



INTERNATIONAL ACTIVITY REPORT **2015**

SECOND EDITION



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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 2015. Staffing figures represent the total full-time equivalent positions per country in 2015.

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.96.

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

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Note on errors in first edition

Due to reporting errors in the first edition of the 2015 International Activity Report, this second edition includes corrections to some figures related to activities carried out by MSF in 2015 that appear on pages 8, 9, 10, 12, 52, 82, 85 and 87 of this report. Expenditure figures for some countries have also been revised to exclude indirect field costs (for example, supply centre warehouse costs and staff costs related to the purchase, inventory and dispatch of medical and non-medical items).



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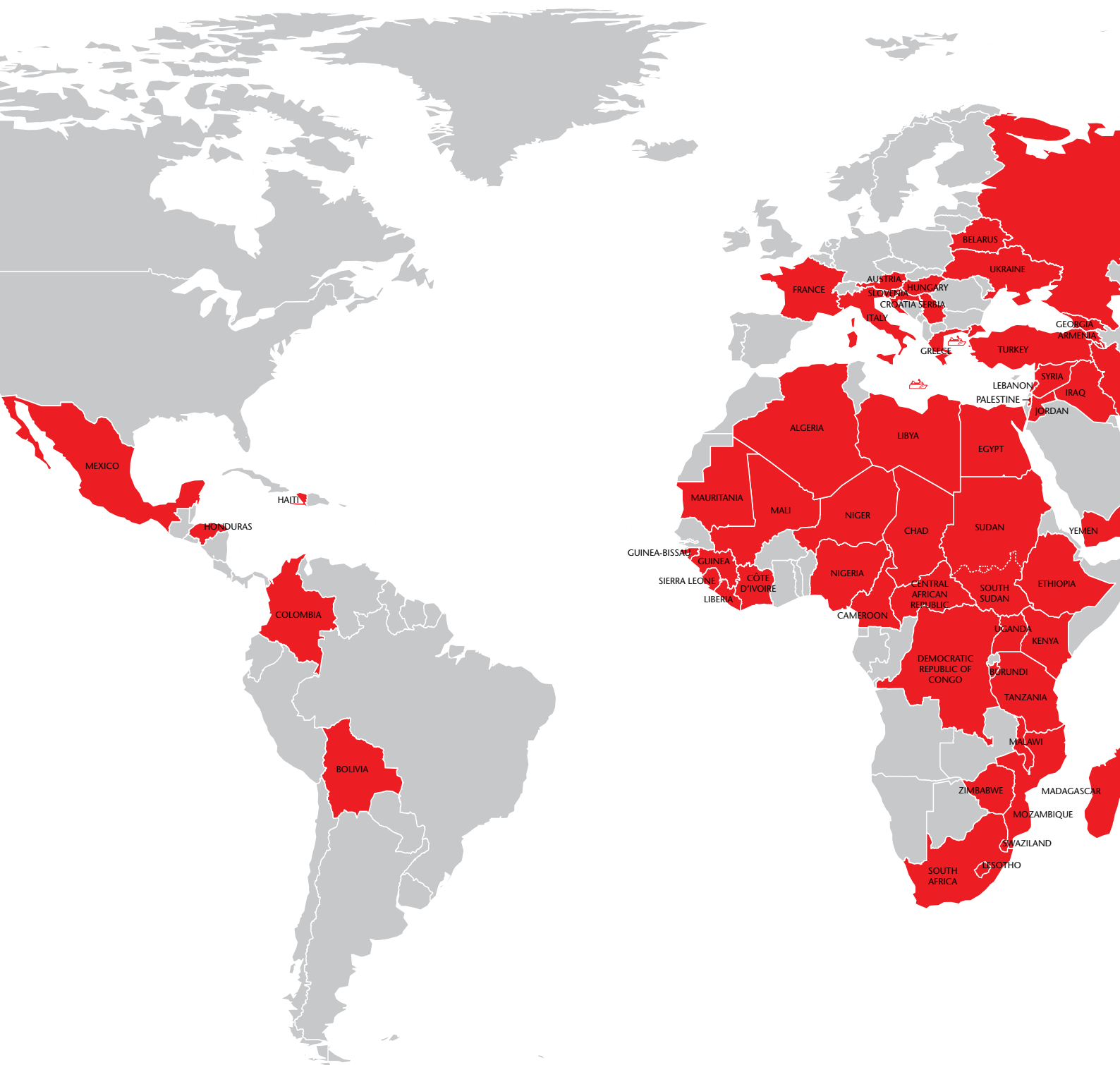


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THE YEAR IN REVIEW

Dr Joanne Liu, International President
Jérôme Oberreit, Secretary General

In October, the Médecins Sans Frontières (MSF) Kunduz trauma centre in Afghanistan was targeted by US airstrikes, which resulted in the deaths of 14 staff, 24 patients and four patient caretakers. Over one million people in northeastern Afghanistan remain deprived of high-quality surgical care as a result.

Our thoughts go out to the friends and families of those who died. We also remember our colleagues who tragically lost their lives this year in a helicopter crash in Nepal and our colleague who was killed in the Central African Republic (CAR). We take this opportunity as well to tell Philippe, Richard and Romy, our staff who are still missing in the Democratic Republic of Congo (DRC), that they are not forgotten.

Attacks on healthcare and the subsequent suffering of civilians

The repercussions of attacks on health facilities continue long after the initial impact. The destruction results in thousands of

civilians being deprived of essential medical care at a time when they need it most.

MSF was able to work in Kunduz thanks to negotiated agreements with all parties to the conflict that they would respect the neutrality of the medical facility. An independent and impartial inquiry into the facts and circumstances of the attack is needed, as we cannot rely only on the US's own internal military investigations. Aerial bombardments of hospitals are not new, but neither can they be dismissed as simple 'mistakes'. The bombing in Kunduz attracted extensive media coverage because an international organisation was targeted by the US military.



© Bruno De Cock/MSF

MSF's Afghanistan Country Representative speaks at a commemoration event in Brussels one month after the attack on MSF's trauma centre in Kunduz.



An MSF-supported hospital in Haydan, Yemen after it was completely destroyed by an airstrike. It was the only functioning hospital serving a population of 200,000 people.

At a time when attacks on healthcare are intensifying and civilians are paying the price, what is often an overlooked issue was pushed into the international spotlight.

In January, an MSF hospital in South Kordofan, Sudan, was bombed by the Sudanese Air Force, injuring one patient and one staff member. This same hospital had also been bombed in June 2014. Medical facilities were also shelled in Ukraine at the beginning of the year, but it is in Syria where we really see medical care becoming the target of both deliberate and indiscriminate violence. Laws passed in 2012 effectively criminalised providing medical aid to the opposition in Syria. Government forces have since strategically attacked medical facilities and medical personnel, including doctors, nurses and ambulance drivers, with the aim of harming the opposition; an alarming trend of impunity. In 2015, there were 94 aerial and shelling attacks on 63 MSF supported facilities, causing varying degrees of damage and, in 12 cases, resulting in the total destruction of the facility; 81 MSF supported medical staff were killed or wounded. Towards the end of the year, medical facilities in Yemen were

also bombed. Airstrikes in October carried out by the Saudi-led coalition destroyed an MSF-supported hospital, leaving over 200,000 people without access to medical care. As a result of these repeated attacks on medical facilities, some civilians regard visits to hospitals as riskier than not seeking medical care at all. The 'security at all costs' logic means that humanitarian aid is welcomed when it serves national security interests but is restricted, even attacked, when it does not.

People on the move

Fleeing violence

Conflict and violence have forced hundreds of thousands of people to flee their homes and their countries this year. In early 2015, large numbers of refugees crossed into Tanzania to escape election-related violence in Burundi. By July, as many as 3,000 people were arriving in the country each week, and it was estimated that 78,000 Burundians were sheltering in Nyarugusu camp.

Since the beginning of the Syrian crisis in 2011, it is estimated that more than 1.5 million Syrian refugees and Palestinian refugees from Syria have arrived in Lebanon

and the small country is struggling to cope. In Jordan, over 600,000 Syrian refugees have been registered to date.

In the Lake Chad region in western Africa, 2.5 million people in Cameroon, Chad, Niger and Nigeria fled their homes following attacks by Boko Haram and sought shelter and protection in refugee or internally displaced person camps. Counter-offensives by armed forces have only added to their suffering.

MSF works in all the countries mentioned above, for example conducting vaccination campaigns in Tanzania, providing free treatment for chronic diseases in Lebanon, running a reconstructive surgery project in Jordan and, despite insecurity, deploying medical teams to the four affected countries in the Lake Chad region. A large part of the global responsibility for hosting refugees is shouldered by countries immediately bordering conflict zones, a fact that rarely makes the headlines.

The journey to Europe

During 2015, at least 3,771 people died while attempting the sea crossing to Europe. MSF conducted search and rescue operations



© Karin Ekholm/MSF

A child is protected from measles during a mass vaccination campaign in the Yida refugee camp in South Sudan.

at sea and provided assistance at Europe's entry points and along the 'migration route', in a telling indictment of Europe's policies towards the displaced. Due to a lack of safe alternatives, people resort to smugglers and risk their lives on dangerous and uncertain journeys to escape war and persecution, or because they are in search of a better and safer life for themselves and their families.

The humanitarian crisis that has unfolded on the borders of the European Union (EU) is largely policy-driven, a result of the EU's failure to put in place effective and humane policies and responses to deal with the unprecedented, but in many ways foreseeable, movement of people. The lack of political will, which became so obvious when dealing with Ebola, was again evident with the 'migration crisis'. World leaders turned their backs, hoping that the situation would remain confined to countries far away, despite the fact that in some cases they themselves are contributing to the suffering. Four of the five permanent members of the UN Security Council – Russia, the US, France and Britain – are involved in bombing Syrian civilians. There has been an unacceptable lack of recognition of the reasons why people

are fleeing their countries, and most efforts to date have concentrated on deterrence measures aimed at stemming the flow of refugees and migrants arriving on EU soil.

It is estimated that one million people fled to Europe in 2015, and that almost 50 per cent of them came from Syria. With no end to the war in sight, the numbers will only continue to grow. The EU has externalised the management of its borders to Turkey, handing over billions of euros in return for a clampdown on Syrians attempting to make the crossing. The end result of border closures from Europe all the way back to Syria is that civilians are being trapped in one of the most brutal wars of our times.

Ongoing and intensifying violence in South Sudan

Civilians in South Sudan continue to be exposed to extreme levels of violence. In 2015, rape, abduction and execution were commonplace in some parts of the country, and regional and international attempts to resolve the conflict failed. MSF teams in Unity state witnessed villages being burnt to the ground and crops looted and destroyed. Hundreds of thousands of people fled into

the bush and swamplands, where they had no access to assistance for months at a time. MSF medical facilities were looted or attacked on three separate occasions and five South Sudanese former staff members were killed. MSF struggled to access vulnerable populations in the worst-affected areas but was able to deliver lifesaving medical care at its projects on the frontlines and through mobile clinics. Compounding the severe humanitarian crisis, South Sudan also experienced the worst outbreak of malaria that MSF has ever witnessed in the country and its second outbreak of cholera in two years.

Response and research and development (R&D) for epidemics

Towards the end of 2015, the Ebola outbreak was declared over in Sierra Leone and Guinea, but new cases have since been reported. The public health systems in the affected countries in West Africa have been devastated and routine vaccination campaigns, including for measles, tetanus and polio, have fallen by the wayside. Reinstating non-Ebola-related healthcare and re-establishing people's trust in it is crucial to ending the epidemic. However, this is further

complicated by a lack of trained medical personnel. It is estimated that over 880 medical staff contracted Ebola in the three worst-affected countries, and over 500 died. There are also over 10,000 Ebola survivors, many of whom are still long-term patients, presenting with mental health issues, general weakness, headaches, memory loss, muscle pain and eye problems.

Ebola is not the only disease threatening populations, though. Outbreaks of measles, meningitis and cholera, for example, are common in places where people are forced to live in unsanitary conditions such as refugee camps, or where routine vaccinations have been interrupted. The extremely high mortality rates during the recent measles epidemic in Katanga region in DRC illustrate how preventive strategies over the past decades have failed. MSF vaccinated over 300,000 children between June and September, and treated 20,000 patients for the disease. In 2015, the MSF Access Campaign launched its 'Fair Shot' campaign in a bid to lower the prices of vaccines, in particular for pneumococcal disease. There has been a 68-fold increase in the price for

the package of childhood vaccines over the last decade.

Malaria also continues to be a major challenge around the world, despite elimination strategies, and there are outbreaks of less common diseases such as yellow fever, chikungunya and Lassa fever. In 2015, there was a large outbreak of Zika virus (first identified in humans in 1952) in the Americas, which resulted in the World Health Organization declaring it a Public Health Emergency of International Concern in early 2016. Very few diagnostic tests are currently available, and there is no specific vaccine or treatment.

R&D must be undertaken with communities and environments in mind to ensure that diagnostics, vaccines and treatments are effective, accessible and affordable, and adapted to the contexts where they are needed most. Ebola exposed a global R&D infrastructure that is unfit for purpose; it cannot help save lives during an emergency. We should be conducting safety studies and working out ethical frameworks during inter-epidemic phases in order to be prepared. This would allow fast-track use of

experimental drugs and vaccines during an outbreak and efficiency trials as an epidemic peaks. Yet, all too often, we scramble to act only as an epidemic peters out. We must act ahead of epidemics, not at the tail end.

Over the past few years MSF has had to adapt its response to meet the challenges of individual contexts, and in Syria in 2015 we continued to run health facilities in the country but also offered support, donated medicines and equipment, and set up partnerships with networks of local doctors. Despite difficult conditions in CAR, MSF staff continued to address basic and emergency healthcare needs across 13 prefectures and 15 localities by carrying out vaccination campaigns, operating mobile clinics and providing emergency surgery, specialised care for victims of sexual violence and treatment for malnutrition.

Out of the spotlight, tens of thousands of MSF staff treat patients with HIV and tuberculosis, malaria and malnutrition, offer specialist care to mothers and children, and conduct vaccination campaigns and surgery in nearly 70 countries around the world. We want to pay tribute to them, and to thank our supporters for making our work possible.



A patient carries an X-ray in the district of Kara-Suu in southern Kyrgyzstan, where MSF focuses on outpatient care to reduce hospitalisation time and help patients adhere to treatment.

OVERVIEW OF ACTIVITIES

Largest country programmes based on project expenditure

- | | |
|---------------------------------|----------------|
| 1. Democratic Republic of Congo | 6. Iraq |
| 2. South Sudan | 7. Niger |
| 3. Central African Republic | 8. Afghanistan |
| 4. Yemen | 9. Lebanon |
| 5. Haiti | 10. Ethiopia |

The total budget for our programmes in these 10 countries is 445.7 million euros, **51 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 | 3,322 |
| 2. Democratic Republic of Congo | 2,867 |
| 3. Central African Republic | 2,629 |
| 4. Afghanistan | 2,303 |
| 5. Haiti | 1,835 |

Outpatient consultations

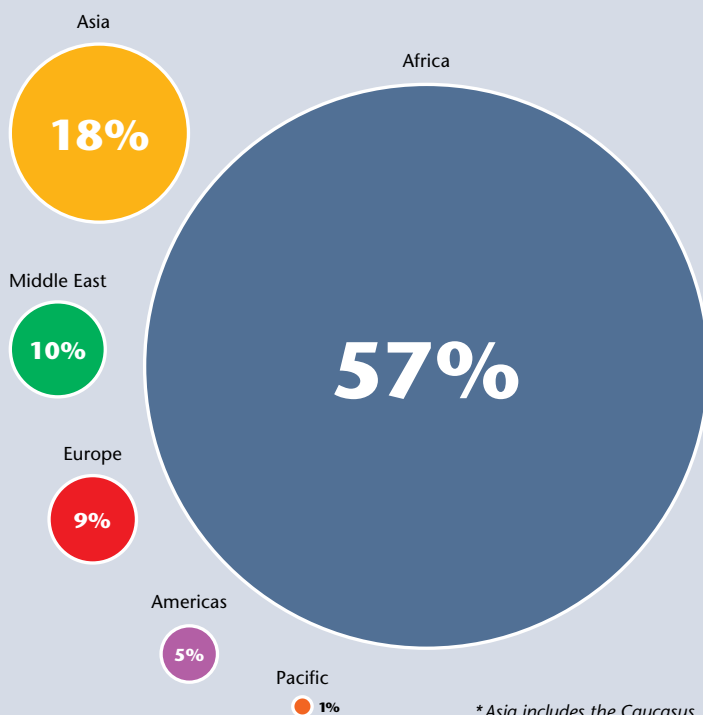
Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.

- | | |
|---------------------------------|-----------|
| 1. Democratic Republic of Congo | 1,652,000 |
| 2. Central African Republic | 1,016,100 |
| 3. South Sudan | 915,900 |
| 4. Ethiopia | 413,200 |
| 5. Niger | 408,000 |
| 6. Afghanistan | 366,200 |
| 7. Pakistan | 358,300 |
| 8. Lebanon | 342,100 |
| 9. Kenya | 281,100 |
| 10. Sudan | 241,700 |

Project locations

Number of projects

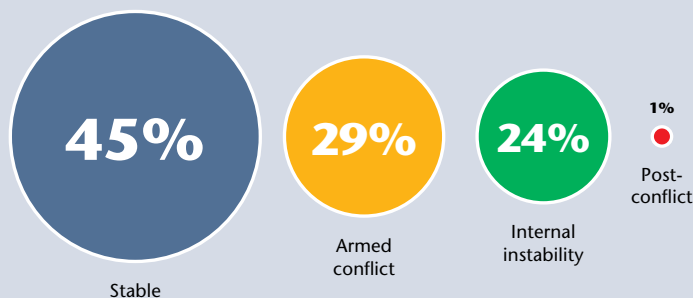
Africa	256	Europe	38
Asia*	81	Americas	22
Middle East	44	Pacific	5



Context of intervention

Number of projects

Stable	203
Armed conflict	130
Internal instability	109
Post-conflict	5



2015 ACTIVITY HIGHLIGHTS

8,132,100
outpatient consultations



594,900
patients admitted



2,299,200
cases of malaria treated



60,500
severely malnourished children admitted to inpatient feeding programmes



333,900
HIV patients registered under care at the end of 2015



230,400
patients on first-line antiretroviral treatment at the end of 2015



9,700
patients on second-line antiretroviral treatment at the end of 2015 (first-line treatment failure)



6,800
HIV-positive pregnant women received prevention of mother-to-child transmission (PMTCT) treatment



4,400
eligible babies born in 2015 who received HIV post-exposure treatment



219,300
births assisted, including caesarean sections



83,500
major surgical interventions, including obstetric surgery, under general or spinal anaesthesia



11,100
patients medically treated for sexual violence



18,100
patients on tuberculosis first-line treatment



2,000
patients on MDR tuberculosis treatment, second-line drugs



184,600
individual mental health consultations



39,300
group counselling or mental health sessions



32,600
people treated for cholera



1,537,400
people vaccinated against measles in response to an outbreak



45,600
people treated for measles



326,100
people vaccinated against meningitis in response to an outbreak



23,700
migrants and refugees rescued and assisted at sea



This data groups together direct and remote support 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 for adults.

Diagnosis is complicated, requiring laboratory analysis of blood samples. There are currently only two medicines available to treat the disease: benznidazole and nifurtimox, which were both developed over 40 years ago. The cure rate is almost 100 per cent in newborns and infants 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 is often toxic and can take longer than two months to complete. Despite the clear need for safer, more effective 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 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 32,600 people for cholera in 2015.

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. While vaccines are currently in development, there is no treatment for the virus and 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, in some cases haemorrhaging, and often death. Despite being so deadly, it is a fragile virus that can be easily killed with sunshine, heat, bleach, chlorine and even soap and water.

Preventing transmission is essential: patients are treated in Ebola treatment centres, where strict infection control procedures are in force. Identifying those 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, how to try and keep themselves safe, and what to do if they develop signs.

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

HIV/AIDS

The human immunodeficiency virus (HIV) is transmitted through blood and body fluids and gradually breaks down the immune system – usually over a three- to 15-year period, although 10 years is more usual – leading to acquired immunodeficiency syndrome, or AIDS. As immunodeficiency 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 with HIV. Combinations of drugs known as antiretrovirals (ARVs) help combat the virus and enable people to live longer, healthier lives without their immune systems deteriorating rapidly. ARVs also significantly reduce the likelihood of the virus being transmitted.

As well as treatment, MSF's comprehensive HIV/AIDS programmes generally include health promotion 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 333,900 people living with HIV/AIDS and antiretroviral treatment for 240,100 people in 2015.



MSF staff unload one tonne of medical supplies – mainly malaria testing kits – from an MSF plane at Paoua airstrip in the Central African Republic.

Kala azar (visceral leishmaniasis)

Largely unknown in high-income countries (although it is present in the Mediterranean basin), kala azar – Hindi for ‘black fever’ – is a tropical, parasitic disease transmitted through bites from certain types of sandfly. It is endemic in 76 countries, and of the estimated 200,000–400,000 annual cases, 90 per cent occur in Bangladesh, India, Ethiopia, South Sudan, Sudan and Brazil. Kala azar is characterised by fever, weight loss, enlargement of the liver and spleen, anaemia and immune-system deficiencies. Without treatment, kala azar is almost always fatal.

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

Treatment options for kala azar have evolved during recent years. Liposomal amphotericin B is becoming the primary treatment in Asia, either alone or as part of a combination therapy. This is safer and involves a shorter course of treatment than previously used medication. However, it requires intravenous administration, which remains an obstacle

to its use in local clinics. In Africa, the best available treatment is still a combination of pentavalent antimonials and paromomycin, which 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 5,400 patients for kala azar in 2015.

Malaria

Malaria is transmitted by infected mosquitoes. Symptoms include fever, pain in the joints, shivering, 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 updated to recommend the use of artesunate over artemether injections for the treatment of severe malaria in children.

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

In 2012, MSF used a seasonal chemoprevention strategy for the first time, in Chad and Mali. Children under the age of five took oral antimalarial treatment monthly over a period of three to four months during the peak season for the disease.

MSF treated 2,229,200 people for malaria in 2015.

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 the age of 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 a ratio using weight and height, or by measurement of the mid-upper arm circumference. According to these measurements and to the clinical state, undernourished children are diagnosed with moderate or severe acute malnutrition.

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

MSF admitted 181,600 malnourished children to inpatient or outpatient feeding programmes in 2015.

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 severe respiratory infection, diarrhoea, dehydration 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, large numbers of people are left susceptible to the disease, especially in countries with weak health systems, where outbreaks are frequent and where there is limited access to health services.

MSF treated 45,600 patients for measles and vaccinated 1,537,400 people in response to outbreaks in 2015.

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. Even with treatment, approximately 10 per cent of people infected will die. 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. The vaccination campaigns have helped to stop the cycle of deadly meningococcal A epidemics in the region, but smaller-scale outbreaks caused by other strains continue to be recorded. An epidemic in Niger in 2015, which was an extension of an epidemic in neighbouring Nigeria, was the first large meningococcal C epidemic ever recorded in the country.

MSF vaccinated 326,100 people against meningitis in response to outbreaks in 2015.

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, process their feelings and learn to cope so that general stress levels are reduced. MSF also offers group counselling, which is a complementary approach.

MSF staff held 223,900 individual and group mental health sessions in 2015.

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 – cooking kits contain a stove, pots, plates, cups, cutlery and a jerrycan so that people can prepare meals, while a washing kit includes soap, shampoo, toothbrushes, toothpaste and laundry soap.

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

MSF distributed 132,300 relief kits in 2015.

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, newborns benefit from medical attention and sick newborns and babies with a low birth weight receive appropriate 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 666,600 antenatal consultations in 2015.

Sexual violence

Sexual violence occurs in all societies and in all contexts at any time. Destabilisation often results in increased levels of violence, including sexual violence. Sexual violence is particularly complex and stigmatising, has long-lasting consequences and can result in important physical and psychological health risks.



Patients suffering from severe malaria can sometimes develop thin, watery blood.

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

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

MSF medically treated 11,100 patients for sexual violence-related injuries in 2015.

Sleeping sickness (human African trypanosomiasis)

Generally known as sleeping sickness, human African trypanosomiasis is a parasitic infection transmitted by tsetse flies that occurs in sub-Saharan Africa. In its latter stage, it attacks the central nervous system, causing severe neurological disorders and 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. The reported number of new cases fell by 77 per cent between 1999 and 2014 (from around 28,000 to 3,700).

During the first stage, the disease is relatively easy to treat but difficult to diagnose, as symptoms such as fever and weakness are non-specific. The second stage begins when the

parasite invades the central nervous system and the infected person begins to show neurological or psychiatric symptoms, such as poor coordination, confusion, convulsions and sleep disturbance. Accurate diagnosis of the illness requires a sample of spinal fluid.

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

Tuberculosis (TB)

One-third of the world's population is currently infected with the tuberculosis (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 sputum 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. Two new drugs – bedaquiline and delamanid – have recently become available to some patients who have no other treatment options left.

MSF treated 20,100 patients for TB, of which 2,000 for MDR-TB in 2015.

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 World Health Organization and MSF. Currently, these are DTP (diphtheria, tetanus, pertussis), measles, polio, hepatitis B, *Haemophilus 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 the age of 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 conducted 258,800 routine vaccinations in 2015.

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.



THE CRISIS IN YEMEN

© Benoit Finck/MSF

Life has been a struggle for the Yemeni people for many years, due to poverty, chronic malnutrition and a weak healthcare system, but the situation deteriorated significantly during 2015 as the conflict escalated.

Violence first erupted over three years ago when President Saleh and his General People's Congress party left office. The Ansarallah/Houthi party, which is associated with Saleh's regime, is now in conflict with an alliance made up of the southern Yemeni independence movement, Islamist groups, local tribal alliances and jihadist forces that are backed militarily by a Saudi-led coalition comprising other Gulf countries and western powers. War is being waged to determine who will control the country.

The international coalition launched an aerial bombing campaign in March, and as the strikes intensified, more and more people were displaced and access to healthcare became increasingly difficult. At this time of immense medical and humanitarian needs, however, most aid agencies present in Yemen evacuated their international staff to Amman in Jordan. No different from others in its initial reaction, Médecins Sans Frontières (MSF) also moved a large number

of its international team out of Yemen but made the decision to keep key staff in both Sana'a and Aden, while also mobilising additional people with experience in conflict settings. This meant that medical and logistical expertise could be deployed in a matter of days.

The Saudi-led coalition imposed a weapons embargo at the beginning of the conflict, which blocked most ships and planes from delivering goods to the country. This disrupted supplies of medicines and fuel, which in turn forced many health facilities to close at a time when the number of civilian casualties had been rising. The clinics that are still open are running at low capacity to save on fuel. In April, the United Nations Security Council approved this punishing practice, although Yemen had depended heavily on imports even before the conflict. Despite the blockade and the destruction of the country's main airports, however, MSF negotiated with

local authorities and the Saudi-led coalition to continue supplying international staff and tonnes of medical supplies and drugs to Yemen by flying chartered planes into Sana'a and sending ships to Aden.

With a supply route in place, MSF continued to operate its surgical trauma centre in Aden and treated patients from both sides of the conflict. The project experienced some security incidents but its neutrality was relatively well respected by ground forces, even when fighting occurred nearby. Patients came to the facility from Lahj governorate and from districts across the city, and the team performed more than 6,000 lifesaving surgical interventions in 2015. In response to an upsurge in fighting, MSF opened a new project in Taiz in the summer. Medical supplies were donated to a number of hospitals and emergency rooms in the city and across frontlines. Staff saw an increase in the number of patients with conflict-related injuries towards the

» ABOVE PHOTO CAPTION: MSF staff working in an operating theatre at the emergency surgical unit in Aden, Yemen.

end of the year. In November, also in Taiz, MSF opened a 100-bed mother and child hospital, which operates as a key obstetrics, gynaecology and paediatrics referral centre in the war-torn city. The team also scaled up their activities in existing projects in northern governorates such as Sa'ada, Amran and Hajjah.

External restrictions like the blockade were not the only hurdles faced by Yemenis in need of urgent medical assistance this year: within an increasingly divided country and with shifting frontlines, people delayed their visits to health facilities to avoid passing through dangerous checkpoints, and in some places medical facilities were deliberately targeted in aerial attacks. In October, an MSF-supported hospital in Haydan was destroyed by an airstrike,

and in December, nine people were wounded when an MSF clinic in Taiz was hit. There was a subsequent reduction in the availability of healthcare in these locations, as MSF activities could not restart immediately. These targeted attacks on health facilities have further complicated emergency medical assistance, as they have fostered a climate of fear, and many Yemenis are now too afraid to go to hospital for treatment.

The international emergency response to the crisis has been limited in its scope and impact – some say no better than a sticking plaster. More needs to be done by humanitarian organisations – the herculean task of providing care for the Yemeni people cannot be left to the few currently working in the country. Field-

experienced aid workers and good-quality humanitarian leadership are required to bring assistance to vulnerable communities beyond frontlines and partisan differences. There are risks for aid workers in Yemen, but the needs are great and some organisations, including MSF, have shown that it is possible to work effectively in the country.

However, it is true that all the goodwill in the world will achieve nothing if the warring factions do not find ways to minimise the suffering of Yemeni civilians and decrease the levels of violence in the country. Truces or more comprehensive ceasefires should be encouraged to make it easier for local communities to procure basic supplies and seek out medical consultations.



© Malak Shaher/MSF

Najeeba, a one-year-old child suffering from acute malnutrition, is treated at MSF Al-Salam hospital in the town of Khamer, Yemen.

THE ATTACK ON KUNDUZ TRAUMA CENTRE

© Victor J. Blue

On 3 October 2015, the Médecins Sans Frontières (MSF) trauma centre in Kunduz, Afghanistan, came under targeted and repeated US airstrikes.

The hospital was destroyed and 42 people died, including 24 patients and 14 staff. It had been open since 2011 and provided free, high-quality medical and surgical care to victims of violent and non-violent trauma. In the year before the attack, staff had treated more 22,000 people and performed almost 6,000 surgical interventions. Below are two edited testimonies from staff who worked there. For details of MSF's ongoing activities in Afghanistan, see pages 26–27.

Sayed Hamed Hashemy, a surgeon from Afghanistan

Dr Hashemy was operating on a patient when the airstrikes hit the hospital. Two weeks later, he went back to visit the site.

It was heartbreaking to walk into the hospital compound and to see the building totally destroyed. Everything was burned. The operating theatre where I had been working on the night of the attack had holes in its ceiling and walls. Oxygen bottles and the operating table were lying in pieces and the C-arm [orthopaedic imaging system] was destroyed. In some parts, the hospital no longer had a roof.

Time had frozen: you could sense the moment when everyone had stopped working. It was really strange to see the building like that, and I was sad as I thought about the colleagues who are not with us any more.

On the night of the bombing, I was the on-call surgeon. I was in the operating theatre with an international colleague doing a complicated procedure on a patient when we heard an explosion quite near us. We didn't move, however, as we didn't expect

a second one. Then, there was another explosion, and the lights went off.

My colleagues were running in the corridor, jumping out of the windows and everyone was looking for a safe place. Everything was falling around us; there was fire, a lot of smoke, loud sounds and shaking from the explosions.

We ran to the sterilisation room but we had stores of gas in there and it didn't feel safe, so we went back into the corridor to try and reach the basement but we found it was not safe to go back to the operating theatre corridor.

People were scared, colleagues were shouting, there were bits of ceiling, windows and doors everywhere. We finally got out of the building after several minutes of trying to find our way through the chaos. The nearest outlying building was several metres away and we could not risk running there to seek safety. We jumped down into a structure about two metres below the ground. We stayed there for almost an hour and only decided to get out of our hiding place

when we saw fire coming out of the nearby windows in the main building. We ran to the caretaker's room several metres away from our hiding place and sought shelter there until the explosions finally stopped. I thought: will I see my friends and colleagues alive in the morning?

When the explosions finally stopped we heard the sound of colleagues looking for injured people. I made my way to the morning meeting room and it was really a bad moment. I saw staff crying and hugging each other. We started to help the wounded. We inserted chest tubes and stopped bleeding wounds. In spite of the limited resources, we did a laparotomy on one of our doctors who was critically wounded but he had already lost a lot of blood and he died shortly afterwards.

The week before the bombing, I worked non-stop and my mother feared for my safety, but I couldn't stay at home when I was needed at the hospital. As a doctor, I consider it my commitment to help everyone in need. When I returned to the hospital, I saw it burned, abandoned and no longer full of hope.

» ABOVE PHOTO CAPTION: A missile hole in the wall of the Kunduz trauma centre, after a sustained attack on the facility killed 42 people, including 38 MSF patients and staff.

Dr Kathleen Thomas, intensive care doctor from Australia

At 7.35am a dozen international staff from all over the world pile into two MSF Land Cruisers – one for the men, one for the women. We peer through the car windows covered in anti-blast film, for our only glimpse at the hustle and bustle of Kunduz city. I see Mujeeb, the administration officer, walking, and Najib, the data entry officer, riding his bike, both heading to the hospital to start their day's work.

By 10am the hospital is its usual flurry of activity. I leave the intensive care unit (ICU) to review a patient on the ward. I pass a lab technician bent over a microscope in pathology, walk through the emergency room (ER) and past the operating theatres. A patient from the wards is being pushed through the doors by a stretcher-bearer, about to undergo specialised trauma surgery by a team of expert international and national surgeons. This is the only facility to offer this type of procedure in all of northern Afghanistan.

Six days before the airstrike

It was about 2am when I was woken by the sounds of intense fighting. Having been in Kunduz for five months of the 'fighting season', I had grown accustomed to the sounds of war ... but this was different. It was close, heavy and coming from all directions. I waited for the phone call from the ER announcing the onslaught of patients and the request for help; it took many hours to arrive as the fighting was too heavy for anyone injured to actually get to the hospital. Then, as the sun rose, the phone call came and so began the longest week of my life.

The first day was chaos – more than 130 patients poured through our doors in only a few hours. Despite the heroic efforts of all the staff, we were completely overwhelmed. When I reflect on that day now, what I remember is the smell of blood that permeated through the ER; the touch of desperate people pulling at my clothes to get my attention, begging me to help their injured loved ones; the wailing, despair and anguish of parents of yet another child

lethally injured by a stray bullet whom we could not save; my own sense of panic as another and another and another patient was carried in and laid on the floor of the already packed emergency department; and all the while in the background the tut-tut-tut of machine guns and the occasional large boom from explosions that sounded far too close for comfort.

The hospital swelled far beyond our capacity that week. On the wards, all the beds were pushed close together to place additional mattresses on the floor. The demand for intensive care treatment was constant. We did our best with our limited resources, but helplessly watched numerous patients die who, in normal circumstances, would have survived. Some needed certain rare blood types but no one could get to the hospital to donate; some needed life support from a ventilator, but we had only four machines – not enough to go around; some had been stuck in their homes unable to come to hospital for several days, and by the time they arrived their bodies were overrun by infection.

When the US military's aircraft attacked our hospital, its first strike was on the ICU. With the exception of one, all the patients in the

unit died. The caretakers with the patients died. Dr Osmani died. The ICU nurses, Zia and Strongman Naseer, died. The ICU cleaner, Nasir, died. I hope with all my heart that the three sedated patients in ICU were deep enough to be unaware of their deaths – but this is unlikely. They were trapped in their beds, engulfed in flames. One small consolation is that among the chaos, Toorialay, the only ICU nurse to survive, in an act of remarkable bravery, somehow managed to scoop a little girl up from her bed and run out of the building to safety.

The same horror that rocked the ICU rocked the rest of the main building. Our colleagues didn't die peacefully like in the movies. They died painfully, slowly, some of them screaming out for help that never came, alone and terrified, knowing the extent of their own injuries and aware of their impending death. Countless staff and patients were injured: limbs blown off, shrapnel through their bodies, burns, and pressure wave injuries to the lungs, eyes and ears. Many of these injuries have left permanent disability. It was a scene of nightmarish horror that will be forever etched in my mind.

**Some names have been changed*



An MSF staff member stands amidst the burning rubble of the MSF trauma centre in Kunduz, Afghanistan after it was destroyed by US airstrikes.

In 2015, 106 aerial bombing and shelling attacks hit 75 MSF hospitals and MSF-supported hospitals. Of these, 63 were in Syria, five in Yemen, five in Ukraine, one in Afghanistan and one in Sudan.

After the Kunduz trauma centre was targeted in October, over one million people in northeastern Afghanistan were – and remain – deprived of high-quality surgical care. In Yemen, Haydan hospital was destroyed in an airstrike – it was the only remaining operational facility in a district of nearly 200,000 people. For each publicised attack, dozens of locally-run hospitals are bombed and their destruction goes unreported or fails to generate outrage.

In the Central African Republic in 2015, MSF was forced to partially suspend its activities at Kabo hospital, after an attack by two unidentified gunmen. In South Sudan, the hospital, office and pharmacies in Denthoma 1 displaced person camp in Melut were looted and vandalised, and the MSF compound in Leer was looted twice by armed men. Teams were forced to evacuate, leaving vulnerable people without treatment.

Behind each attack on health facilities are tens of thousands of people who are deprived of access to medical care.

AROUND LAKE CHAD: PEOPLE LIVING IN FEAR

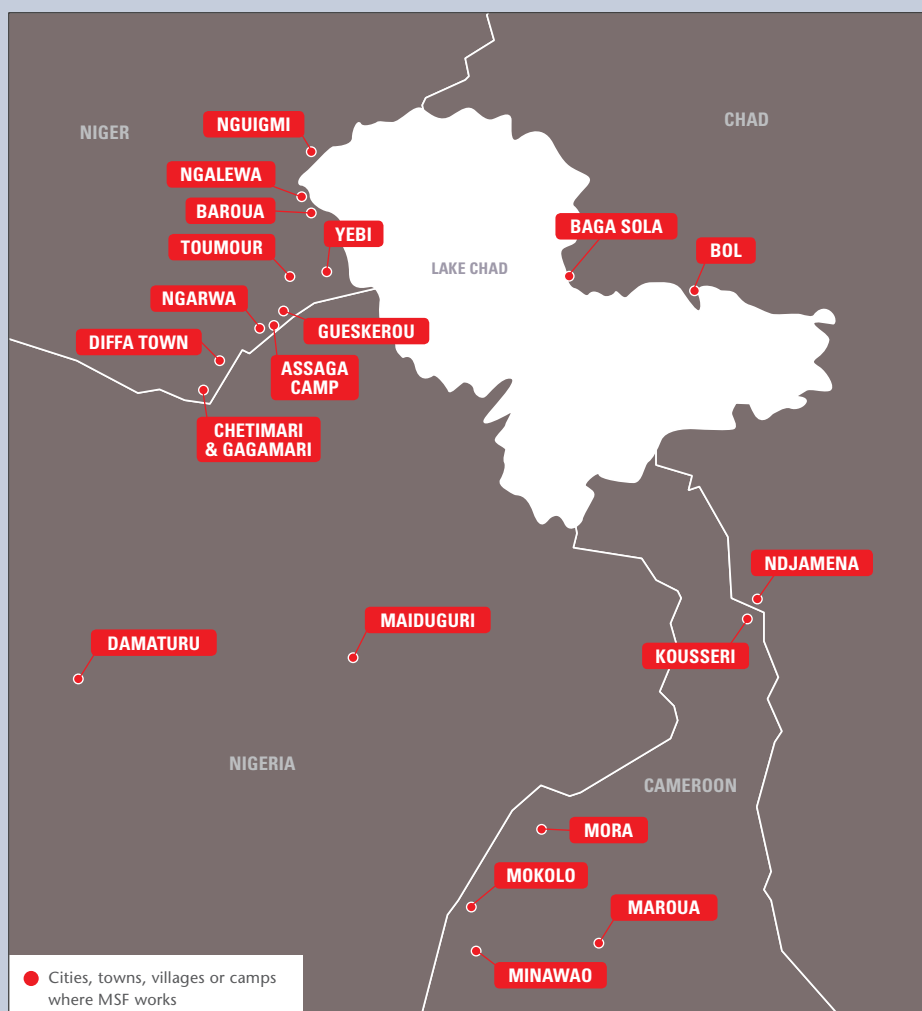
In recent years the region around Lake Chad – a body of fresh water in west-central Africa that straddles Chad, Cameroon, Nigeria and Niger – has become an epicentre of violence. The resulting suffering and displacement has meant that Médecins Sans Frontières (MSF) has expanded its operations in the region but unfortunately the magnitude of the humanitarian crisis remains largely unknown.

For many years the lake has been shrinking, which has forced people to compete for resources and has resulted in conflict, food insecurity, livestock deaths and increased poverty. There are recurrent outbreaks of disease in the region, and healthcare is almost non-existent.

Since May 2013, attacks by Islamic State's West Africa Province (ISWAP), also known as Boko Haram, have put even more pressure on the populations and have forced thousands of people from their homes and across borders. Retaliatory governmental military operations have also contributed to mass displacement, and to date over 2.5 million people have been rendered homeless as a result of violence. This is fast becoming Africa's largest displacement crisis, and is aggravating what was already a desperate situation.

DR JEAN-CLÉMENT CABROL, MSF Director of Operations

"What is striking about this crisis is the sheer terror under which people are living. Attacks are occurring at markets, [in] places of worship and schools causing widespread fear and displacement. Meanwhile, counter-offensives and violence force people out of their villages to search for a place to live in safety and peace. People feel unsafe and are unwilling to return to their homes. It is as if they are just waiting. It is difficult to see what the future will hold for them."





In April 2015, after ISWAP attacked the island of Karamga and killed Nigerian soldiers and civilians, thousands of people living in around 100 island villages on Lake Chad were ordered by the authorities to evacuate ahead of an offensive. With little in place to receive them, many found themselves living in dire conditions.

MOHAMMED,
from Nigeria and now in Chad

"The government asked us to leave our village for security reasons. We found this place ourselves. Since then, nobody has visited us. We are surviving on what we have or can find. We have nothing to do."



ESTHER, 24, from Nigeria

"Boko Haram fighters attacked our village in the middle of the night ... They killed several people including my father and one of my sisters. We tried to flee, but they attacked us again while we were on the road. My mother and my sister had to stay behind. I hope I will find them one day. I arrived in Cameroon with my 9-month-old daughter and my 14-year-old sister after walking for two days."

Health facilities are few and far between in the region and some have closed as they lack essential drugs, equipment or medical staff. The insecurity also impedes thousands of people from accessing the healthcare they need, as they cannot reach hospitals or clinics or fear violence on the road. This is especially problematic as the rainy season causes an increase in the number of people suffering from waterborne diseases such as malaria and diarrhoea which, combined with malnutrition, are especially dangerous for young children.



Close to Baga Sola in Chad, MSF is working in the Dar as Salam refugee camp and is providing mental healthcare to refugees, many of whom display symptoms of depression and anxiety. In 2015, there was also a weekly workshop for children, where they were encouraged to express their emotions through drawing what they had witnessed (see left). MSF is also providing psychosocial support to people in Diffa in Niger, due to the high levels of violence.

The living conditions of displaced people and refugees – who have little access to safe water and sanitation – are critical. Many are unable to harvest their fields, and food prices have risen dramatically. This is adding pressure to an already fragile and neglected region where basic services are not sufficient. Hundreds of thousands of people are being supported by local communities, who are coming under strain as they struggle to survive with limited means.

**HASSAN,
from Nigeria and now in Chad**

"We left our fishing tools behind when we fled our village. Survival is very difficult. If we had our tools, we would be able to fish to survive."



In Cameroon, the security situation along the border with Nigeria remains volatile and over 100 refugees continue to arrive on a daily basis in the camp established by national authorities in the Extreme North region. Here, MSF provides basic and nutritional healthcare consultations. MSF is also present in Kousseri, on the border with Chad, where tens of thousands of displaced people are scattered around the city.



© Christelle Nsama/MSF

In mid-August, the first cases of cholera appeared in the camps in Nigeria, and as well as providing medical care it was essential to prioritise hygiene and sanitation activities. Cholera is more common in densely populated areas, and the infection can spread rapidly.

For more details on MSF's response in the Lake Chad region, see the country reports for Cameroon, p.31; Chad, pp. 34, Niger, pp. 70–71; and Nigeria, pp. 72–73.



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WHY MÉDECINS SANS FRONTIÈRES (MSF) NEEDS INDIA TO REMAIN OPEN FOR BUSINESS

Carmen Jose-Panti is 36 years old. She lives with her husband and her two children in Tete, Mozambique. She runs a small business from home selling items such as soap and salt, and works in a health clinic where she manages patient files.

A mother, a wife, a business owner, an employee and a community member, Carmen is also HIV positive.

Having discovered she was infected with the virus in 2007, Carmen started antiretroviral (ARV) treatment in 2009. Carmen is alive, healthy and able to contribute to her community because she takes generic versions of HIV medicines, ARVs made in India.

Carmen is one of more than 230,000 people worldwide living with HIV who receive treatment through MSF-supported HIV programmes. A recent survey of the drugs MSF buys for its field programmes shows that 97 per cent of those it uses to treat people living with HIV are generic medicines from India. It's not just ARVs that MSF turns to India for, though; more than three-quarters (77 per cent) of the drugs MSF uses to treat its 23,000 patients with tuberculosis (TB),

and nearly a quarter (22 per cent) of the medicines it uses to treat 2.1 million cases of malaria are also generics from India.

India is known as the 'pharmacy of the developing world' for the volume of affordable essential medicines it supplies to developing countries – to people like Carmen.

How did India take on this role? While the US, Switzerland and other high-income countries granted patent monopolies on medicines (meaning that companies had the sole right to make and sell them for a set period of time), India didn't allow them until 2005, as it considered drugs to be an essential commodity requiring multiple suppliers and affordable prices.

Although international trade rules forced India to start granting product patents on medicines in 2005, it did so within stricter

parameters – far tougher than those in wealthy and most developing countries – and also introduced other pro-public health provisions in the patent law that allowed for the continued supply of generic medicines already in production.

All this meant that the generics industry in India flourished and was able to produce medicines that were more affordable than the originals. In 2001, ARVs to treat HIV were priced at over US\$10,000 per patient per year. Millions of people living with the disease in Africa and other parts of the developing world died. Indian generics company Cipla then started producing a single pill containing three drugs for just under US\$1 per day. Fifteen years later, nearly 16 million people – including Carmen – are receiving HIV treatment. Today, standard HIV treatment costs around US\$100 per person per year.

Indian generics under threat

The laws and policies that enabled India to become the generics-producing powerhouse it is today are under increasing threat. Major pharmaceutical companies like Novartis first went on the attack in 2006. After being denied a patent for a cancer drug in India, Swiss company Novartis legally challenged part of its patent law, which – if Novartis had won – would have had a dramatic impact on the country's ability to produce generics, as it would have forced the Indian Patent Office to grant patents that were not merited under India's public health and innovation-friendly law. The case lasted seven years and went all the way to India's Supreme Court, but in April 2013, Novartis – to the relief of MSF and millions of people everywhere – lost the case and India's law remained intact.

The EU is applying pressure on India in a different way, by pushing it to sign a free trade agreement that would severely curtail its production of generics. Negotiations started nine years ago and are ongoing.

In another agreement involving countries across south and southeast Asia – the Regional Comprehensive Economic Partnership – wealthy countries like Japan and South Korea are trying to introduce provisions that could block the trade in generic medicines between developing countries.

The greatest pressure has come from the US, however, with the US Trade Representative threatening India with trade sanctions if the government does not take steps to modify its patent law in line with the preferences of US drug companies, and grant more patents.

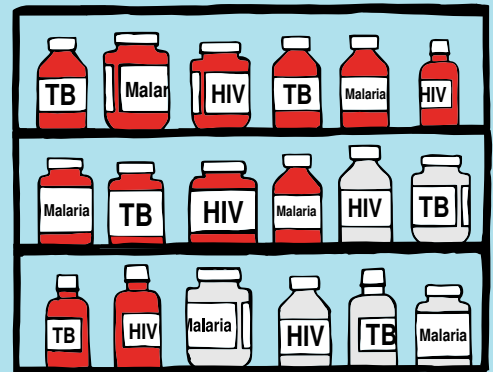
Over the years, Indian ministers, policy makers and government officials have withstood the pressure but now a new intellectual property policy drawn up by the Indian government could signal a change in the way in which the patent law is interpreted and pharmaceutical patents are enforced. This policy could even eventually lead to legislative changes that would permanently undermine India's status as the pharmacy of the developing world.

As MSF relies so heavily on generic medicines from India, it keeps a close eye on developments in the country through the Access Campaign. If the laws and policies change, newer generations of drugs won't be available as generics, and MSF won't be able to treat as many people. New restrictions could also halt the production of paediatric versions and combinations of drugs to treat diseases like HIV – which make treatment for patients and the work of medical staff much easier. It would mean that in the future, our medical staff wouldn't be able to provide the level of care that patients like Carmen deserve.

It's for this reason that MSF continues to raise the alarm on this issue to make sure that India can remain open for business in the future. In 2015, through the Access Campaign, MSF launched its 'Hands Off Our Medicines' campaign, urging India to stand strong amid the pressure to grant patents more widely and limit the production of affordable medicines.

2/3

of the medicines MSF uses to
**treat people with TB, HIV and
malaria are generics made in India.**



#HandsOffOurMeds

Find out more: handsoff.msf.org





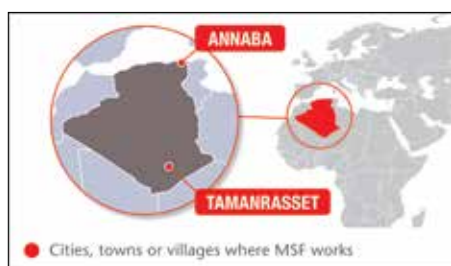
A woman and child in the Nyarugusu refugee camp in Tanzania, where MSF conducted a cholera vaccination campaign to protect more than 130,000 refugees from the disease.

ACTIVITIES BY COUNTRY

25	ALGERIA	40	GEORGIA	56	GREECE	74	PAKISTAN
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28	BANGLADESH	42	HAITI	59	FRANCE	77	SIERRA LEONE
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29	BOLIVIA	43	IRAN	62	LIBYA	79	SUDAN
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				72	NIGER	90	YEMEN
					NIGERIA		

ALGERIA

No. staff in 2015: 1 | Expenditure: €0.8 million | Year MSF first worked in the country: 1998



Médecins Sans Frontières (MSF) started working in Algeria again in 2015, after an absence of 13 years.

MSF opened a new programme this year to increase the availability of HIV care for vulnerable groups of people, such as migrants, intravenous drug users and sex workers. MSF is working closely with two Algerian organisations in a number of centres run by the Ministry of Health and other partners, including one in Annaba. The aims

of the project are to raise awareness of HIV prevention strategies; offer testing services in the community; create strong links with HIV reference centres in order to provide them with technical support to standardise treatment, monitoring and protocols; and to donate laboratory equipment. The team will also support the decentralisation of care.

ARMENIA

No. staff in 2015: 80 | Expenditure: €2.4 million | Year MSF first worked in the country: 1988 | msf.org/armenia



KEY MEDICAL FIGURES:

210 patients under treatment for TB,
of which **150** for MDR-TB

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

To respond to the TB epidemic in Armenia and the high number of people suffering from the drug-resistant form of the disease, Médecins Sans Frontières (MSF) started supporting the Armenian National Tuberculosis Control Centre (NTCC) in 2005. A first project was set up in Yerevan to treat patients with drug-resistant tuberculosis (DR-TB), and today MSF works in seven *marzes* (regions) of the country, as well as in prisons. By the end of December, 226 DR-TB patients were under treatment in MSF-supported facilities. In November, MSF also supported



Doctors in Vanadzor review chest X-rays of a patient under treatment for drug-resistant tuberculosis.

the NTCC to re-establish thoracic surgery at the Central hospital for TB patients.

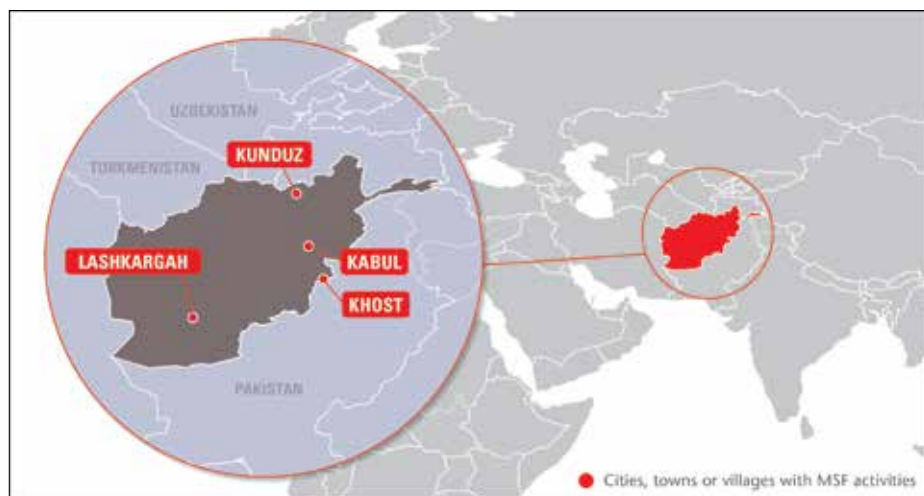
The treatments currently available for patients with DR-TB are largely unsatisfactory, because of their length, toxicity, complexity and limited effectiveness. Outcomes are poor for people suffering from MDR-TB and particularly for those suffering from extensively drug-resistant TB (XDR-TB). Since 2013, MSF has been helping the Armenian health ministry to introduce two

new TB drugs, bedaquiline and delamanid, and between April 2013 and December 2015, 81 MDR-TB and XDR-TB patients were started on these.

As the NTCC increases its capacity, MSF is shifting its focus away from support for 'conventional' MDR-TB treatments and towards the management of MDR-TB and XDR-TB patients receiving new TB drugs. This is part of the UNITAID-funded endTB partnership.

AFGHANISTAN

No. staff in 2015: 2,303 | Expenditure: €27.2 million | Year MSF first worked in the country: 1980 | msf.org/afghanistan | blogs.msf.org/afghanistan



KEY MEDICAL FIGURES:

366,200 outpatient consultations

55,800 births assisted

8,100 surgical interventions

On 3 October 2015, the Médecins Sans Frontières (MSF) Trauma Centre in Kunduz, Afghanistan, was destroyed in an aerial attack that killed 42 people, including 14 MSF staff, 24 patients and four patient caretakers.

At the time of this report going to print, MSF had not yet made a decision regarding restarting medical activities in Kunduz and was in the process of analysing and understanding the circumstances of the attack. MSF is seeking explicit agreement from all parties to the conflict, including the Afghan authorities and the US military, that there will be no military interference or use of force against MSF medical facilities, personnel, patients or ambulances. Equally, that MSF staff can safely provide medical care based solely on medical needs, without discrimination, and regardless of patients' religious, political or military affiliations.

MSF opened the hospital in Kunduz in August 2011, in order to provide free, high-quality surgical care to victims of general trauma, such as traffic accidents, as well as patients with conflict-related injuries. It was the only facility of its kind in the whole northeastern region of Afghanistan. Independently run by MSF, the 84-bed hospital had an emergency room, an intensive care unit, three operating theatres, outpatient and inpatient departments (with separate surgical wards for male and female patients), a physiotherapy department, a laboratory, an X-ray room and a pharmacy. Other services included mental healthcare and health promotion. The hospital

offered services not only to the residents of Kunduz province but also to patients from neighbouring provinces such as Badakhshan, Takhar, Baghlan, Balkh and Samangan. The hospital's capacity reached 92 beds by September 2015, just before it was bombed.

Between January and August, more than 2,400 patients were admitted to the centre, most of whom (88 per cent) had been injured in road or domestic accidents. Twelve per cent presented with injuries caused by explosions, gunshots or bombings. Over the same period, MSF staff carried out 18,088 outpatient consultations and 4,667 surgical interventions, including orthopaedic surgery involving internal fixation techniques to repair bones.

Following heavy fighting in Kunduz province in May and June, there were huge influxes of wounded people. In the three weeks after the announcement of the start of the annual 'fighting season', medical staff treated 204 war-wounded patients, 51 of whom were women and children. In June, MSF opened a district advanced post (DAP), a stabilisation clinic in Chahardara – 15 kilometres from Kunduz city – because people living in the area were struggling to access the trauma centre due to fighting, road blocks and checkpoints. Nurses there tended to the wounded and then arranged for them to be transferred to Kunduz trauma centre for advanced care. With the hospital closed, nurses are now only able to provide much-needed basic care in Chahardara.



A young patient has her leg assessed by staff at the MSF trauma centre in Kunduz. The facility was destroyed in an aerial attack six months later, depriving over a million people of access to high-quality surgical care.

On 1 July, three months before the aerial attack, heavily armed men from the Afghan Special Forces entered the MSF hospital compound, physically assaulted and threatened MSF staff, and proceeded to arrest three patients. After an hour, the men released the patients and left the hospital. MSF condemned this incident as an unacceptable breach of international humanitarian law, which protects medical services from attacks.

To read testimonies of the attack on Kunduz trauma centre, see pages 16–17.

Ahmad Shah Baba hospital, Kabul

At Ahmad Shah Baba hospital in eastern Kabul, MSF's support has concentrated on upgrading the facility so it can cater effectively to the needs of the growing population in the area, and capacity has increased to 58 beds. A range of free, high-quality medical services is offered, with a particular focus on emergency and maternal care. Working with the Ministry of Health, MSF ensures treatment for malnutrition, paediatric care, family planning services, health promotion activities and vaccinations. MSF also supports the hospital's laboratory and X-ray department and the Ministry of Health's tuberculosis (TB) treatment programme. In partnership with the International Psychosocial Organisation, MSF provides mental health and psychosocial counselling services.

As the population is growing, and because MSF offers the highest-quality obstetric care in the district, the maternity department is one of the busiest in the hospital. On average, 1,400 deliveries were assisted each month and 16,654 antenatal consultations conducted over the course of the year.

MSF continued running mobile clinics in the most remote of eastern Kabul's suburbs to increase access to free, high-quality preventive and curative healthcare for children under the age of five, and referred severely ill patients to Ahmad Shah Baba hospital. In 2015, more than 5,370 pregnant women were vaccinated, and 6,721 children under five were screened for malnutrition.

Dasht-e-Barchi hospital, Kabul

MSF continued to run a maternity department in Dasht-e-Barchi hospital dedicated to complicated deliveries, and emergency neonatal and obstetric services. The population of Dasht-e-Barchi is estimated to have grown tenfold over the past decade, and the limited public healthcare services in the area are failing to keep pace with the demographic boom. Today, Dasht-e-Barchi hospital and three small satellite health centres are the only options for public healthcare in the district.



A mother struggling to get her baby to breastfeed gives it breast milk through a syringe at the specialised maternity centre managed by MSF in the Dasht-e-Barchi public district hospital in western Kabul.

© Kate Stegemann/MSF

Opened in November 2014, the maternity department is open around the clock, and offers free medical care. During its first year, 10,727 deliveries were assisted, 558 caesarean sections were performed and 1,303 babies were admitted to the neonatal unit with complications such as hypoglycaemia. By the end of the year, up to 300 women were being admitted to the maternity ward each week and 40 babies were being delivered per day.

Khost maternity hospital

Afghanistan is considered one of the most dangerous places in the world to give birth, due to the high number of women who die during pregnancy or labour. The specialised maternity hospital in Khost aims to reduce maternal deaths in the province by providing free, high-quality maternal and neonatal care. In rural areas and away from the big cities, the majority of women do not have adequate access to essential obstetric care, which, in places like Khost, is further restricted by the limited availability of female midwives and doctors.

In 2015, approximately one out of every three babies born in Khost province was delivered in MSF's maternity hospital; in December, deliveries reached a record high of approximately 58 a day and 1,733 in one month. In addition to the maternity ward, there are two operating theatres, a neonatal unit and a dedicated women's health clinic. MSF also offers vaccinations for newborns, family planning and health promotion activities.

In order to focus on caring for women with complicated deliveries, who are most at risk of dying, and to manage the large number of patients, MSF is working to improve the referral system to the Ministry of

Health's hospital. When the MSF maternity hospital reaches maximum capacity, patients showing no signs of complications are referred to the provincial hospital.

Boost hospital, Lashkargah, Helmand province

Much of the area surrounding Lashkargah was the scene of active fighting in 2015, although MSF's Boost hospital continued to function in the provincial capital as normal. For the past six years, MSF has been supporting Boost hospital, one of only three referral hospitals in southern Afghanistan. In 2015, MSF began extensive rehabilitation of the hospital building. Modern central heating was installed, and the interior was painted and refurbished to provide better infection control. A new 54-bed maternity ward, a 24-bed neonatal intensive care unit and a 10-bed paediatric intensive care unit were also built. By the end of the year, 12,721 babies had been delivered in the hospital.

MSF supports the hospital with surgery, internal medicine, emergency services and intensive care. In mid-2015, the team also began supporting the diagnosis and follow-up of TB patients, addressing a major yet under-reported public health concern in Afghanistan, and 181 patients started first-line treatment. At the end of the year, an MSF surgical burns specialist provided training to improve treatment for the high number of burns patients seen at the hospital.

Malnutrition continues to be one of the main causes of child mortality in the region, and the hospital's intensive therapeutic feeding centre treated 2,281 children this year, many of whom were suffering from severe malnutrition.

BANGLADESH

No. staff in 2015: 335 | Expenditure: €3.6 million | Year MSF first worked in the country: 1985 | msf.org/bangladesh



KEY MEDICAL FIGURES:

110,600 outpatient consultations

18,100 antenatal care consultations

6,100 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 Rohingya who have 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. Close to the Kutupalong makeshift camp in Cox’s Bazar, MSF runs a clinic providing comprehensive basic and emergency healthcare, as well as inpatient and laboratory services to Rohingya refugees and the local community. During the year, teams carried out around 93,000 outpatient, 2,700 inpatient and 3,300 mental health consultations. Almost 8,000 women attended an initial antenatal consultation, and around 16,000 antenatal and 5,000 postnatal consultations were performed overall.

Poor living conditions in slums

In Kamrangirchar and Hazaribagh, teams visited factories and tanneries and conducted more than 8,000 outpatient consultations. MSF is looking for ways to increase access to healthcare for workers based in the slum, many of whom are exposed to hazardous conditions for long hours.

MSF scaled up its sexual and intimate partner violence programme in Kamrangirchar, providing medical and psychological support to nearly 400 people who had been raped. MSF also provided psychological support to more than 700 victims of intimate partner violence.

Emergency response in Dhaka

From January to April, MSF supported the burns unit in Dhaka medical college hospital, offering psychological support to 68 victims of arson attacks during a period of political unrest in the city.

Kala azar research

MSF closed its project in Fulbaria, Mymensingh district, having concluded its research into improved treatment for post-kala azar dermal leishmaniasis (PKDL), a disease that represents a public health threat as it furthers the spread of primary kala azar. The research was a success, and has contributed to the endorsement of a new treatment regimen based on the results.

PATIENT STORY

AMBIA KHATUN – 39 year old post-kala azar dermal leishmaniasis (PKDL) patient, Solimpur village, Trishal subdistrict of Mymensingh

“I work at home and my husband has a job at a Chinese restaurant in Dhaka. In this village there have been plenty of cases of kala azar. In our family two out of three members contracted the disease. Kala azar hit me five years ago. I got frequent fevers; I became very weak and even lost my appetite. I went to doctors in Mymensingh but they failed to identify kala azar. Finally in Trishal subdistrict they treated me with tablets for one month. After that I felt good, but one and a half years later I developed PKDL. I consulted doctors in Trishal again, but the medicines didn’t help. MSF tested me and referred me to their clinic in Fulbaria. With the treatment my lesions have almost disappeared. I think it is crucial to get cured of PKDL. I know that the kala azar virus was in my lesions. Luckily I got rid of it.”

BELARUS

Year MSF first worked in the country: 2015 | msf.org/belarus



In 2015, MSF opened its first project in Belarus, where the incidence of drug-resistant tuberculosis (DR-TB) is extremely high. Over half of Belorussian TB patients are considered to have multidrug-resistant TB.

MSF is supporting the Ministry of Health in three TB dispensaries in the capital Minsk, and is working in a nearby hospitalisation centre in Volkovichi, with the main aim of improving outpatient DR-TB treatment. MSF also provides counselling and socio-economic support for patients, and is using new drugs to treat people with extensively drug-resistant TB (XDR-TB).

More than 100 TB patients received pre-treatment diagnosis, treatment with regular follow up counselling sessions, and social support (food) in order to improve their adherence. MSF also provided treatment using new drugs (bedaquiline and delamanid) for 12 patients with XDR-TB.

BOLIVIA

No. staff in 2015: 10 | Expenditure: €0.5 million | Year MSF first worked in the country: 1986 | msf.org/bolivia



From this year, an integrated strategy with the Ministry of Health for the treatment of Chagas has been applied in Bolivia.

Teams have also been working to facilitate access to treatment for patients with secondary complications of the disease by training medical staff in early detection.

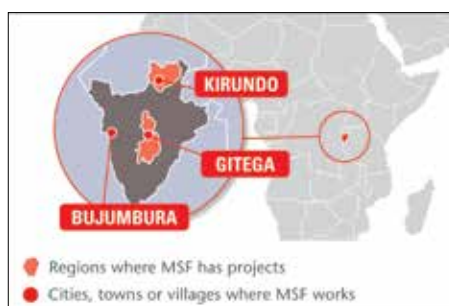
Chuquisaca is one of the departments with the highest prevalence of Chagas in the country, currently 70 per cent. In 2015, MSF initiated the second phase of a rural project in Monteagudo municipality, which involves recruiting and training health staff who work in the 17 health facilities in the area. The project offers free diagnosis and treatment, and so far 3,286 people have been screened (1,186 were confirmed as having Chagas and 224 started treatment).

MSF has been working with the national programme to strengthen community surveillance by training local volunteers and has also assisted in the spraying of houses. The vinchuca bug (*Triatoma infestans*) that transmits Chagas lives in the cracks in the walls and roofs of rural adobe houses.

This year MSF tested EMOCHA, an e-mobile surveillance application. Upon detection of a vinchuca infestation, a community volunteer sends a free SMS to a central information system, and a vector control team is deployed. EMOCHA will be implemented at the beginning of 2016 in Aiquile, Omereque and Pasorapa, in Narciso Campero province.

BURUNDI

No. staff in 2015: 118 | Expenditure: €3.9 million | Year MSF first worked in the country: 1992 | msf.org/burundi



KEY MEDICAL FIGURES:

2,200 outpatient consultations

1,000 surgical interventions

Médecins Sans Frontières (MSF) started working in Bujumbura, the capital of Burundi, in April 2015 when violence increased in the run-up to elections.

Between May and July, MSF supported health posts near where demonstrations took place, enabling 120 patients to access free care in public facilities. MSF also trained the medical staff at Prince Rwagasore hospital in Bujumbura in the treatment of trauma victims, and donated medicines and medical supplies.

MSF has been running a 43-bed trauma centre in Arche hospital in Kigobe, in the north of the city, since July. The centre has an emergency room, two operating theatres and an intensive care unit. Teams provide free medical care to victims of violence, and by the end of the year had treated 693 patients, 417 of whom required hospitalisation.

Due to the upsurge in violence, tens of thousands of Burundians fled over the border to neighbouring Tanzania. MSF started projects there, and more details can be found on page 86.

Handing over the malaria project in Kirundo

In January 2015, the handover of the Kirundo malaria project to the Ministry of Health was finalised with the transfer of the Mukenke district programme. The project had focused on reducing severe malaria-related mortality, and as the use of injectable artesunate is now integrated into the country's malaria treatment policy, MSF's presence is no longer required. This treatment is shorter and more effective than quinine, and there are fewer side effects.

Obstetric fistula in Gitega

Five years after its launch, management of the Urumuri obstetric fistula centre was officially handed over to Gitega regional hospital in August 2015. Fistula is a frequent consequence of birth complications in Burundi, and causes not only pain but also urinary and even faecal incontinence. This in turn often leads to social exclusion and sometimes rejection by friends and family. Since 2010, MSF has treated nearly 1,800 women for fistula at the Urumuri centre and the majority have made a full recovery.

CAMBODIA

No. staff in 2015: 109 | Expenditure: €1.8 million | Year MSF first worked in the country: 1979 | msf.org/cambodia



KEY MEDICAL FIGURES:

640 patients under treatment for TB

In 2015, a project providing prevention, screening with advanced diagnostics and treatment for artemisinin-resistant strains of malaria was launched in Preah Vihear province.

Resistance to artemisinin, currently the most effective antimalarial drug, has been identified in certain parts of Cambodia, and this means that the disease is becoming more difficult to treat and eliminate in these areas. If the resistant parasites spread beyond the Mekong region and reach other parts of Asia or Africa, they would pose a huge public health threat, as was the case when parasites became resistant to earlier antimalarial drugs. Médecins Sans Frontières (MSF) has opened a project in Preah Vihear province, where there is proven resistance to artemisinin. This is an underdeveloped and remote border region, where population movement and a lack of healthcare make malaria hard to control. The new project targets the most at-risk people, and focuses on researching how resistant malaria is transmitted and evaluating which strategies could contribute to the elimination of the disease locally. Throughout the year, MSF worked with the

Ministry of Health and the communities to increase awareness and case detection.

Treating tuberculosis (TB) in Kampong Cham

MSF started to hand over the last of its comprehensive TB care programmes in Kampong Cham province this year, including activities in Cheung Prey, to the Cambodian health authorities and other organisations. The team transferred the resources required for the screening, detection, treatment and follow-up TB patients. The project closed at the end of 2015, with final patient follow-up planned for June 2016.

Staff also carried out three rounds of active TB case-finding in 2015, in Tboung Khmum and Krouch Chhmar districts.

While this brings MSF's response to TB to a close in the country, an agreement has been reached with health authorities to open a hepatitis C programme in 2016.

COLOMBIA

No. staff in 2015: 105 | Expenditure: €2.5 million | Year MSF first worked in the country: 1985 | msf.org/colombia



KEY MEDICAL FIGURES:

14,400 outpatient consultations

13,600 individual and group mental health consultations

In 2015, Médecins Sans Frontières (MSF) shifted its focus in Colombia away from conflict-related projects to providing mental healthcare.

As a result of peace talks, the conflict has decreased in intensity over the last year. The mobile clinics and health posts that MSF was running in the rural areas of Cauca Pacifico were wound down and the clinics finally closed in December. The mental health programme supporting victims of violence, including sexual violence, in Cauca Cordillera is set to close in mid-2016. An emergency response team has been established to intervene when needed in Nariño, Norte de Santander and Uraba. This team, and those of the projects, responded to 39 emergencies during the year, most of them between April and June due to conflict when the ceasefire between FARC and the government broke down.

Throughout the year, MSF teams in Tumaco municipality in Nariño offered mental health support to over 1,500 people who had suffered violence, and offered comprehensive care (medical care and mental health) to 240 victims of sexual violence.

In Buenaventura, where crime rates are very high, a centre offering free, around-the-clock telephone counselling for victims of violence, including sexual violence, was set up in February. Since then, 1,099 people have been assisted.

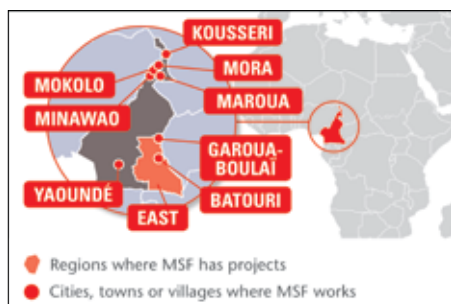
PATIENT STORY

**CAMILO –
30 year old man from Buenaventura**

"Ten years ago my life was quiet but as the violence intensified the only way to continue living and to protect my family was by joining an illegal armed group. I became one of the most respected guys in the area. In a fight with another group I was beaten and suffered paralysis to the left side of my body ... I learned about MSF and have been undergoing psychological therapy for two months already. I am learning how to live with my disability."

CAMEROON

No. staff in 2015: 639 | Expenditure: €12.2 million | Year MSF first worked in the country: 1984 | msf.org/cameroon



KEY MEDICAL FIGURES:

68,400 outpatient consultations

7,900 patients treated in feeding centres

Médecins Sans Frontières (MSF) opened an emergency programme in the far north of Cameroon this year in response to an influx of people fleeing violence in Nigeria.

Conflict and Boko Haram insurgency in northeast Nigeria caused hundreds of thousands of people to seek refuge in Cameroon, Chad and Niger in 2015. During the course of the year, violence spread from Nigeria into the three neighbouring countries, leading to the displacement of tens of thousands more. By December, there were some 70,000 refugees and around 90,000 internally displaced people in Cameroon.

In response, MSF started to provide medical assistance to people in several locations in the north of the country. From February, a team offered medical care, maternal services and nutritional support in the UNHCR-administered Minawao refugee camp. MSF also carried out water and sanitation activities, constructing latrines and showers, and supplying clean water. Some 58,000 people, both refugees and members of the local community, were vaccinated against cholera and tetanus



A child receives the first dose of oral cholera vaccine in Minawao refugee camp.

in a preventive immunisation campaign in August. In the towns of Mokolo and Mora, near the border with Nigeria, MSF provided specialised nutritional and paediatric care to the displaced and the local population, carrying out a total of 12,921 consultations. Nearly 5,000 children were admitted for care. In June, MSF started supporting the surgical ward at the local hospital in Kousséri, on the Chadian border, performing emergency interventions and caesarean sections.

In July, two suicide attacks in the city of Maroua caused a large number of casualties, and MSF helped the local health authorities to treat the wounded.

Assistance to refugees from Central African Republic (CAR)

In the eastern part of Cameroon, MSF continued to assist refugees who had escaped conflict and violence in neighbouring CAR in 2014. MSF supported the Ministry of Public

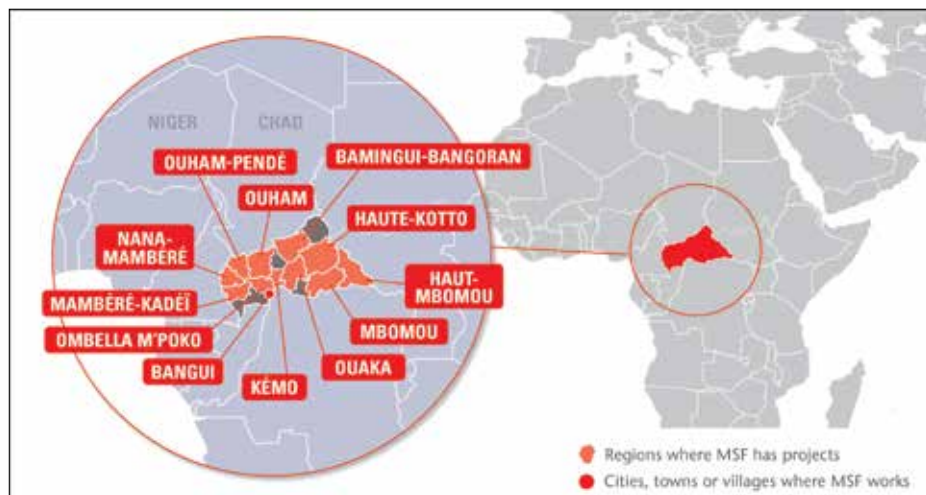
Health by providing medical, nutritional and psychological care to the refugee and host communities in Garoua-Boulai, Gbiti and Batouri. The majority of patients were suffering from malnutrition, malaria and respiratory infections.

In July, MSF handed over its medical activities at the Protestant hospital in Garoua-Boulai to the French Red Cross. During its year at the facility, MSF treated 1,635 children for malnutrition.

In the border town of Gbiti, MSF ran a therapeutic feeding centre, provided primary healthcare consultations and referred severely ill patients to the district hospital in Batouri. MSF also supported the local health authorities at Batouri hospital in the management of patients with severe complicated malnutrition, the majority of whom were children under the age of five. Over 1,800 children were treated in the 90-bed therapeutic feeding centre during the year.

CENTRAL AFRICAN REPUBLIC

No. staff in 2015: 2,629 | Expenditure: €52.9 million | Year MSF first worked in the country: 1997 | msf.org/car | blogs.msf.org/car



KEY MEDICAL FIGURES:

1,016,100 outpatient consultations

585,100 patients treated for malaria

71,800 patients admitted to hospital

51,500 routine vaccinations

10,800 patients treated in feeding centres

9,500 surgical interventions

There were hopes for peace in Central African Republic (CAR) following reconciliation talks in May, but sporadic violence persisted throughout the country and escalated in September in Bangui. This increased the need for urgent humanitarian assistance.

The political crisis that sparked the violent conflict in 2013 has still not been resolved and has exacerbated a pre-existing humanitarian and health emergency. Armed groups have remained active and an estimated 447,000 people are internally displaced, with tens of thousands living in overcrowded, improvised shelters such as schools and churches without adequate food, water, sanitation or healthcare. Over 70 per cent of health facilities have been damaged or destroyed and there is a shortage of trained healthcare workers. Many people are afraid to travel to the few health centres that remain, or cannot afford to pay for treatment.

Médecins Sans Frontières (MSF) and other NGOs provide the majority of the health services, but their work is repeatedly obstructed by armed groups and organised crime. This year, mobile clinics, support activities and vaccination campaigns had to cease operating several times in the areas of Kabo, Bambari and Boguila, and

MSF and other NGO facilities were robbed, attacked and looted. In this atmosphere of insecurity, it was difficult to maintain the supply of medical materials. In Batangafo – located on the frontline between areas controlled by different militias and one of the most insecure areas in CAR – MSF continued to provide basic and specialist healthcare at the referral facility and five health posts, and this included outpatient consultations, surgical interventions and maternal and child health. Batangafo is also the location of one of the country's largest camps for internally displaced people, with a population of over 30,000. More than 10,000 people sought protection in the hospital compound after violent clashes erupted in the town in October.

Despite such incidents, MSF continued to run a substantial programme of basic and emergency healthcare for communities with urgent needs across 13 prefectures and 15 localities, in both MSF hospitals and public health facilities. Teams carried out vaccination campaigns, operated mobile clinics and provided emergency surgery, maternity services, specialised care for victims of sexual violence and treatment for malnutrition, HIV and tuberculosis (TB).

Responding to children's needs

Malaria remains the biggest killer in the country and the leading cause of death in children under the age of five. Three rounds of preventive malaria treatment were administered in Ndele, Kabo and Batangafo between July and November, reaching around 14,000 children.

High malnutrition rates and low vaccination coverage are also compromising children's health and shortening their lives. Only 13 per cent of infants under the age of one are receiving a full immunisation package. In July, MSF launched a year-long campaign across 13 prefectures, targeting 220,000 children under the age of five for comprehensive vaccination against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type B, hepatitis B, pneumococcus, yellow fever and measles.

Healthcare in Bangui

In the capital Bangui, violence is rife, and MSF focuses on emergency services in the city's general hospital. In 2015, the team carried out 4,100 surgical interventions and provided medical and psychological care to 675 victims of sexual violence. A new surgical hospital for emergencies is under construction and should open in 2016. MSF also conducted 37,000 consultations in the predominantly Muslim PK5 enclave, treating children under the age of 15 at Mamadou Mbaïki health centre and people of all ages at the Grand Mosque.

During the year, MSF carried out up to 400 consultations a day at M'poko hospital in the airport displacement camp, and 15,400 emergency cases were treated and/or referred to facilities in Bangui. At Castor health centre, MSF continued to treat victims of violence and provide free maternal and emergency healthcare around the clock. The team assisted over 7,400 births, admitted 10,500 people to hospital and offered comprehensive care to 275 victims of sexual violence.

On 26 September, the death of a motorbike taxi driver sparked retaliatory violence, violent protests against the interim government and clashes with international peacekeepers. Buildings were looted and destroyed and over 44,000 people were displaced. MSF treated almost 200 casualties in two days, many with gunshot wounds. Mobile clinics were also launched after the consequent displacement, and 9,800 consultations undertaken between October and December.

Comprehensive care projects

MSF continued to provide comprehensive inpatient and outpatient care to residents and displaced people at its longstanding projects in Kabo (Ouham), Boguila (Ouham-Pendé) Paoua (Ouham-Pendé), Carnot (Mambéré-Kadéï) and Ndélé (Bamingui-Bangoran). This included basic health consultations, emergency, maternity and children's services, and diagnosis and treatment for HIV and TB. Numerous health centres and/or satellite health posts were also supported through these projects. The maternity and surgery departments of Paoua hospital were handed over to the Ministry of Health in April.

The large emergency project that began in Bossangoa (Ouham) in 2013 continued to offer basic and specialist care through the hospital and a health centre in Nana-Bakassa, and also supported three health posts (Bowara, Benzambé and Kouki). An intensive care unit and a TB building were built this year. In May, the nutrition programme and outpatient department were handed over to the Ministry of Health.

In Berbérati (Mambéré-Kadéï), MSF supported the regional hospital as well as four health centres focusing on care for pregnant women and children under the age of five. Around 6,000 children were admitted to the hospital in 2015, and over 20,000 outpatient consultations were carried out in the four health centres. A total of 1,800 children were treated for severe acute malnutrition. In May, 28,000 children aged between six months and 10 years received measles vaccinations in Berbérati and Mbako. In Bambari (Ouaka), MSF provided basic medical care to the host population and around 80,000 people living in camps through the health centre, mobile clinics and nine malaria treatment points. Nutritional rehabilitation is a key part of the programme and 1,380 children were treated for severe malnutrition.

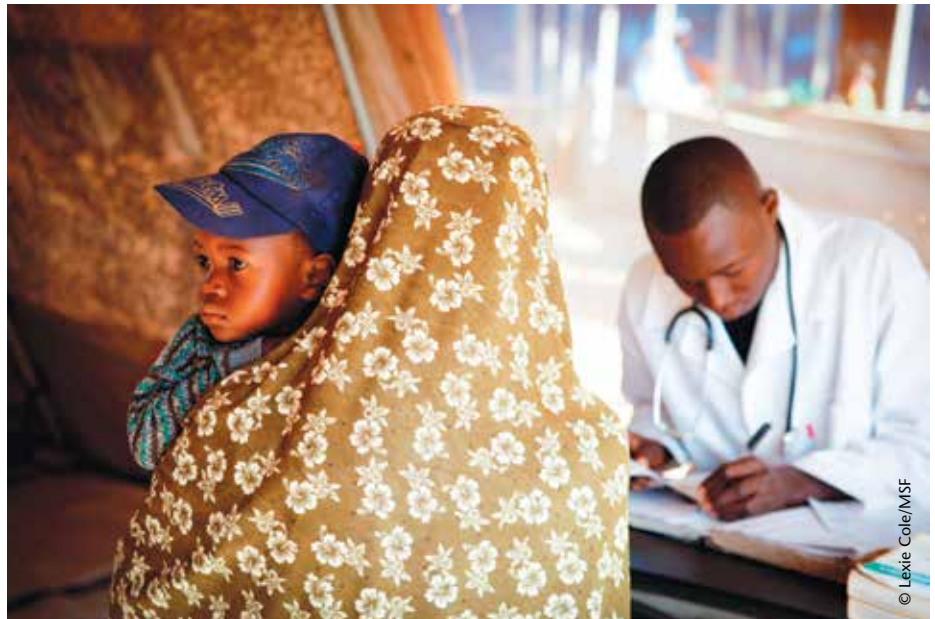
In Bria (Haute-Kotto), MSF provided healthcare to children under the age of 15, including HIV treatment, and vaccinated 16,600 children against measles in March. In Zémio (Haut-Mbomou), teams offered basic and specialist care in the hospital, with a focus on HIV care, and supported four peripheral health posts and eight malaria treatment points.

In Bangassou, the capital of Mbomou prefecture, MSF continued to work in the

referral hospital offering basic and specialist healthcare, including maternity, paediatric and surgical services. Over 120,000 people in the region depend on Bangassou hospital, and there were over 48,000 outpatient consultations in 2015. Teams also began supporting health centres in Niakari and Yongofongo. In February, MSF launched a measles vaccination campaign in Rafai that reached almost 4,900 children, and another in August in Bangassou that reached 37,000 children.

Emergency response team

MSF's Equipe d'Urgence RCA (Eureca) responds to acute localised emergencies in the country. Between April and September, Eureca completed emergency health and nutrition interventions in Kouango and Vakaga, where they trained 80 Ministry of Health staff and donated drugs to five health posts. The Eureca team also vaccinated 9,700 children against measles and pneumococcus in Gadzi in December and provided healthcare to people displaced in the immediate aftermath of the violence in Bangui in September.



A mother and child have a medical consultation in Bria, where MSF runs a paediatric programme for children under the age of 15.

BLOG Benjamin Black, obstetrician/gynaecologist

AGAINST THE ODDS

"The patient had been sent to us from a health centre across the border (a river) in Congo. I started trying to piece the story together. This was her first pregnancy and she had apparently been in labour for four days already; the membranes had also ruptured four days earlier and now all that was draining was thick green meconium-stained fluid (where the baby has passed a motion in the womb). She had come to us by boat, car and foot at full term and in a ridiculously prolonged labour. No wonder she looked terrible.

I went on to auto-pilot, and as I continued gathering information I started placing an intravenous cannula. I was already planning our trip to the operating theatre. I started a fast-running drip and asked the midwife to get some intravenous antibiotics started.

I methodically started feeling her abdomen, the baby was head down but still quite high ...

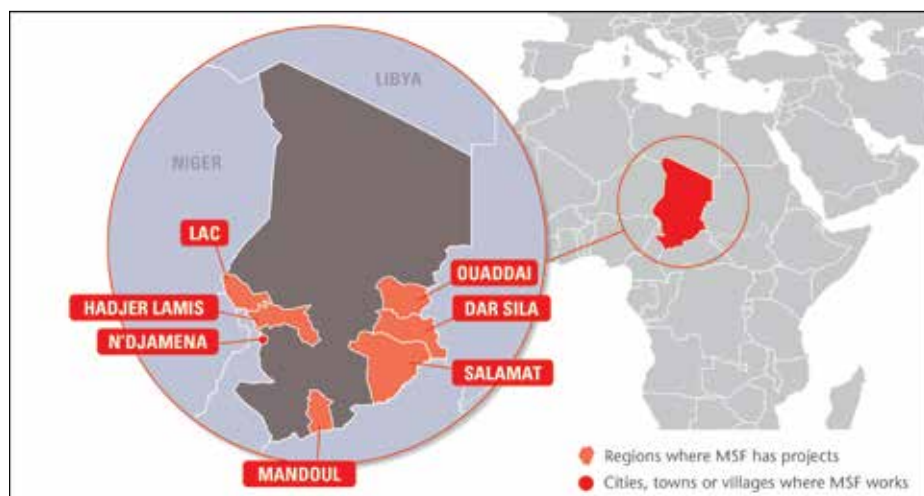
During my time in CAR over 17 per cent of women needing surgery during labour were for ruptured uterus – one of the most serious and life-threatening obstetric complications – all had had a previous caesarean section. Whilst we are fortunate enough to be set up to perform emergency caesarean sections, I cannot guarantee that the same would be true for this women in her future pregnancies, particularly given the wider social, economic and political context.

The birthrate is very high, there is poor access to family planning and poor infrastructure. If she has a caesarean what would be her risk of complication or death in her next six to 10 pregnancies, assuming the time for transfer remained the same?"

To learn more about Benjamin's decision and how the mother returned home with a healthy baby, visit <http://blogs.msf.org/en/staff/blogs/may-the-forceps-be-with-you/against-the-odds>

CHAD

No. staff in 2015: 754 | Expenditure: €19.5 million | Year MSF first worked in the country: 1981 | msf.org/chad



KEY MEDICAL FIGURES:

103,600 outpatient consultations

22,200 measles vaccinations in response to an outbreak

56,600 patients treated for malaria

12,500 routine vaccinations

12,300 patients treated in feeding centres

Conflict in neighbouring Nigeria spilled over into Chad in 2015, increasing the need for medical and humanitarian assistance.

By May, nearly 18,000 Nigerian refugees had arrived in Chad; meanwhile, Islamic State's West Africa Province (ISWAP), formerly known as Boko Haram, started to launch attacks inside the country and clashed with government military forces, causing further waves of displacement. Thousands of people congregated in makeshift sites throughout the Lake Chad region, without adequate shelter, food or water. Médecins Sans Frontières (MSF) began to provide assistance in March and scaled up its activities over the year in response to the urgent medical and humanitarian needs of these vulnerable people.

In Baga Sola, where 7,000 refugees had gathered at Dar es Salam camp, MSF offered healthcare to refugees, displaced people and the host community, carrying out over 33,400 medical consultations and nearly 900 mental health consultations, some for victims of sexual violence. Teams distributed more than 2,000 hygiene kits and 660 water-purifying kits. From September, mobile clinics served the host community and displaced people in Bol, providing over 2,700 consultations and distributing 350 kits of hygiene items and 264 water purifying kits. In November, a team started working at Bol regional

hospital, offering maternal and neonatal care, nutritional support for children under the age of five and paediatric healthcare for children under 15.

Protecting the lives of women and children

MSF continued to fill some of the critical gaps in healthcare in Chad, primarily responding to disease outbreaks and implementing programmes for women and children. In Bokoro, Hadjer Lamis region, MSF runs a project for malnourished children through inpatient and mobile therapeutic feeding centres. The team also supports the government's immunisation programme, treats patients for malaria, diarrhoea and acute respiratory tract infections, ensures access to safe water and runs community health promotion activities. This year, 4,400 children were treated for severe malnutrition at the inpatient feeding centre.

In Am Timan, Salamat region, MSF supports the public hospital's paediatric and maternity wards, tuberculosis (TB) and HIV care, a nutrition programme and three mobile clinics. In 2015, teams carried out more than 24,400 outpatient and 4,400 antenatal consultations, treated 8,100 children for malaria and assisted 2,100 deliveries. Some 1,620 patients volunteered for HIV counselling and testing and 68 new patients were initiated on treatment for TB.

In Moissala, Mandoul region, MSF focuses on the health needs of pregnant women and children under the age of five and runs a prevention, detection and treatment programme for paediatric uncomplicated

and severe malaria. Four rounds of seasonal malaria chemoprevention (SMC) were administered, reaching around 100,000 children each time. A malaria unit also admitted over 990 children. Oral polio vaccinations were administered to 28,800 children under the age of two, and 14,000 received pentavalent vaccines to protect them against the five most common and dangerous diseases. Over 48,000 children were vaccinated against measles.

In MSF's surgical programme in Abéché, Ouaddaï region, the team performed 928 surgical interventions this year, mostly on people injured in road accidents or as a result of domestic violence.

Chad Emergency Response Unit (CERU)

MSF's CERU responded to an outbreak of measles in April by vaccinating 80,000 children in Goz Beida, Dar Sila region. The team also put medical supplies in place and trained Ministry of Health staff on mass casualty management in two hospitals in N'Djamena and one in Abéché, helping them to improve their response in the case of an influx of severely wounded people.

Project closures and handovers

In February, a project providing healthcare to refugees from Central African Republic in Bitoye, Gore Sido region closed, as other healthcare providers were present. A basic and specialist healthcare programme was closed in Tissi, Dar Sila in May for the same reason, and a long-term paediatric and nutrition programme in Massakory, Hadjer Lamis region, was handed over to the Ministry of Health in November.

COTE D'IVOIRE

No. staff in 2015: 134 | Expenditure: €3.6 million | Year MSF first worked in the country: 1990 | msf.org/cotedivoire



KEY MEDICAL FIGURES:

3,100 births assisted

Due to the increase in maternal mortality rates,¹ Médecins Sans Frontières (MSF) works with the Ministry of Health in Côte d'Ivoire to improve maternal and child health.

In Hambol region, around 50 per cent of women give birth at home, and a study undertaken by Epicentre in March 2015 found significant levels of maternal mortality.²

Katiola is the main town in Hambol region and MSF runs a programme in the Centre Hospitalier Régional (CHR) there in partnership with the Ministry of Health. MSF provides resources and technical support, enabling the CHR to operate a high-quality emergency obstetric and neonatal care unit for complicated cases. MSF manages the 20-bed maternity department, three intensive-care beds, two operating theatres and 10 neonatal beds.

In 2015, the facility served as a referral hospital for 98,000 women of child-bearing age, 14,800 pregnant women and 14,000 newborns. Staff managed 755 obstetric emergencies, high-risk pregnancies and complicated births, as well as 600 gynaecological emergencies. They also assisted 2,600 births, 374 of which required caesarean sections.

Since May, MSF has been supporting and improving (through the renovation of buildings, medical equipment and staff training) the basic emergency obstetric and neonatal care units in outlying areas in order to ensure that good-quality medical care is more easily accessible for mothers and children. In addition, MSF has been working to improve the management of straightforward deliveries and referrals to Katiola. In the second half of the year, staff in two outlying health centres treated 106 women during obstetric emergencies, high-risk pregnancies or complicated births, as well as 28 gynaecological emergencies. They assisted over 400 births, and referred around 50 patients to the maternity unit at Katiola.

¹ From 543/100,000 live births in 2005 to 614/100,000 in 2012 (Enquête Démographie et de Santé et à Indicateurs Multiples de 2011–2012 (EDSCI-III))

² 660/100 000 (Epicentre)

EGYPT

No. staff in 2015: 104 | Expenditure: €2.5 million | Year MSF first worked in the country: 2010 | msf.org/egypt



KEY MEDICAL FIGURES:

12,700 outpatient consultations

11,200 individual and group mental health consultations

Egypt is a key transit and destination country for African and Middle Eastern refugees and migrants.

The number of people arriving in Egypt has risen sharply recently due to conflict and instability in countries such as Syria, Iraq, Sudan, South Sudan and Libya. There has also been an increase in the number embarking on the sea journey to Europe.

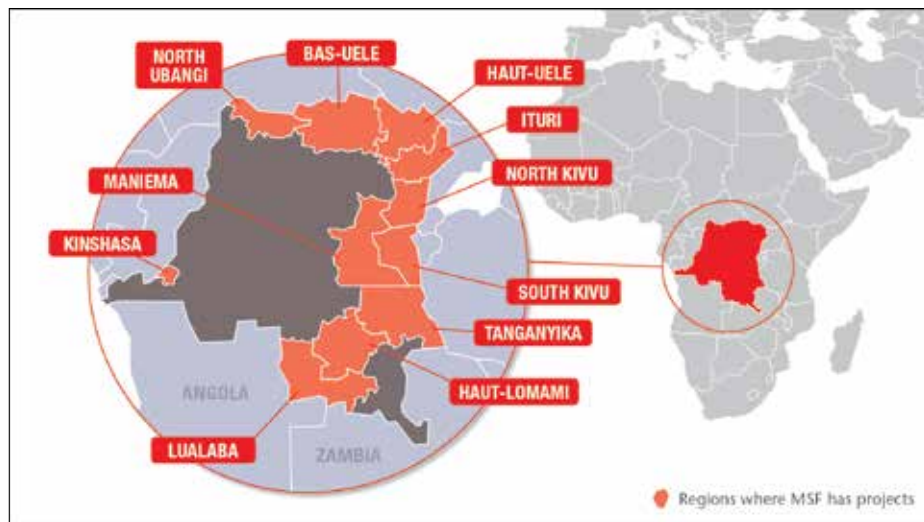
The main challenges for refugees and migrants are limited employment opportunities, integration and everyday hardships. Around 115,000 registered asylum seekers and refugees live in Greater Cairo. Many of those assisted by Médecins Sans Frontières (MSF) have been victims of violence in their home countries or during their journeys to Egypt. MSF offers patients rehabilitative care, comprised of medical and mental health assistance, as well as physiotherapy and social support through

the development of individual multi-disciplinary treatment plans. In 2015, a total of 1,663 new patients were admitted, of which 51 per cent had suffered ill treatment. The MSF team also assisted vulnerable individuals by conducting nearly 2,800 medical consultations and distributing over 2,300 hygiene kits through mobile clinics.

In addition to responding to the regional refugee crisis, MSF entered into discussions with the Egyptian Ministry of Health and Population and national medical institutions regarding establishing partnership projects in key public health areas. MSF would like to support national efforts to tackle hepatitis C in the country, and is willing to contribute technical medical expertise to existing initiatives.

DEMOCRATIC REPUBLIC OF CONGO

No. staff in 2015: 2,867 | Expenditure: €100.3 million | Year MSF first worked in the country: 1981 | msf.org/drc | [@MSFcongo](https://twitter.com/MSFcongo)



KEY MEDICAL FIGURES:

1,652,000 outpatient consultations

882,500 patients treated for malaria

156,500 patients admitted to hospital

30,500 individual and group mental health consultations

22,300 number of patients treated in feeding centres

17,000 surgical interventions

5,000 patients received first-line ARV treatment

The Katanga region in the Democratic Republic of Congo (DRC) was hit by a huge measles epidemic in 2015, and tens of thousands of people were affected.

Such health emergencies occur with alarming regularity in DRC, a result of poor infrastructure and inadequate health services, which are unable to prevent or respond to outbreaks of disease. In Katanga, for example, there have been measles epidemics every few years, owing to the failure of routine vaccination programmes and the shortage of healthcare in remote parts of the region. Médecins Sans Frontières (MSF) launched activities in April in Malemba Nkulu health zone, eventually deploying multiple teams and intervening in over half of the affected health zones. Teams carried out vaccinations and supported measles treatment for patients at over 100 health centres. By early December, they had vaccinated over 962,000 children against measles and supported the treatment of nearly 30,000 who had caught the disease.

At the beginning of the year, MSF mobile clinics responded to malnutrition and malaria among internally displaced people in camps in Nyunzu and Kabalo in Katanga, and vaccinated children under the age of five living in the camps and the

surrounding areas against measles. MSF also continued its efforts to bring cholera under control in Kalemie and in Kituku, Undugu and Kitaki health zones, monitoring and treating diarrhoeal diseases, providing oral vaccinations, improving the water supply infrastructure and distributing filters. In addition, over 30,100 people were treated for malaria during May and June in Kikondja, and measles vaccinations were provided between July and November in Kikondja, Bukama and Kiambi. A South Kivu emergency response team also vaccinated 81,590 children against measles in Haut Lomami between September and November.

As the security situation in the Shamwana area stabilised, displaced people began returning home. MSF expanded its support from six to seven health centres and increased the number of specialised community health sites where patients with malaria, malnutrition and diarrhoeal diseases are identified and treated. Teams continued to provide comprehensive healthcare at Shamwana hospital, carrying out 76,293 outpatient consultations and 1,680 individual mental health sessions.

Despite some improvements, the eastern provinces remained largely insecure, as the Congolese army and several different armed groups fought for control over resource-rich territory. There were attacks on civilians, which caused further waves of displacement, and many incidents of banditry and

kidnapping. MSF remains one of few international organisations providing medical care in these areas.

North Kivu

In Mweso health zone, at the border between Walikale, Masisi and Rutshuru, where almost 105,000 internally displaced people live, MSF continued its comprehensive medical programmes at the respective hospitals, and assisted at local health centres. Teams distributed emergency and relief items to newly displaced people in Mweso and carried out over 185,000 outpatient consultations – about a quarter of which were for malaria. More than 13,200 individual mental health sessions were completed, over 4,000 children received treatment for malnutrition and 6,500 births were assisted. At the Walikale project, close to half of the 133,000 outpatient consultations were related to malaria. Women with high-risk pregnancies were followed up and accommodated at a women's centre in Masisi hospital. Mobile clinics visited displacement camps and remote villages in the area. Teams treated 343 victims of sexual violence, provided 168,801 outpatient consultations and ran general health education and information activities for over 18,000 people.

The MSF-supported general hospital in Rutshuru remains the only referral hospital



An MSF doctor examines patients with severe malaria at a hospital in Rutshuru.

in the area and teams there provided over 33,300 emergency consultations – many for malaria – and admitted over 3,700 patients for surgery in 2015.

MSF continued to offer screening and treatment for HIV, including for patients co-infected with tuberculosis (TB), at its HIV project based in Goma, which supports five other health facilities. MSF also treated 1,000 people in Goma for cholera.

South Kivu

MSF opened a project in Lulingu in August, supporting the general hospital and six peripheral health centres, with a particular focus on care for children and pregnant women. Malaria, gastrointestinal and respiratory tract infections were the main illnesses staff treated in 2015. Services include paediatrics, emergency services and an operating theatre. In a similar project in Kalehe, Hauts-Plateaux, MSF supports Numbi reference health centre and three other centres in the area. Some 124,000 outpatient consultations and over 37,000 reproductive health consultations were carried out and around 35,700 children received routine vaccinations. Through support to Shabunda general hospital, Matili hospital and seven health centres, MSF continues to bring medical assistance to displaced people and local communities in isolated areas experiencing protracted conflict.

An increase in malaria in recent years has overwhelmed the MSF-supported Baraka hospital, where capacity has been exceeded

by 300 per cent. A 125-bed facility was built for patients who are no longer in critical condition but still need medical care. Several community-based sites helped thousands of children access treatment for malaria, pneumonia and diarrhoea. Staff carried out 287,000 outpatient consultations and admitted nearly 17,000 patients for care. Teams at Kimbi hospital, associated health centres in Lulimba, Misisi and Lubondja, and community sites provided 149,500 outpatient consultations and treated 125,600 patients for malaria, 373 patients for TB and 311 patients for HIV. A South Kivu emergency response team launched seven different interventions to tackle epidemics and address the needs of displaced people.

Maniema

In March, MSF opened a new project in Bikenge city, a remote city in the mining area, focusing on the needs of vulnerable groups: pregnant women, children under the age of 15, victims of sexual violence and surgical emergencies. The team carried out around 24,700 consultations, treated 116 victims of sexual violence, and assisted 1,090 births.

Ituri, Haut-Uélé and Bas-Uélé

MSF opened a project to assist returnees and displaced people in Boga health zone. The team supports Boga general regional hospital and Rubingo health centre, offering reproductive, emergency and intensive healthcare. The team's health education and information activities reached over 25,000 people this year. There are frequent

clashes between armed groups and the UN and Congolese forces in the Gety region, and civilians are displaced repeatedly. MSF continues to support the regional general hospital and three health centres, focusing on emergency services and care for pregnant women and children. Staff treated 381 victims of sexual violence in 2015.

The Bunia Emergency Pool works throughout Ituri, Haut-Uélé and Bas-Uélé, and this year responded to 12 emergencies including outbreaks of cholera, meningitis and measles.

Equateur

An emergency intervention responding to an influx of refugees from the crisis in Central African Republic evolved into a new project in 2015. Teams worked in Bili and Bossobolo health zones, and mobile clinics delivered basic healthcare to Boduna, Gbagiri, Gbangara, Nguilizzi and Gbabuku. More than 62,500 outpatient consultations were provided.

Kinshasa

MSF's Kinshasa-based project has been ensuring comprehensive medical and psychosocial care for people with HIV/AIDS since 2002. Staff working at an MSF hospital and seven partner facilities supported the health ministry in managing a cohort of over 5,300 patients in 2015. They carried out 43,000 outpatient consultations and 32,600 educational sessions.

The Pool d'Urgence Congo, an MSF emergency team, received 171 alerts and intervened in seven emergencies for malnutrition, measles, cholera and refugee crises that benefited over 300,000 people across the country.

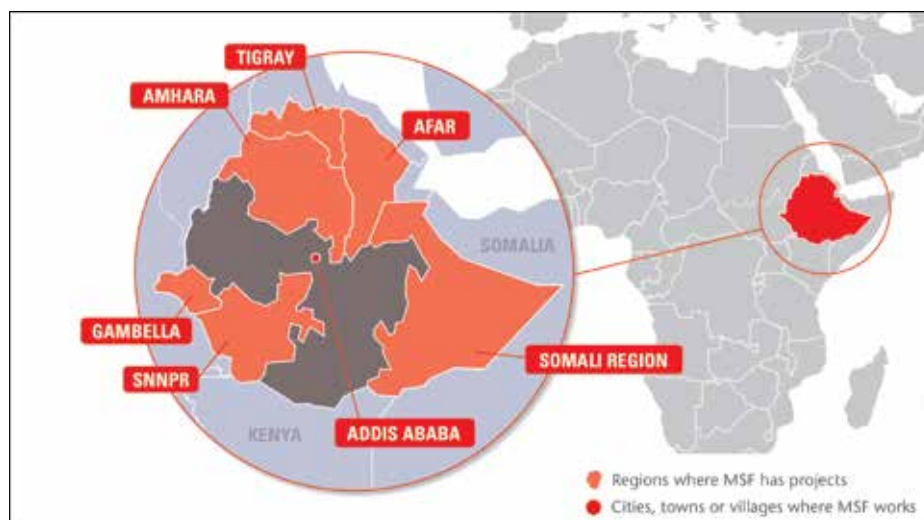
PATIENT STORY

RÉGINE – mother of five, Manono health zone, Katanga

"The day the doctors came to my village to vaccinate children against measles, I buried one of my children who had died of measles. Another of my boys also suffered from the disease and he could no longer breathe, so we took him to the Manono hospital. The doctors put him on a machine to help him breathe and he received medication. I told the doctors I had three other children all alone at home who were also suffering from measles. I had no choice but to leave them alone because their father was not there ... so we left on motorbikes for my village, to bring them to the hospital for treatment."

ETHIOPIA

No. staff in 2015: 1,610 | Expenditure: €26.6 million | Year MSF first worked in the country: 1984 | msf.org/ethiopia



KEY MEDICAL FIGURES:

413,200 outpatient consultations

6,200 routine vaccinations

4,000 births assisted

There were significant improvements in Ethiopia's main health indicators in 2015, but unstable weather patterns causing drought and floods meant that vulnerable groups struggled to access the services they needed.

Médecins Sans Frontières (MSF) and the national authorities have been working together to increase capacity, respond to outbreaks of disease and fill gaps in basic and emergency healthcare for the fast-growing population, which includes a large number of refugees.

Between 2014 and 2015, more than 220,000 South Sudanese refugees, mostly women and children, arrived in Gambella, where infrastructure and services are limited. Until May, MSF managed a clinic providing comprehensive services inside Leitchuor refugee camp and ran mobile clinics to the Burbiey and Matar transit sites. Leitchuor and Nip-Nip camps had been set up in an area prone to flooding and consequently were completely inundated during the rainy season, forcing the relocation of more than 40,000 refugees to Jewi, a newly established camp 18 kilometres from Gambella town. MSF reduced activities in Leitchuor and now runs the main health centre in Jewi, providing medical consultations, emergency and maternity services, and outreach activities. Teams conducted over 19,600 outpatient consultations over the course of the year.

MSF's Itang health centre, near Kule and Tierkidi camps, was damaged in the 2014 floods and was therefore temporarily relocated. It returned to its original site in February, with a 55-bed capacity and provided outpatient and 24-hour inpatient services. Over 200,000 outpatient consultations were carried out, 70,000 patients were treated for malaria, and mobile clinics travelled to the Pagak and Pamdong

refugee sites. As hospital capacity increased in the camps, the project was closed in July. From December 2015 to January 2016, however, MSF conducted a meningitis vaccination campaign that reached 29,196 people in Kule and 29,317 people in Tierkidi.

In November, MSF teams started providing basic and specialist healthcare, including treatment for malnutrition, tuberculosis (TB)



MSF vaccinated 50,000 children against pneumococcal disease and 26,000 against *Haemophilus influenzae* type b in three refugee camps in the Gambella region of western Ethiopia.



© Matthias Steinbach

A patient looks at her X-ray picture outside Degahbour hospital in the Somali region.

and HIV, at the Pugnido camps near Gambella. A network of community health workers was established to help monitor disease outbreaks and to refer people for medical care. There had been more than 9,700 outpatient consultations by December.

The third round of a vaccination campaign in Gambella targeting refugee children aged between six and 59 months was completed in February with 13,862 children vaccinated against pneumococcal disease and 3,376 vaccinated against diphtheria, whopping cough, tetanus and hepatitis B.

Somali region

MSF provides medical and nutritional support to Somali refugees at Dolo Ado reception centre and Buramino and Hiloweyn refugee camps. People living in the *woreda* (district), the five refugee camps, and Somalis crossing the border with medical needs make use of these services. At Buramino and Hiloweyn camps, over 2,800 children received supplementary nutrition and 1,300 antenatal consultations were carried out.

MSF has been working with the Regional Health Bureau (RHB) to improve services at Dolo Ado health centre. In 2015, the team started providing TB treatment and a blood bank was set up. Over 1,800 patients were seen in the emergency room and 1,000 patients were admitted for care. People commonly presented with lower respiratory tract infections and gastric disorders.

In Jerar zone, located in an area of low-intensity conflict, MSF supported the hospital

as well as health centres, and mobile clinics in up to 23 outreach locations in Degehabur, Birqod, Ararso and Yocale *woredas*, mainly through capacity-building activities in collaboration with the RHB. At the end of the year MSF scaled down outreach to streamline services and increase quality. A second base and supported health centre was scaled up in Yocaale *woreda*, with full 24/7 medical support. In Degehabur hospital, MSF runs specialist services including lifesaving and emergency obstetric care, an inpatient department, an emergency room and emergency TB referral. In 2015, a maternal waiting room was constructed, and the therapeutic feeding centre and TB ward were handed over to the hospital. Teams continue to provide nutritional support to acutely malnourished children and vulnerable people in Jerar. Some 76 community health workers conduct regular surveillance activities in Degehabur and 26 locations outside the city. MSF also offers logistical support for vaccination campaigns implemented by the RHB.

Fik *woreda* in Nogob zone is another area affected by protracted conflict, and a team has been strengthening capacity at Fik hospital, providing medical and nutritional support, in collaboration with the RHB.

In Wardher zone, MSF focuses on mother and child health, offering reproductive healthcare and paediatric services, treatment for malnutrition and care for victims of sexual violence. Basic healthcare is also available at Yucub health centre and through mobile clinics. In 2015, MSF carried out more than 22,400 outpatient and 2,700

antenatal consultations, and admitted 1,000 patients for care. Nearly 1,000 people of all ages were admitted to the therapeutic feeding programme.

Siti zone in northern Somali region has been heavily affected by drought, leading to very high malnutrition rates. An assessment in November in Hadigala, Erer and Afdem *woredas* found malnutrition rates of up to 14 per cent among the nomadic population and MSF began an emergency intervention in December.

Northeast Ethiopia has been badly affected by drought and regional authorities also granted MSF approval to begin an emergency nutritional intervention in October in Gewane *woreda* and in Bidu, north Afar in December.

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

MSF started an emergency preparedness project to carry out epidemiological surveillance, develop local contacts, gain knowledge and build capacity to respond to crises in SNNPR. Together with the RHB, six zones were identified for training and 112 health ministry staff were trained on epidemiological surveillance in 2015.

Treating kala azar

Kala azar (visceral leishmaniasis), a parasitic disease transmitted by sandflies, is endemic in Ethiopia and is almost always fatal without treatment. Since 2003, MSF has been running a project in Abdurafi, providing free diagnosis, treatment and referrals for the local population and migrant workers, resulting in a reduction in the incidence of kala azar and deaths from the disease. More than 2,500 people were screened for kala azar in 2015 and 325 patients suffering from the disease were treated. Additionally, 249 patients in Abdurafi received nutritional support for severe acute malnutrition and 325 patients were treated for snakebite.

Mental health in Tigray

In February, MSF opened a project focusing on mental healthcare for Eritrean refugees at camps in Tigray region. Outpatient psychosocial and psychiatric services are available at Shimelba and Hitsats camp clinics, complemented by community-based care in Hitsats camp. A psychiatric care centre was opened in Shimelba for inpatient treatment. Over 600 individual mental health consultations were completed, and community education and awareness activities are being implemented to reduce stigma and ensure that those in need make use of the services available.

GEORGIA

No. staff in 2015: 27 | Expenditure: €1.3 million | Year MSF first worked in the country: 1993 | msf.org/georgia



On average, 500 patients are enrolled on treatment for multi-drug resistant tuberculosis (MDR-TB) in Georgia each year. Approximately 10 per cent have the extensively resistant form of the disease.

Georgia has one of the highest rates of MDR-TB in the world. As part of the UNITAID-funded endTB partnership, Médecins Sans Frontières (MSF) has been supporting the Ministry of Health since 2014 with the introduction of the two new TB drugs developed in recent years – bedaquiline and delamanid. Between July 2014 and December 2015, 146 patients were treated with bedaquiline and 11 with delamanid. At the end of 2015, MSF was leading the preparations for a clinical trial in Georgia aimed at identifying new, shorter and less toxic regimens for patients with MDR-TB, based on these two drugs.

Abkhazia

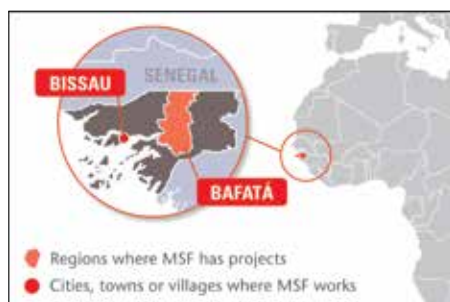
MSF continued to support the Abkhazia national TB programme with the transportation of sputum samples from Gulripsh (Sokhum) TB hospital to Tbilisi referral TB laboratory. Results are sent back to the hospital on a weekly basis. In 2015, a total of 523 samples were processed. Despite handing over activities in 2014, MSF still financially supports AMRA, a local NGO that works with elderly and vulnerable people and provides support to MDR-TB patients to help them better adhere to their treatment.

KEY MEDICAL FIGURES:

139 patients under treatment for MDR-TB

GUINEA-BISSAU

No. staff in 2015: 63 | Expenditure: €2.6 million | Year MSF first worked in the country: 1998 | msf.org/guinea-bissau



Due to the political instability and the chronic failure of state institutions, Guinea-Bissau is ranked among the poorest and least developed countries in the world.

The public health system is dysfunctional, which means that many people have no access to medical services, and this is causing unacceptable levels of mortality, particularly among children and pregnant women.

During 2015, Médecins Sans Frontières (MSF) continued working in the central region of Bafatá, managing the paediatric ward of the regional hospital. As the population is scattered in Bafatá, another team worked in four rural health centres to ensure early diagnosis and treatment for children living far from the hospital. MSF also improved the referral system for paediatric patients so that they were admitted to hospital for care when necessary. More than 30,000 consultations were carried out with children under the age of five, and between September and December many patients presented with malaria as there was an especially sharp peak in cases during this period.

In July, in response to a measles outbreak in the region, MSF supported the Ministry of Health in vaccinating more than 28,500 children between six months and five years of age.

Working to prevent epidemics

Cholera is endemic in the country and there have been numerous outbreaks over the past decade, especially in the capital, Bissau. Between July and December, MSF conducted several campaigns in the city to raise awareness about how to prevent the disease. During this period, MSF also ran training courses on cholera treatment and water and sanitation protocols for Ministry of Health staff.

In addition, in view of the ongoing Ebola epidemic in neighbouring Guinea, MSF assisted with the preparation of the national Ebola response plan.

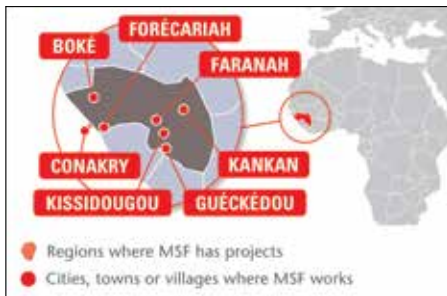
KEY MEDICAL FIGURES:

48,200 outpatient consultations

8,000 measles vaccinations in response to an outbreak

GUINEA

No. staff in 2015: 732 | Expenditure: €19.2 million | Year MSF first worked in the country: 1984 | msf.org/guinea



KEY MEDICAL FIGURES:

8,100 patients on first-line ARV treatment

3,800 individual and group mental health consultations

230 patients treated for haemorrhagic fevers

Médecins Sans Frontières (MSF) continued to respond to the Ebola epidemic in Guinea, supporting Ebola treatment centres (ETCs) and assisting with safe burials, health promotion, community surveillance and contact tracing.

A year into the outbreak, it was evident that new ways of fighting the disease were necessary, and MSF was involved in research studies to find them. These included a vaccine trial targeting frontline workers in the capital Conakry, and the towns of Forécariah and Coyah, and people who had been in contact with newly confirmed cases. MSF also started an infection study, looking at which bodily fluids are more at risk of transmitting the disease and for how long after recovery.

Between January and March, MSF set up a rapid-response mobile team that could travel to wherever new Ebola cases were reported, quickly analyse the needs and propose an adapted approach. This team was deployed twice, to Faranah and Kissidougou.

In April, the ETC in Guéckédou was closed and what was formerly a Ministry of Health transit centre (set up with the support of MSF) in Forécariah was converted into an ETC by the French Red Cross. MSF supported the transfer of patients and ongoing work to identify new cases and conduct outreach activities.



In Conakry, three-week-old Nubia, an Ebola survivor, is carried to her waiting family by an MSF maternal assistant.

In July, MSF opened new ETCs in Nongo, an area of Conakry, and the city of Boké. The centre in Nongo had capacity for 72 beds, and activities were transferred to this new site from Donka hospital. The result was an improvement in treatment standards and a greater focus on innovative solutions in patient care, such as scanning patient files using a camera in order to transfer them from a high- to a low-risk area.

The end of the Ebola outbreak in Guinea was declared on 29 December¹. Since it started in March 2014, there had been 3,804 reported cases and 2,536 confirmed deaths, of which 110 were health workers.

Adherence to HIV treatment

The Ebola epidemic had acute consequences for people living with HIV, who need uninterrupted, life-long care. Many patients abandoned their treatment because they feared going to health facilities and contracting Ebola. MSF addressed this issue and sought to mitigate the risk of infection by implementing a six-month refill strategy (R6M) between April and June 2014. This meant stable patients needed to come only twice a year to pick up their medicine. Thanks to this strategy, over 90 per cent of HIV patients under R6M were still under treatment by March 2015; other healthcare providers reported significantly lower adherence.

HIV prevalence in Guinea is relatively low, affecting 1.7 per cent of the population. However, at the moment only one in four people living with HIV is on antiretroviral

treatment. MSF has been providing high-quality HIV care in Guinea since 2003; this has included implementing strategies like R6M, and ensuring viral load monitoring is available to patients (an important laboratory measure of HIV in the blood that can indicate treatment success or failure). MSF currently manages a mid-level facility in Matam where a few beds are available for simple cases, and provides mentoring and training to support six health centres where HIV care is offered alongside other basic health services. In total, MSF works with a fifth of all people under treatment for HIV in the country.

¹ New cases of Ebola were declared in Guinea in March 2016

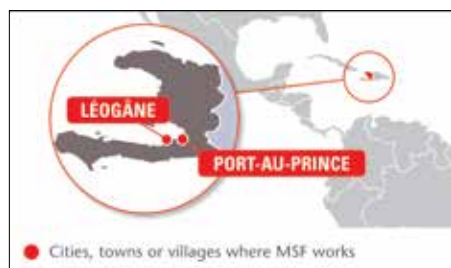
PATIENT STORY

BABY NUBIA – the last Ebola patient in Guinea

No one expected a baby who had been born with Ebola to survive for long. Previously, no babies born to infected mothers had been known to live for more than a few hours. Despite the poor prognosis, and the challenges of caring for a newborn in an isolation zone while wearing protective clothing, the medical team were determined to save her. Nubia was given two new experimental drugs and gradually her condition improved. One month later, tests showed that she had beaten the virus and on 28 November she was discharged.

HAITI

No. staff in 2015: 1,835 | Expenditure: €32.1 million | Year MSF first worked in the country: 1991 | msf.org/haiti | [@MSFHaiti](https://twitter.com/MSFHaiti)



KEY MEDICAL FIGURES:

12,900 surgical interventions

6,700 births assisted

5,000 individual and group mental health consultations

The healthcare system in Haiti is struggling to meet some of Haitians' most basic medical needs, such as treatment for trauma and maternal healthcare.

While a segment of the population can purchase healthcare at private clinics or seek healthcare outside of country, healthcare is out of reach for a large proportion of Haiti's population. Medical facilities are understaffed and lack the funding to cover operating costs and purchase sufficient medical supplies. Without longer-term investment from the Haitian government and international donors, the most vulnerable people will remain unable to access the services they need. Médecins Sans Frontières (MSF) continues to fill critical healthcare gaps – most of which pre-date the 2010 earthquake.

Health services in Port-au-Prince

A large number of Haitians live in crowded, unsafe environments, where domestic accidents have become common. Violence, including sexual violence, is also a public health problem but accessible emergency services are scarce.

MSF runs a burns unit in Drouillard hospital, which has become the de facto national referral site for burns patients, nearly half of them (47 per cent) under five years old. In 2015, over 17,550 consultations were provided, including over 3,550 surgical interventions, 12,100 physiotherapy sessions and 1,600 mental health consultations. MSF plans to train more medical personnel and institute a referral system to improve access to quality care for burns patients.



A woman undergoes a caesarean section in the operating theatre of the Centre de Référence en Urgence Obstétricale (CRUO) in Port-au-Prince.

In Tabarre, MSF's 122-bed Nap Kenbe hospital provides surgery and trauma-related care. The team attended to over 13,000 emergency patients in 2015 and over 6,400 surgical interventions were performed. Physiotherapy and social and mental health support for rehabilitation were also offered.

Around-the-clock services are available in MSF's emergency and stabilisation centre in Martissant, and the team attended to 50,000 patients this year. Of these, 30,000 were treated for accidental trauma and 5,000 for violent trauma. The rest were suffering from burns, obstetric complications or other injuries.

Sexual and reproductive care

Sexual and gender-based violence is an overlooked emergency in Haiti. In May, MSF opened the Pran Men'm clinic, a facility offering the emergency medical assistance required during the 72 hours following an assault, along with longer-term medical care and psychological support. More than a third of the 258 patients treated at the clinic were younger than 18 years old.

Located in the Delmas 33 neighbourhood of Port-au-Prince, MSF's 148-bed Centre de Référence des Urgences en Obstétrique (CRUO) provides care to pregnant women experiencing serious and life-threatening complications such as pre-eclampsia, eclampsia, obstetric haemorrhage, obstructed labour or uterine rupture. Services include postnatal care, family

planning and prevention of mother-to-child transmission of HIV, as well as neonatal care and mental health support. In 2015, the team carried out more than 18,300 consultations, assisted over 6,000 births and admitted 2,500 babies to the neonatal ward. The 10-bed 'Cholernity' ward, which provides specialised treatment for pregnant women with cholera, admitted 144 patients.

Ongoing cholera crisis

The cholera outbreak that began after the 2010 earthquake remains a public health threat. In 2015, more than 2,300 patients were admitted to the 55-bed Diquini cholera treatment centre (CTC) in Delmas, which MSF runs in partnership with the health ministry, and some 750 patients were treated at the Delmas Figaro CTC. MSF closed the Martissant CTC in May, as it was no longer required, but a team continues to be involved in surveillance and response activities.

Chatuley hospital closes

MSF had been reducing its activities at Chatuley hospital in Léogâne since 2013 and finally closed the facility in August. The container hospital was set up in 2010 as an expansion of an initial earthquake response, with two surgical blocks providing medical care to victims of road traffic accidents and women with complicated pregnancies. In 2015, the team assisted 747 births, admitted 300 babies to the neonatal ward and treated 60 children in the paediatric ward.

HONDURAS

No. staff in 2015: 46 | Expenditure: €1.2 million | Year MSF first worked in the country: 1974 | msf.org/honduras



KEY MEDICAL FIGURES:

780 individual and group mental health consultations

600 people treated after incidents of sexual violence

Honduras has experienced years of political, economic and social instability, and has one of the highest rates of violence in the world. This has medical, psychological and social consequences for the population.

Médecins Sans Frontières (MSF) continued its *servicio prioritario* or priority service in collaboration with the Honduran Ministry of Health, offering emergency medical and psychological care to victims of violence, including sexual violence. This free, confidential, one-stop service is available at two health centres and in Tegucigalpa's main hospital.

In 2015, MSF treated 1,367 victims of violence, including 593 victims of sexual violence, and carried out 1,436 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. Mental healthcare

includes counselling and psychological first aid. MSF has also been involved in training and sensitising medical staff to the needs of victims of sexual violence, and ensuring the necessary human resources are available.

The emergency contraceptive pill remains banned in Honduras, despite ongoing debate in the Honduran Congress to change the policy on emergency contraception. MSF continues to advocate for access to medical care for victims of sexual violence (including emergency contraception) that is in accordance with international protocols. MSF has highlighted the psychological and medical consequences of pregnancy as a result of sexual assault.

IRAN

No. staff in 2015: 30 | Expenditure: €0.9 million | Year MSF first worked in the country: 1990 | msf.org/iran



Despite improvements in health services and in the treatment of addictions and stigmatised diseases such as HIV, many people in Iran still have difficulty accessing the care they need.

Médecins Sans Frontières (MSF) has been running a health centre in Darvazeh Ghar, one of the poorest areas of Tehran, since 2012. The project aims to reduce the incidence of diseases among vulnerable women and children under the age of 15 by providing access to healthcare for former drug addicts (including children) and their families, pregnant women, sex workers, child labourers and other marginalised people.

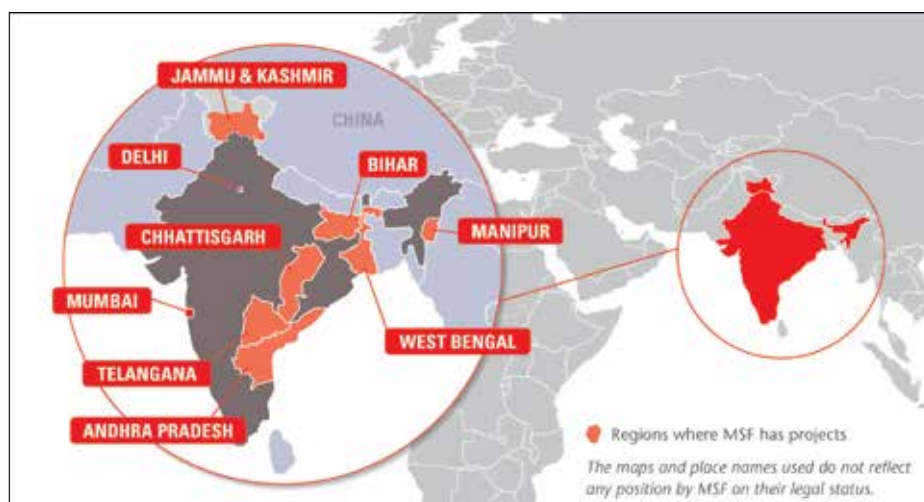
MSF provides medical and psychological care, as well as social support, in collaboration with other organisations. In 2015, 6,583 outpatient, 1,899 gynaecological and obstetric and 1,742 mental health consultations were carried out. Special attention is paid to the groups most at risk of sexually transmitted infections and infectious diseases such as HIV, hepatitis C and tuberculosis. Rapid diagnostic

tests are available and patients can be referred to specialised Ministry of Health centres for treatment. This year, 764 voluntary counselling and testing sessions for HIV were conducted.

The centre has a community-based approach and integrates basic healthcare with health promotion activities adapted to people's needs in this area of southern Tehran. Outreach activities include patient follow-up and health education sessions in the community. Peer workers play an essential role in helping MSF communicate with harder-to-reach populations.

INDIA

No. staff in 2015: 588 | Expenditure: €11.7 million | Year MSF first worked in the country: 1999 | msf.org/india



KEY MEDICAL FIGURES:

76,100 outpatient consultations

1,800 patients treated in feeding centres

3,400 individual and group mental health consultations

1,600 patients on first-line ARV treatment

730 patients under treatment for kala azar

Médecins Sans Frontières (MSF) continued to focus on improving diagnosis and treatment of HIV, tuberculosis (TB) and kala azar (visceral leishmaniasis) for people unable to access healthcare in India.

Due to poverty, social exclusion and an under-resourced health service, basic medical care is out of reach for a significant portion of India's population. MSF works to fill some of these gaps and to increase capacity in the system.

Mobile clinics

MSF continued to run weekly mobile clinics providing free basic healthcare to villages in southern Chhattisgarh, and to displaced people in Andhra Pradesh and Telangana. These communities have limited access to medical services because of the ongoing, low-intensity conflict in the area.

In Chhattisgarh, the mother and child health centre in Bijapur district provides obstetric, neonatal and paediatric care. MSF teams run mobile clinics offering basic and specialist medical services to people living in the surrounding area. More than 56,400 consultations were carried out and over 13,800 patients were treated for malaria.

Extending care for HIV, TB and hepatitis

MSF's clinic in Mumbai provides psychosocial and outpatient medical care to patients with

HIV, drug-resistant TB (DR-TB), hepatitis B and C, and those co-infected with any of these diseases. The team also supports infection control activities for DR-TB and works closely with staff at Sewri TB hospital to increase treatment capacity. Towards the end of the year, MSF started working with the Revised National Tuberculosis Control Programme to find ways to reduce the number of people contracting and dying from TB in eastern Mumbai, where the number of cases is particularly high.

The northeastern state of Manipur has some of the highest rates of HIV in the country, and in mid-2015, MSF began treating HIV patients co-infected with hepatitis C – more than 25 per cent of all patients. The comprehensive care programme for HIV and TB patients continued in Churachandpur, Chakpikarong and Moreh, as did MSF's work supporting a local NGO with oral substitution therapy for intravenous drug users.



© Sami Siva

Mothers with young children wait for a consultation with the MSF mobile clinic in Pusuguppa.

Fighting infectious diseases in Bihar and West Bengal

Kala azar is endemic in the Vaishali district of Bihar, and patients with HIV are particularly susceptible to the disease. After sustained lobbying by MSF, the Indian government rolled out a new first-line treatment in the form of single-dose liposomal amphotericin B in October 2014. In 2015, MSF treated 582 patients for kala azar, half the number in the previous year.

In November, a fever management project was set up at Asansol district hospital in West Bengal, in collaboration with the state health department. By the end of the year, MSF had treated 178 children for acute fever. The project provides free diagnosis, treatment and referrals for children aged between two months and 14 years. Common causes of acute fever are diseases such as dengue and chikungunya.

Mental healthcare in Kashmir

MSF currently runs mental health programmes in the districts of Srinagar, Baramulla, Bandipora, Pattan, Pulwama and Sopore. To increase awareness and the visibility of mental health issues, MSF worked with a Kashmiri production company to produce a TV soap opera called *Aalav Baya Aalav*. It was first broadcast in late 2014 and continued into 2015. The programme highlights the free counselling services run by MSF that are available to everyone.

Also in 2015, a mental health survey was conducted in 10 districts in Kashmir in collaboration with the psychology department of Kashmir University and the psychiatric hospital. The survey aims to estimate the prevalence of mental health-related problems, including depression, anxiety and post-traumatic stress disorder in the area. The findings of the report were published in May 2016.

Treating victims of sexual and gender-based violence in Delhi

A new 24-hour treatment centre for victims of sexual and gender-based violence opened in Delhi in November. Unmeed Ki Kiran clinic in the north of the city provides medical care to people who have been sexually assaulted or subjected to domestic violence, including children.

Patients' physical injuries are treated, and they are provided with post-exposure prophylaxis to prevent transmission of HIV and sexually transmitted infections.



An MSF doctor examines a patient for kala azar at Sadar hospital in Bihar.

They are also offered counselling, and pregnancy tests, if relevant. A referral process is in place for patients needing additional services, such as legal advice or emergency accommodation. The team also raises awareness within the community through education and outreach activities on the importance of seeking timely medical and psychological care.

Emergency response in Chennai

Heavy rain led to widespread flooding in Chennai in December, and many people were forced from their damaged homes. MSF teams distributed 500 hygiene kits

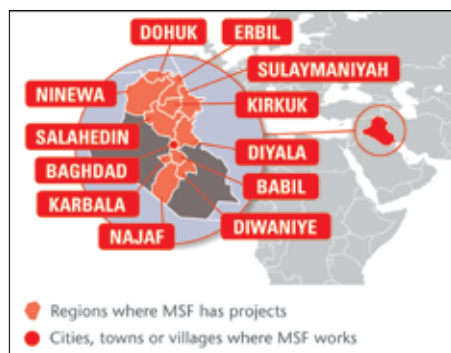
(containing toothpaste, washing powder, soap, towels, etc) and 500 shelter kits (containing ground mats, blankets, etc), as well as 1,000 mosquito nets.

Darbhanga project handover

In August, MSF handed its nutrition project over to Darbhanga medical college and hospital and the health ministry, as community-level care had been successfully integrated into the public health system. Between 2009 and 2015, more than 17,000 children under the age of five suffering from acute malnutrition received treatment through the programme.

IRAQ

No. staff in 2015: 547 | Expenditure: €31.0 million | Year MSF first worked in the country: 2003 | msf.org/iraq | [@MSF_Iraq](https://twitter.com/MSF_Iraq)



KEY MEDICAL FIGURES:

218,300 outpatient consultations

20,700 individual and group mental health consultations

12,500 relief kits distributed

The conflict in Iraq continues to cause massive displacement and hardship, yet funding shortfalls resulted in a reduced international response, which was largely concentrated in the more secure areas of Iraqi Kurdistan.

Over 3.2 million Iraqis are now displaced within the country, putting an immense strain on host communities. In 2015, Médecins Sans Frontières (MSF) expanded its activities to provide basic healthcare and relief to displaced families, returnees, impoverished host communities and Syrian refugees in locations across 11 governorates: Dohuk, Erbil, Sulaymaniyah, Ninewa, Kirkuk, Salahedin, Diyala, Baghdad, Najaf, Karbala and Babil.

Throughout these governorates, MSF deployed mobile clinics to deliver medical care to those unable to reach health facilities due to movement restrictions and security risks. The teams visited a number of locations regularly, basing themselves in clinics, tents and even buses. In highly militarised areas, doctors provided referral documents to ensure safe passage for patients requiring treatment at secondary care facilities. MSF teams also monitored possible disease outbreaks.

Most of the health problems seen by MSF staff were related to people's poor living

conditions, and included respiratory and urinary tract infections, gastrointestinal problems, arthritis and skin diseases. MSF also focused on chronic diseases, particularly hypertension and diabetes, and mother and child health. Female medical staff were present to encourage women to attend clinics.

Mental health activities

MSF efforts this year were also directed at increasing psychological first aid for the growing number of people who have been traumatised by the recurrent violence and their precarious living conditions. In Karbala, Najaf and Babil governorates, MSF continued its regular mental health programmes assisting internally displaced people. Over 1,500 individual counselling sessions were completed and 9,220 people participated in group psychosocial education. The team trained health ministry staff, as well as teachers working with children, in mental healthcare. In Erbil governorate, a team of MSF psychologists and psychiatrists provided support to Syrian refugees in Kawargosk, Gawilan and Darashakran camps.

Mobile medical care

During most of 2015, MSF medical teams provided healthcare (21,775 consultations) to displaced people sheltering in unfinished buildings in Dohuk governorate. As people were gradually moved into formal camps offering medical services, MSF shifted its

activities to Tel Afar district in Ninewa governorate, where medical infrastructure had been destroyed during the conflict and needs were very high. Teams ran clinics close to the frontline, where people were afraid to move and could not afford to travel long distances to reach medical facilities. Mobile teams conducted 19,505 outpatient consultations for chronic diseases, sexual and reproductive health and mental health for IDPs and the local community. MSF teams also ran mobile clinics in several other locations between Mosul and Erbil, and an emergency field surgical unit was established in the district to provide care for people directly affected by armed conflict.

Two mobile teams provided basic healthcare and mental health services in a number of locations in and around Kirkuk, and a third supported the Directorate of Health in Laylan camp with chronic disease management and sexual and reproductive health services. A total of 48,895 consultations were provided. Towards the end of the year, as other medical organisations moved into Kirkuk, MSF handed over most of activities in Kirkuk to other NGOs and redirected its efforts to outlying areas, for example deploying a mobile clinic to displaced people living in small settlements along the road to Baghdad, near Tuz Kurmato, who were afraid to travel across the militarised area to seek medical treatment.



A displaced woman who fled her home in Hawija sits with her son as he is assessed for malnutrition.



© Gabrielle Klein/MSF

An MSF staff member shares health promotion information with people waiting for relief items to be distributed at the Dalal camp for displaced people in northern Iraq.

Activities in Baghdad started in March in Abu Ghraib district, with one mobile clinic serving the local community and the displaced people living in Abu Ghraib and Al Salam camps. In response to the massive needs, a second team started working in September to bring medical care to several other locations in this impoverished district.

MSF also assisted displaced people and host communities in north Garmian district and neighbouring Diyala governorate with activities ranging from basic healthcare in health ministry facilities to mobile clinics. Teams provided mental health services in three camps in Khannaqin, Diyala.

Cholera epidemic

In September, MSF responded to a cholera outbreak that spread across central Iraq and affected Dohuk, Kirkuk, Erbil, Baghdad, Diyala, Najaf, Diwaniya and Babil governorates. Water and sanitation assessments were carried out in all locations affected and MSF teams supported the Ministry of Health with training, health promotion, and hygiene and infection

control activities in all the hospitals dealing with the outbreak.

Iraqi Kurdistan

Since May 2012, MSF has been the main humanitarian organisation providing medical services, in collaboration with the Dohuk Directorate of Health, to Syrian refugees in Domiz camp, the largest refugee camp in Iraq and home to 40,000 people.

In October, the general medical services were handed over to the Directorate of Health, but MSF continues to run chronic disease, sexual and reproductive health and mental health services, as well as regular health promotion activities. The team assisted 1,155 deliveries in the maternity unit this year.

MSF also worked in Sulaymaniyah and Arabat camps, undertaking water and sanitation and health promotion activities. In December, MSF started supporting Kalar maternity hospital with staff training and donations.

MSF continued to run basic healthcare and mental health services in a clinic in Diyala

governorate, focusing on the needs of displaced people.

Reconstructive surgery in Jordan

Since August 2006, a network of Iraqi doctors has been referring victims of violence from all over Iraq to MSF's reconstructive surgery hospital in Amman, Jordan. The team is specialised in complex surgery requiring multiple stages of treatment, in particular maxillofacial (dealing with the head, neck, face, jaw and sinuses), orthopaedic and reconstructive burn surgery. Patients also receive physiotherapy and psychosocial support.

Additional support to the Ministry of Health

Periodically MSF organises medical training programmes for Iraqi doctors in collaboration with the Ministry of Health. In early 2015, 12 Iraqi physiotherapists attended a 10-week physiotherapy training course.

MSF has also supported the Baghdad-based Poisoning Control Centre for many years by providing antidotes that are difficult for the Ministry of Health to obtain.

JORDAN

No. staff in 2015: 529 | Expenditure: €12.9 million | Year MSF first worked in the country: 2006 | msf.org/jordan



KEY MEDICAL FIGURES:

5,400 individual and group mental health consultations

1,700 surgical interventions

Restrictions on working and reductions in international aid have made it even harder for Syrian refugees living in Jordan to access healthcare.

One of the few stable countries in the region, Jordan has registered over 600,000 Syrian refugees (UNHCR, the UN refugee agency) since the beginning of the Syrian conflict, and its infrastructure is understandably under pressure. Since November 2014, Syrians have had to pay to access healthcare in public hospitals, but their resources have been diminishing as they are not allowed to work legally in the country. International funding has also decreased.

There is a huge need for treatment for non-communicable diseases and in 2015 Médecins Sans Frontières (MSF) expanded a project offering care to Syrian refugees and vulnerable Jordanians with hypertension, diabetes, cardiovascular diseases and chronic obstructive pulmonary disease. In Irbid governorate, activities continued at the Ministry of Health's Ibn Sina primary health clinic and a second clinic, Ibn Rushd was opened in mid-April in partnership with a local NGO. Home visits were introduced in August. Over 20,000 consultations were conducted for new patients at these clinics over the course of the year.

Maternity care

A maternity and neonatal project run by MSF moved to a specialist hospital in January and emergency caesarean sections were performed there from February. By year's end, the team had admitted over

3,900 pregnant women and assisted 3,400 deliveries. They also conducted mental health sessions with 274 patients, three quarters of whom had witnessed a violent death and a third of whom had lost a close relative and/or had their house destroyed. The neonatology intensive care unit (NICU) increased to eight beds, four incubators and four cots in 2015 and the team treated their first patient with nasal continuous positive airway pressure in September. A total of 498 babies were admitted to the NICU during the year.

Trauma surgery and post-operative care

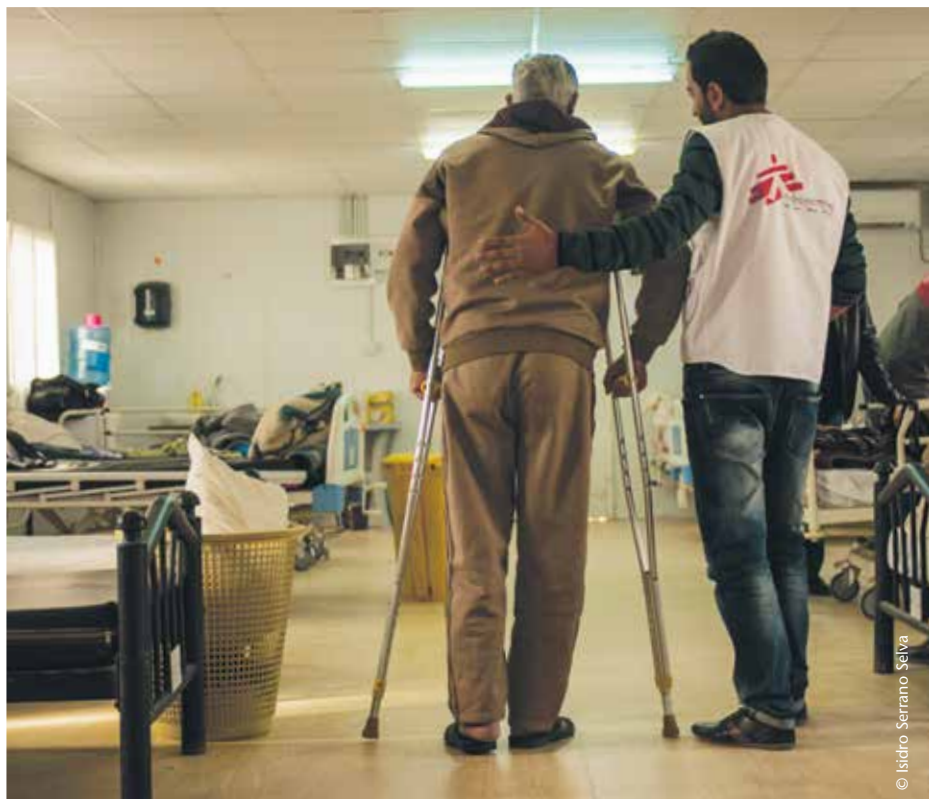
MSF continues to treat war-wounded Syrians at Ar Ramtha government hospital, Irbid governorate, at the Syrian border. Working with the Ministry of Health, MSF provides emergency surgery and general inpatient care, as well as physiotherapy sessions and psychosocial support. In 2015, the team in the emergency room attended to 863 wounded patients, 315 of whom were admitted for surgery. They also undertook over 1,600 individual counselling sessions.

MSF runs a 40-bed post-operative facility in Zaatar refugee camp, Mafraq governorate,

which admits patients from Ar Ramtha and other Jordanian hospitals for rehabilitative and convalescent care. More than 1,540 psychosocial sessions conducted in 2015.

Reconstructive surgery in Amman

The reconstructive surgery project in Amman offers orthopaedic, plastic and maxillofacial surgery, along with physiotherapy and mental health support, primarily to war-wounded patients from neighbouring countries who would not otherwise be able to access specialised care. In February, the project moved to a new hospital where surgeons performed over 880 surgical interventions. A network of doctors in the region refers patients and this year 58 per cent were from Syria, 30 per cent from Iraq and 7 per cent from Palestine. MSF opened a fully equipped microbiology laboratory in the hospital to improve the quality of care for patients with infections resulting from their injuries. Antibiotic-resistant infections are a common and important medical challenge in the region. The opening of the laboratory will improve the quality of medical interventions for patients with conflict injuries that have infectious complications.



Inside the MSF post-operative facility at Zaatar refugee camp, where patients receive physiotherapy and rehabilitative care.

KYRGYZSTAN

No. staff in 2015: 84 | Expenditure: €2.2 million | Year MSF first worked in the country: 2005 | msf.org/kyrgyzstan



KEY MEDICAL FIGURES:

130 patients under treatment for MDR-TB

Kyrgyzstan has high rates of drug-resistant tuberculosis (DR-TB) and yet many people have difficulty accessing care, particularly in rural areas.

Initial hospitalisation of TB patients is standard practice in the country, but since starting work in Kara-Suu district in Osh province Médecins Sans Frontières (MSF) has focused

on providing outpatient care to limit the amount of time a patient spends in hospital. This reduces their risk of contracting an infection while in hospital, and improves their adherence to the long and arduous treatment regimen. MSF is providing comprehensive DR-TB services in Kara-Suu district, including early detection, enrolment onto the treatment programme, monthly medical consultations for patients, and social and psychological support. Teams work in three TB clinics in Kara-Suu district, providing drugs and laboratory items and mentoring Ministry of Health staff.

MSF continues to support the diagnosis and treatment of patients with DR-TB in the Kara-Suu hospital, which has a separate ward for those infected. The team also assists with the management of the hospital's waste, and with infection control.

Teams also carry out around 20 home visits per month for patients who are unable to reach the TB clinics, providing them with their treatment as well as psychological support.

Within the framework of the endTB project, MSF is planning to introduce two new DR-TB drugs, bedaquiline and delamanid, in Kyrgyzstan in 2016. Treatment regimens

will be shorter and patients will not have to endure injections.

In 2015, there were 127 DR-TB patients enrolled in MSF's treatment programme.



A nurse dispenses TB medication at a rural health post in southern Kyrgyzstan.

LESOTHO

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



After nearly a decade of working in Lesotho, Médecins Sans Frontières (MSF) handed over all its projects to the government in November 2015.

Lesotho is a mountainous, landlocked country with few roads, where many people face barriers to accessing healthcare – not only because of the cost of travelling to health facilities, but also because of the shortage of skilled health workers.

During its time in the country, MSF focused mainly on providing free maternal care to women, as well as family planning and HIV treatment. There is a high prevalence of HIV in Lesotho – it is 27 per cent among pregnant women – and this, along with tuberculosis (TB) co-infection, contributes to high rates of maternal death.

Family planning services, and ante- and postnatal care were offered at the MSF-supported St Joseph's district hospital in Roma, six health clinics in the lowlands and three clinics in remote Semonkong.

Within a year of MSF covering all expenses for antenatal care and deliveries at

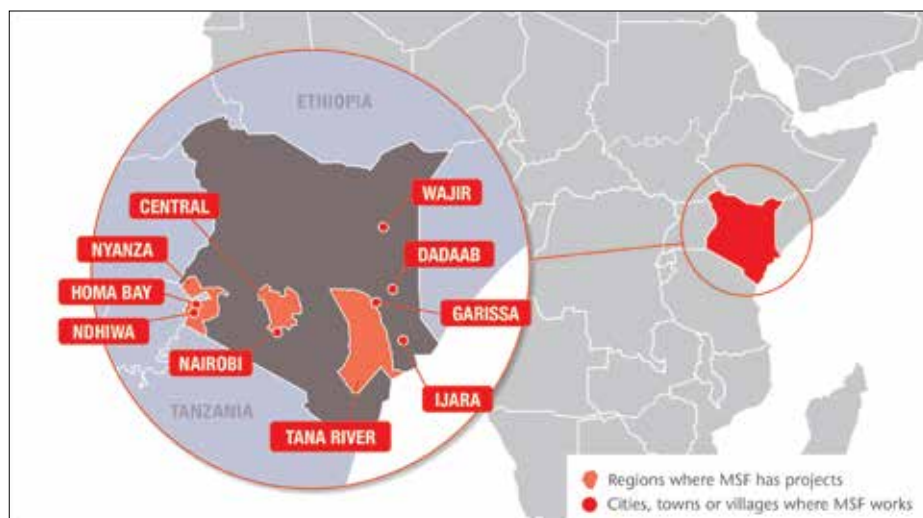
St Joseph's hospital, the number of women giving birth there increased by 45 per cent. During 2015, an average of 130 babies were delivered there every month.

MSF also trained and mentored local staff at these facilities in how to provide integrated care for patients co-infected with HIV and TB. Local counsellors and community health workers initiated and followed up patients on antiretroviral (ARV) treatment. HIV viral load monitoring was also expanded, and lay counsellors were trained to deliver counselling to help patients understand the importance of adhering to their ARV treatment. As a result, by the time MSF left, over 80 per cent of first-line ARV patients had attained virological suppression.

UNICEF has now taken over the funding of free maternal care at St Joseph's hospital, and MSF continues to advocate for the national rollout of free maternal care in Lesotho.

KENYA

No. staff in 2015: 1,175 | Expenditure: €22.4 million | Year MSF first worked in the country: 1987 | msf.org/kenya | [@MSFNairobi](https://twitter.com/MSFNairobi)



KEY MEDICAL FIGURES:

281,100 outpatient consultations

24,100 patients on first-line ARV treatment

2,800 patients treated after incidents of sexual violence

730 patients under treatment for TB

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 and gender-based violence.

Dadaab is the world's largest long-term refugee settlement, made up of five camps, which are home to some 345,000 refugees, mostly Somalis. As a result of an agreement signed by UNHCR, the UN refugee agency, and the governments of Kenya and Somalia in 2013, Somali refugees are being urged to return home voluntarily. However, very few refugees are making this choice and they remain in Dadaab, where funding for humanitarian assistance continues to decrease. Although MSF has not been able to have a permanent international presence there since 2011 due to insecurity, staff have continued to work in the 100-bed hospital in Dagahaley camp and at four health posts, providing outpatient and mental health consultations, surgery, and antenatal, HIV and TB care. In May, prevailing insecurity caused MSF to evacuate a number of staff and close two of its four health posts. In 2015, teams carried out 182,351 outpatient consultations and admitted 11,560 patients to the hospital.

HIV/AIDS and TB care

In Ndhiwa, western Kenya, an estimated 24 per cent of adults are HIV positive, and the number of people infected has been increasing annually. In mid-2014, MSF began a four-year programme aimed at reducing the number of new HIV infections, treating people living with HIV and reducing mortality rates. In 2015, the programme continued to provide support to local health authorities by improving access to HIV testing, offering voluntary medical male circumcision and preventing mother-to-child transmission. Trained counsellors ensured

follow-up of HIV-positive patients to improve treatment adherence.

In December, MSF completed the handover of its long-running HIV and TB programme in Homa Bay hospital to the Kenyan Ministry of Health. By the end of 2015, more than 7,300 people were receiving antiretroviral (ARV) treatment in the programme, 265 of them having been enrolled in 2015. MSF had been working in Homa Bay county since 1996, and Homa Bay was the first public hospital to provide ARV treatment free of charge in Kenya.



A patient receiving care at the MSF cholera treatment centre in Migori county.



An aerial view of Dagahaley refugee camp in Dadaab, where MSF staff provide outpatient and mental health consultations, surgery, and antenatal, HIV and TB care.

Providing healthcare in Nairobi

Sexual and gender-based violence is under-reported in Kenya, and it is hard to find dedicated healthcare in public clinics and hospitals. In the Eastlands slums, MSF continued its programme at Lavender House clinic, where victims of sexual and gender-based violence have access to a 24-hour hotline and ambulance pick-ups. They also receive treatment for physical injuries, post-exposure prophylaxis to prevent transmission of HIV and sexually transmitted infections, a pregnancy test, when relevant, and psychological counselling. Swabs are taken for legal purposes and referrals for social and legal support are made available. In 2015, more than half of the 2,429 people treated at the clinic were under the age of 18, and a quarter of those were younger than 12. MSF is working with the health ministry to make comprehensive treatment for sexual and gender-based violence available in public health facilities.

MSF also runs the trauma room in Lavender House, managing outpatient medical emergencies and stabilising patients before transporting them to

other facilities if necessary. Three ambulances are available and the call centre responded to over 4,200 calls in 2015. MSF supports the emergency department of Mama Lucy Kibaki hospital with additional staff, equipment, training and supervision. In 2015, the emergency department handled 25,481 patient visits. This is the only hospital accessible to Eastlands' 2.5 million residents.

The team at Green House clinic in Eastlands continues to diagnose and care for patients with drug-resistant TB. In 2015, 30 people with the multidrug-resistant form of the disease received treatment and three patients with extensively drug-resistant TB were initiated on the new drug bedaquiline.

In Kibera, Nairobi's largest slum, MSF provides comprehensive basic healthcare, as well as treatment for HIV, TB and non-communicable diseases, to the 240,000 inhabitants through two clinics. In 2015, teams carried out 132,500 consultations, and assisted 2,469 deliveries in the maternity ward in Kibera South. Over the past few years the Kenyan government has

made general healthcare and HIV and TB treatment more widely available in Kibera, and MSF will hand over these centres to the Ministry of Health in 2017.

Responding to a cholera outbreak

MSF supported the Ministry of Health's response to a massive cholera outbreak in 2015. In Nairobi, teams set up cholera treatment units (CTUs) and over 570 patients were also treated at a CTU in Dagahaley refugee camp. By the end of the year, MSF had supported 47 facilities in 17 counties and had provided care to more than 8,300 patients.

Garissa university attack

In April, Al Shabab militants stormed a university in northeastern Kenya. Over 100 people were killed in the incident, most of them students. An MSF team treated survivors of the attack, including more than 70 with gunshot and blast wounds, and people who had sustained cuts from shattered glass. MSF provided medical consultations, food and water at Garissa airport, where around 300 evacuated students spent the night.

LEBANON

No. staff in 2015: 343 | Expenditure: €27.1 million | Year MSF first worked in the country: 1976 | msf.org/lebanon | [@MSF_Lebanon](https://twitter.com/MSF_Lebanon)

KEY MEDICAL FIGURES:

342,100 outpatient consultations

2,300 births assisted

Since the beginning of the Syrian crisis in 2011, it is estimated that more than 1.5 million Syrian refugees and Palestinian refugees from Syria have arrived in Lebanon and the small country is struggling to cope with their acute humanitarian and medical needs.

Five years into the conflict, most of the refugees are still largely reliant on humanitarian assistance for their daily survival. No official refugee camps have been established, so families are forced to live in informal settlements such as garages, farms, old schools or unfinished buildings.

Overcrowding and inadequate food, water and shelter have had a negative impact on people's health, but they are unable to access the medical services they need. Médecins Sans Frontières (MSF) is providing free healthcare to refugees, including those whose regular treatment for chronic diseases such as diabetes, hypertension and asthma has been interrupted because of the war, and expectant mothers, who have often had no access to specialised care or medical surveillance during their pregnancies.

Bekaa Valley

MSF continues to provide basic and reproductive healthcare, health promotion activities, mental health counselling and treatment for chronic diseases to the vulnerable Lebanese and Syrian refugees living in the Bekaa Valley near the Syrian border. Teams working at clinics in Baalbek, Majdal Anjar, Aarsal and Hermel carried out a total of 126,000 outpatient consultations and assisted 768 deliveries during the year.

Beirut

In southern Beirut, MSF works in Shatila camp, a Palestinian refugee settlement dating back to 1949, where more recent Palestinian refugees from Syria and Syrian refugees are also living. The focus here



is on unregistered refugees who are not eligible for official assistance, and registered refugees with medical needs falling outside the eligibility criteria of UNHCR, the UN refugee agency. MSF's care includes basic healthcare for children under the age of 15, treatment for chronic diseases, mental health support services and a women's health centre assisting around 170 deliveries per month. 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.

Northern Lebanon

Northern Lebanon is also currently home to a large number of Syrian refugees. An MSF team is working in the Abu Samra neighbourhood of Tripoli, providing reproductive health services, treatment for acute and chronic diseases, routine vaccinations and counselling.

Other MSF teams work in the districts of Jabal Mohsen and Bab el Tabbaneh in Tripoli, where fighting between local communities has intensified. MSF offers treatment for acute illnesses, reproductive health services and counselling to the local population. In Jabal Mohsen clinic, MSF also supports surgery to stabilise patients before they are transferred to hospital.

In January, MSF distributed urgently needed winter essentials to Syrian refugees in Akkar district in the mountainous northeast of the country, in response to a severe storm and sub-zero temperatures. Around 900 families — 4,700 people — were given stoves, fuel or blankets. Few other organisations work



Syrian refugees face harsh winter conditions in Lebanon's Bekaa valley, where some 400,000 people are sheltering in makeshift camps.

in this area, and the refugees here are very afraid of being sent back to Syria.

From April, MSF worked in the city of El Abdeh, treating acute and chronic diseases and providing ante- and postnatal care.

Southern Lebanon

MSF handed over its long-running mental health programme for the Palestinian population in the Sidon area to the United Nations Relief and Works Agency for Palestine Refugees in the Near East. The team shifted its focus to healthcare for Palestinians from Lebanon, newly arrived Palestinian refugees from Syria and Syrians, particularly children under the age of 15. Throughout 2015, MSF supported three health centres, providing treatment for acute and chronic diseases, mental healthcare and reproductive and maternal health services, and also a referral system for patients in need of specialist care.

THE OBSTACLE COURSE TO EUROPE

By the end of 2015, it was estimated that approximately 60 million people had been displaced worldwide due to conflict, persecution and unliveable conditions in their home countries. On average, almost 4,600 people are being forced to flee their countries every day. Syria's war remains the single biggest generator worldwide of both new refugees and continuing mass internal and external displacement.



© Ikram N'gadi/MSF

An MSF and Migrant Offshore Aid Station (MOAS) team assist in the rescue of 561 people aboard a single, 18-metre wooden fishing boat in distress on the Mediterranean Sea.

Having seen that the number of people attempting the dangerous Mediterranean crossing was growing every day, and aware of the clear lack of Search and Rescue resources at sea, Médecins Sans Frontières (MSF) decided that preventing thousands of people from drowning had become a humanitarian imperative. Within six weeks, it was operating three SAR vessels in the Mediterranean – read more about their activities on page 55. An MSF team also operated in Tunisia, providing training to the Libyan Red Crescent in dead body management because of the number of drowned people washing up on the shore.

An estimated one million migrants and refugees crossed into Europe in 2015, and MSF increased its operations accordingly, focusing on setting up mobile responses to attend to the needs of the unprecedented

numbers of people on the move. Despite community-level mobilisation to provide them with support and information, many were faced with squalid and inhumane reception conditions, razor wire fences, intimidating soldiers and closed borders. For details of MSF activities in Greece, Italy, France and along the western Balkan route, see pages 56–59.

The rise in the number of refugees stuck in exile means that the pressures on the countries hosting them are increasing too. Turkey is the world’s biggest hosting country, while Lebanon is home to more refugees per head than any other country. Overall, the lion’s share of the global responsibility for hosting refugees continues to be carried by countries immediately bordering conflict zones. For details on MSF activities in Turkey and Lebanon, see pages 85 and 52.

“We fled to Europe for the security of the children. To make sure they were safe and had access to good education. Because there is nothing left in Syria. My entire town is destroyed. But if I’d known that it’s so hard to reach Europe, I would never have sent them. I’d rather have died in Syria than go through this. I thought people in Europe would treat us well. Because of all the difficulties on the road, some of us gave up and went back to Syria. They are dead now. In total, I was arrested 33 times. I was thrown in prison in Greece, in Macedonia, in Serbia, in Hungary. Why? I don’t understand. I did nothing wrong. I flee death, but I only find death. My future is the future of my children. If only I knew where they were.”

Syrian man living alone in a forest in Serbia after he lost track of his wife and four children.



OPERATIONS IN THE MEDITERRANEAN AND AEGEAN SEAS

Médecins Sans Frontières (MSF), in collaboration with other organisations, started Search and Rescue (SAR) operations in 2015 in an attempt to reduce loss of life at sea and provide emergency aid to survivors of perilous boat journeys.

Hundreds of thousands of desperate refugees and migrants pay large sums of money – sometimes all their life savings – to smugglers in order to reach Europe by sea. The majority travel across the eastern Mediterranean from Turkey to Greece, a journey that takes between 45 minutes and three hours. Others, however, set off for Italy from Libya, a crossing that can take several days. Shipwrecks are common, especially if weather conditions are poor. The vessels used are mainly small inflatable Zodiacs or old, wooden fishing boats and they are overcrowded and often unseaworthy. Migrants and refugees, many of them with no experience of the sea, are frequently left alone on board with no navigation equipment and insufficient fuel. It is little wonder that the vessels often get into trouble soon after setting sail. More than 3,700 people lost their lives at sea in 2015.

MSF SAR operations were initiated following a decision by the EU and Italy in late 2014 to discontinue Mare Nostrum, a large rescue-at-sea operation led by the Italian navy in the Mediterranean that saved over 170,000 lives. In 2015, MSF teams on board three boats patrolling the Mediterranean Sea assisted over 23,000 people in distress in 120 separate rescue missions, either by directly rescuing them or by transferring them from or to other vessels.

MY Phoenix, Bourbon Argos and Dignity I

Between May and September, MSF in partnership with Migrant Offshore Aid Station (MOAS) conducted SAR operations and post-rescue care in the central Mediterranean, on board the *MY Phoenix*. MSF and MOAS rescued and helped 6,985 people, the vast majority of them Eritrean. Of the people rescued, 1,646 received medical consultations, and those needing further care, including pregnant women, were referred to Italy's Ministry of Health upon arrival on shore. A second ship, the *Bourbon Argos*, operated by an experienced SAR team and 10 MSF staff, had the capacity to carry 700 rescued people

to land and had provided medical care for 4,443 people by December. In total, 9,560 people were rescued during eight months at sea. A third ship, the *Dignity I*, was launched from Barcelona in June, with a crew of 18 people, including medical staff. It had the capacity to transport 300 people to land, and rescued more than 6,000, mostly off the Libyan coast, during its six-month mission.

The deplorable conditions in Libya and on the boats resulted in various medical and humanitarian needs. In addition to medical care, the teams provided food, water, clothing, protection against the elements, and information and reassurance to the people rescued at sea. Common medical complaints included headaches, exhaustion, skin and upper respiratory tract infections, scabies, motion sickness and hypothermia. Some people were dehydrated or suffering from asphyxiation from being crowded together inside wooden boats. Staff also treated

chemical burns caused by fuel spills in the boats, and sexually transmitted infections as a result of sexual abuse, including rape.

MSF and Greenpeace in the Aegean Sea

Despite deteriorating weather conditions, in November 2015 alone around 150,000 people crossed the sea from the Turkish coast to the Greek islands, the majority landing in Lesbos. Between September and November, more than 320 people, mainly children, lost their lives in the Aegean Sea while attempting to reach Europe. In collaboration with Greenpeace, MSF provided assistance to boats in distress in the Aegean Sea, off the coast of Lesbos. Between 7 and 28 December, 6,055 people were helped in 143 separate interventions; 455 were directly rescued and 5,600 were guided or towed to safety. MSF medical teams treated people at the landing point and 30 individuals were referred to hospital for further assistance, mainly for trauma.



A commercial cargo ship offers protection against wind and waves as 95 people onboard a rubber dingy wait for rescuers to intervene.

GREECE

No. staff in 2015: 12 | Expenditure: €1.4 million | Year MSF first worked in the country: 1991 | msf.org/greece



KEY MEDICAL FIGURES:

46,300 outpatient consultations

35,400 relief kits distributed

3,400 individual and group mental health consultations

More than 856,000 refugees and migrants arrived by sea or land in Greece in 2015, making it the main entry point for people attempting to reach Europe.

Volunteers and civil society organisations mobilised to help new arrivals, and Médecins Sans Frontières (MSF) provided healthcare. A third of the people landing on Greece's shores were women and children. Approximately 91 per cent came from countries affected by war and violence – predominantly Syria, Afghanistan, Iraq and Somalia. Most disembarked on the islands of Lesbos, Samos, Chios, Kos and Leros. On Lesbos alone, as many as 6,000 people were arriving each day in October.

Lesbos and Samos

In July, MSF opened clinics in Moria and Kara Tepe camps on Lesbos and set up a mobile clinic in the port, where thousands of people waited out in the open in sweltering heat to travel on to Athens. MSF improved water and sanitation facilities, provided waste management and installed chemical toilets and water points in Moria. The team also organised buses for medical referrals and to transport new arrivals to the registration centres, located 70 kilometres away. A transit centre was opened in Matamados to provide assistance to new arrivals, including shelter, transportation, food, blankets and wi-fi (enabling contact with families and friends). Over 16,100 medical consultations were carried out and 3,000 people received mental health support.



An Afghan family stand together at a pier on the island of Kos. Approximately 91 per cent of people who arrived on Greece's shores in 2015 came from Syria, Afghanistan, Iraq and Somalia.

An MSF team began to offer medical assistance to people landing on Samos in October. A mobile team welcomed them and transferred them to the registration office at the main port, where staff conducted medical consultations. The team also distributed relief items and an average of 540 meals a day to those living in the reception centre.

MSF was the only humanitarian organisation present on Agathonisi, a small island near Samos. A team met arrivals and provided shelter and medical care.

Dodecanese Islands

As there were no official reception systems on any of the Dodecanese Islands, MSF started to provide shelter, food and medical screening on Kos in March. In September, local authorities closed Captain Elias camp, an abandoned hotel used by asylum seekers as temporary shelter and where MSF provided basic emergency assistance. The migrants and refugees had few options but to sleep outdoors in Kos town until MSF set up a tent camp near an archaeological park. There, a team worked with other organisations to offer basic medical and humanitarian assistance.

In June MSF started operating a mobile medical clinic visiting Leros, Simi, Tilos and Kalymnos islands. MSF established a permanent presence on Leros in September, with teams working on shelter, water and sanitation and providing mental health support and basic healthcare. Across Kos and Leros, the team carried out over

14,000 medical consultations and provided mental health support to 6,000 people. MSF teams also distributed 35,358 relief kits (soap, blankets, etc) to people who had lost their belongings during the journey.

On the mainland

In Athens, MSF conducted 708 medical consultations at Eleonas transit centre, which houses people who want to apply for asylum in Greece. Those identified as victims of torture received specialised care at the Kypseli rehabilitation centre, in collaboration with Babel and the Greek Council for Refugees.

In Idomeni transit camp, close to the border with the Former Yugoslav Republic of Macedonia (FYROM), MSF ran a mobile medical clinic offering basic healthcare and mental health support, and donated relief items such as blankets and washing kits. Over 13,000 consultations were carried out between April and December. MSF built shelters, showers and latrines for more than 1,500 people at Idomeni camp and maintained the electricity grid and sanitation services. Between June and December, MSF mental health teams also provided individual and group sessions to over 14,000 people. When the camp was closed, refugees and migrants travelling to the FYROM border had no option but to spend hours waiting at Polykastro petrol station, less than 20 kilometres from the camp. MSF organised shelter, offered medical services and distributed food and water at congregation points on the road towards the border area.

ITALY

No. staff in 2015: 28 | Expenditure: €8.5 million | Year MSF first worked in the country: 1999 | msf.org/italy



KEY MEDICAL FIGURES:

9,400 outpatient consultations

2,200 individual and group mental health consultations

Italy has long been a landing point for migrants and refugees, and in 2015 more than 153,000 people arrived by sea, mainly from countries such as Eritrea, Nigeria, Somalia, Sudan and Syria.

The main ports of landing were Augusta, Pozzallo, Palermo, Reggio Calabria and Lampedusa. The reception system in Italy suffers from serious shortcomings as a result of the lack of political will to manage new arrivals. Access to humanitarian assistance and international protection for those in need is in no way guaranteed.

In 2015, Médecins Sans Frontières (MSF) supported the Ragusa Provincial Health Agency with the medical screening of new arrivals and a 24-hour medical service, and worked inside Pozzallo's first reception centre providing medical care. More than 3,000 consultations had been carried out by year's end. Many patients presented with skin diseases (often a result of poor living conditions in Libya), respiratory tract infections, suspected tuberculosis (TB) and trauma.

MSF also launched a programme focusing on mental healthcare in 16 reception centres in Sicily's Ragusa province, temporary home to 400 refugees and migrants. A team of two psychologists and several cultural mediators screened all new arrivals for psychological vulnerabilities and provided care to those in need. The team carried out 1,052 individual mental health consultations and organised

69 group sessions for 549 people. Most of the patients were from Nigeria, the Gambia, Senegal, Mali and Bangladesh and 41 per cent had symptoms of post-traumatic stress disorder, while others were suffering from psychological distress or depression.

Throughout 2015, MSF undertook bilateral meetings and public advocacy efforts to call for change in the Italian reception system. A report was submitted to the Italian Parliament in November detailing problems at the primary reception centre in Pozzallo, such as overcrowding and poor hygiene conditions, and making recommendations for improvements. No changes were made and at the end of the year MSF made the difficult decision to cease activities in the centre.

Psychological first aid

As the migrants and refugees had had arduous and often traumatic journeys, MSF began offering psychological first aid to those in urgent need of support upon arrival in Sicily. From May, a team made up of cultural mediators and a psychologist were on standby to deploy to different landing ports in Italy within 72 hours of receiving an alert. They responded 14 times in eight Italian ports, assisting 2,500 people.

In Rome, an MSF team also provided psychological first aid to migrants and refugees staying in a transit centre managed by civil society activists. Most of these people left for northern Europe a few days

after their arrival. Between 16 July and 1 November, teams provided information to 6,540 people, mental health support to 903 people through individual or group sessions, and completed 79 individual psychological consultations.

In Rome, MSF launched a project in October working with asylum seekers who have been the victims of torture, in collaboration with Medici Contro la Tortura. In total, there were more than 340 consultations. The centre offers medical, psychological and socio-legal assistance to any migrant, refugee or asylum seeker who has been tortured or subjected to targeted violence, regardless of their place of origin or legal status.

Shelter and medical care in Gorizia

Towards the end of the year in the northern city of Gorizia, on the border with Slovenia, a team provided medical care, shelter and assistance to hundreds of refugees who had been sleeping outdoors next to a river. In December, MSF opened a temporary centre there, made from 25 converted shipping containers, with a capacity of 96. The team worked in collaboration with the local health service and the Red Cross, and distributed relief items such as hygiene kits. The people in Gorizia were mainly Pakistanis and Afghans, who had entered Italy after a long journey across the Balkans. In the first three weeks of the project, more than 200 people were given temporary shelter.



This Sudanese man was rescued from a small, waterlogged boat by the Phoenix vessel. A former teacher, he dreams of studying in Europe.

© Gabriele François Casini/MSF

BALKAN ROUTE

After reaching Greece, most migrants and refugees in 2015 travelled onwards along the Balkan Route, hoping to make western Europe their final destination.

People left Greece to travel through the Former Yugoslav Republic of Macedonia (FYROM) and on to Serbia from where they crossed into Hungary, Croatia or Slovenia – depending on where the borders were open – and north into Austria and beyond. Médecins Sans Frontières (MSF) provided over 40,000 medical consultations to people along the way, often treating conditions caused by their gruelling journeys and a lack of adequate shelter and sanitation.

Serbia

MSF deployed mobile teams in Serbia, so they could assist people as they moved across the country. At the border with FYROM, MSF worked in Miratovac and Preševo, where up to 4,000 people waited to be registered without shelter in poor weather conditions, MSF set up a clinic and provided basic and mental healthcare near the registration centre as well as at a transit camp near the border. Teams distributed relief items such as washing kits, food, tents, blankets and raincoats, while medical staff treated people suffering from common colds, respiratory tract infections and hypothermia. MSF also supported rubbish collection, set up toilets and offered transportation to disabled people and vulnerable families. In November, a team

rehabilitated a 1.5-kilometre road, enabling thousands of people to proceed in greater safety, and set up toilets and six heated tents providing shelter for up to 270 people. Between June and December, the team completed 9,184 medical consultations.

In Belgrade, care was provided to refugees in two parks close to the train and bus stations. The team carried out 3,950 medical consultations between April and September.

Some nights, up to 3,000 people waited in line to be registered or they were stranded at the border with Croatia and had to sleep outside. Mobile clinics assisted people at the crossing points, for example at Sid, where teams inside the transit centre offered consultations as they waited for the train. MSF also set up eight large heated tents

providing shelter for more than 2,000 people at the new transit points designated by the authorities. Between mid-September and early December, over 15,200 medical consultations were carried out.

Hungary

In September, MSF started running a mobile clinic in the border town of Röszke, where between 2,000 and 4,000 people crossed from Serbia each day. Medical care was provided to 400 people in four days, until a wire fence was erected and the border was closed on 14 September. People then diverted west to Croatia, until that border was also closed on 17 October and they diverted again, this time to Slovenia.

Most of the patients in Röszke were children with respiratory problems, pregnant women, and men with infected wounds caused by the long journey on foot and climbing over fences.

Slovenia and Croatia

In September and October, between 10,000 and 15,000 people per day were arriving in Slovenia and Croatia, most of them families. Due to a lack of coordination between the two countries, Slovenia's reception centres were overwhelmed and unable to cope with the first influx of refugees. MSF supported the Ministry of Health at the Brežice transit centre on Slovenia's border with Croatia in October and November, providing around-the-clock medical assistance to people entering Slovenian territory until trains were organised from Croatia to transport them directly to the Slovenian–Austrian border for onward travel. In Croatia, MSF teams set up a clinic in a transit camp about 15 kilometres from Tovarnik, near the Croatian border with Serbia, providing healthcare to refugees who were waiting to be transferred to Hungary. Around 5,000 people attended the clinic each day.



At the Bapska border crossing between Serbia and Croatia a woman received medical treatment from an MSF doctor as her niece looks on.

FRANCE

No. staff in 2015: 9 | Expenditure: €1.0 million | Year MSF first worked in the country: 1987 | msf.org/france



In September 2015, Médecins Sans Frontières (MSF) started providing medical care to refugees and migrants living in the 'Jungle' camp in Calais.

In early 2016, the 'Jungle' camp was home to up to 6,000 refugees and migrants. The living conditions were dire, despite the efforts of non-profit organisations and local charitable initiatives. Calais is near the Channel Tunnel, a railway link between France and the UK. For several years, people have been trying to reach the UK on trucks via the tunnel.

With Médecins du Monde, MSF started providing medical services in the camp in September. The team then built an outpatient department to improve working conditions and patient care, as the site is prone to flooding. Between 100 and 120 people were seen every day and benefited from medical



People huddle around a fire to keep warm in heavy rain and freezing temperatures in the refugee camp in Grande Synthe, near Dunkirk.

consultations, nursing care and physiotherapy. The team also undertook water and sanitation activities, built 66 chemical toilets and set up a system for collecting and managing rubbish. As people were living in small tents unsuitable for rainy and wintry weather, MSF built 80 wooden shelters, each accommodating four to five people.

Grande-Synthe, Dunkirk

Around 2,500 mainly Kurdish refugees and migrants were living in appalling conditions

at a site in Grande-Synthe, north of Calais, near the port of Dunkirk. MSF set up 22 latrines and two water points, and provided medical consultations three days a week. MSF also decided, with the support of the local council, to build a new site offering better shelter and living conditions. In November and December, over 2,100 medical consultations were carried out in this area – the majority for respiratory tract infections and scabies, predominantly caused by poor hygiene and sanitation.

🐦 2015 TOP TWEETS FROM @MSF_Sea



Live updates from MSF projects assisting migrants and refugees in Europe and on the Mediterranean and Aegean seas.



Thousands of people were trapped at the border between Greece and the Former Yugoslav Republic of Macedonia in the summer of 2015. Chaos followed the border closures and tear gas was used to disperse crowds.

LIBERIA

No. staff in 2015: 535 | Expenditure: €10.5 million | Year MSF first worked in the country: 1990 | msf.org/liberia | blogs.msf.org/ebola



KEY MEDICAL FIGURES:

35,200 measles vaccinations in response to an outbreak

145 patients treated for haemorrhagic fevers

The Ebola epidemic in Liberia was almost over in 2015, but the country still needs support to deal with any new outbreaks that occur and to help rebuild the health system.

The health situation in Liberia was precarious even before the Ebola outbreak, but the country was brought to its knees by the epidemic. Many hospitals closed in 2014 and have not yet reopened, and it is estimated that eight per cent of health workers in the country died from the virus, while others have never returned to work. Médecins Sans Frontières (MSF) is supporting the Ministry of Health to improve access to healthcare.

Liberia was declared Ebola free in May 2015, but new cases were reported in July and November. As part of the Ministry of Health's national plan, MSF organised training sessions on Rapid Isolation and Treatment for Ebola teams in four districts of the country, and in certain health centres in Monrovia supported the improvement of infection prevention and control measures by, for example, setting up isolation areas.

In March, MSF handed over an Ebola transit unit in Monrovia to the International Rescue Committee, and in May, the Ebola treatment



Thousands of children in Monrovia were immunised during the first post-Ebola integrated deworming and polio and measles vaccination campaign in May.

centre (ETC) to the Ministry of Health. During the first few months of the year, the transit unit team diagnosed patients, and isolated and referred them to an ETC if necessary; 81 patients were triaged and seven were diagnosed as having Ebola.

It is estimated that there are around 1,000 Ebola survivors in Monrovia and Montserrado County, who suffer from joint pain and eye problems and also have to contend with being ostracised by their community. MSF therefore opened a survivors' clinic in Monrovia in January, which currently provides outpatient and mental health consultations, and referrals to more than 500 people. In addition, the team treats patients who do not have certificates from ETCs and so are not formally identified as survivors; these people have even more difficulty accessing medical care.

Paediatric care in Monrovia

Approximately 17 per cent of Monrovia's population of 1.4 million are aged under five. As paediatric wards and hospitals closed during the Ebola outbreak, MSF opened

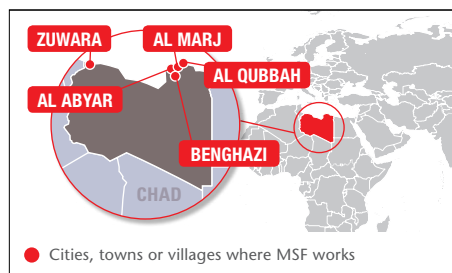
the 74-bed Bardnesville Junction paediatric hospital in April to try and address some of the subsequent gaps in specialised care for young children. The facility comprises a 10-bed intensive care unit, an emergency room, a neonatal unit, a therapeutic feeding centre and an inpatient ward. At the end of the year, the capacity of the hospital was increased to 91 beds.

Measles response

A measles outbreak was declared in Monrovia at the beginning of 2015, and in March MSF organised a two-day vaccination campaign in Peace Island district which reached 542 children. Due to the continued risk of Ebola, MSF chose small sites for the campaign and followed strict infection prevention and control measures. This protocol was replicated in May when the Ministry of Health ran a countrywide vaccination campaign, which was supported by MSF.

LIBYA

No. staff in 2015: 40 | Expenditure: €4.4 million | Year MSF first worked in the country: 2011 | msf.org/libya



KEY MEDICAL FIGURES:

3,700 outpatient consultations

Since the end of the Muammar Gaddafi regime in 2011, Libya has been divided by armed conflict and the violence has escalated in recent years.

Libya had two governments: one based in the east in Tobruk, which was internationally recognised, and the other based in the west in Tripoli.

In 2015, the Islamic State group took control of the coastal city of Sirte and established a presence in several other cities such as Derna, while fighting continued between political factions in several areas. As a result, it became extremely difficult to maintain medical and drug supplies, foreign health workers evacuated and many hospitals and clinics were unable to function properly. However, Médecins Sans Frontières (MSF) donated drugs and vaccines to hospitals in the cities of Al Beyda and Al Marj, and also improved hygiene conditions at Al Qubba hospital in the east.

MSF donated materials such as chlorine, masks and protective gloves to the local crisis committee at Al Marj, which is near

the Mediterranean coast, to help cope with the bodies washing up on the shore there – people who had drowned while attempting to cross the sea.

As armed conflict continued in Benghazi, MSF increased the capacity of Al Abyar field hospital, located 60 kilometres from the city, so that it could stabilise the wounded. The team provided training in emergency care management in Al Abyar and Al Marj hospitals. MSF donated drugs to the only three functional hospitals in Benghazi, including Benghazi paediatric hospital, and provided regular donations to diabetic and renal centres. Between July and November, MSF distributed food to 2,400 displaced families in partnership with a Libyan NGO.

In November, MSF started supporting Zuwara hospital in western Libya with drugs, medical supplies, training and staff.

MADAGASCAR

No. staff in 2015: 60 | Expenditure: €1.8 million | Year MSF first worked in the country: 1987 | msf.org/madagascar



KEY MEDICAL FIGURES:

2,500 patients treated for malaria

1,300 patients treated in feeding centres

In 2015, Médecins Sans Frontières (MSF) returned to Madagascar to respond to a malnutrition crisis and a malaria outbreak.

Low rainfall in the south of Madagascar meant that the harvest was poor in 2015. The subsequent food shortage was compounded by a lack of infrastructure and access to medical care. When the first MSF teams arrived to assess the gravity of the crisis, they found that people were collecting wild plants and leaves to eat, and selling household items, livestock and even land in order to buy food. Most stockpiles of food had already been exhausted. In June, MSF started providing treatment for malnutrition in Ambovombe district, Androy region. The intensive therapeutic feeding centre admitted a total of 139 children (90 per cent of whom were aged under five), and 1,486 were admitted as outpatients (75 per cent of whom were aged under five).

Thanks to the unexpected arrival of the rains, however, the situation improved in September and the number of cases of malnutrition was not as high as estimated. 'Nutrition surveillance caravans' were launched in order to monitor the nutritional status of the scattered population in several parts of this largely rural region. These activities are expected to end in March 2016.

Malaria response

In May, there was an increase in the incidence of malaria in the south of Madagascar, but the country's response was limited due to a lack of drugs – artemisinin-based combination therapy (ACT), the most effective treatment – and the remote nature of the area. Mobile clinics started running in the Atsimo-Andrefana region and covered four districts and 13 communes. Between early June and mid-July, 4,190 patients were tested for malaria, and over half tested positive and were treated with ACT. In addition to running the mobile clinics, MSF supported two hospitals, 16 clinics and 18 basic health centres by donating malaria drugs and medical equipment.

MALAWI

No. staff in 2015: 390 | Expenditure: €9.0 million | Year MSF first worked in the country: 1986 | msf.org/malawi



KEY MEDICAL FIGURES:

100,300 outpatient consultations

46,800 patients on first-line ARV treatment

Malawi experienced the most severe floods in living memory in 2015; 176 people were killed and over 200,000 were displaced. Médecins Sans Frontières (MSF) responded with a five-month emergency operation in the south of the country.

MSF mobile clinics provided 40,000 outpatient consultations and distributed relief items such as water treatment kits and mosquito nets to over 13,000 households. Teams also delivered three million litres of drinking water, which helped to contain a cholera epidemic that had flared up in neighbouring Mozambique and spread to Malawi: 279 cases of the disease were recorded in MSF-supported facilities in Nsanje and Chikhwawa.

HIV care

Despite significant progress in prevention in recent years, an estimated one million people are still living with HIV in Malawi and only half of them receive treatment. The health authorities have launched an ambitious plan to accelerate the fight against the disease by increasing the resources allocated to it and focusing on assisting the most vulnerable and hard-to-reach people, such as sex workers.

The four-year handover process that started in Chiradzulu in August 2014 continued, and is due to complete by mid-2018. In this district, MSF supported more than 33,000 HIV patients, of which 18,800 are enrolled in the so-called 'six month appointment' schedule, whereby stable patients attend a consultation only twice



An MSF nurse performs a rapid diagnostic test for malaria. It quickly detects whether the malaria parasite is present in a patient's blood.

a year. This not only benefits patients, but also reduces staff workload, allowing them to focus on more complex cases. MSF has implemented point-of-care viral load testing in seven of the health centres, facilitating access to rapid confirmation of suspected treatment failures. MSF is advocating for this type of decentralised testing in areas with high prevalence like Chiradzulu district.

In December, MSF finished handing over the HIV project it had been running for 18 years in Thyolo, to the Ministry of Health.

In Nsanje, MSF continues to supervise the implementation of the policy to put all HIV-positive pregnant and breastfeeding women on antiretroviral (ARV) treatment, regardless of their clinical status, to prevent transmission of the virus to their babies. This year, the Ministry of Health requested MSF's support to launch community ARV groups, too. The handover to the ministry of the programme to integrate HIV and tuberculosis (TB) treatment will be completed in 2016.

MSF also continued a three-year project in two of the three central prisons in the country – Maula in the capital, Lilongwe, and Chichiri in Blantyre. The aim of the project is to adapt models of care to reduce HIV and TB transmission in these severely overcrowded environments, by increasing diagnostics and access to treatment.

The 'corridor' project continued in 2015, offering testing for HIV and other sexually transmitted infections to truck drivers and

sex workers in Mwanza and Zalewa, near the border with Mozambique. The team also worked over the border, along the busy route between Beira and Tete.

Emergency activities

In April, following an outbreak of xenophobic violence in South Africa, MSF supported the Ministry of Health to offer medical and psychological care to 3,831 Malawians, most of whom had been forcibly repatriated. Three months later, MSF organised mobile clinics in the village of Kapise, near the border, for Mozambicans fleeing sporadic violence in Tete province. The influx of refugees continued into 2016.

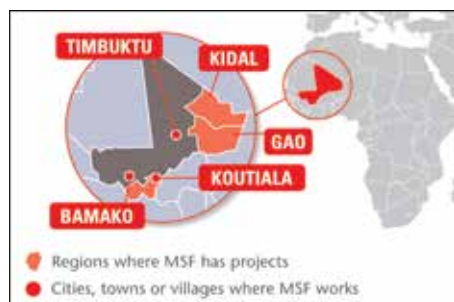
PATIENT STORY

BERITA TCHELENI – from Makhanga village, South Malawi

"I was eight months pregnant when the floods hit, and we had to spend four days on top of a tree until the water receded. Then, on 22 January, I felt the baby coming. We went to Makhanga clinic, but it was closed because it had been completely destroyed by the floods. There was no one there to help; our village had become an island completely cut off from the rest of the country. I was told to wait, that a helicopter was coming, and it could take me to another clinic. Fortunately, when the helicopter arrived, it brought with it someone from MSF to help us and my baby girl was born."

MALI

No. staff in 2015: 631 | Expenditure: €11.5 million | Year MSF first worked in the country: 1992 | msf.org/mali



KEY MEDICAL FIGURES:

182,300 outpatient consultations

70,000 patients treated for malaria

22,900 routine vaccinations

Despite the peace agreement reached between the government and the main armed groups in northern Mali in June, the security situation remained volatile for the rest of the year.

Clashes between armed groups impeded humanitarian access, and the lack of medical supplies and qualified personnel meant that people were left with little or no basic healthcare. There were deadly security incidents in the south, notably an attack by Islamic militants on a restaurant in March and an attack on a luxury hotel in November, both in Bamako.

In Gao region, Médecins Sans Frontières (MSF) continued to support the hospital in Ansongo district, where a team manages outpatient services, admissions, maternal health, nutrition, surgery and the laboratory. MSF staff also worked with health centres in rural areas to arrange medical referrals. In September, a special project was launched to meet the basic medical needs of both pregnant women and children under the age of five among the seasonal pastoralist population in the region. In addition, more than 46,000 children under the age of five received antimalarial treatment during the seasonal peak between August and November to guard against the disease. At the same time, and in accordance with the national vaccination schedule, they were also



A seven-month-old boy is diagnosed with severe pneumonia and malnutrition at Molobala community health centre.

vaccinated against diphtheria, tetanus, pertussis, hepatitis B, *Haemophilus influenzae* type B, polio, pneumococcus, rotavirus, measles, yellow fever and tuberculosis. This resulted in significant improvement in vaccination rates in the area.

From August, to improve access to healthcare for people living in Kidal region, north of Gao, a team supported two health centres in the town and worked with a local organisation, SoliSa (Solidarité au Sahel) in other facilities in outlying areas.

Healthcare in Timbuktu and the surrounding area

In Timbuktu, MSF supported the 86-bed regional hospital, focusing on medical and surgical emergencies. There were an average of 390 inpatient admissions and 80 assisted deliveries every month. Teams also provided consultations for patients with chronic diseases, such as diabetes and hypertension, at the referral health facility.

Over 40 per cent of people living in the Timbuktu region are more than 15 kilometres from the nearest health centre. To ease access to healthcare, MSF mobile teams support staff in three peripheral health centres that offer basic care, vaccinations, maternal care and malnutrition screening. These clinics had to be suspended for several months due to insecurity.

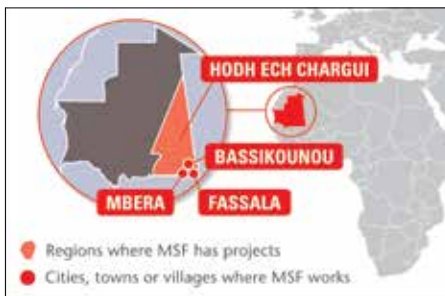
Southern Mali

The main cause of child mortality in the relatively peaceful south of the country is malaria. In 2015, MSF continued to focus on child health and severe acute malnutrition in Koutiala, Sikasso region. MSF supports the paediatric unit within the Koutiala referral health facility and five health centres in Koutiala district. MSF increased the number of beds to 300 in the paediatric unit during the seasonal malaria peak.

MSF has been running a seasonal malaria chemoprevention programme in this area for four years and in 2015 delivered antimalarial treatments to 190,067 children. A preventive paediatric care project, including vaccinations and bed net distribution, continued in the Konséguéla health area, with vaccinations extended to all five health centres that MSF supports.

MAURITANIA

No. staff in 2015: 370 | Expenditure: €4.9 million | Year MSF first worked in the country: 1994 | msf.org/mauritania



There are approximately 50,000 Malian refugees living in Mauritania's Mbera refugee camp. They are almost entirely dependent on international aid for survival, and many lack adequate food and shelter.

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 2015, caesarean sections and visceral and orthopaedic surgeries represented the majority of the life-saving surgical procedures performed by MSF teams in the region.

KEY MEDICAL FIGURES:

204,100 outpatient consultations

1,800 births assisted

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 and are largely absent in the region. Armed groups

MEXICO

No. staff in 2015: 111 | Expenditure: €3.4 million | Year MSF first worked in the country: 1985 | msf.org/mexico | [@MSF_Mexico](https://twitter.com/MSF_Mexico)



Médecins Sans Frontières (MSF) continued to run its programme for migrants, offering mental healthcare and psychosocial support, hospital referrals and follow-up for emergency cases.

During the first eight months of the year, some 19,000 people were registered in the shelters where MSF works and nearly 50 per cent received support of some kind. More than 900 medical and 1,100 mental health consultations were carried out in Ixtepec, Tenosique, San Luis Potosí, Apaxco, Lechería, Huehuetoca and Bojay.

but teams continued to work in Reynosa and other smaller hospitals on the border with the US, providing staff training, mental health services and care for victims of sexual violence, and donating equipment and drugs.

MSF continued to work with the health authorities to implement a comprehensive response to Chagas disease in San Pedro Pochutla municipality, Oaxaca state.

In the first few months of the year, MSF continued to provide psychological support to the parents of the 43 students who disappeared in Ayotzinapa, Guerrero state, Mexico.

KEY MEDICAL FIGURES:

1,000 outpatient consultations

8,000 individual and group mental health consultations

At the end of the year, a new centre for migrants who had been victims of inhumane treatment was opened in the capital. Support was offered to people who had been identified and referred by MSF teams and other organisations working in the area.

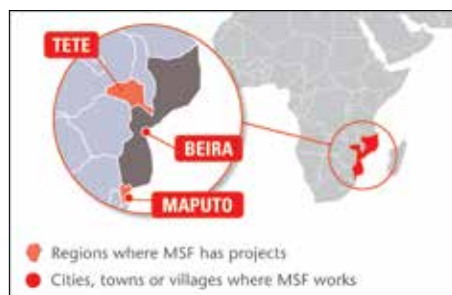
In Colonia Jardín, Acapulco, MSF offered mental health support to victims of violence and carried out over 3,000 consultations.

In the northern state of Tamaulipas, the general hospitals in Reynosa and Nuevo Laredo offer free, high-quality medical care. In September, MSF handed over its project in Nuevo Laredo to the health authorities,

MSF also started operations in Tierra Caliente, where violence has led to staff shortages and has disrupted access to medical services by forcing several rural health posts to close. MSF began working in Arcelia hospital, providing access to emergency obstetric services and assisting caesarean sections.

MOZAMBIQUE

No. staff in 2015: 382 | Expenditure: €10.0 million | Year MSF first worked in the country: 1984 | msf.org/mozambique



In Mozambique, Médecins Sans Frontières (MSF) continues to work with the Ministry of Health to develop innovative strategies to combat HIV/AIDS and tuberculosis (TB), and to respond to emergencies such as cholera epidemics.

KEY MEDICAL FIGURES:

34,300 patients on first-line ARV treatment

1,000 patients on second-line ARV treatment

4,700 patients treated for cholera

800 patients under treatment for TB, of which **100** for MDR-TB

Despite adopting an ambitious acceleration plan to tackle HIV/AIDS in 2013, Mozambique is still struggling to deal with the epidemic; 11.5 per cent of adults living in the country have HIV, and worryingly, the number continues to grow, in part because of structural problems such as shortages of health staff and a recurrent lack of essential medicines. MSF is providing a wide range of services, from specialised medical care for patients with advanced stages of AIDS to supporting strategies that enable stable, healthy HIV patients to access their medicines more easily.

In the capital Maputo, MSF focuses on HIV/AIDS patients who need specialised care,

including those who have failed first-line antiretroviral treatment or are suffering from co-infections such as multidrug-resistant TB (MDR-TB) and viral hepatitis, or cancers like Kaposi's sarcoma or those caused by human papillomavirus. Comprehensive care is also provided to MDR-TB patients and HIV-infected women and children. In 2015, MSF provided viral load monitoring to 28,394 patients.

MSF scaled up its activities in the 'corridor project' that was started in 2014 along the commercial route linking the busy Beira harbour to the mining area of Tete province. This year, it provided testing for HIV and sexually transmitted infections to 967 long-distance truck drivers and 548 sex workers, a particularly vulnerable group with an HIV prevalence of 55 per cent.

Cholera is endemic in Mozambique, and there were several exceptionally large and unrelated outbreaks in the centre and north of the country in 2015. MSF teams in Tete and Zambezia provinces treated a total of 416 patients.

PAPUA NEW GUINEA

No. staff in 2015: 226 | Expenditure: €6.9 million | Year MSF first worked in the country: 1992 | msf.org/png



KEY MEDICAL FIGURES:

870 patients under treatment for TB

Médecins Sans Frontières (MSF) started supporting Gerehu hospital in Port Moresby in March 2015 to increase its capacity for screening, diagnosing, treating and following up patients with tuberculosis (TB).

Port Moresby is in National Capital District, where around 25 per cent of the people in the country suffering from TB live. In Gerehu, there are around 1,500 patients diagnosed with TB annually and the number of cases of drug-resistant TB (DR-TB) is increasing. The next step for the project is to set up a dedicated TB unit at Gerehu hospital.

The TB programme that opened in Gulf province in May 2014 was expanded this year, and the MSF team supported not only Kerema general hospital but also outreach activities in two health centres. In total, there were over 2,800 outpatient consultations and 2,347 people with suspected TB were screened. However, the lack of an effective follow-up system resulted in a high number of patients not completing their treatment. This loss to follow-up is of concern as it increases the incidence of DR-TB. In 2015, 15 DR-TB cases were detected and treated. In collaboration with the provincial authorities, MSF is

developing a decentralised model of care so that people do not need to come to a medical facility so frequently.

Discussions between MSF and the authorities are ongoing to identify the best way to tackle TB in Papua New Guinea.

Treatment for victims of sexual and domestic violence

The Port Moresby Regional Treatment and Training project was handed over to the National Department of Health in 2015, and MSF started the gradual handover of Tari hospital. When this is completed, MSF will cease its activities treating victims of sexual and domestic violence in the country. While incidents of sexual, family and general violence remain high in Tari and the Highlands region, from April 2016 onwards the provincial health authorities will lead the response to meet the medical and psychological needs of people affected, and victims will still have access to vital services.

MYANMAR

No. staff in 2015: 1,076 | Expenditure: €16.4 million | Year MSF first worked in the country: 1992 | msf.org/myanmar



KEY MEDICAL FIGURES:

35,200 patients on first-line ARV treatment

1,100 patients under treatment for TB

In late July, cyclone Komen caused major flooding in large parts of Myanmar. It was the worst natural disaster in the country since cyclone Nargis in 2008. Médecins Sans Frontières (MSF) responded in Rakhine state and Sagaing region, both declared disaster zones by the president.

In Kalay and Tamu townships in Sagaing, and Minbya and Maungdaw townships in Rakhine, MSF teams distributed water and hygiene kits to reduce the risk of sanitation-related illnesses, and bed nets to prevent mosquito-borne diseases such as malaria and dengue fever, which are endemic in these areas. In Monywa, Kalay and Tamu, MSF trained Ministry of Health staff and volunteers to clean up potential mosquito breeding sites such as flower pots and open water vessels with stagnant water, and provided door-to-door health advice on preventing dengue. Dengue rapid tests were donated to the Ministry of Health, whose staff was trained on how to use them. Teams also ran mobile health clinics with the Ministry of Health in the main shelters, which included monasteries, mosques, a high school and an orphanage.

Providing healthcare in Rakhine state

MSF continued consolidating the activities that had been stopped by the authorities for nine months during 2014. These included supporting the Ministry of Health's mobile clinics that visited camps for internally



An MSF emergency team arrives in a village in Chin state, after being alerted of severe flooding.

displaced people in Pauktaw and Sittwe, and in ethnic Rakhine villages, as well as medical activities in Maungdaw, in the north of the state. In total, the teams conducted 84,689 outpatient consultations, supported vaccination campaigns for measles and polio and provided over 900 referrals to secondary health facilities. Access to healthcare remained unacceptably limited for many people in northern Rakhine, due to the severe restrictions on movement imposed on the Rohingyas, and the stark absence of other national and international humanitarian organisations.

New project in Wa Special Region 2

A survey conducted by MSF in Wa Special Region 2 confirmed a shortage of both basic and secondary healthcare services and disease prevention, as well as gaps in both vaccination and the provision of maternal health services.

In Lin Haw, MSF opened a new clinic inside a local health facility. Since September, teams have been running weekly mobile clinics providing basic healthcare at the market in Pang Yang. Teams also conducted general health and hygiene education and information sessions in two nearby schools.

Caring for people living with HIV

In 2015, MSF provided care for more than 35,000 people living with HIV through

its projects in Yangon and Tanintharyi regions, as well as in Shan and Kachin states – MSF's most substantial activity in Myanmar. The government has made great progress in the provision of HIV treatment but unfortunately only half of the estimated 210,000 people who need antiretroviral (ARV) therapy receive it. Treatment remains too centralised, so MSF is supporting the National AIDS Programme's (NAP) initiatives to make care available to people nearer to where they live. In Dawei, MSF has started transferring stable patients to decentralised NAP sites. In all of its HIV projects this year, MSF continued putting the focus on vulnerable groups, including injecting drug users, men who have sex with men (MSM), sex workers and patients with co-infections such as tuberculosis, drug-resistant tuberculosis or cytomegalovirus.

Mental health projects in Myanmar and Indonesia

MSF teams offered medical and psychosocial care to more than 700 people who had been detained after being rescued from abandoned smuggling boats in the Bay of Bengal in May and June.

In August, MSF started a mental health project for Rohingya refugees from Myanmar in Lhokseumawe camp in Banda Aceh, Indonesia. In November, the activities were extended to two camps in Langsa.

NEPAL

No. staff in 2015: 58 | Expenditure: €10.1 million | Year MSF first worked in the country: 2002 | msf.org/nepal | blogs.msf.org/nepal



KEY MEDICAL FIGURES:

2,100 outpatient consultations

14,800 relief kits distributed

Two earthquakes hit Nepal on 25 April and 12 May 2015, killing an estimated 8,500 people and injuring another 20,000.

After the first 7.8 magnitude earthquake struck, Médecins Sans Frontières (MSF) teams quickly arrived in the country and focused on reaching the people living in remote mountainous areas. The earthquake's epicentre was in Gorkha district, 80 kilometres west of Kathmandu.

MSF ran a system of helicopter clinics to provide healthcare and hospital referrals for emergency cases. Regular clinics were conducted in villages spread across Gorkha, Dhading, Nuwakot, Rasuwa, Sindhupalchowk and Dolakha districts. Their focus, in accordance with the needs expressed by the communities, was children under the age of five, pregnant women and mental healthcare.

In Arughat, Gorkha district, MSF set up a 20-bed inflatable hospital with an operating theatre, and emergency, maternity and resuscitation rooms. This replaced the local healthcare centre that had been destroyed by the earthquake until the Ministry of Health was able to open a semi-permanent structure at the end of June.

MSF also set up a temporary tented clinic in Chhapchet, Dhading district, an area that was severely affected. Staff provided basic healthcare and carried out minor surgical interventions, for example on patients whose wounds had become infected.

MSF teams were already operational by the time the second earthquake struck on

12 May, and were able to start providing healthcare in the hours that followed.

With many remote villages completely flattened, and the monsoon season fast approaching, shelter distribution and sanitation work were the priorities. MSF transported around 6,000 family-sized tents into the mountains by both land and air, as well as almost 13,000 iron sheets and 3,000 reconstruction kits for the building of more permanent dwellings. By the time the monsoon arrived, almost 10,000 households in Dhading, Nuwakot, Dolakha, Gorkha, and elsewhere in the Budhy Gandaki valley had some form of shelter.

Between April and July, MSF conducted over 2,500 health consultations and provided psychological support to more than 7,000 people, mostly via helicopter. Staff also treated 240 patients with emergency needs and carried out over 1,200 physiotherapy sessions in the Kathmandu orthopaedic hospital. MSF distributed food, as well as shelter, cooking and hygiene items, to almost 15,000 households. Teams also set up a water supply network for 7,000 displaced people in Cheechipathi camp in Kathmandu, and sanitation systems in a number of other camps around the city.

Following this immediate emergency phase, MSF reduced its activities in July 2015, but continued working through two projects in Sangha and Charikot. In Sangha, MSF worked in the Spinal Injury Rehabilitation Centre, a

50-bed facility situated east of Kathmandu.

After the earthquake, a large number of patients needed surgery, particularly for injuries to their lower limbs. They were fitted with external fixation (a procedure to stabilise and join the ends of broken bones with a splint or cast), or put in traction. MSF provided extra capacity in general rehabilitation for post-operative patients with physiotherapy, dressings, medical follow-up and mental healthcare, and also constructed a new ward for general rehabilitation with capacity for 50 patients. All activities had been handed over to the Spinal Injury Rehabilitation Centre by the end of the year.

Another MSF team worked with Ministry of Health staff in the emergency room, inpatient department and operating theatre at the primary healthcare centre in Charikot, a village in Dolakha district (the epicentre of the second earthquake), and also supported laboratory and X-ray services. All these activities had been handed over to a public-private partnership by the end of 2015.

Three colleagues lost in a helicopter crash

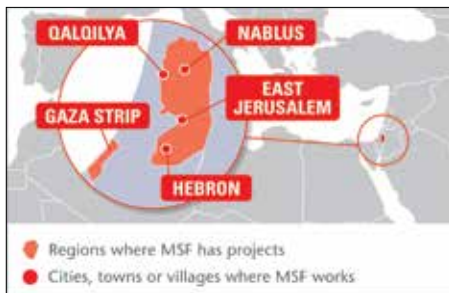
During a clinic on 2 June, three of our colleagues and their pilot lost their lives in a helicopter crash. Sandeep Mahat, Jessica Wilford and Sher Bahadur Karki (Raj), and their pilot, Subek Shrestha, were flying back to Kathmandu after delivering assistance to villages in Sindhupalchowk district when the accident occurred. It is with great sadness that we bid them farewell.



An MSF team evacuates a pregnant woman who has gone into labour.

PALESTINE

No. staff in 2015: 132 | Expenditure: €5.5 million | Year MSF first worked in the country: 1989 | msf.org/palestine



KEY MEDICAL FIGURES:

5,800 individual and group mental health consultations

Médecins Sans Frontières (MSF) provides medical and psychological assistance to people affected by the ongoing conflict in Palestine.

The continued expansion of Israeli settlements on the West Bank increased tensions and violence in 2015. In October, two settlers were shot dead in what was believed to be revenge for an arson attack which had killed a Palestinian family in July. Residents of Gaza are still suffering the consequences of 2014's 50-day war, and are still waiting for their houses to be rebuilt due to restrictions on the importation of construction materials.

According to the United Nations, 170 Palestinians and 26 Israelis were killed, and more than 15,300 Palestinians and 350 Israelis injured, in 2015.

Jerusalem and the West Bank

MSF's mental health programmes in Hebron, Nablus and Qalqilya governorates, and East Jerusalem, provided psychological and social support to victims of political violence. In 2015, MSF carried out 5,522 individual and group mental health consultations, more than 50 per cent of which were in Hebron (2,959). From October, spiralling violence there, particularly in the 'H2' area of the old city, led to a significant increase in activities. In an atmosphere of tension and fear, many people sought help for problems with sleeping, anger and anxiety; many



A five-year-old boy is prepared for a dressing change under anesthesia at MSF's Khan Younis tent clinic in Gaza.

children were suffering from nightmares and bed-wetting. Over 5,300 people attended psycho-education sessions run by MSF to help them develop coping mechanisms. MSF also provided training for medical staff, teachers and counsellors.

In 2015, MSF commemorated 10 years of working in Nablus with a series of events to highlight the importance of mental health services in Palestine, including a public debate, an interactive play, three comic strips telling the personal stories of some of MSF's patients and a conference on psychological care.

In October, MSF started a partnership in East Jerusalem with a local NGO, the Treatment and Rehabilitation Centre for Victims of Torture (TRC), in an effort to improve access to people in need of care.

Gaza Strip

MSF's burn and trauma centres in Gaza City and Khan Younis treated over 2,500 patients, mostly children. Staff conducted more than 35,000 physiotherapy and 1,000 occupational therapy sessions. The majority

of patients had burns, usually the result of domestic accidents in conflict-damaged homes. In September, MSF requested authorisation to open a third specialised clinic in the north of Gaza. From late 2014 to April 2015, an MSF burns awareness campaign reached more than 35,500 children in schools and nurseries, and a new campaign was launched in November.

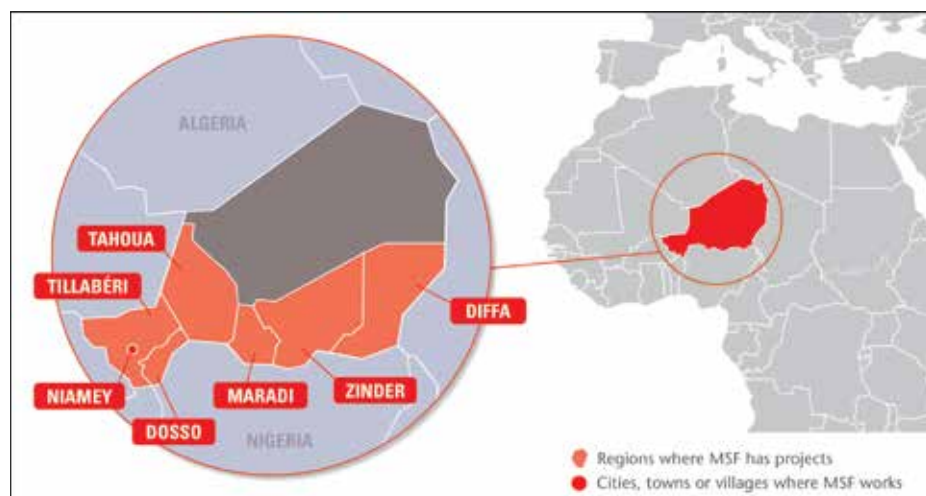
In conjunction with the health ministry, MSF ran surgical programmes in Al Shifa and Nasser hospitals and staff performed a total of 390 surgical interventions. The majority of patients were suffering from burns.

Complex cases that cannot be handled in Gaza are referred to MSF's reconstructive surgery hospital in Jordan. However, the administrative component of referrals caused delays and only six out of 67 patients were successfully referred in 2015.

MSF resumed mental health activities in Gaza during the 2014 war, but it was ordered by the Ministry of Health to suspend activities in April and by the end of the year had not been able to restart.

NIGER

No. staff in 2015: 1,800 | Expenditure: €28.5 million | Year MSF first worked in the country: 1985 | msf.org/niger



KEY MEDICAL FIGURES:

141,500 patients treated for malaria

101,500 meningitis vaccinations in response to an outbreak

65,700 patients treated in feeding centres

60,000 routine vaccinations

Niger was affected by a severe outbreak of meningitis in 2015, and also had to contend with rising numbers of refugees and people internally displaced by violence.

The violent activities of the group known as Islamic State's West Africa Province (ISWAP), also known as Boko Haram, in neighbouring Nigeria caused people to flee over the border into Niger's Diffa region. There were also direct attacks in Diffa, and the military response to the group caused further displacement. By the end of the year, over 300,000 returnees, refugees and displaced people in Diffa region were living in precarious conditions without access to healthcare, and vulnerable to diseases and violence.

To improve healthcare for both the host and displaced populations, Médecins Sans Frontières (MSF) worked alongside the Ministry of Health in the main maternal and paediatric health centre in the city of Diffa, in the district hospital in Nguigmi town, and several health centres in the districts of Diffa, Nguigmi and Bosso. MSF also provided medical care and water and sanitation activities in Assaga camp, which hosted some 12,000 Nigerian refugees, and in Yebi, where 30,000 people sought refuge. Teams carried out more than 142,000 medical consultations in the region. In Assaga camp, 2,700 children were vaccinated against measles. MSF also responded in the localities of Gueskerou, Bosso, Chetimari, Gagamari, Assaga, Diffa, Damasak and Djamea, distributing over 2,500 relief kits to refugees and internally displaced people, as well as to host communities where resources were overstretched.

The cholera emergency response that began in December 2014 in Diffa region ended in mid-January. MSF had set up two cholera treatment centres in Diffa town and Chetimari, with a total capacity of 130 beds and treated 260 patients.

Meningitis response

There was a particularly severe outbreak of meningitis between April and June, and MSF teams implemented a vaccination campaign in Dogondoutchi and Gaya, Dosso region, reaching over 101,500 children aged between two and 14. A team also provided treatment for nearly 900 patients

and distributed meningitis treatment kits to health centres in the region. In the capital district of Niamey, MSF supported 430 beds at a hospital in the northern suburb of Lazaret and 10 clinics in the city. Over 4,800 patients were treated in Niamey alone. Staff also worked in the district hospital for Oullam and Filingué, in the Tillabéri region that surrounds Niamey. At the end of the year, new cases of meningitis appeared in some areas of the country.

Maradi region

MSF runs comprehensive medical and nutrition projects in Madarounfa and



Women and children gathered in Bouza district, where MSF provides comprehensive paediatric medical and nutritional care.



© Sylvain Cherkakou/Cosmos for MSF

This family living in a camp for displaced people near Baroua were forced to flee their village after a Boko Haram attack.

Guidan Roundji departments, providing support for children with severe malnutrition. There are 11 outpatient centres, and an inpatient feeding centre in the respective district hospitals, where MSF also manages the medical care of children in the paediatric and neonatal wards. Teams run community-based activities to combat malaria, including the distribution of bed nets, seasonal malaria chemoprevention (SMC) – the repeated administration of antimalarials as a prophylactic – and outpatient treatment for uncomplicated cases. In Madarounfa, MSF supported four additional health centres in Dan Issa during the height of the malaria season, carrying out almost 10,000 consultations, and set up a temporary inpatient unit to treat children with severe malaria. In Guidan Roundji, MSF supports a laboratory and blood bank at the hospital. Four of the five health centres MSF was supporting in Guidan Roundji were handed over to the Ministry of Health at the end of March.

Access to safe water is limited in the region, and MSF has been working to regenerate water wells in partnership with the Regional Directorate of Maradi Hydraulics. In 2015, 15 boreholes were rehabilitated.

Tahoua region

MSF continues to provide comprehensive medical and nutritional care for children in the departments of Madaoua and Bouza, supporting a total of 11 outpatient feeding centres as well as inpatient feeding centres and paediatric units in the district hospitals. In Madaoua, a network of community volunteers in 80 villages screened children for severe acute malnutrition; malnourished children were also tested for HIV. In Bouza, MSF introduced a preventive and curative comprehensive care programme (known by its French acronym PPCSI) in Tama. It involves monitoring all children under the age of two, treating them quickly if they fall ill, and preventing the main causes of death by administering vaccinations, nutritional supplements, deworming, and malaria prophylaxis.

Zinder region

In Magaria, the peak malnutrition season was particularly severe. MSF supported the inpatient feeding centre and paediatric unit of the district hospital, where nearly 800 children were hospitalised in October, and seven outpatient feeding centres. MSF also provided vaccinations for common childhood diseases and SMC in seven health zones. In Zinder city, MSF supported the inpatient paediatric unit at the national

hospital and an inpatient feeding centre, as well as the feeding centre in Chare Zamna. MSF offered financial aid, staff training and medical supplies to the hospital and started to slowly hand over activities to the Ministry of Health.

An MSF team focused on water treatment at the household level in 89 villages in Dossou health zone, targeting 17,000 children and benefiting 52,300 people overall.

PATIENT STORY

FOUREZA NOURA – 30 years old, has come with her son to Dan Issa, Maradi region, where MSF supports an outpatient feeding centre

“I came from my village in Nigeria with my two-year-old son. He has a fever and is not eating. We made a deal with a driver to drive us the two hours to get here. Several women in my village advised me to come to the MSF health centre because in Nigeria medical care costs a lot and is poor quality. The MSF nurses told me that my son Bassirou had malaria and was malnourished. I received medication and nutritional paste. We were told to come back in a week to be sure my child had recovered.”

NIGERIA

No. staff in 2015: 655 | Expenditure: €17.2 million | Year MSF first worked in the country: 1971 | msf.org/nigeria



Insecurity and suicide attacks by insurgents led to further displacement, increasing the need for medical and humanitarian aid in Nigeria in 2015.

Over two million Nigerians have been displaced across the northeast of the country, largely as a result of brutal violence linked to the Islamic State's West Africa Province (ISWAP), also known as Boko Haram. Rural communities have been devastated. The population of Maiduguri, capital of Borno state, has more than doubled with the influx of internally displaced people, which has overwhelmed basic services in the city. Despite a significant military presence, insecurity remains high, with Maiduguri targeted in repeated suicide bomb attacks, and people are afraid to return home.

Médecins Sans Frontières (MSF) has been providing healthcare to people displaced by violence, as well the host community in and around Maiduguri, since mid-2014. In 2015, around 10,000 outpatient consultations

were carried out across four sites (two in the camps, two in the community) each month. Nearly a quarter of the patients presented with respiratory tract infections. In May, the team started offering maternal healthcare, and by the end of the year had seen more than 16,200 women for at least one antenatal consultation and assisted 1,330 deliveries. More than 5,900 children attended the nutrition programme, and from June, an inpatient paediatric unit admitted around 100 children each month. MSF started providing emergency services at Maiduguri's Umaru Sheu hospital in October, and emergency surgery by the end of the year.

Towards the end of 2015, in Kukerita camp, Yobe state, an MSF team undertook 2,000 outpatient consultations, referred complicated cases for further care, and provided six million litres of clean drinking water to displaced people. Antenatal care was also provided. In addition, MSF worked to rehabilitate the local healthcare centre in Kukerita, which was supplied with a generator to ensure power around the clock.

Child health

MSF has been working in Zamfara state since 2010 following an outbreak of lead poisoning in children. This year, the team continued

KEY MEDICAL FIGURES:

224,600 meningitis vaccinations in response to an outbreak

33,500 outpatient consultations

18,100 patients treated for malaria

9,200 births assisted

2,400 surgical interventions



People living in a camp near Maiduguri, where MSF provides healthcare to those displaced by violence, as well the host community.



MSF surgeons operate on a six-year-old boy to reconstruct a hole in his jaw and repair damage to his eye caused by Noma.

© Advize BAIYE/MSF

to monitor lead levels and fewer than 10 per cent of children tested needed chelation treatment to remove it from their bodies. The Zamfara project has now evolved to provide healthcare to children under the age of five in five villages, focusing on malaria, upper and lower respiratory tract infections, malnutrition and diarrhoea. Routine vaccinations are also administered, and inpatient care for children is available in a paediatric inpatient department run jointly by MSF and the Ministry of Health. Overall, more than 19,300 consultations were carried out and 3,200 children were admitted.

In June, a new programme began in Niger state to address lead exposure in children, which is typically caused by unsafe mining and ore processing. MSF trained Kagara hospital staff on lead protocols in August, and a health promotion team worked with residents in two villages, teaching them how to reduce lead exposure in their homes. MSF advocacy efforts resulted in a government decision to remediate lead from the two villages. From October, MSF also supported the Ministry of Health at Magiru clinic to ensure children under the age of five received good-quality care for common childhood diseases.

MSF launched a new programme in Kebbi state consisting of three mobile clinics and a health centre that offers inpatient and outpatient services for children under the age of 15. A malaria clinic opened in August and over 4,000 patients had been treated for malaria by the end of the year. MSF expanded

its outpatient services in October to include people of all ages, and had carried out 5,400 consultations by the end of the year. In December, the team were also able to expand their inpatient activities – this had been delayed by insecurity.

Reconstructive surgery for children

In August, a surgical team made its first visit to Sokoto to operate on 25 children suffering from noma (a facial gangrene infection that usually affects children under the age of six), cleft palate, cleft lip and other facial disfigurements. MSF ensured pre- and post-operative care, including nutritional and psychosocial support for families, which helped reassure parents about their children undergoing surgery and also enabled the children – who are often shunned because of their appearance – gain social skills. Around 450 individual and group mental health sessions were undertaken. Outreach and educational activities were launched in November to raise awareness of noma and the possibility of surgery. More surgical visits are planned for 2016. Referrals were also made for children needing continued nutritional care, and over 300 children were admitted to the therapeutic feeding centre.

Sexual and reproductive healthcare

A new programme for victims of sexual and gender-based violence started in June in Port Harcourt, and following an awareness campaign delivered through schools, health clinics and the media in September, monthly

attendance at the clinic doubled from around 35 to 70 patients. The comprehensive package of care includes prophylaxis for HIV and sexually transmitted infections, vaccinations for tetanus and hepatitis B, wound care, emergency contraception and counselling.

The well-established Jahun emergency obstetrics programme at the government hospital in Jigawa state admitted an average of 900 patients per month, of whom around 100 needed intensive care. Staff cared for 116 babies in the neonatal unit each month. During the year, surgeons carried out approximately 2,400 interventions, including 300 for obstetric fistula. About 60 per cent of patients were aged between 15 and 19.

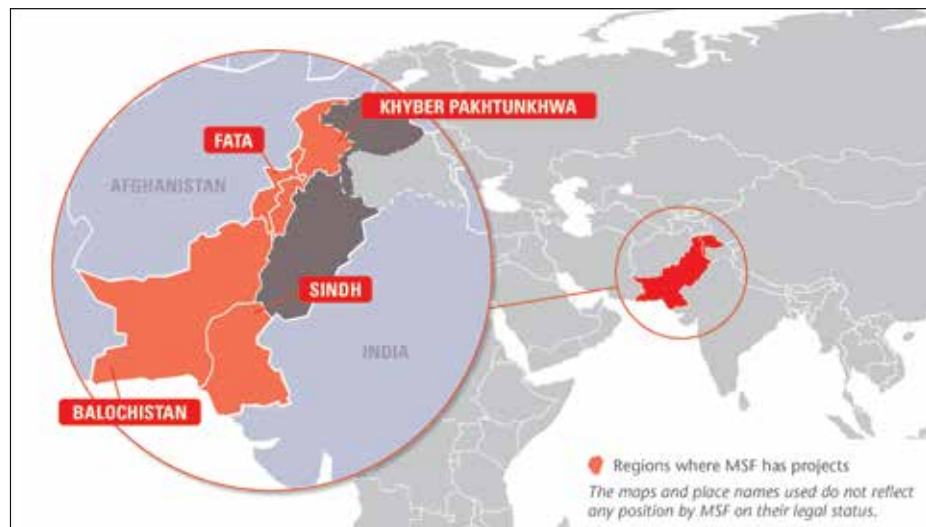
Responding to emergencies

An early warning surveillance system based in Sokoto facilitates rapid response to emergencies. In 2015, an outbreak of meningitis led to a mass vaccination campaign that reached 229,500 people, and over 6,300 people received treatment for the disease. In November, MSF supported a measles vaccination campaign run by the Ministry of Health in three states.

An Abuja-based emergency team ensured health facilities were prepared for possible post-election violence by training medical staff on mass casualty response and assessing facilities. The team also responded to an outbreak of cholera in Maiduguri, where more than 1,700 patients were treated.

PAKISTAN

No. staff in 2015: 1,636 | Expenditure: €20.1 million | Year MSF first worked in the country: 1986 | msf.org/pakistan
blogs.msf.org/pakistan | [@MSFPakistan](https://twitter.com/MSFPakistan)



KEY MEDICAL FIGURES:

358,300 outpatient consultations

27,700 births assisted

12,300 patients treated in feeding centres

12,000 individual and group mental health consultations

2,600 surgical interventions

1,400 patients treated for cutaneous leishmaniasis

Access to good-quality healthcare, including treatment for communicable diseases and lifesaving obstetric and neonatal services, remains a significant challenge for many people in Pakistan.

Living in isolated communities in the mountains between Pakistan and Afghanistan and in areas affected by conflict, Afghan refugees and residents of urban slums are some of the vulnerable groups in desperate need of medical assistance. Healthcare for women and children is a particular concern: women regularly die from preventable complications during pregnancy, neonatal care is inaccessible for many, and one in ten children dies before their fifth birthday. Médecins Sans Frontières (MSF) continues to support provincial and district health authorities in responding to some of the most urgent needs. MSF activities in Pakistan are funded solely by donations from individuals, with no institutional or government contributions.

Mother and child health in Balochistan

Government-funded inpatient paediatric care in Balochistan's capital, Quetta, is insufficient to meet the population's needs and many people cannot afford private clinic fees. In 2011, MSF opened the 67-bed Quetta paediatric hospital, housing a neonatal ward, an inpatient therapeutic feeding centre for children with complicated malnutrition, and general and isolation wards. Some 1,300 patients were admitted in 2015 and more

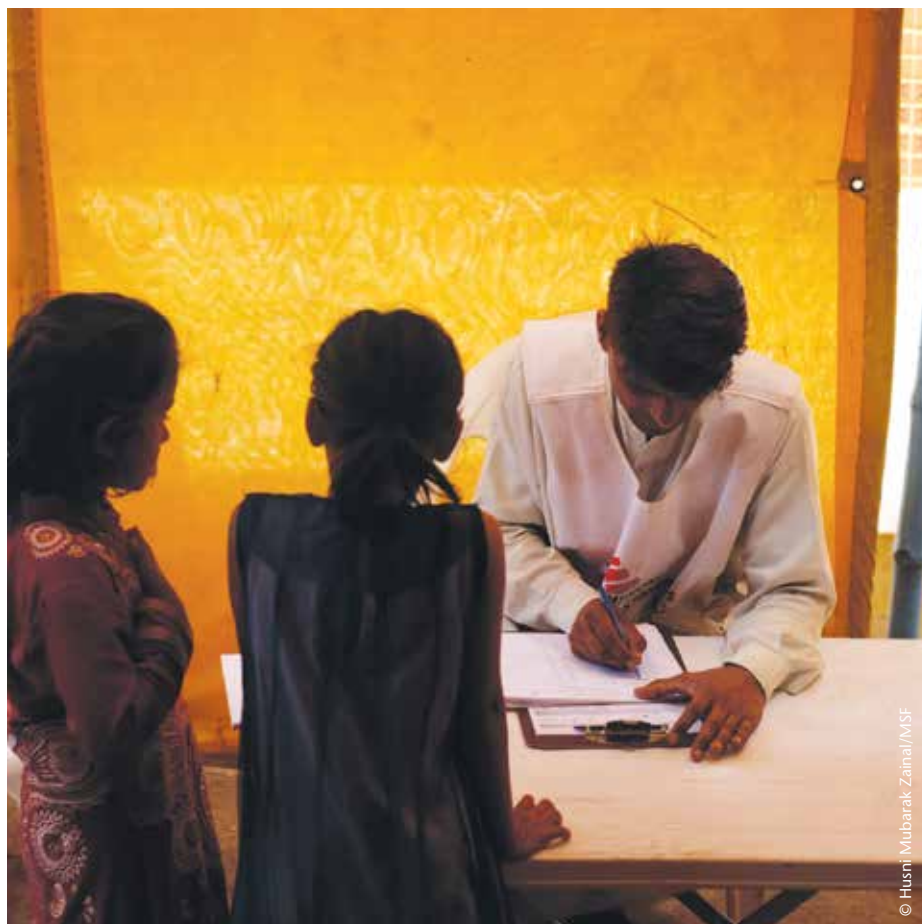
than 1,900 severely malnourished children received treatment. Over 4,000 individual and group mental health consultations were held in 2015.

In Kuchlak, 20 kilometres north of Quetta, MSF runs a mother and child health centre offering outpatient treatment, 24-hour emergency obstetrics, and nutritional support for children under the age of five. More than 9,100 children were vaccinated against childhood diseases in 2015. In Kuchlak and Benazir Bhutto hospital in old Marriabad town, MSF also treated over 1,700 patients for cutaneous leishmaniasis, a disfiguring and debilitating parasitic disease transmitted by sandflies.

On the Afghan border, at Qila Abdullah district headquarters hospital in Chaman, MSF works with the health authorities, offering free healthcare to local residents, Afghan refugees and people who cross the border seeking medical assistance. Services focusing on women and children include reproductive, neonatal and paediatric healthcare. Teams carried out 10,900 antenatal consultations and assisted 4,400 births in 2015. There is also an emergency room for trauma cases, where staff attended to over 5,800 patients this year. More than 1,500 severely malnourished children under the age of five were treated in the nutrition programme and 8,200 children



Women and children sit outside the MSF clinic in Sadda.



MSF undertook a measles vaccination campaign in Machar Colony that reached 31,000 people.

in 2015. The team also provided training on high-risk obstetrics and maternity care to staff working in the basic healthcare facilities within the hospital's referral network.

Approximately 200 kilometres north of Peshawar, MSF supports the district headquarters hospital in Timurgara with medical expertise in the emergency, resuscitation and observation rooms and the neonatal unit. Staff provide treatment for complicated obstetric cases, including surgery, and 8,395 births were assisted in 2015. In March, MSF set up a 'cardiac corner unit' to treat patients suffering from acute coronary syndrome, and 560 patients were admitted over the course of the year. In addition, 4,500 mental health consultations were carried out. The team also ran awareness activities to inform communities about dengue fever. More than 6,600 health promotion sessions were conducted overall.

The team at the Hangu emergency surgical project carried out over 15,000 emergency room consultations, performed 800 surgical interventions and assisted 3,202 births before handing over activities to the health authorities in September.

Healthcare for Machar Colony

A clinic in Machar Colony slum, run jointly by MSF and SINA Health Education & Welfare Trust, provided over 102,000 consultations in 2015. Machar is a densely populated community of around 115,000 people living in polluted, unsanitary conditions on the edge of Karachi's Fish Harbour. The programme includes basic, emergency, obstetric and postnatal healthcare, as well as mental health services. Health promotion teams run educational health and hygiene sessions for parents and children aimed at preventing illness. The team vaccinated 31,000 children against measles during a 15-day campaign in April, and also began a treatment programme for people with hepatitis C that meant patients could access free diagnosis and high-quality treatment without having to travel long distances to a hospital.

Earthquake relief

An earthquake measuring 7.5 on the Richter scale struck northeastern Afghanistan and northwestern Pakistan on 26 October. MSF responded quickly to an influx of 250 patients at Timurgara district hospital and Khar hospital in Bajaur Agency, and also supported health ministry staff by providing aftercare to the more seriously injured patients. More than 2,100 kits containing items such as soap, washing powder, buckets and cooking pots were distributed in Timurgara and the surrounding districts and to several villages in Chitral district.

received essential vaccinations. Through health education sessions, MSF teams highlight the need to seek timely medical assistance, especially during pregnancy. MSF also supervises the women's outpatient department, which is managed by government staff.

In Dera Murad Jamali, in eastern Balochistan, MSF continues to support the inpatient therapeutic feeding centre for children with complicated malnutrition, and the general paediatric and neonatal wards at the district headquarters hospital. More than 8,000 severely malnourished children received treatment in the feeding programme in 2015.

Federally Administered Tribal Areas (FATA)

MSF provides medical care to vulnerable communities in Bajaur Agency, the northernmost tribal agency. International staff do not currently have access to Bajaur, so a team of national staff manage the project. At Nawagai civil hospital, 43,000 outpatient and 30,000 emergency consultations were conducted, and support was provided to the mother and child health department. Paediatric services include vaccinations in support of the National Expanded Programme on Immunisation, and therapeutic feeding for malnourished children – over 12,500

children were screened for malnutrition this year. MSF also supported outpatient and antenatal services at two basic healthcare centres in Talai and Bilot by donating drugs and medical equipment.

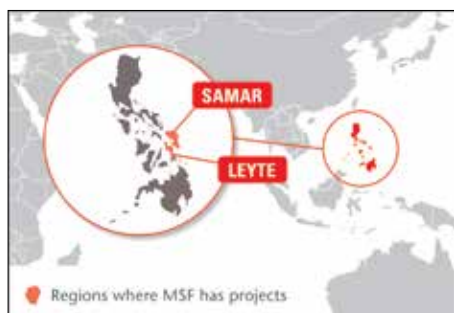
At Sadda Tehsil headquarters hospital in Kurram Agency, MSF provided inpatient care for children under the age of 12 and carried out an average of 600 consultations per week. In 2015, there were 300 children admitted for measles and post-measles complications. MSF also provided treatment for cutaneous leishmaniasis, and managed the hospital's obstetric and general emergency referrals. At the smaller Alizai hospital, around 100 paediatric consultations were carried out each week for children under the age of 12.

Emergency and maternal care in Khyber Pakhtunkhwa

MSF offers comprehensive emergency obstetric services at Peshawar women's hospital for patients with a history of complicated pregnancies and/or difficult deliveries. These women come from FATA, Peshawar and the surrounding districts, and the hospital also admits female refugees and displaced people living in Peshawar district. There are 33 obstetric beds and 18 beds in the neonatal unit. More than 5,200 patients were admitted and 4,700 babies delivered

PHILIPPINES

No. staff in 2015: 100 | Expenditure: €1.4 million | Year MSF first worked in the country: 1987 | msf.org/philippines | blogs.msf.org/philippines



Médecins Sans Frontières (MSF) completed the closure of all its post-typhoon activities in the Philippines this year.

By June 2015, the response and recovery activities put in place to support communities affected by typhoon Haiyan in 2013 were all closed. These included support for maternal and child health activities in Leyte provincial hospital and the rehabilitation of three hospitals on Leyte and Samar islands.

long-term programmes. As a result, a sexual and reproductive health programme will be opened in 2016 in the capital Manila. This programme will be run in collaboration with Likhaan, a national organisation, and will include early screening and vaccination against the human papilloma virus (HPV) to prevent cervical cancer.

KEY MEDICAL FIGURES:

1,300 outpatient consultations

During the year, MSF conducted a number of assessments in different locations in the country to identify possible needs for

RUSSIAN FEDERATION

No. staff in 2015: 137 | Expenditure: €5.4 million | Year MSF first worked in the country: 1992 | msf.org/russian-federation



Médecins Sans Frontières (MSF) continues to run tuberculosis (TB), mental health and cardiac care programmes in Chechnya, and provides basic healthcare to marginalised migrants in Moscow.

Drug-resistant TB is a life-threatening issue in Chechnya, the result of years of poor TB diagnosis and interrupted treatment. A comprehensive programme, including diagnosis, treatment and counselling for TB, multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB), is integrated in health ministry facilities. MSF handed the management of MDR-TB patients over to the Ministry of Health in July and is now focusing on the extensively drug-resistant form of the disease. MSF provided medicines for XDR-TB patients, including new treatments that have recently become available. MSF's programme also includes laboratory support, health promotion and psychosocial assistance for patients and their families.

MSF also runs a mental healthcare programme in Grozny and the mountainous districts of Chechnya still affected by violence.

KEY MEDICAL FIGURES:

5,100 individual and group mental health consultations

65 patients under treatment for MDR-TB

Cardiac care in Chechnya

MSF continued to support the cardio-resuscitation unit of the Republican Emergency Hospital in Grozny by donating medicines and medical equipment, providing technical advice for case management and organising training in coronarography (an imaging technique to examine the inside of coronary arteries) and angioplasty (a procedure to widen narrowed or obstructed coronary arteries). A total of 83 patients were treated during the two workshops organised by MSF in 2015.

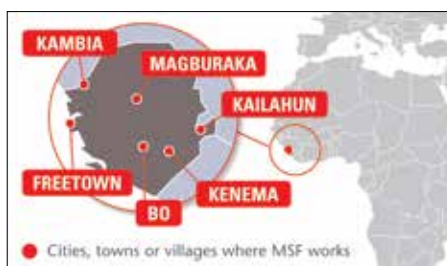
Healthcare in Moscow

A team offered basic healthcare to migrants from the former Soviet republics and other countries with limited or no access to medical services, and referred them for specialist care in state medical facilities when necessary.

MSF observed that between 10 and 20 per cent of XDR-TB patients also suffer from diabetes, and this further complicates the management of the disease. As a result, teams began addressing co-morbidity with regular education sessions and the monitoring of blood sugar levels.

SIERRA LEONE

No. staff in 2015: 779 | Expenditure: €18.2 million | Year MSF first worked in the country: 1986 | msf.org/sierraleone | blogs.msf.org/ebola



KEY MEDICAL FIGURES:

6,600 outpatient consultations

630 mental health consultations

530 patients treated for haemorrhagic fevers

There were new Ebola cases in Sierra Leone during 2015, but the World Health Organization declared the outbreak over on 7 November.

Médecins Sans Frontières (MSF) continued its Ebola response, and the 100-bed Prince of Wales School Ebola treatment centre in Freetown provided medical care and psychological support for Ebola patients until February. Of the 400 patients admitted, 170 were confirmed as having the virus. The team performed triage, isolated and tested patients, and ran health promotion activities.

A specialised unit was opened in Freetown in January to care for pregnant women suffering from Ebola, and for their babies, who are particularly vulnerable to the disease. At the peak of the epidemic, mortality rates for pregnant women reached as high as 90 per cent. Later in the year, the team also began seeing patients who were not pregnant but required medical attention, such as children.

Many Ebola survivors are reporting eye and joint problems, as well as anxiety and depression. In February, MSF opened



A young Ebola survivor has his eyes checked by a doctor at an Ebola survivor's clinic in Freetown.

a survivor clinic in Freetown, where the team provided medical and psychological support, referred patients as necessary and ensured free access to ophthalmic care at the Kissy eye hospital. In July, MSF began providing survivor support in Tonkolili district through mobile clinics, and also started running mobile clinics in Kailahun district in December that offered medical consultations and referrals to mobile eye care clinics managed by Partners in Health for specialised care.

In addition, until the end of May MSF surveillance teams supported the Ministry of Health following up on Ebola alerts and accompanied decontamination outreach teams who worked in the slum areas of Freetown. Their activities played an essential role in infection control. The homes of people suspected of having Ebola were disinfected, hygiene items such as soap and chlorine were distributed, and health promotion messages were shared. MSF also provided personal protective gear such as goggles, surgical masks, gowns and gloves to healthcare workers.

Ebola project closures and handovers

The Kailahun treatment centre was closed early in 2015 after Ministry of Health staff received extensive training in biosafety and isolation protocols, the referral process and disease surveillance. An isolation ward was also built before the handover to manage any cases referred from around the district. The Magburaka treatment centre closed in May and the Bo centre in October.

Tackling measles and malaria

During the Ebola outbreak, routine vaccination schedules fell by the wayside, resulting in a resurgence of preventable diseases. In April, MSF responded to a measles outbreak in Freetown and until June teams supported 10 public health units by training staff, supervising case management and donating medication.

MSF also undertook a mass distribution of antimalarials in Western province in January, reaching over 1.8 million people.

SOUTH AFRICA

No. staff in 2015: 242 | Expenditure: €8.6 million | Year MSF first worked in the country: 1999 | msf.org/southafrica



KEY MEDICAL FIGURES:

11,000 patients on first-line ARV treatment

960 patients under treatment for TB, of which **220** for MDR-TB

In July, Médecins Sans Frontières (MSF) opened the Kgomotso care centre to provide emergency medical and psychosocial care to victims of sexual violence in Rustenburg, a large town in the 'Platinum Belt' mining area of South Africa.

In Rustenburg, one in three women reports having been raped at some point in their life. Since the project opened, MSF health promotion teams have spoken to over 25,000 adults and high school students about sexual and gender-based violence. MSF aims to use this project as a model for providing comprehensive care for victims of sexual violence in South Africa, and to advocate for a primary care-level response run by nurses and psychologists instead of a centralised physician-led service. Raising public awareness and encouraging women to break their silence is also extremely important, as the preliminary results of an MSF survey show that up to 30 per cent of women do not seek medical care after a sexual assault.

Emergency intervention in Durban

In April, an emergency team from our Eshowe project responded to an outbreak of xenophobic violence in the coastal city of Durban. Over 7,000 migrants, mainly Malawians, Zimbabweans, Mozambicans, Congolese and Burundians, fled and sought refuge in three hastily erected displacement camps. MSF provided medical care, psychosocial counselling, water and sanitation logistics, and helped



In the lead-up to World AIDS Day 2015, MSF worked with local artists, activists and young people to paint two giant murals on the side of a well-known building in Khayelitsha.

coordinate the response with other organisations like the International Committee of the Red Cross and UNHCR, the UN refugee agency.

Stop Stockouts

The Stop Stockouts Project (SSP) is a civil society initiative in which MSF, in collaboration with other organisations, monitors availability of essential drugs in clinics across the country, engages with health authorities to monitor stockouts, and pushes for shortages to be resolved more quickly. Published at the 7th SA AIDS Conference in Durban in July, the second SSP report revealed that one in four clinics surveyed experienced shortages of medicines, thereby confirming that drug stockouts are a threat to public health and could undermine the progress made in South Africa's antiretroviral (ARV) treatment programme, which is the largest in the world, reaching over 3 million patients.

Khayelitsha

In Khayelitsha, on the outskirts of Cape Town, MSF's oldest HIV project in South Africa

continues to provide specialised treatment for children failing first-line ARV treatment, as well as develop innovative ways to support HIV-positive young people and pregnant women, and is at the forefront of operational research to diagnose and treat HIV-infected infants at birth. MSF provides testing and treatment for HIV and also tuberculosis (TB), as co-infection rates are high. Recently, for the first time in South Africa, a patient with extensively drug-resistant TB was started on a combination of drugs including delamanid and bedaquiline, the only new drugs developed to treat TB in the last 50 years.

KwaZulu-Natal

MSF's HIV-TB programme covering Mbongolwane and Eshowe in KwaZulu-Natal continues to 'bend the curves' of the epidemic. In 2015, more than 60,000 people were tested for HIV, 750,000 condoms were distributed and over 3,600 men underwent voluntary circumcision, which is proven to decrease the risk of HIV transmission.

PATIENT STORY

THEMBISA – 24 year old

"Coming from the clinic that day in 2008, I felt like everyone could tell I was HIV positive. I didn't know whether or not to cry. Not everyone in Khayelitsha has a problem with people with HIV. But some people are judgmental, of course, and will not want to speak to you or date you because they don't even understand how people get HIV. I want people to know my status, because hiding it doesn't help. I volunteered to be on the mural because the youth don't have much courage like I do. I'm hoping the mural will help young girls to not feel alone once they've found out about their status and that they build courage from my bravery. When they see that it's a young woman in the mural, they can find hope that they can still live for many years."

SUDAN

No. staff in 2015: 555 | Expenditure: €10.9 million | Year MSF first worked in the country: 1979 | msf.org/sudan

KEY MEDICAL FIGURES:

241,700 outpatient consultations

30,100 antenatal care consultations

6,000 routine vaccinations

In Sudan, Médecins Sans Frontières (MSF) continues to provide medical assistance to people in some of the most remote and challenging environments, but our access to those most affected by conflict is severely restricted.

MSF aims to support the provision of basic healthcare and helps detect and respond to disease outbreaks, particularly in Darfur, where there are significant medical needs and the Ministry of Health at times calls for specialist healthcare support to boost its capacity. However, denial of access to Blue Nile state, forced closure of activities in East Darfur state, and administrative obstacles and blockages in South Darfur state made it impossible for MSF to respond to medical emergencies and provide life-saving services in three major conflict-affected parts of Sudan.

The project in El Sireaf, North Darfur – a gold mining area where there were recurrent tribal clashes – continued to offer basic healthcare at the hospital, including reproductive health services, inpatient wards and emergency surgery. Two additional clinics, North and South, provide basic healthcare to displaced people. MSF uses a network of community health workers to spread preventive healthcare messages and awareness of the free health services available. Over 54,000 outpatient consultations were undertaken in 2015.

Further east, the MSF clinic in Tawila is the only health facility for the population in the



The ruins of the MSF hospital in Frandala, after it was struck by aerial bombing.



Jebel Marra region. The team conducted over 59,000 outpatient consultations, provided 16,700 children with routine vaccinations and treated 1,300 children for malnutrition.

A project based in remote Dar Zaghawa provided healthcare to people living in Um Baru, Furawiya and Jurajeem and carried out 54,200 outpatient consultations.

North Darfur Emergency Response (NDER)

The joint MSF and Ministry of Health NDER team undertook two measles vaccination campaigns. The first was in March and reached 80,000 people in El Sireaf locality. The second followed in June in the Zam Zam and Korma camps for internally displaced people, and reached over 55,000 children. The team also screened the children for malnutrition and gave them vitamin A supplements.

NDER opened a health centre in Zam Zam, and MSF provided basic healthcare for four months before a local NGO took over activities. The team also supported El Fasher hospital for a month during an outbreak of dengue fever, working with local NGO Zulfa to construct 11 rooms for basic healthcare, and running clinical services until the end of July. In addition, NDER supported the Ministry of Health during a two-month intervention for acute jaundice in Um Kadada and participated in case management for whooping cough and dengue fever near El Sireaf.

West Darfur

In Kerenek locality, MSF teams supported three clinics in Hajar Tama, Goderni and Kongi, and a bi-weekly mobile clinic in Watsani, carrying out more than 33,800 outpatient consultations.

An outbreak of viral haemorrhagic fever in November led MSF to establish an isolation ward in Al-Geneina hospital and two mobile clinics for the identification, treatment and referral of cases. Over 3,000 people with fever were examined, 1,000 of whom

were confirmed as having malaria and five of whom were suspected of having viral haemorrhagic fever. The exact cause of the outbreak remains unclear.

MSF responded to measles outbreaks in West Darfur by vaccinating children between six months and 15 years of age. Treatment was provided via mobile clinics and the team managed an isolation unit in Al-Geneina. An MSF team also trained Ministry of Health staff on disease surveillance, and emergency preparedness and response.

Al-Gedaref state

Kala azar is endemic in the Atbara area of Al Gedaref state and MSF screened over 1,500 people and treated 359 patients for the disease in Tabarak Allah government rural hospital in 2015. The team also supported the sexual and reproductive health services of the hospital, conducting around 2,200 antenatal consultations, assisting births and referring women with obstetric fistula to Kassala fistula treatment centre. In response to a measles outbreak, MSF vaccinated 266,600 children.

South Sudanese refugees

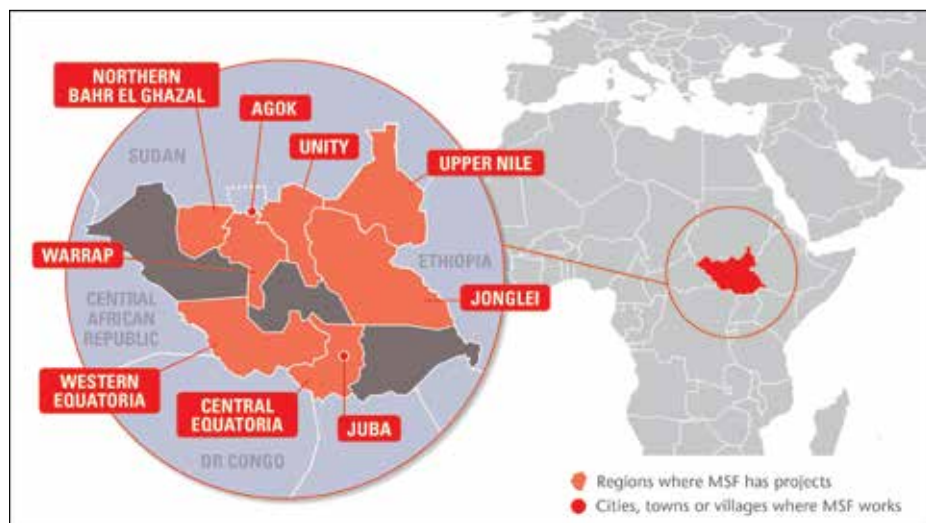
MSF continued to provide healthcare to South Sudanese refugees in Elsalam locality, White Nile state, where 80,000 live in three camps: Kashafa, Joury and Reaise. Working out of Kashafa, the team offered basic healthcare to residents of all three camps and the host population, and undertook over 44,300 outpatient consultations. MSF also provided inpatient care and developed a referral system between the camp and the main hospital of White Nile state.

Project closure after Frandala hospital bombing

MSF's hospital in Frandala, South Kordofan state, was bombed by Sudanese government forces in January and MSF subsequently withdrew. Teams had provided over 80,000 consultations to the people living in this area of active conflict.

SOUTH SUDAN

No. staff in 2015: 3,322 | Expenditure: €81.7 million | Year MSF first worked in the country: 1983 | msf.org/southsudan
blogs.msf.org/southsudan | [@MSF_SouthSudan](https://twitter.com/MSF_SouthSudan)



KEY MEDICAL FIGURES:

- 915,900** outpatient consultations
- 295,000** patients treated for malaria
- 46,400** measles vaccinations in response to an outbreak
- 65,300** antenatal care consultations
- 38,700** routine vaccinations
- 11,600** patients treated in feeding centres
- 3,400** patients on first-line ARV treatment

Médecins Sans Frontières (MSF) responded to immense medical needs amid a major upsurge in conflict and violence against civilians, as well as an exceptionally severe malaria season.

More than two years of sustained conflict and violence against civilians have taken a huge toll on the people of South Sudan. Over one million people have been displaced and hundreds of thousands have been unable to access medical or humanitarian assistance for months at a time, particularly in Jonglei, Unity and Upper Nile states. MSF scaled up its programmes in response, but access was disrupted repeatedly by fighting and attacks on medical facilities. Compounding this humanitarian crisis, there were frequent drug shortages, even in areas not affected by conflict, and the country also experienced one of its worst malaria seasons in years. MSF treated a total of 295,000 patients for malaria during the year – nearly ten times as many as in 2014.

Extreme levels of conflict, violence and humanitarian need

There was an escalation in conflict and violence in Unity state between April and November, forcing hundreds of thousands of people to flee their homes. Many hid in the bush and swamps and MSF received reports of executions, mass rapes, abductions and the razing of entire villages.

Five South Sudanese MSF staff were killed amid the extreme levels of violence, and 13 remain unaccounted for. MSF was forced to temporarily evacuate from Nyal, in May, and twice from Leer, in May and October. As people sought shelter, the population of the UN protection of civilians site (PoC) in Bentiu in northern Unity state increased from 45,000 to over 100,000 by the end of 2015. MSF runs the only hospital in Bentiu PoC and the team rapidly expanded capacity to meet the enormous medical

needs of this vulnerable population. MSF also operated mobile clinics and therapeutic feeding programmes in southern Unity state and Bentiu town whenever access was possible. Many patients suffering from severe violence-related injuries were referred to the MSF hospital in Lankien for surgical care. Thousands also fled into northern Jonglei state, where MSF opened a project in Old Fangak providing assistance in a medical centre, mobile clinics for the region and referrals by boat ambulance.



Medical charts are scattered on the ground inside a looted MSF hospital in Leer, where fighting forced the suspension of medical services and evacuation of some staff.



© Karin Ekholm/MSF

A young boy is vaccinated against measles at a camp for displaced people in Bahr el Ghazal.

MSF opened another clinic in Mayom, a remote location in northern Unity state, providing basic healthcare and secondary referrals to its hospital in Agok. Teams also responded to outbreaks of diseases including measles, malaria and meningitis in Yida refugee camp, currently home to 70,000 Sudanese refugees.

Assisting populations caught on the frontline

In Upper Nile state, the surge in conflict impacted populations accessing care in MSF's projects along the White Nile river in Malakal, Wau Shilluk and Melut. In May, the river became a frontline and humanitarian access was severely restricted. People in Wau Shilluk had extremely limited access to assistance for months, and thousands of civilians crossed the river in search for protection and assistance. The population of the PoC site in Malakal swelled from 21,000 to 48,000 and many were forced to live in overcrowded, unsanitary and inhumane conditions. MSF runs the only hospital in the Malakal PoC and teams

responded to major outbreaks of disease including malaria, respiratory tract infections and diarrhoea. In Wau Shilluk, MSF expanded the capacity of its primary healthcare centre to include secondary care, in order to meet the increased needs of the population. Elsewhere in Upper Nile state, MSF continued to provide medical assistance in Doro refugee camp for 50,000 Sudanese refugees from the conflict-affected Blue Nile state as well as the host population in Maban county. MSF handed over the medical programmes it had been running for Sudanese refugees in Batil and Gendrasa camps since 2011 to other health organisations.

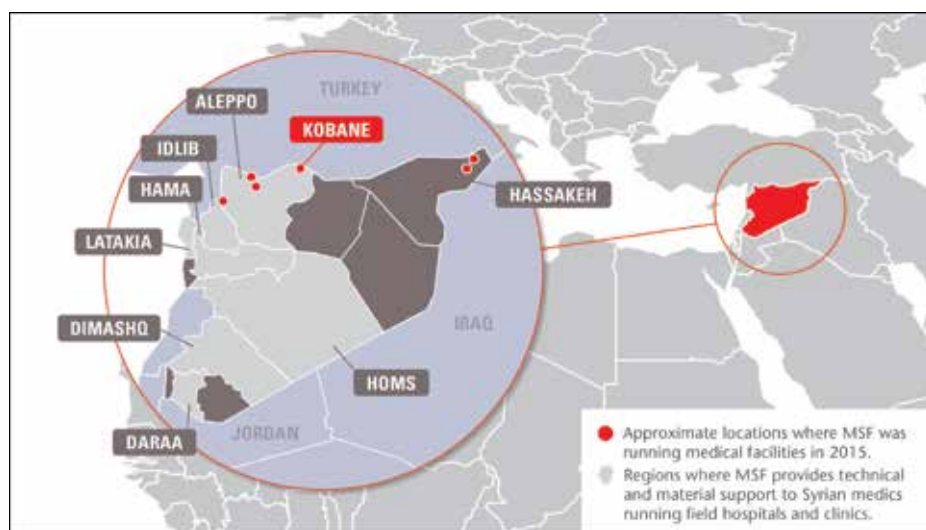
Responding to emergencies and outbreaks of disease

For the second year running, there was an exceptionally severe malaria season across South Sudan, particularly in the northwest. The impact of the outbreak was exacerbated by severe shortages and stockouts of essential medicines in non-MSF health facilities throughout the

country. MSF teams saw dramatic spikes in the disease in its projects in Agok, Aweil, Bentiu, Doro, Gogrial, Mayom and Yida and responded by rapidly increasing treatment and bed capacity, conducting large malaria outreach programmes and scaling up support to other medical facilities in the surrounding areas. South Sudan was also hit by its second outbreak of cholera in two years. In response, MSF provided treatment, technical capacity and logistical support to the cholera treatment unit in Bor hospital in Jonglei state. Another team in the capital, Juba, opened a cholera treatment centre and vaccinated over 160,000 people against the disease. In Western Equatoria state, MSF conducted mobile clinics and donated medical supplies for conflict-affected communities. In September, following the explosion of a fuel truck that killed more than 200 people and injured over 100 in Maridi, MSF provided surgical care, medical supplies and long-term nursing support for injured patients. MSF also continued to run its HIV 'test and treat' programme in Yambio, despite outbreaks of violence.

SYRIA

No. staff in 2015: 494 | Expenditure: €17.8 million | Year MSF first worked in the country: 2009 | msf.org/syria
blogs.msf.org/syria | [@MSF_Syria](https://twitter.com/MSF_Syria)



KEY MEDICAL FIGURES:

130,300 outpatient consultations

3,500 relief kits distributed

7,000 surgical interventions

2,000 births assisted

The Syrian conflict that began in 2011 has created the biggest displacement crisis since the Second World War, and millions of people are in desperate need of lifesaving humanitarian aid.

Some 4.3 million people have fled the country and an estimated 6.6 million have been internally displaced as government troops, opposition forces and insurgent groups battle for power and control of territory. The complex war has been characterised by extreme violence: civilian areas have been routinely bombed – often in ‘double-tap’ attacks in which the initial strike is followed by a second on rescue teams or on the healthcare facility receiving the wounded; and there have been attacks resulting in symptoms of exposure to chemical agents. At least 1.5 million people are still trapped in besieged areas without access to humanitarian aid, healthcare or medical evacuation.

The Syrian government continues to deny repeated requests by Médecins Sans Frontières (MSF) to access government-controlled areas. In a country where we should be running some of our largest medical programmes, the opportunities to reach people and to respond in a timely manner to the enormous needs remains extremely limited. This is a forceful reminder of how access to medical care is

by and large not respected and is in many cases directly targeted by those involved in the conflict and used for political purposes.

Following the Islamic State (IS) group’s abduction and release of MSF staff in 2014, and the impossibility of obtaining the necessary guarantees from IS leadership that MSF patients and staff will not be taken or harmed, the difficult decision was taken to withdraw from IS-controlled areas. MSF’s activities have consequently been limited to regions controlled by opposition forces, or restricted to cross-frontline and cross-border support to medical networks.

In 2015, MSF continued to operate six medical facilities in different locations across northern Syria and saw an increase in the number of people with medical complications caused by delayed medical care, and in infections and deaths due to shortages of antibiotics.

MSF also increased its support programme to around 70 healthcare facilities run by Syrian doctors, with a particular focus on besieged areas. MSF provides technical advice, medical supplies, salaries and fuel, and helps rebuild damaged buildings. MSF also provides ad hoc support to around 80 other medical facilities, such as medical donations for use in emergency situations, for example massive influxes of casualties. No MSF staff are present in these supported facilities.

During 2015, 23 MSF-supported Syrian health staff were killed and 58 wounded. Furthermore, 63 MSF-supported hospitals

and clinics were bombed or shelled on 94 separate occasions in 2015; 12 of these facilities were completely destroyed.

Aleppo governorate

In March, MSF released a report highlighting the challenges of delivering aid in Aleppo governorate.¹ The research focused on MSF’s direct experience, but also highlighted the violence suffered by many of the Syrian medical networks and facilities that MSF supports.

The situation deteriorated significantly in Aleppo city in 2015, with targeted attacks on civilian infrastructure such as markets, water supplies and health facilities throughout the year. The intensification of the conflict in Hama and Idlib forced thousands of families to flee to Aleppo governorate.

MSF staff at the 28-bed MSF-run hospital in Azaz district conducted over 32,500 outpatient and 17,000 emergency consultations, and performed 1,200 surgical interventions. The teams also saw 6,000 patients for antenatal, postnatal and family planning consultations and delivered 409 babies.

MSF received reports of attacks on nine health facilities around Aleppo in May, including six hospitals – one was the MSF-supported al Sakhour hospital in Aleppo city, which was forced to suspend activities after being bombed at least twice on consecutive days. In June, MSF had to close its field hospital in Maskan due to ongoing insecurity – the hospital had performed 5,834 outpatient and 2,495 emergency

consultations, and assisted 51 deliveries. MSF was able to hand over the hospital's activities to a Syrian medical network. In August, MSF treated patients with symptoms of exposure to chemical agents in Azaz district.

In early December, convoys carrying essential aid were targeted. This temporarily reduced hospital services and delayed the delivery of emergency supplies, including winter kits containing items such as warm clothes, blankets, torches and soap that MSF, in conjunction with Aleppo city council, was delivering to displaced families. More than 7,800 kits were distributed by year's end.

In March, MSF began supporting the rehabilitation of healthcare systems and infrastructure following the destruction of much of Kobane (Ein Al Arab). MSF built an interim hospital, but the facility was destroyed in an attack in June. MSF supports two urban outpatient health posts, three rural health posts and a small inpatient and emergency room in the town. Routine immunisations were resumed, mass measles vaccinations undertaken and relief items distributed to 4,000 households.

Hassakeh governorate

Fighting between armed groups intensified in northeast Syria in 2015. MSF worked in a maternity hospital in the area, where 1,559 births were assisted, including 393 caesarean sections. Regular medical equipment and supplies were also donated. Three MSF clinics provided more than 35,000 outpatient medical consultations to displaced people and the local population, including for chronic conditions and mother and child health.

Idlib governorate

MSF continued to run the Atmeh burns unit in Idlib, where over 6,800 medical consultations and 5,500 surgical interventions were conducted, and 3,100 patients were enrolled for mental health services. More than 7,000 children were vaccinated against measles and over 3,500 newborns against hepatitis B.

Besieged areas in Homs and Damascus governorates

More than a million people in opposition-controlled neighbourhoods have been under military siege in Damascus and Homs governorates, plus several hundreds of thousands more in Deir ez-Zor and other areas where MSF has not been able to organise support activities. Delivery of official medical supplies from Damascus into these areas is highly restricted; when rare convoys are allowed in, critical items



A dwelling in the Atmeh camp for internally displaced people in Idlib governorate, where access to adequate shelter and basic services remains severely disrupted.

such as surgical materials, antibiotics and therapeutic food are usually removed at checkpoints. Medical evacuations of critically sick patients are hardly ever permitted. Most of these neighbourhoods came under sustained bombing and shelling throughout 2015. On average, more than 300,000 patient consultations were carried out per month in MSF-supported health facilities in besieged areas.

Dara'a governorate

MSF provided medical donations, relief items and technical support to six hospitals and health posts across Dara'a governorate, helping Syrian medical networks undertake 118,000 outpatient consultations, admit 5,800 patients for care and assist more than 2,000 deliveries. These hospitals also treated more than 8,000 victims of violence.

Documentation of the war-wounded

A report compiled by MSF and released in early 2016² showed that 154,647 war-wounded patients were received in 2015 in MSF-supported hospitals and clinics in northwestern, western and central Syria (Aleppo, Homs, Hama, Idlib, Latakia and Damascus governorates), and 7,009 war dead were documented. Women and children accounted for 30 to 40 per cent of the victims. In 10 documented mass-casualty influxes, such as after the bombings of schools or playgrounds, between 60 and 90 per cent of the victims were women and children.

¹ http://www.msf.org/sites/msf.org/files/alepposyria_medical_aid_besieged_9march2015.pdf

² <http://www.msf.org/en/article/syria-war-wounded-and-war-dead-syria-%E2%80%93-medical-data-provides-stark-warning-2015-must-not-be>

STAFF STORY

Testimony of a medical practitioner who acts as a hospital director, human resource manager, surgeon and senior doctor in an MSF-supported hospital near Damascus

"August was the worst we've seen [here] medically. Hundreds of injured are coming in. Sometimes we have to go two or three days without sleeping. This month is incomparable to before. It is the worst I've seen. We are trying our best. We are trying to save lives and that's what is keeping us going. We cannot do anything about the siege, it is what it is, and we are just struggling to survive. Of course, I have to hang on to hope. There is always hope.

There is much fear and depression in our community. You see it everywhere. Whenever there is a shelling or the sound of a plane, everyone desperately rushes home or to a shelter. The sound of a plane in the sky is terrifying. It is hard to explain how the situation is on the ground. You have to see it with your own eyes to understand, and even then it is unbelievable. We have seen huge numbers of injured over the past month; in these circumstances anyone who isn't injured or dead can count themselves lucky.

Medically, we've had to become used to the situation, so we do things like rationing of medicine. Rationing has become an important part of our work. We have no choice, so we try to make do with what we have. There are too many patients, too many stories. But one patient shows the madness of this crisis – a child – who I will never forget until I die: he had injuries all over his face, his arms, his legs, and yet he was laughing! Just laughing and laughing. Children usually are afraid of our injections and needles, but he was not. He just laughed, laughed at everything."

SWAZILAND

No. staff in 2015: 439 | Expenditure: €9.4 million | Year MSF first worked in the country: 2007 | msf.org/swaziland



KEY MEDICAL FIGURES:

19,700 patients on first-line ARV treatment

1,400 patients under treatment for TB, of which **200** for MDR-TB

During 2015, Médecins Sans Frontières (MSF) continued to improve access to diagnostics and treatment for HIV and tuberculosis (TB) patients through decentralised and integrated care and innovative approaches.

Swaziland is struggling to cope with the dual epidemic of TB and HIV. It has the world's highest incidence of TB, and the number of people with drug-resistant forms of the disease (DR-TB) is increasing. Furthermore, around 80 per cent are co-infected with HIV. Since 2007, MSF has been collaborating with the Ministry of Health to tackle this crisis.

Responding to the growing number of extensively drug-resistant TB (XDR-TB) cases in the country, MSF advocated the introduction of new drugs (bedaquiline and delamanid) in 2014. In 2015, staff started treating XDR-TB patients with these in combination with repurposed drugs – a major change for these patients. By the end of the year, 22 XDR-TB patients were on this treatment programme in MSF projects in Manzini and Shiselweni.

Shiselweni

MSF teams in Shiselweni continued to support the integration of HIV and TB care in 22 community-based health clinics.



A nurse listens to a patient's lungs at an MSF clinic in Matsapha.

As part of this support, MSF has been operating 20 point-of-care mini-labs since 2012. In 2015, these labs carried out 47,842 biochemistry tests, 19,340 CD4 tests and 30,726 viral load tests – the latter of which measure the amount of HIV in a sample of blood and are the strongest predictor of HIV progression. To improve adherence to treatment, MSF has trained people living with HIV as 'expert clients' or lay counsellors to work with patients.

This year, to bring services closer to home, MSF piloted multiple community outreach models, including community antiretroviral (ARV) treatment groups and clubs and new ways of delivering medication to patients. Following the positive outcomes in the Shiselweni pilot, these models will now be implemented as a national strategy.

The 'test and treat' approach implemented in Nhlanguano was also successful and has now been adopted as the standard in the health zone. It had a high acceptance rate, with 84 per cent of people agreeing to be initiated on ARV treatment. Acceptance was even higher among pregnant women (96 per cent).

Since 2013, MSF has been carrying out research into thin layer agar, a drug sensitivity test for multidrug-resistant TB

treatments that would cost less and provide a more sustainable option for the region than the mycobacteria growth indicator tube (MGIT) typically used.

Manzini

In Matsapha, the industrial heart of Swaziland where HIV prevalence is the highest, MSF continued to offer comprehensive healthcare with integrated HIV and TB services. In 2015, teams carried out 34,101 consultations, ranging from maternity care, infant immunisations, family planning, general outpatient services, and medical and psychosocial care for victims of sexual violence, as well as HIV and TB treatment.

MSF also supported TB drug-resistance diagnostics at the National TB Reference Laboratory. In Matsapha and Mankayane, alongside the standard 20-month regimen for DR-TB patients, the team continued the roll-out of the nine-month regimen as part of an observational study. The results so far are promising.

MSF launched a new project supporting the national TB hospital in Moneni, the referral hospital for DR-TB in the country. A key aim of the programme is to strengthen outpatient care. By the end of the year, the team had treated 117 DR-TB patients.

TAJIKISTAN

No. staff in 2015: 73 | Expenditure: €1.8 million | Year MSF first worked in the country: 1997 | msf.org/tajikistan



KEY MEDICAL FIGURES:

130 patients under treatment for TB

This year, Médecins Sans Frontières (MSF) started to treat five tuberculosis (TB) patients with bedaquiline, one of the first new drugs for the disease in 50 years.

In Dushanbe hospital, a team is working with the Ministry of Health to support a comprehensive care programme for young people with TB and their families. Care is provided on an outpatient basis whenever possible, and the team looks for ways to improve access for people who live a long way from the hospital, for example by covering transport costs. Since 2014, MSF has been using drug compounding (combining drugs to create a formulation tailored to a patient's needs) to make formulations suitable for children with multidrug-resistant TB (MDR-TB) and 16 of them were initiated on treatment this year. Other aspects of the programme include nutritional and psychosocial support to help patients adhere

to their often arduous regimens, activities to reduce the stigma of the disease, and systematic tracing of those people the patient has been in contact with.

Diagnostic tools, such as sputum induction and gastric lavage, are being used for the first time in the country, and the team is hoping to introduce others, including stool sampling and rapid drug sensitivity testing with GeneXpert, in the future. The paediatric TB protocol developed by MSF has been adopted as the national guideline.

In 2015, MSF also opened a new project in Kulob, southern Tajikistan, treating paediatric HIV and TB. Medical activities started in the spring of 2016.

TURKEY

Expenditure: €1.8 million | Year MSF first worked in the country: 1999 | msf.org/turkey | [@MSF_Turkiye](https://twitter.com/MSF_Turkiye)



KEY MEDICAL FIGURES:

10,200 individual and group mental health consultations

Over 2.5 million Syrians had sought refuge in Turkey by the end of 2015.

The situation for Syrian refugees living in Turkey remains extremely difficult: the vast majority are living in poor conditions in urban slums, with few work opportunities and limited access to medical care. Since the Syrian conflict started in 2011, more than 67,000 Syrian children have been born in Turkey.

In June, Médecins Sans Frontières (MSF) was granted authorisation by the Turkish authorities to carry out medical and humanitarian activities for the growing number of refugees in the country.

Working on the Syrian-Turkish border

In Hatay, in collaboration with the Union of Medical Care and Relief Organizations (known by its French acronym UOSSM), MSF carries out reconstructive surgery missions. It also supports the mental health clinic run by the UOSSM.

In Kilis, MSF works with the Helsinki Citizens' Assembly, whose clinic provides basic healthcare, including mental health services, to Syrian refugees. The clinic conducted 35,636 outpatient and 10,508 antenatal and postnatal consultations in 2015.

In late December, in partnership with Physicians Across Continents (PAC), MSF opened a new facility in Gaziantep offering free healthcare to Syrian women and children. A Syrian team of gynaecologists and midwives provides antenatal and postnatal care, family planning services and gynaecology consultations; PAC covers paediatric care. MSF had already treated

117 patients between the opening of the facility on 21 December and the end of the year. The clinic has the capacity to carry out 2,000 reproductive health consultations per month. Deliveries and more complicated cases are referred to a local Turkish hospital.

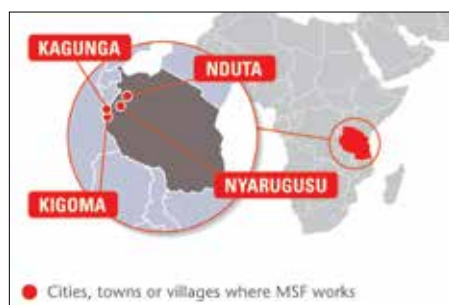
Sanliurfa province

MSF continued to support partner organisation Hayata Destek (Support to Life) in the implementation of a mental healthcare programme for Syrian refugees. In May, a water and sanitation project was completed in Suruç, providing latrines, showers and water for refugees from Kobanê, Syria, who had been living in temporary camps since September 2014. From June to September in Akçakale, in collaboration with Hayata Destek, MSF distributed food and hygiene items to 20,000 refugees displaced from Tal Abyad in Syria. MSF also supported an International Blue Crescent Relief and Development Foundation mental healthcare centre in Akçakale, treating Syrian refugees.

Towards the end of the year, security deteriorated significantly in the southeast of the country, which is predominantly Kurdish. MSF is monitoring the situation.

TANZANIA

No. staff in 2015: 19 | Expenditure: €6.1 million | Year MSF first worked in the country: 1993 | msf.org/tanzania



KEY MEDICAL FIGURES:

36,400 outpatient consultations

1,200 patients treated in feeding centres

650 patients treated for cholera

Médecins Sans Frontières (MSF) provides assistance to refugees from Burundi and the Democratic Republic of Congo (DRC) living in overcrowded camps in Tanzania, with poor sanitation and little access to healthcare.

The unhygienic conditions mean that people are at risk of diseases such as cholera. Malaria is rife, and many suffer from respiratory tract infections and diarrhoea.

In 2015, according to figures from UNHCR, the UN refugee agency, there were almost 200,000 refugees in Tanzania, the majority from the DRC and Burundi. Many have been in the country since the 1990s, but the number from Burundi increased significantly as a result of political unrest in the country in May. Following reports of a cholera outbreak among the new arrivals, MSF set up a cholera treatment centre (CTC) in a football stadium that was serving as a transit site for refugees in Kigoma, and another at a transit site in Kagunga, about four hours by boat from Kigoma. MSF worked in Kagunga transit camp for just over a month until the end of June. Around 37 people were admitted to the 20-bed centre during the five weeks. Staff also carried out health promotion activities and provided water and sanitation in the camp.

Nyarugusu refugee camp

MSF began work in Nyarugusu camp in May 2015, and set up a CTC. In June, following the unrest in Burundi, there was a new influx



MSF staff administer an oral cholera vaccine to a boy at the Nyarugusu refugee camp in Tanzania.

of refugees and at one point there were up to 1,000 new arrivals every day. The camp was quickly overwhelmed, and humanitarian organisations struggled to provide enough water, food, shelter and medical services. Teams started running mobile clinics and outpatient nutrition programmes, and supported the intensive therapeutic feeding centre in the Tanzanian Red Cross hospital. In the absence of other organisations with emergency response capacity, teams also distributed around 90 million litres of water.

In collaboration with the Ministry of Health, the World Health Organization and UNHCR, the UN refugee agency, MSF supported an oral cholera vaccination campaign and 232,997 doses of the vaccine were administered. The campaign was completed in July and transmission was successfully halted. There was no cholera outbreak inside Nyarugusu camp.

MSF treated 18,836 people in Nyarugusu, mostly for malaria, diarrhoea or respiratory tract infections. Towards the end of the year, teams began to offer mental health services, and around 600 consultations were carried out per week.

Nduita refugee camp

In October, MSF set up a 100-bed hospital in Nduita refugee camp, providing care for malnutrition, reproductive health and victims of sexual violence. Teams also ran mobile clinics and conducted medical and malnutrition screening for new arrivals. Between October and December, staff

carried out 17,591 outpatient consultations, assisted 62 deliveries and performed 9,535 malaria tests (of which 6,201 were positive). In addition, MSF donated 3,500 tents and distributed over 1,500,000 litres of water.

PATIENT STORY

MELANIE KABURA – 33 year old community leader, from Burundi

“They were beating and killing people in the street. We had to leave everything behind; we only came with the clothes we were wearing. We arrived in Nyarugusu in July 2015. Here, life is not good. We sleep on the ground. When the rain comes, it is a big problem. The roof is not strong and we are afraid of what will happen. We do not have everything we need, we want to feel safer. We cannot return to Burundi because we are afraid. I am tired of fleeing from my country. My dream is to have a job that is paid well so that I can look after my children. I want to live in a place where it is stable. But for now, there is no future for my children.”



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UGANDA

No. staff in 2015: 309 | Expenditure: €5.4 million | Year MSF first worked in the country: 1986 | msf.org/uganda



At the end of 2015, Médecins Sans Frontières (MSF) opened a new project in Kaseke district, southwest Uganda.

This project focused on access to healthcare for adolescents and the fishing communities on lakes George and Edward. Both groups are particularly vulnerable to HIV and other sexually transmitted diseases. Activities are run in complete integration with the public health system.

Response to a malaria outbreak

MSF conducted an epidemiological assessment in Kole, Apach and Oyam districts, and at the request of the Ministry of Health, donated more than 81,000 treatments for malaria and supported case management in health centres in two districts and a hospital in Kole. Teams also ran mobile clinics and referred patients to Lira regional hospital when required. Over five months, 63,000 patients with malaria were treated in the districts supported by MSF.

KEY MEDICAL FIGURES:

49,500 outpatient consultations

33,400 patients treated for malaria

HIV care

Since 2013, MSF has supported the HIV laboratory in Arua district, and has introduced devices to measure CD4 and viral load as part of a UNITAID-funded project. In 2015, MSF started offering early infant diagnosis to test babies born to HIV-positive mothers so that they can start antiretroviral (ARV) treatment as quickly as possible, if necessary. MSF is also supporting genotyping tests, which identify resistance to second-line ARVs.

Project handovers

In July, MSF handed over the outpatient, inpatient and maternity care services it had been providing for South Sudanese refugees in Adjumani district since January 2014 to Medical Teams International. Between January and July, more than 48,600 consultations were carried out, and 574 patients were admitted to hospital.

UZBEKISTAN

No. staff in 2015: 214 | Expenditure: €7.8 million | Year MSF first worked in the country: 1997 | msf.org/uzbekistan



Médecins Sans Frontières (MSF) is currently implementing and evaluating a shorter treatment regimen for multidrug-resistant tuberculosis (MDR-TB) in Uzbekistan, lasting nine months instead of the usual two years.

The medical outcomes from this shorter regimen will be published in 2016. MSF also hopes to start a clinical trial in the country in 2016, combining the first new TB drugs available in over 50 years with existing drugs to treat drug-resistant forms of the disease. Both of these initiatives reflect MSF's drive to develop shorter, more effective and more tolerable treatment regimens for people suffering from TB.

and food packages for those on low income or suffering weight loss. The goal is to ensure patients' adherence to treatment and to help them manage the sometimes severe side effects of their medication, and to prevent the spread of the disease.

KEY MEDICAL FIGURES:

2,500 patients under treatment for TB, of which **650** for MDR-TB

400 patients on first-line ARV treatment

TB programme in Karakalpakstan

In the Autonomous Republic of Karakalpakstan, MSF continues to run the long-standing 'comprehensive TB care for all' project with the regional and central health ministries. This project provides access to outpatient care, rapid diagnostic tests and a comprehensive support programme, including education, psychosocial support,

HIV treatment in Tashkent

In the capital, Tashkent, MSF supports the Tashkent City AIDS Centre to increase access to diagnosis and treatment for people living with the disease. In 2015, the team started over 700 patients on antiretroviral treatment, and offered counselling and screening for opportunistic infections (infections that occur more frequently and are more severe in individuals with weakened immune systems). In 2016, the project will begin treating patients who are co-infected with hepatitis C.

UKRAINE

No. staff in 2015: 254 | Expenditure: €15.5 million | Year MSF first worked in the country: 1999 | msf.org/ukraine



KEY MEDICAL FIGURES:

166,700 outpatient consultations

13,700 individual and group mental health consultations

180 patients under treatment for MDR-TB

In January and February, fighting between the Ukrainian army and the self-proclaimed Donetsk and Luhansk People's Republics escalated to a level not seen since August 2014, and had a devastating effect on civilians caught in the conflict zone.

Médecins Sans Frontières (MSF) teams urgently expanded their support to hospitals on both sides of the frontline. However, heavy fighting trapped civilians in frontline towns and made it difficult for MSF to reach the hardest hit areas. Medical facilities were regularly shelled, forcing staff to flee and depriving thousands of people of healthcare. A ceasefire came into effect following the fall of the strategic city of Debaltseve on 18 February, three days after the signature of the Minsk II agreement.

In 2015, MSF donated medicines and medical equipment to more than 350 health facilities on both sides of the frontline, enabling the treatment of over 9,900 patients with conflict-related injuries and more than 61,000 with chronic diseases; additionally, 5,100 births were assisted. Teams also carried out around 159,900 basic healthcare consultations and 12,000 mental health consultations in cooperation with the Ministry of Health.

Supplying essential medicines

Although there was less fighting after the Minsk II agreement, shelling continued in many areas and medical needs remained on both sides of the demarcation line. Drug supplies had been disrupted or cut off for more than a year by this point and prices had increased significantly. People struggled to obtain antibiotics, painkillers and psychiatric drugs, as well as medications for chronic illnesses such as high blood pressure, diabetes and heart and kidney disease. The supply of essential drugs for tuberculosis (TB) and HIV, as well as vaccinations for measles and polio, was also disrupted.

MSF became one of the major suppliers of medicines for chronic diseases to hospitals, health centres and homes for elderly and disabled people in the east of the country. Teams provided insulin to more than 5,000 diabetic patients in 16 hospitals in Gorlovka, Donetsk, Yenakevo, Starobesheve, Telmanovo and Novoazovsk, and also provided haemodialysis supplies for patients with advanced kidney failure in Gorlovka and Donetsk.

In addition, teams ran mobile clinics in 80 towns and villages around Donetsk, Luhansk, Artemovsk, Mariupol and Debaltseve and throughout Luhansk region, offering basic healthcare and mental health support to residents and displaced people.

Providing psychological support

MSF psychologists provided individual and group counselling sessions for people affected by the conflict, including those displaced or wounded, and the elderly and children. They also trained health workers, teachers and social workers.

Continuing multidrug-resistant TB (MDR-TB) treatment

Throughout the conflict, the MDR-TB programme that MSF has been managing in the penitentiary system in Donetsk region since 2011 continued until October. The team expanded its support to patients in penitentiary facilities in Mariupol, Artemovsk, Dnepropetrovsk and Zhdanivka.

First aid at checkpoints

MSF teams opened first aid and water points to assist people waiting in long queues in the freezing cold or intense heat who wanted to cross the frontline at the

Artemovsk–Gorlovka, Volnavakha–Donetsk, and Mayorsk checkpoints.

MSF forced to cease activities in Luhansk and Donetsk People's Republics

Although MSF succeeded in working on both sides of the frontline for most of the year, in September MSF's permission to work was refused in the self-proclaimed Luhansk People's Republic, and at the end of October, its accreditation in the self-proclaimed Donetsk People's Republic was also withdrawn. The projects were closed, leaving thousands of people vulnerable and without access to essential medical care.



A woman has her blood pressure checked at an MSF mobile clinic in the village of Gorodishe, near Lugansk.

PATIENT STORY

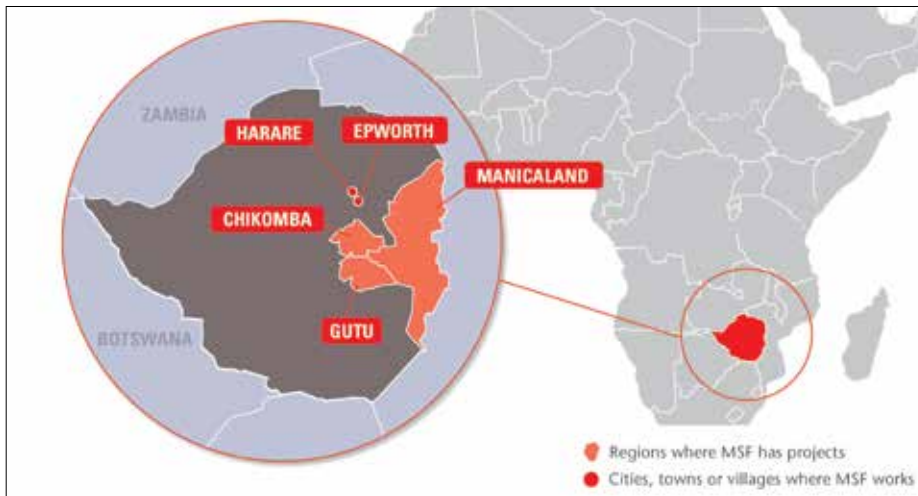
NINA DEDUKH – 64-year old patient receiving counselling from an MSF psychologist in Popasnaya

"When the war started, I was in Pervomaïsk. My apartment and my daughter's apartment were destroyed. We sought refuge here, in Popasnaya. Now we live 10 people in a one-room apartment. We hear shelling at night: it's terrifying.

There is nothing crueller than when people close to you die. During this war my aunt, uncle and sister died. But when my daughter died it was horrible. She died in Pervomaïsk in February. She was standing just behind the house when the shelling hit. Doctors were fighting for her life for one hour, but were unable to save her."

ZIMBABWE

No. staff in 2015: 219 | Expenditure: €10.4 million | Year MSF first worked in the country: 2000 | msf.org/zimbabwe



KEY MEDICAL FIGURES:

35,300 patients on first-line ARV treatment

3,600 individual and group mental health consultations

1,400 people treated after incidents of sexual violence

1,400 patients under treatment for TB

HIV prevalence in Zimbabwe has reduced from over 30 per cent at its peak in 2000 to around 15 per cent, but major gaps in treatment remain.

Médecins Sans Frontières (MSF) continues to support the Ministry of Health and Child Care (MoHCC) to achieve the 90-90-90 targets set by UNAIDS. In order to improve the management of large cohorts of stable patients, community-based models of care have been introduced in Gutu, Buhera, Chikomba, Epworth, Makoni, Mutare, Mutasa and Nyanga. These models involve setting up community groups where people take turns picking up antiretroviral (ARV) drug refills. These groups have quickly grown and now include more than 5,040 patients. MSF also continues to promote the use of targeted and routine viral load monitoring, testing a total of 58,434 patients in 2015.



Major, an MSF patient, completed his treatment for DR-TB in the summer of 2015.

In a new project in Mutare, MSF is supporting the MoHCC to roll out viral load monitoring and alternative drug refill models in Manicaland province.

Paediatric and adolescent care is another focus of MSF's HIV programme. This includes conducting ARV treatment adherence counselling and support group sessions. MSF also provides second-line ARV therapy to patients whose first-line treatment has failed.

MSF has been providing treatment, based in the community rather than in hospital, where possible, to 31 patients with multidrug-resistant tuberculosis in Epworth, Buhera and Gutu. The HIV-TB programmes in Buhera and Nyanga were successfully handed over to the MoHCC in 2015.

MSF is supporting the MoHCC in Epworth and Gutu to provide cervical cancer screening services.

Sexual violence

MSF provided treatment and psychosocial support to victims of sexual violence at the Mbare and Epworth clinics. Teams also conducted health promotion activities to raise awareness of the importance of seeking medical care within 72 hours of abuse to prevent unwanted pregnancies, HIV and other sexually transmitted infections. A total of 2,325 consultations were carried in 2015 at the Mbare clinic alone and, of these, 1,361 were new patients.

Psychiatric care

MSF continues to provide diagnosis, treatment and care to around 330 inmates with mental illness at Chikurubi maximum security prison and Chikurubi female prison in Harare. A total of 1,615 mental health consultations were carried out this year.

In collaboration with the MoHCC, MSF started a new mental health project in Harare

central hospital, offering treatment and support to patients in the psychiatric unit.

Water and sanitation

In 2015, more than 30,000 people benefited from MSF's projects providing clean water and better sanitation in suburbs of Harare prone to outbreaks of disease such as typhoid, which is caused by poor water supply and hygiene conditions. Through its programmes, MSF rehabilitated 20 boreholes, and collaborated with other partner organisations like Africa AHEAD to ensure that the communities knew how to protect water to avoid contamination both at the source and at home.

PATIENT STORY

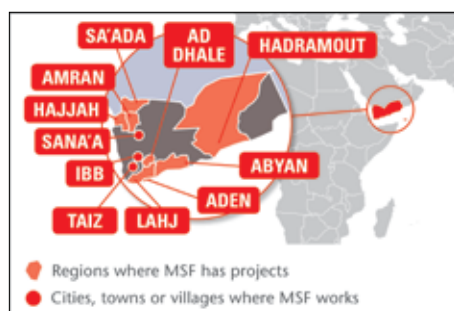
JABULANI SIMANGO* – 21 year old, from Epworth

"When I was eleven years old, I fell seriously ill and I was taken to hospital in a wheelbarrow. I was started on ARVs but I didn't understand why I was taking them. My parents died when I was young and my other family members didn't have much information about HIV and AIDS ... I was advised to join support groups for young people living with HIV. I then realised that I was not alone. There were many people my age who were HIV positive and from that moment onwards, I started to adhere to my treatment. MSF used to visit me at home to check if I was taking my medication consistently and in a proper way. After a while, my condition began to improve. When I showed signs of recovering, my family members began to accept me and my status. They began to realise that being HIV positive is not the end of one's life"

* Name has been changed

YEMEN

No. staff in 2015: 551 | Expenditure: €38.4 million | Year MSF first worked in the country: 1994 | msf.org/yemen
blogs.msf.org/yemen | [@msf_yemen](https://twitter.com/msf_yemen)



KEY MEDICAL FIGURES:

151,000 outpatient consultations

14,700 patients admitted to hospital

11,700 patients treated for intentional physical violence, including war wounds

10,400 surgical interventions

9,800 antenatal care consultations

Armed conflict escalated into a full-scale war in Yemen in 2015, exacerbating already massive medical and humanitarian needs and severely restricting access to healthcare.

The Houthis continued to advance in 2015, taking over the presidential palace in Sanaa in January. President Hadi fled to Aden, and a Saudi-led coalition supporting his government began airstrikes to recover lost territory, including the port of Aden. Meanwhile, the war allowed Al Qaida and Islamic State (IS) group fighters to reinforce their presence in the country. By year's end, the United Nations estimated that 2,800 people had been killed and some 2.5 million were internally displaced. The healthcare system has been decimated: medical staff have fled the country, facilities have been destroyed and medical supplies cut. To read more about the situation in Yemen, see *The Crisis in Yemen* on pages 14 and 15.

Médecins Sans Frontières (MSF) managed to maintain its operations in Aden when it was divided by a frontline. In other areas it also scaled up its activities as much as security allowed, despite an attack that destroyed the hospital it supports in Haydan, Sa'ada governorate, on 26 October and another



War-wounded patients receive emergency care at the MSF-operated hospital in Aden.

on its tented clinic in Al-Houban, Taiz governorate, on 2 December, which wounded nine. A fuel blockade hampered the delivery of aid, while fighting, shifting frontlines and airstrikes restricted the movement of people and humanitarian organisations.

Sa'ada

Sa'ada governorate was one of the worst-affected areas. From March, there were daily airstrikes targeting many civilian areas, including healthcare facilities, and access to medical care was almost impossible in some districts. In April, MSF started supporting Haydan hospital's emergency room and maternity services, but had to suspend activities following an airstrike in October. They could only resume in December, using an undamaged part of the building. In May, a team started working in Al Jomhuri hospital in Sa'ada city, providing emergency, inpatient and intensive care, and maternity and mental health services for a population of about 700,000 people. Over 6,110 patients were attended to in the emergency room, and over 2,900 surgeries were performed. In November, another team began to support the Shiara hospital in Razah district. In 2015, more than 100 births were assisted every week and over 1,000 emergency room consultations were performed. Staff also assisted in Majz and Nushur hospitals towards the end of the year.

Ad Dhale

Intense conflict broke out in Ad Dhale governorate in April but had subsided by August, when the frontline moved towards

Ibb. People were trapped in the conflict areas and there were many deaths resulting from war injuries. MSF expanded its support in Ministry of Health hospitals and basic healthcare clinics such as Al Salaam and Al-Azariq, providing outpatient and emergency consultations, surgery, inpatient care and reproductive healthcare. The teams carried out more than 60,000 outpatient and emergency consultations, performed over 700 surgical procedures and made around 1,000 referrals.

Aden

There was intense fighting in Aden between March and July. In Sheikh Othman district of Aden city, MSF continued to run the emergency trauma centre, comprising an emergency room, two operating theatres, an intensive care unit and an inpatient ward. Mental health and physiotherapy consultations were also provided. Bed capacity was increased from 45 to 74 to accommodate the surge in needs, including several mass casualty incidents involving over 100 wounded each time. Many of the patients were children wounded by landmines and unexploded ordnance. Overall, teams carried out 7,778 emergency consultations and 4,300 violence-related surgical interventions. During the peak of the conflict, emergency healthcare was available in three health clinics in districts where medical access was very limited.

Taiz

Taiz city, with an estimated population of around 600,000, was the scene of intense fighting as of July. Some residents were

trapped in an enclave under siege, and a blockade on medical supplies began in August, which has had a major impact on healthcare access. MSF donated medical supplies to hospitals on both sides of the frontline. On the Al-Houban side, MSF provided assistance to the military hospital, Yemeni International and Al-Risalah, and inside the enclave, MSF supported Al-Thawra and Al-Rawda hospitals. Altogether, MSF provided more than 15,400 emergency room consultations, 6,800 consultations for people with war wounds, 1,100 surgical interventions and 10,900 wound dressings. Relief items such as blankets, food and jerry cans were also distributed to displaced people in the city.

In November, MSF opened a mother and child hospital in the Al-Houban neighbourhood, providing emergency services and reproductive healthcare, and an outpatient department for children under the age of 10. Some 7,800 outpatient consultations and 7,500 emergency room consultations were completed.

Amran

MSF continued its project at Al-Salam hospital, providing emergency, maternity, inpatient and outpatient services and assisting in the laboratory and blood bank. As access to medical care in other healthcare facilities decreased, MSF scaled up its activities in Amran hospital, carrying out 3,000 surgical interventions and 28,200

emergency consultations. More than 5,500 patients were admitted to hospital and over 2,900 babies were delivered. MSF supported the health centre in Huth, completing 9,300 emergency consultations, and provided drug donations and training to three facilities in the north of the governorate. As displacement increased, MSF launched mobile clinics and helped with water and sanitation activities in Khamir and Huth.

Hajjah

In May, MSF opened a project supporting Beni Hassan health centre, and offering medical aid to 15,000 internally displaced people through mobile clinics. The team provided outpatient consultations, and distributed relief items and up to 240,000 litres of water per day. In July, the programme moved to Abs hospital, a more comprehensive facility in Abs district, to provide a greater range of services, including emergency and maternal healthcare and surgery. Since August, MSF has supported Al Jamoorhi hospital in Hajjah city by responding to emergencies, treating war injuries, performing surgery and assisting in the inpatient department. Over 4,550 patients were received in the emergency room.

Sana'a

MSF continued its HIV programme at Al Gumhuri hospital in Sana'a city, providing antiretroviral treatment to 770 people.

Hadramout

Two cyclones hit the southeast coast of Yemen in November. MSF set up a mobile clinic in Mukalla to assist families who had lost their homes, and made donations to the local hospital and blood bank. Around 300 consultations were undertaken. Blankets, jerry cans and washing kits were distributed to 200 displaced families. About 50 kilometres away on the west coast, in the district of Borom Mayfa, the team set up 14 water tanks to provide water for over 400 displaced families.

STAFF STORY

MSF nurse supervisor Husni Mansoor works in Aden

"Our biggest fear is that the fighting will surround the hospital. Many times, when the clashes intensify, we go down to the basement. But this creates a different problem. Before we save ourselves, we move the patients who are in beds near the windows to a safe place. This has happened many times. We hear the sound of gunshots and shelling or airstrikes and we move all the patients to safe areas before finding a safe place for ourselves. Windows at the hospital have been broken more than once and bullets have entered, but no one has been hurt inside the hospital."



A man clears debris revealing the Médecins Sans Frontières (MSF) logo on the roof of an MSF-supported hospital in Haydan, Yemen after it was completely destroyed by an airstrike.

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, Republic of Korea, India and Ireland. MSF International is based in Geneva.

The search for efficiency has led MSF to create 11 specialised organisations, called 'satellites', which take charge of specific activities such as humanitarian relief supplies, epidemiological and medical research, and research on humanitarian and social action. These satellites, considered as related parties to the national offices, include: MSF Supply, MSF Logistique, Epicentre, Fondation MSF, Etat d'Urgence Production, MSF Assistance, SCI MSF, SCI Sabin, Fondation MSF Belgique, 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.

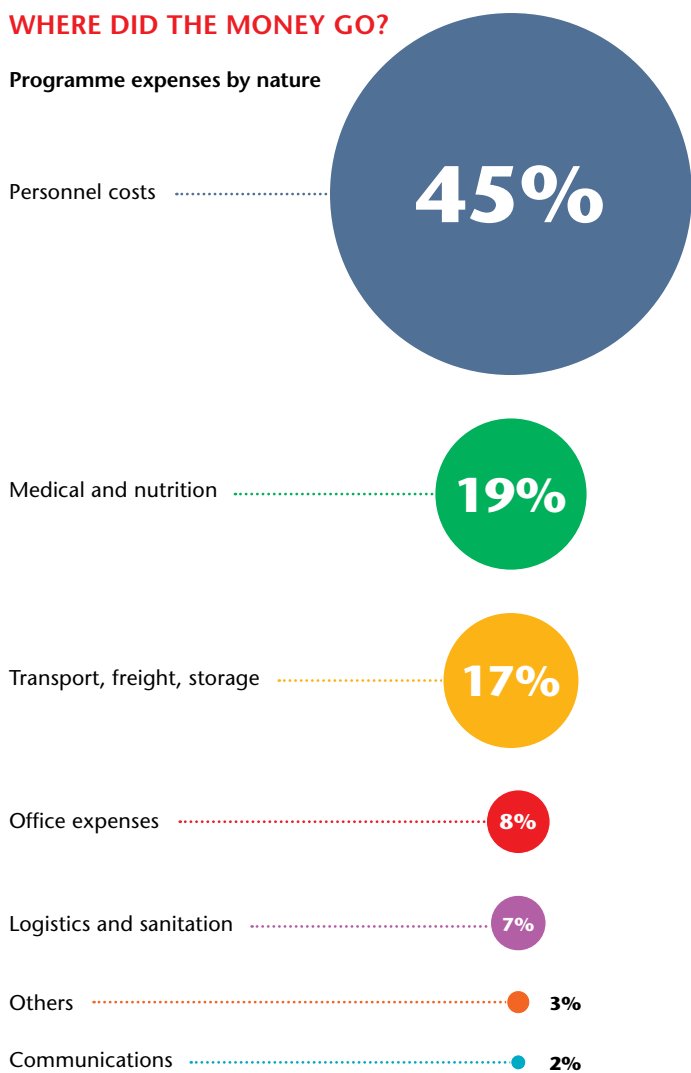
These figures describe MSF's finances on a combined international level. The 2015 combined international figures have been prepared in accordance with MSF international accounting standards, which comply with most of the requirements of the International Financial Reporting Standards (IFRS). The figures have been jointly audited by the accounting firms of KPMG and Ernst & Young, in accordance with International Auditing Standards. A copy of the full 2015 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 2015 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?

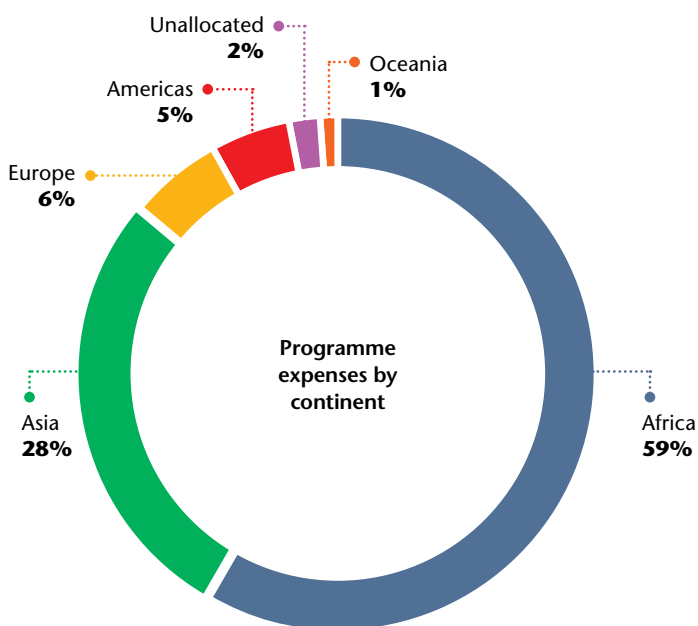
Programme expenses by nature



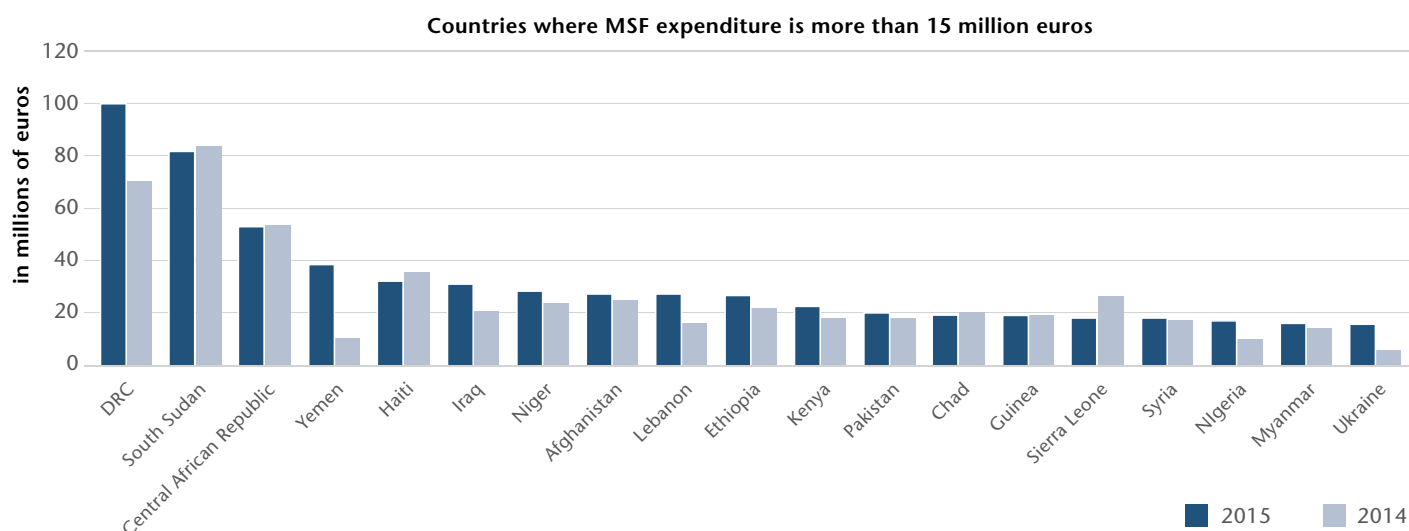
The biggest category of expenses is dedicated to personnel costs: about 45 per cent of expenditure comprises all costs related to locally hired and international staff (including plane tickets, insurance, accommodation, etc).

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.



COUNTRIES WHERE WE SPENT THE MOST



AFRICA

	<i>in millions of €</i>
Democratic Republic of Congo	100.3
South Sudan	81.7
Central African Republic	52.9
Niger	28.5
Ethiopia	26.6
Kenya	22.4
Chad	19.5
Guinea	19.2
Sierra Leone	18.2
Nigeria	17.2
Cameroon	12.2
Mali	11.5
Sudan	10.9
Liberia	10.5
Zimbabwe	10.4
Mozambique	10.0
Swaziland	9.4
Malawi	9.0
South Africa	8.6
Tanzania	6.1
Uganda	5.4
Mauritania	4.9
Libya	4.4
Burundi	3.9
Côte d'Ivoire	3.6
Guinea-Bissau	2.6
Egypt	2.5
Madagascar	1.8
Other countries*	1.8

Total Africa**515.9**

ASIA AND THE MIDDLE EAST

	<i>in millions of €</i>
Yemen	38.4
Iraq	31.0
Afghanistan	27.2
Lebanon	27.1
Pakistan	20.1
Syria	17.8
Myanmar/Burma	16.4
Jordan	12.9
India	11.7
Nepal	10.1
Uzbekistan	7.8
Palestine	5.5
Bangladesh	3.6
Armenia	2.3
Kyrgyzstan	2.2
Turkey	1.8
Cambodia	1.8
Tajikistan	1.8
Philippines	1.4
Georgia	1.3
Other countries*	2.5

Total Asia**244.6**

THE AMERICAS

	<i>in millions of €</i>
Haiti	32.1
Mexico	3.4
Colombia	2.5
Honduras	1.2
Other countries*	0.7

Total America**39.8**

EUROPE

	<i>in millions of €</i>
Migrant support East Europe	16.3
Ukraine	15.5
Italy	8.5
Russian Federation	5.4
Greece	1.4
Other countries*	1.7

Total Europe**48.9**

OCEANIA

	<i>in millions of €</i>
Papua New Guinea	5.3
Other countries*	0.1

Total Oceania**6.9**

UNALLOCATED

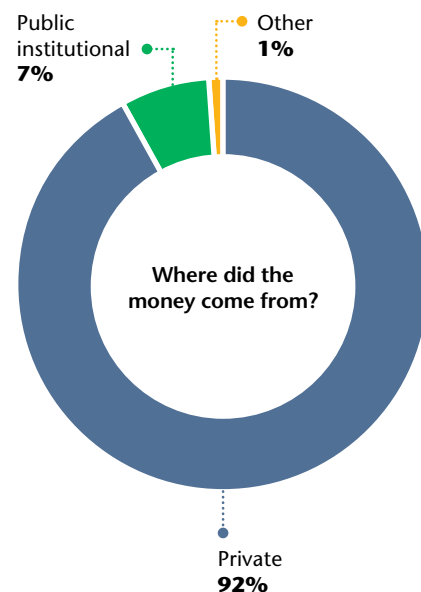
	<i>in millions of €</i>
Other	7.0
Transversal activities	5.0
Mediterranean Sea Operations	4.2

Total unallocated**16.2****Total programme expenses****872.2**

* 'Other countries' combines all the countries for which programme expenses were below one million euros.

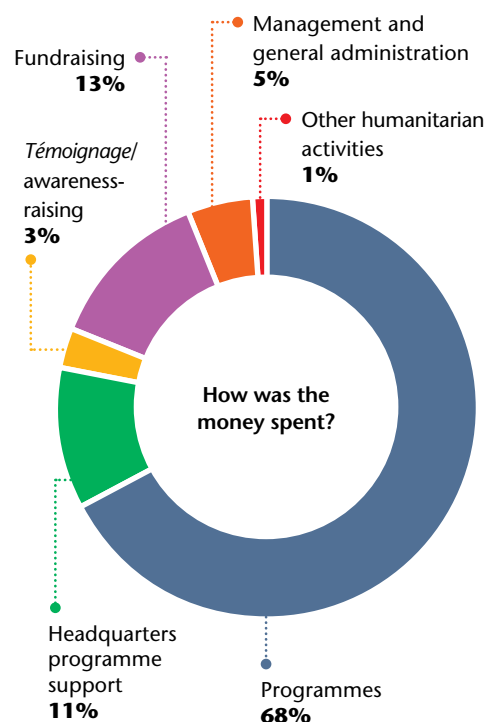
WHERE DID THE MONEY COME FROM?

	2015		2014	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Private	1,332.1	92%	1,142	89%
Public institutional	94.6	7%	115	9%
Other	17.1	1%	24	2%
Income	1,443.8	100%	1,280.3	100%



HOW WAS THE MONEY SPENT?

	2015		2014	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Programmes	872.2	68%	699.1	66%
Headquarters programme support	134.8	11%	113.9	11%
Témoignage/awareness-raising	37.2	3%	31.1	3%
Other humanitarian activities	13.3	1%	14.1	1%
Social mission	1,057.6	82%	858.1	80%
Fundraising	163.8	13%	147.2	14%
Management and general administration	61.3	5%	60.2	6%
Income tax	0	-	0.6	-
Other expenses	225.1	18%	207.9	20%
Expenditure	1,282.8	100%	1,066.1	100%
Net exchange gains/losses	5.7		9.7	
Surplus/deficit	166.8		223.9	



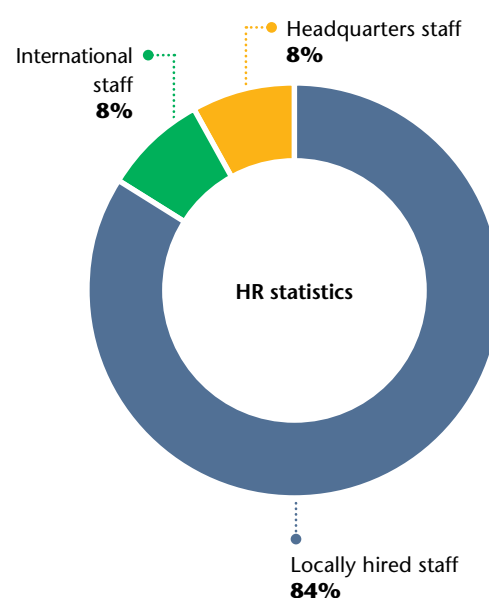
YEAR-END FINANCIAL POSITION

	2015		2014	
	<i>in millions of €</i>	<i>percentage</i>	<i>in millions of €</i>	<i>percentage</i>
Cash and cash equivalents	1,024.7	81%	857.8	82%
Other current assets	134.0	11%	106.2	10%
Non-current assets	98.9	8%	88.3	8%
Assets	1,257.7	100%	1,052.3	100%
Permanently restricted funds	3.3	0%	3.2	0%
Unrestricted funds	1,031.3	82%	851.6	81%
Other retained earnings and equities	56.2	4%	24.5	2%
Retained earnings and equities	1,090.7	87%	879.3	84%
Current liabilities	166.9	13%	173.0	16%
Liabilities and retained earnings	1,257.7	100%	1,052.3	100%

5.7
MILLION
private donors

HR STATISTICS

	2015		2014	
Medical pool	1,787	23%	1,836	26%
Nurses and other paramedical pool	2,469	32%	2,298	32%
Non-medical pool	3,515	45%	2,952	42%
International staff departures (full year)	7,771	100%	7,086	100%
	<i>no. staff</i>	<i>percentage</i>	<i>no. staff</i>	<i>percentage</i>
Locally hired staff	30,988	84%	31,052	85%
International staff	2,924	8%	2,769	8%
Field positions	33,912	92%	33,821	93%
Positions at headquarters	2,970	8%	2,661	7%
Staff	36,882	100%	36,482	100%



The majority of MSF staff (84 per cent) are hired locally in the countries of intervention. Headquarters staff represent 8 per cent of total staff. Departure figures represent the number of times international staff left on field missions. Staff figures represent total full-time equivalent positions.

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 2015, 92 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 Austria, Belgium, Canada, Czech Republic, Denmark, France, Germany, Holland, Ireland, Italy, Japan, Luxembourg, Spain, Sweden and the UK.

Expenditure is allocated in line with to 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 82 per cent of the total costs for 2015.

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 2015, the available portion (excluding permanently restricted funds and capital for foundations) represented 10.2 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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Special thanks to

Kate de Rivero, Marc Gastellu Etchegorry, Jérôme Oberreit.

We would also like to thank all the field, operations and communications staff who provided and reviewed material for this report.

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Designed and produced by

ACW, London, UK

www.acw.uk.com







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COVER PHOTO

A surgeon operates on a woman with a gunshot wound at MSF's hospital in Agok, South Sudan.

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