3.1
Cambodia	2.3
Armenia	2.2
Kyrgyzstan	2.1
Tajikistan	1.4
Other countries*	3.1
Total Asia	**168.7**

THE AMERICAS

	in millions of €
Haiti	35.2
Colombia	3.9
Mexico	2.9
Honduras	1.2
Other countries*	0.5
Total America	**43.7**

EUROPE

	in millions of €
Ukraine	5.5
Russian Federation	4.9
Other countries*	2.1
Total Europe	**12.5**

OCEANIA

	in millions of €
Papua New Guinea	5.3
Total	**5.3**

UNALLOCATED

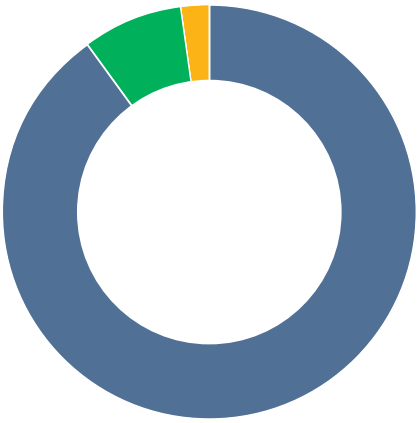
	in millions of €
Other	3.2
Transversal activities	3.5
Total unallocated	**6.6**

Total programme expenses	**669.1**

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

WHERE DID THE MONEY COME FROM?

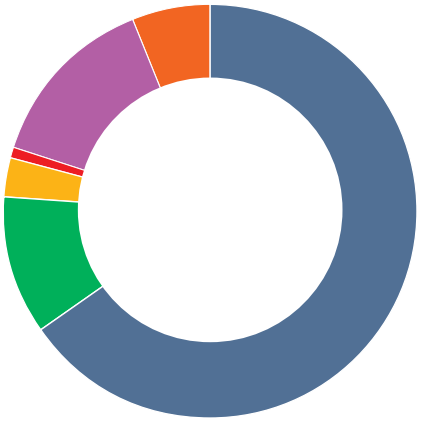
	2014		2013	
	in millions of €	*percentage*	*in millions of €*	*percentage*
Private	1,141.7	89%	899.7	89%
Public institutional	114.7	9%	93.0	9%
Other	24.0	2%	15.9	2%
Income	**1,280.3**	**100%**	**1,008.5**	**100%**



- Private income 89%
- Public institutional income 9%
- Other income 2%

HOW WAS THE MONEY SPENT?

	2014		2013	
	in millions of €	*percentage*	*in millions of €*	*percentage*
Programmes	699.1	66%	615.4	65%
Headquarters programme support	113.9	11%	108.8	11%
Témoignage/awareness-raising	31.1	3%	30.2	3%
Other humanitarian activities	14.1	1%	9.3	1%
Social mission	**858.1**	**80%**	**763.7**	**80%**
Fundraising	147.2	14%	131.6	14%
Management and general administration	60.2	6%	57.1	6%
Income tax	0.6	–	0	–
Other expenses	**207.9**	**20%**	**188.8**	**20%**
Expenditure	**1,066.1**	**100%**	**952.5**	**100%**
Net exchange gains/losses	9.7		-7.9	
Surplus/deficit	**223.9**		**48.1**	



- Programmes 66%
- Headquarters programme support 11%
- Témoignage/awareness-raising 3%
- Other humanitarian activities 1%
- Fundraising 14%
- Management and general administration 6%

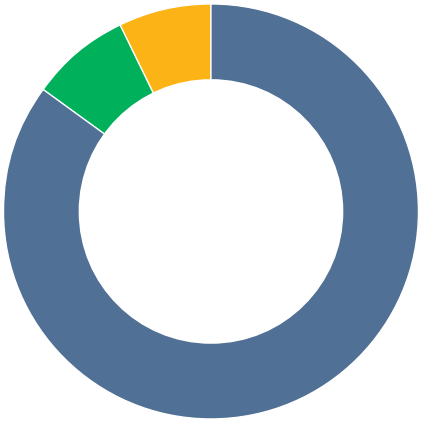
YEAR-END FINANCIAL POSITION

	2014		2013	
	in millions of €	*percentage*	*in millions of €*	*percentage*
Cash and cash equivalents	857.8	82%	616.3	81%
Other current assets	106.2	10%	87.3	11%
Non-current assets	88.3	8%	61.7	8%
Assets	**1,052.3**	**100%**	**765.3**	**100%**
Permanently restricted funds	3.2	0%	3.1	0%
Unrestricted funds	851.6	81%	627.7	83%
Other retained earnings and equities	24.5	2%	3.4	0%
Retained earnings and equities	**879.3**	**83%**	**634.2**	**83%**
Current liabilities	173	16%	131.1	17%
Liabilities and retained earnings	**1,052.3**	**100%**	**765.3**	**100%**

5.7
MILLION
private donors

HR STATISTICS

		2014		2013
Medical pool	1,836	26%	1,593	26%
Nurses and other paramedical pool	2,298	32%	1,892	30%
Non-medical pool	2,952	42%	2,714	44%
International departures (full year)	**7,086**	**100%**	**6,199**	**100%**
	no. staff	*percentage*	*no. staff*	*percentage*
Locally hired staff	31,052	85%	29,910	85%
International staff	2,769	8%	2,629	8%
Field positions	**33,821**	**93%**	**32,539**	**93%**
Positions at headquarters	2,661	7%	2,493	7%
Staff	**36,482**	**100%**	**35,032**	**100%**



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 2014, 89 per cent of MSF's income came from private sources. More than 5.7 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, Czech Republic, Denmark, France, Germany, Ireland, Luxembourg, Norway, Spain, Sweden, Switzerland and the UK.

Expenditure is allocated in line with the main activities performed by MSF according to the full cost method. Therefore all expense categories include salaries, direct costs and allocated overheads (e.g. building costs and depreciation).

Programme expenses represent expenses incurred in the field or by headquarters on behalf of the field.

Social mission includes all costs related to operations in the field as well as all the medical and operational support from the headquarters directly allocated to the field and "*témoignage*/awareness-raising" activities. Social mission costs represent 80 per cent of the total costs for 2014.

Other expenses comprises costs associated with raising funds from all possible sources, the expenditures incurred in the management and administration of the organisation, as well as income tax paid on commercial activities.

Permanently restricted funds may be capital funds, where donors require the assets to be invested or retained for long-term use rather than expended; or the minimum compulsory level of retained earnings to be maintained in some countries.

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 are foundations' capital and translation adjustments arising from the translation of entities' financial statements into euros. Unspent donor-designated/restricted funds are not included as retained earnings, but are treated as deferred income.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. At the end of 2014, the available portion (excluding permanently restricted funds and capital for foundations) represented 9.8 months of the preceding year's activity. The purpose of maintaining retained earnings is to meet the following needs: working capital needs over the course of the year, as fundraising traditionally has seasonal peaks while expenditure is relatively constant; swift operational response to humanitarian needs that will be funded by forthcoming public fundraising campaigns and/or by public institutional funding; future major humanitarian emergencies for which sufficient funding cannot be obtained; the sustainability of long-term programmes (e.g. antiretroviral treatment programmes); and a sudden drop in private and/or public institutional funding that cannot be matched in the short term by a reduction in expenditure.

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

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COVER PHOTO
A nurse entering the high-risk zone of an Ebola management centre in Kailahun, Sierra Leone.
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